SUMMARY OF MATERIAL MODIFICATIONS

STONE AND MARBLE MASONS OF METROPOLITAN WASHINGTON, D.C.
HEALTH & WELFARE FUND
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June 1, 2013

SUMMARY OF MATERIAL MODIFICATION #2

Dear Participant:

This Summary of Material Modifications is being provided to advise you as to certain new developments relating to the Stone and Marble Masons of Metropolitan Washington, D.C. Health and Welfare Fund (the Plan), which are applicable to the Plan and its Schedule of Benefits, effective January 1, 2013, except as otherwise noted. This Summary of Material Modifications describes changes to the terms of the Plan adopted by the Board of Trustees.

I. The Eligibility Rules of the Plan set forth on page 5 of the Summary Plan Description are amended to state as follows:

ELIGIBILITY RULES

INITIAL ELIGIBILITY

If you are an Employee within the jurisdiction of the Stone and Marble Masons of Metropolitan Washington, D.C. Health and Welfare Fund and employed by a participating Employer who has signed a Collective Bargaining Agreement with the Union, you will become eligible for benefits under one of two Schedules of Benefits on the first day of the month following any period within the preceding twelve months in which you have been credited with at least 950 hours of employment for which contributions have been paid by one or more contributing Employers. If you are a Stone Mason, upon reaching 950 hours of employment for which contributions have been paid for work as a Stone Mason by one or more contributing Employers, you will be eligible for the Benefits for Stone Masons. If you are a Rubble Man or Caulker, upon reaching 950 hours of employment for which contributions have been paid by one or more contributing Employers, you will be eligible for the Benefits for Rubble Men and Caulkers.

Effective October 1, 2012, for purposes of determining a participant's initial eligibility under the Plan consisting of 950 hours worked during the previous twelve (12) months, an employee will be credited with the total number of hours for which employer contributions shall have been made to the Plan regardless of whether such employee has actually worked the number of hours for which contributions shall have been paid under

the collective bargaining agreement. In the event an employee shall be credited with 950 hours as a result of any contributions made to the Plan by his employer for hours that were not actually worked, the employee shall be eligible the first of the month following the month in which the contributions are paid. Hours to be credited under this eligibility provision may only be credited with respect to an employee who has a legitimate employment relationship with a contributing employer and who is employed pursuant to a collective bargaining agreement requiring contributions to this Plan and who has had one or more hourly employer contributions made for hours actually worked under such a collective bargaining agreement. In the event an employee shall have attained initial eligibility based in part upon employer contributions for hours not actually worked, once the employee has ceased performing employment pursuant to the collective bargaining agreement with the contributing employer, hours credited, but not worked, shall be disregarded for purposes of determining continuing eligibility. These expedited eligibility provisions permitting credit based upon receipt of employer contributions for hours not worked will cease to be applicable effective December 31, 2013 unless extended by a majority vote of the Trustees.

Each qualified dependent will become eligible on the date you become eligible or the date he or she becomes a dependent, whichever is later. Eligible adult children that enroll (or re-enroll) after January 31, 2011 will receive coverage that begins on the first of the month following the date the Plan receives the completed application.

II. Modification of the "Dispense as Written" Program. Effective January 1, 2013, the Fund will only pay the cost of a generic medication if the generic medication is the chemical equivalent of a brand name drug. The paragraph on page 54-55 of your Summary Plan Description is revised to state as follows:

Generic Drugs/ Dispense As Written Savings Program

The Plan provides for certain prescription benefits for participants and dependents through its pharmacy benefit manager, Caremark. Many brand name prescription drugs have a generic equivalent that has the same chemical components as the brand name drug and are just as effective. Generic drugs are, however, less expensive alternatives to brand name drugs. If a participant or dependent presents a prescription from the participant's or dependent's physician which has a generic equivalent, the participating pharmacy will substitute the generic equivalent for the brand name drug, unless the physician specifically requires that the brand name be dispensed instead of the generic drug, but the Plan will only pay the amount it would have paid for the generic equivalent. This is a program provided by Caremark known as "dispense as written savings program". Even if your physician specifically requires that the brand name drug be dispensed, the Plan will only pay for the generic price, and you are responsible for the remainder. Substitution of the generic drug will provide both the Plan and the participant a savings on the cost of the medication.

III. Generic Incentive Co-Pay for all Drugs. Effective January 1, 2013, if you are taking a brand name medication and switch to a generic equivalent, the

Plan will pay your co-pay for the first prescription fill of the generic medication. This Plan feature is no longer limited to Ulcer medication. The paragraph on page 55 of your Summary Plan Description is replaced with the following:

Generic Incentive Co-Pay Program
The Plan has also implemented Caremark's Generic Incentive Co-Pay. Under this program, when you substitute a brand name drug with a generic drug, you are eligible to receive an initial one-time prescription fill of the generic substitute with a $0.00 co-pay. Substitution of the generic drug will provide both you and the Plan a savings on the cost of the medication.

IV. Mandatory Step Therapy Program. A new Plan provision is adopted effective January 1, 2013 called the Mandatory Generic Step Therapy Program. If you are prescribed a brand name medication, but there is an alternative generic medication available to treat your condition, (not a chemical equivalent) you will be required to use the generic medication first, before the Plan will pay for the brand name medication:

Mandatory Generic Step Therapy Program.
If you are prescribed a brand name medication, but there is a generic medication of the same class that is available to treat your medical condition, the Plan will only pay for the generic medication, unless you try the generic medication and your physician certifies that the generic medication is not effective to treat your medical condition and provides a prescription that requires filling with the brand name medication. The Plan will pay for the generic medication first, to see if it works, and if your physician certifies that it does not, the Plan will pay the appropriate amount, subject to your co-pay, for the brand name medication. Usually available generic medications that are not the chemical equivalent to the brand name medication will be effective to treat your condition. Use of these generic medications will provide both you and the Plan savings on the medication.

