FOR YOUR BENEFIT

SUMMARY OF MATERIAL MODIFICATIONS EDITION

THE LOCAL 295/LOCAL 851 EMPLOYER GROUP BENEFIT FUNDS NEWSLETTER
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THIS SUMMARY OF MATERIAL MODIFICATIONS IS REQUIRED BY FEDERAL LAW In accordance with the requirements of the Employee Retirement Income Security Act of 1974, as amended, The Board of Trustees of the Local 295/Local 851 Employer Group Welfare Fund (the "Plan") is providing this Summary of Material Modifications ("SMM"), which describes changes in the plan of benefits adopted by the Board of Trustees effective as of February 1, 2007.

The most recent summary of the Plan is in a booklet revised in 2004 entitled "Local 295/Local 851 Employer Group Welfare Fund." This SMM updates the health benefit plan coverage referenced in that booklet.

The purpose of this SMM is to provide you with a general explanation of the most recent changes in the Plan in non-technical terms. It is important that you understand how the Plan works.

As of February 1, 2007 the following changes have been implemented in the health plan of benefits:

- The medical/surgical/diagnostics PPO has been changed over to the Blue Cross/Blue Shield PPO.
- The co-payment has been increased for services of a specialist.
- Some prescription drug co-payments have been increased.
- The out-of-pocket expense will be higher for brand-name drugs if a generic equivalent is available.
- Specialty drugs will be provided through a new program with Broadreach Medical Resources.
- A prescription drug step therapy program has started. This is the practice of utilizing the most cost-efficient method to treat a patient according to protocol that calls for using one drug therapy before proceeding to another drug therapy that is more expensive or difficult to use.
- The major medical annual deductible has been increased.
- Retiree health benefit coverage is no longer provided to the spouse of a retiree who remarries after retiree coverage has started.
- The Welfare Fund is the secondary payer of benefits for retirees and their spouses who have coverage available to them through their employment.
- The Medicare Part B premium reimbursement will be $93.50.
- The Medicare HMO coverage of all retirees and their eligible spouses will be terminated and supplemental coverage to Medicare will be provided directly by the Welfare Plan's self-funded benefit program.
- The Welfare Fund's definition of spouse has been revised.

Detailed information about all of these changes is provided in this special edition of For Your Benefit. We urge you to read this SMM very carefully.

We recommend that you keep this SMM with your Summary Plan Description (SPD). If you have lost or misplaced your copy of the SPD, please feel free to request another one from the Welfare Fund Office. If you still have questions after reading this SMM, please contact the Welfare Fund Office.

The Fund Office is located at Sixty Broad Street, 37th Floor, New York, New York 10004. The telephone number is (212) 308 4200. The hours are 8:30 A.M. to 5:30 P.M., Eastern Time, Monday through Friday, except for holidays. ■

MEDICAL/SURGICAL/DIAGNOSTIC PPO CHANGEOVER As of February 1, 2007 all medical/surgical/diagnostic services are provided through the Empire Blue Cross/Blue Shield PPO. The Horizon Healthcare, HMC and Beech Street PPO arrangements will be terminated as of January 31, 2007. The PPO changeover is applicable to all active plan participants and their dependents as well as the eligible retirees and spouses who are not covered by Medicare.

(Continued on page 2)

PPO Changeover

(Continued from page 1)

PPO is the abbreviated terminology we use for Preferred Provider Organization. We use the term network interchangeably.

PPOs are networks of medical care practitioners such as doctors, dentists and other health care professionals and facilities such as hospitals, laboratories and ambulatory surgical centers. Empire Blue Cross/Blue Shield has established a large network of participating hospitals, other health care facilities, home health care agencies, doctors and other health care professionals in 28 eastern counties of New York.

If you live or travel outside of the 28 county operating area, Empire Blue Cross/Blue Shield provides benefits through three programs known as Blue Card PPO, Blue Card Program and Blue Card Worldwide. Empire Blue Cross/Blue Shield is affiliated with all of the other Blue Cross and Blue Shield networks throughout the United States, its territories and many foreign countries.

