SUMMARY OF MATERIAL MODIFICATIONS TO
THE HEALTH AND BENEFIT TRUST FUND OF THE INTERNATIONAL UNION OF OPERATING ENGINEERS
LOCAL UNION NO. 94-94A-94B, AFL-CIO
(COMMERCIAL DIVISION)

To: **All Participants and Beneficiaries in the Health and Benefit Trust Fund of the International Union of Operating Engineers Local Union No. 94-94A-94B, AFL-CIO**

From: **The Plan Administrator of the Health and Benefit Trust Fund of the International Union Operating Engineers Local Union No. 94-94A-94B, AFL-CIO**

Re: **Prescription Benefit – Dispensed as Written Penalty**

Date: **September 7, 2013**

This document is a Summary of Material Modifications ("SMM") intended to notify you of important changes to the prescription benefits available under the Health and Benefit Trust Fund of the International Union of Operating Engineers Local Union No. 94-94A-94B, AFL-CIO ("the Plan"). This summary is intended to satisfy the requirements for issuance of a SMM under the Employee Retirement Income Security Act of 1974, as amended. You should take the time to read this SMM carefully and keep it with the Summary Plan Description ("SPD") that was previously provided to you. If you need another copy of the SPD or if you have any questions regarding this change to the Plan, please contact the Plan Administrator during normal business hours at: 331-337 West 44th Street, New York, New York, 10036, telephone number: (212) 541-9880.

In an effort to keep the Plan's overall prescription drug costs down and preserve the general plan of benefits available under it, the Board of Trustees of the Plan recently approved the implementation of an additional Dispensed as Written ("DAW") Penalty regarding the reimbursement of covered prescriptions paid by eligible participants (those who satisfy the eligibility requirements under the SPD for such benefit).

Effective October 1, 2013, if either you or your doctor request a brand-name medicine when a generic equivalent is available, you will pay the applicable co-payment* for the brand name medicine, plus the difference in the Plan's cost between the brand-name medicine that was dispensed to you and the generic medicine that was available and could have been dispensed to you. This cost difference (which can range into the hundreds or thousands of dollars) is considered a penalty for not taking the otherwise "generic" medicine. Effective October 1, 2013, there will be two (2) different DAW penalties under the Plan – DAW-1 and DAW-2. Please note that the amount of the DAW-1 and DAW-2 penalties is identical to each other.

The first penalty (known as the DAW-1 Penalty) is new and is applied when a generic medicine is available but the pharmacy dispenses the brand name version pursuant to your physician's request. For example, your physician says you must take Coumadin (an anticoagulant (blood-thinner) medication) to treat heart disease, but there is a generic called Warfarin available for such condition. Effective October 1, 2013, under these circumstances, the participant will pay the applicable co-payment* for the brand name medicine, plus the difference between the Plan's cost of such brand name medicine and the generic medicine that was otherwise available to you.

The second penalty (known as the DAW-2 Penalty) is currently in effect and is applied when a generic medicine is available but the pharmacy dispenses the brand name version pursuant to your (or your dependent's) request. Effective October 1, 2013, under these circumstances, you will pay the applicable co-payment* for the brand name medicine, plus the difference between the Plan's cost of such brand name medicine and the generic medicine that was otherwise available to you.

When using most pharmacies, including CVS Caremark Mail Service Pharmacy, a generic medicine, if available, will be substituted for a brand-name medicine unless your doctor indicates "Dispense as Written" on the prescription, or you request that only the brand-name medicine be provided.

Notwithstanding the foregoing, the DAW-1 or DAW-2 penalties will not apply if you receive approval from CVS that the brand name prescription medicine is required to be taken due to medical necessity. If it is determined that you are medically required to take a brand-name prescription drug, you will only have to pay the applicable co-payment* per prescription. You can request approval by contacting CVS at the following number 1-888-769-9054. Your physician must submit your medical records to CVS to review the request and for approval. If it is not approved, you will have to pay the additional DAW penalty per prescription in order to receive the brand name medicine, or file an appeal with the Plan. If you decide to appeal and it is denied, you will have to pay the additional DAW penalty per prescription in order to receive the brand name medicine.

To learn more about your specific cost-savings, visit Caremark.com and click "Find Savings and Opportunities". You may also call CVS toll-free using the number on your prescription card or call the Fund Office at 212-331-1800.

This SMM is intended to provide you with an easy-to-understand description of certain changes to the Plan. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan. If any conflict should arise between this SMM and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases.

The Board of Trustees or its duly authorized designee, reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan and the Agreement and Declaration of Trust establishing the Plan (the "Trust Agreement"). The Trust Agreement is available at the Fund Office and may be inspected by you free of charge during normal business hours.

No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and decide all matters arising under the Plan.

IMPORTANT GOVERNMENT NOTICE REGARDING THE PLAN'S GRANDFATHERED PLAN STATUS

The Board of Trustees believes that the Plan is a "grandfathered plan" as such term is defined under the Patient Protection and Affordable Care Act of 2010 (more commonly known as Health Care Reform). As permitted by Health Care Reform, a grandfathered health plan can preserve certain basic health coverage that was already in effect when Health Care Reform was enacted. Being a grandfathered health plan means that the medical coverage that you have elected under the plan may not include certain consumer protections of Health Care Reform that apply to other group health plans, for example, the requirement for the provision of preventive health services without any cost sharing (*i.e.*, co-payments*, coinsurance, deductibles). However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits and extension of coverage to dependents until age 26. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator during normal business hours at: 331-337 West 44th Street, New York, New York, 10036, telephone number: (212) 541-9880. You may also contact the Department of Labor at (866) 444–3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered plans.

*Co-payment, copay or coinsurance means the amount a plan member is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan. **If you have taken a generic in these drug classes previously, you may not be affected by this change. [1] IMS Health, 2009. ^Your savings will vary based on your plan and/or drug prescribed. Source: Generic