V. Retiree and COBRA rates.

Effective January 1, 2013, the monthly Stone Mason Health premium for single coverage will be $528.93, and the rate for family coverage will be $1,163.64. The rate for a retiree between the ages of 58 and 61 who has 30 years of eligibility under the plan while an active employee with no dependents will be $374, and $498 those same retirees with dependents.

The monthly Retiree Premium rates for 2013 will therefore be as follows:

COBRA Rates:

Single	$528.93/month
Family	$1,163.64/month

Retiree Rates:

Age 58-61, 30+ Years of Service, no Dependents	$374.00/month

Age 58-61, 30+ Years of Service, with Dependents	$498.00/month
Age 62-64, no Dependents	$374.00/month
Age 62 -64 with Dependents	$498.00/month
Age 65+ (or Medicare-eligible disabled retiree), no Dependents	$125.00/month
Age 65+ (or Medicare-eligible disabled retiree), with Deps 65+	$187.00/month
Age 65+ (or Medicare-eligible disabled retiree), with Deps <65	$374.00/month

Surviving Spouse Rates:

Not Medicare Eligible	$374.00/month
Medicare Eligible	$125.00/month

Rates for Disabled Retiree Rates, prior to Medicare Eligibility (same as COBRA):

Single	$528.93/month
Family	$1,163.64/month

Because these new rates are effective January 1, 2013, they will apply to monthly contributions due on and after that date.

VI. Retiree and COBRA Rates for Caulker Plan

Effective January 1, 2013, the monthly Caulker Health premium for single coverage will be $400.00, and the rate for family coverage will be $879.00. The rate for a Caulker retiree between the ages of 58 and 61 who has 30 years of eligibility under the plan while an active employee with no dependents will be $283, and $376 those same retirees with dependents.

COBRA Rates:

Single	$400.00/month
Family	$879.00/month

Retiree Rates:

Age 58-61, 30+ Years of Service, no Dependents	$283.00/month
Age 58-61, 30+ Years of Service, with Dependents	$376.00/month
Age 62-64, no Dependents	$283.00/month
Age 62 -64 with Dependents	$376.00/month
Age 65+ (or Medicare-eligible disabled retiree), no Dependents	$94.00/month
Age 65+ (or Medicare-eligible disabled retiree), with Deps 65+	$141.00/month
Age 65+ (or Medicare-eligible disabled retiree), with Deps <65	$283.00/month

Surviving Spouse Rates:

Not Medicare Eligible	$283.00/month
Medicare Eligible	$94.00/month

Rates for Disabled Retiree Rates, prior to Medicare Eligibility (same as COBRA):

Single	$400.00/month
Family	$879.00/month

Because these new rates are effective January 1, 2013, they will apply to monthly payments due on and after that date.

VII. Prescription Drugs Requiring Precertification

Effective January 1, 2013, certain prescription drugs will cease being covered by the Plan unless prior authorization is obtained from CVS/Caremark for use of these medications. These specific medications are listed below. Each of these medications has a therapeutic equivalent prescription drug that is covered under the Plan.

You may have received written notification or a telephone call advising you that these prescription drugs will no longer be covered, if you have an existing prescription for these medications. You and your physician should discuss whether to use the alternate medication instead of the prescription drug on this list. If your physician believes that you should use one of the excluded drugs rather than the therapeutic equivalent, your physician will be asked to provide CVS/Caremark with certain information, so that CVS/Caremark may determine whether to provide you with prior authorization for use of this drug.

If CVS/Caremark provides prior authorization, then the drug will be covered under the normal rules of the Plan. If CVS/Caremark does not provide prior authorization, your prescription for the excluded drug will not be covered under the Plan rules at all. If you agree to use the alternate medication, rather than the excluded drug, the alternate medication will be covered under the normal rules of the Plan.

The reason this prior authorization procedure is being implemented, and the reason the list of excluded drugs has been adopted is that these medications are extremely expensive and alternate medications have proven to be as effective in most cases. The following drugs are excluded from coverage under the Plan, effective January 1, 2013, without prior authorization:

LIST OF EXCLUDED DRUGS:

ADVICOR	HUMALOG MIX 50/50	ONGLYZA
ALTOPREV	HUMALOG MIX 75/25	OXYTROL
ANDROGEL	HUMULIN 70/30	QNASL
ARTHROTEC	HUMULIN N	RHINOCORT AQUA
ATACAND	HUMULIN R	RIOMET
ATACAND HCT	INTERMEZZO	ROZEREM
BECONASE AQ	JALYN	RYZOLT
DETROL LA	KOMBIGLYZE XR	SAIZEN

EDARBI	LEVITRA	SANCTURA XR
EDARBYCLOR	LIVALO	TESTIM
FLECTOR	LUMIGAN	TEVETEN
FORTAMET	MAXAIR	TEVETEN HCT
FREESTYLE STRIPS AND KITS	NUTROPIN/NUTROPIN AQ	TEV-TROPIN
GENOTROPIN	OLEPTRO	TOVIAZ
GLUMETZA	OLUX-E	VERAMYST
HECORIA	OMNARIS	XOPENEX HFA
HUMALOG	OMNITROPE	

This is the second Summary of Material Modification issued to the Summary Plan Description (Fund Booklet) effective February 2012 as recorded on the outside front cover. Please place this with your Summary Plan Description (Fund Booklet) for handy reference and safekeeping. If you need a Summary Plan Description (Fund Booklet), please contact the Fund Office at (410) 872-9500.

June 1, 2013

Board of Trustees
Stone and Marble Masons of Metropolitan Washington, D.C. Health and Welfare Fund