The Blue Cross/Blue Shield network has hundreds of thousands of participating health care professionals and thousands of participating hospitals and other health care facilities. This much broader network means that patients will have more choices of network providers which will then result in fewer out-of-network claims which in turn will greatly reduce a patient's out of pocket expense. New directories will not be mailed out, but you can easily locate Blue Cross/Blue Shield participating providers by calling the toll-free telephone number, 1 800 810 2583 (1 800 810 BLUE) or by signing on to the internet (www.empireblue.com).

You don't have to fill out a claim form if you are treated by a participating provider any where in the U.S. Be sure to tell your doctor, hospital or other health care professional that you are now covered through the Blue Cross/Blue Shield program so that your claims are filed in the right place. Simply show your identification card and your claim will be filed directly with Blue Cross/Blue Shield. All providers may now file your claims electronically. If your provider is not equipped for electronic filing, claims can be mailed to the Blue Cross office.

If you receive health care outside of the U.S. you could be required to pay the bill and then file a claim with Empire Blue Cross/Blue Shield.

Now plan participants need only one identification card to use at the doctor's office, hospital, pharmacy or other health care provider. New identification cards were mailed out in late January, 2007.

The new card has Empire Blue Cross/Blue Shield information and all of the pharmacy program information that participants need to get a prescription drug at any of the more than 56,000 Broadreach participating drug stores.

More details about covered services and information about pre-certification, maternity care, hospice care, home health care, physical, occupational, speech and vision therapy and organ transplants can be found in your summary plan description. ■

SPECIALIST CO-PAYMENT HAS BEEN INCREASED Any time that you, your spouse, or an eligible dependent receives the care of a network doctor, your out-of-pocket expense will be a small co-payment.

As of February 1, 2007, the patient co-payment has been increased from $20 to $35 for the services of a specialist.

The co-payment for the services of a primary care physician is not being increased at this time. That co-payment is still just $20. The $20 co-payment applies to the services of your family physician or gynecologist, a pediatrician or an internist.

Any time you, your Spouse, or an eligible Dependent uses a Blue Cross/Blue Shield doctor, your cost will be only $20 or $35. If that doctor decides that it is necessary to send you to another in-network physician or specialist, your cost will be an additional $20 or $35. No co-payment is required for any diagnostic laboratory services. A $20 co-payment is required for network provider X-rays, sonograms, MRIs and CAT scans.

Co-payments represent a fraction of the cost to provide quality medical care. The co-payments have been level for many years while medical costs have escalated at the rate of 8 to 10% a year.

The co-payment increase applies to all active plan participants and their dependents as well as the eligible retirees and spouses who are not covered by Medicare. ■

SOME OF THE CO-PAYMENTS FOR PRESCRIPTION DRUGS HAVE BEEN INCREASED As of February 1, 2007, some prescription drug co-payments have been increased. The co-payment for generic drugs continues to be just $10 and the co-payment for retail purchases of most brand-name prescription drugs is increased from $20 to $25. The Co-payment for retail purchases of certain third tier prescription drugs or non-preferred formulary drugs has been increased from $25 to $40. A listing of the second-tier/preferred formulary drugs can be found in the information you received with your new identification card.

Two of the mail order prescription co-payments have also been increased. The mail order co-payment for a 90 day supply of drugs remains at $10 for generic drugs. The mail order co-payment has been increased from $10 to $25 for most brand-name drugs and $40 for third-tier drugs.

The co-payment increases apply to all active and retired plan participants and their dependents.

Under the terms of the Welfare Fund's arrangement with its pharmacy benefit manager, you can refill the same prescription at your local pharmacy only two times. If you need to refill a prescription for the same medication for longer periods of time, it may be ordered through the mail order program. The mail order service is available for those who require long-term prescriptions for a chronic ailment.

In any case where your prescription drug card or mail order form is not accepted (or if you do not have a prescription drug card), you must use a direct reimbursement form to file a claim. Forms for mail order service and for direct reimbursement for a prescription are available at the Welfare Fund office.

Certain limitations and exclusions apply. Please refer to your summary plan description for more information. ■

MANDATORY DAW IN EFFECT AS OF FEBRUARY 1, 2007 **DAW** is a shorthand reference to the term Dispense as Written. When a doctor specifies DAW on a prescription form, it means that the pharmacy should fill the prescription exactly as directed by the doctor and should not substitute a generic drug for the brand-name drug specified on the prescription form.

Many generic drugs are available now as inexpensive substitutes for the much higher priced brand-name drugs. Generic drugs are priced at the pharmacy at a fraction of the cost of brand-name drugs.

Companies that market generic drugs have to submit data to the Food and Drug Administration to prove that the drugs are equivalent to the original brand-name drug. Some patients, however, feel that generic drugs are not as effective as the brand-name drugs or they simply don't want to make a change.

The Welfare Fund has always encouraged the use of generic drugs. This results in lower cost for both the patient and the Welfare Fund.

The Welfare Fund's prescription drug program is continuing to cover brand-name drugs, but if a generic equivalent is available, the patient will have to pay more to get the brand-name item.

If you have a DAW brand-name prescription filled on or after February 1, 2007, and if a generic equivalent is available, your co-payment will be $10 and you will have to pay the difference in cost between the generic and the brand-name drug. If, for example, the price of a brand-name drug is $85 and the generic equivalent is priced at $25, your out-of-pocket expense will be $70 ($10 for the co-payment and $60 for the price difference). If you get the generic drug instead of the brand-name drug, your cost will be just $10.

When your doctor writes a prescription for you, ask if there is a generic equivalent available instead of paying a much higher amount for a brand-name drug. ■

SPECIALTY DRUG COVERAGE NOW PROVIDED THROUGH BMR As of February 1, 2007 specialty drugs must be obtained through a specialty pharmacy program of Broadreach Medical Resources, Inc. (BMR). Specialty drugs are high-cost medications for people with complex and chronic conditions such as rheumatoid arthritis, hemophilia, cancer and multiple sclerosis. The annual cost of specialty drug therapy can range from several thousand to several hundred thousand dollars.

(Continued on page 4)

Specialty Drug Coverage

(Continued from page 3)

Before this change in the program, patients needing specialty drugs had to find a supplier, buy the drugs and then file a major medical claim with the Welfare Fund. The covered expense was subject to the major medical deductible and the rate of payment was 75% after the deductible was satisfied.

As of February 1, 2007, the only patient out-of-pocket expense is a $50 co-payment for a three-month supply of the specialty drug.

Contact BMR for more information and to order specialty drugs. The telephone number is 1 866 718 2375.

You can sign also sign on to the BMR website (www.BMR-INC.com) for prescription drug plan information. The website provides an overview of the services and tools available to the participants and dependents.

Not all specialty drugs are covered by the plan of benefits. There are limitations and exclusions. All persons needing specialty drugs should check the Summary Plan Description or contact BMR.

All covered specialty drugs must be obtained through the BMR program. Specialty drugs obtained from other sources or suppliers cannot be covered by the Plan. ■

DRUG STEP THERAPY PROGRAM IS IN PLACE AS OF FEBRUARY 1, 2007 A step therapy program has been implemented in the Welfare Fund's prescription drug program as of February 1, 2007.

Step therapy is the practice of utilizing the most cost-efficient method to treat a patient according to protocol that calls for using one drug therapy before proceeding to another drug therapy that is more expensive or difficult to use.

The objective of the program is to ensure that patients are receiving appropriate, yet cost-effective drug therapy.

Three types of drugs come within the step therapy program. They are:

- Cox-1 Sparing NSAIDs (prescribed for the treatment of arthritis),
- Proton Pump Inhibitor-PPI (prescribed for the treatment of gastrointestinal disorders and ulcers), and
- Non-sedating Antihistamines.

Each of these types of drugs is set into two or three categories. The categories are A and B and C. Category A includes the least expensive drugs and categories B and C include the higher cost drugs. The step therapy program requires that patients first try a category A drug before a category B drug will be provided. For example, Prilosec OTC 20mg is a category A Proton Pump Inhibitor and Nexium is a more expensive category B Proton Pump Inhibitor. Patients should first use Prilosec OTC 20mg and if there is no relief a category B drug can be covered.

When patients use drugs that come within these high profile drug categories, it is necessary that the physician, pharmacist and Broadreach work together to be sure that the drug is covered by the prescription drug program.

Patients who are already using step therapy drugs will not have to undergo step therapy. Only patients who need a high profile drug for the first time must undergo the step therapy.

If you have any questions about the drug step therapy program, please visit the Broadreach Medical Resources, Inc. website at www.BMR-INC.com or you can call the Broadreach customer service at 1 866 718 2375. ■

MAJOR MEDICAL DEDUCTIBLE IS INCREASED If you choose to use the services of an out-of-network provider, a portion of your medical expenses may be reimbursed through the major medical benefit.

After meeting a deductible each year, the major medical coverage pays 75% of the permissible plan charges for the first $10,000 of covered expenses during the year. Major medical then pays 100% of the permissible plan charges for the remainder of the calendar year.

Until January 31, 2007, the annual deductible was $300 for each covered person and the family maximum was $900. As of February 1, 2007 the annual deductible has been increased to $400 for each person and the family maximum is $1,200.

Major medical benefits are paid up to a maximum of $250,000 per injury or illness.

(Continued on page 5)

Major Medical Deductible

(Continued from page 4)

Refer to your Summary Plan Description for the exclusions and limitations. ■

RETIREE DEPENDENT COVERAGE IS LIMITED If you are already married to your spouse at the time you cease covered employment your spouse will continue to be eligible for dependent benefits on the date that you begin coverage as a retired participant.

Spouses acquired after the effective date of retiree coverage cannot become covered by the Welfare Fund's plan of benefits. ■

RETIREE HEALTH PLAN WILL BE COORDINATED When a person is entitled to receive benefits under this Plan is also eligible for similar benefits under another group health insurance or self-insured plan, the two plans will coordinate benefit payments so that the combined payment from both plans will not exceed the actual expenses incurred by the person receiving treatment.

One plan (the "Primary Plan") will pay the full benefits available under the terms of the plan for the treatment provided. The other plan (the "Secondary Plan") will pay any expenses that remain beyond the primary plan benefits, up to the maximum amount that the secondary plan would pay if there was no coordination of benefits.

The coordination of benefits provisions are applicable to all retirees and their dependents. This health plan is the secondary plan in all cases where a retiree or covered dependent has other health plan coverage in force or available through their employment, even if the retiree or dependent is required to pay part or all of the cost. ■

MEDICARE PART B PREMIUM REIMBURSEMENT FROZEN AT 2007 RATE If you are covered by the Welfare Plan and you have Medicare coverage in force, you can apply for a reimbursement of the Medicare Part B premium.

All retired covered plan participants and dependents are entitled to the reimbursement. In the past, the reimbursement kept pace with the annual Medicare increases and the Welfare Plan reimbursed the full Part B cost including penalties.

As of 2007 the Medicare premium reimbursement is $93.50 per month.

The reimbursement is not automatic. Your claim must submitted to the Fund Office in writing and you have to provide proof that the premium is being deducted from your Social Security benefit. Contact the Fund Office for complete claim filing information. ■

MEDICARE HMO COVERAGE WILL BE TERMINATED As of 2007 all Medicare supplemental coverage will be provided directly by the Welfare Fund for all of the eligible retired participants and their eligible dependents. This self-funded plan of benefits replaces the Medicare Risk HMOs or Medicare+Choice plans that have been in effect.

The benefit program will supplement the coverage of Medicare for hospital, medical and surgical claims. The supplemental plan will provide coverage for some of the deductibles and co-insurance amounts required under the traditional Medicare program.

The supplemental coverage is subject to a deductible and certain limitations and exclusions apply. Please contact the Welfare Fund Office for more information.

All eligible retirees and dependents will also be covered by the Welfare Fund's prescription drug plan, the eye care and dental plans. ■

SPOUSE DEFINITION HAS BEEN MODIFIED As of February 1, 2007, the definition of dependent spouse has been changed from:

> An eligible spouse is an active employee's or retired member's spouse, if not legally divorced from the active employee or retired member.

to the following:

> An eligible spouse is a person who is the opposite sex of the employee or retired employee and who is lawfully married to the employee or retired employee as husband or wife.

Definitions of other eligible dependents may be found in your Summary Plan Description. ■

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