THE
WASHINGTON
WHOLESALERS
HEALTH and WELFARE FUND

Washington, D.C.

CLASS C-A
EMPLOYEES

Summary Plan
Description

AUGUST 2012

JOINT BOARD OF TRUSTEES

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August, 2012

To All Covered Employees:

This booklet describes the comprehensive benefits provided to Participants and their Eligible Dependents under the Washington Wholesalers Health and Welfare Fund ("Fund").

The Fund provides a wide range of benefits, as outlined in this booklet, financed by the monthly contributions made by Employers in compliance with collective bargaining agreements with the United Food and Commercial Workers of North America ("UFCW") Local 400. In recent years, the cost of health care has continued to rise. As a result, it is important that all of us take an active part in controlling health care costs. If we work together to spend our benefit dollars wisely, the Fund will continue to prosper and provide important protection for many years to come.

This booklet includes a detailed summary of the Fund's plan of benefits ("Plan"). This booklet serves as the Fund's Plan Document and the Summary Plan Description ("SPD") for purposes of the Employee Retirement Income Security Act of 1974 ("ERISA"). The terms contained herein constitute the terms of the Plan. However, it does not include the Agreement and Declaration of Trust or the Trustees' recorded rulings, regulations and interpretations of Plan provisions. These documents also govern the operation and administration of the Plan and the Plan must be interpreted in accordance with these documents as well, which are available for your inspection at the Fund Office.

We urge you to read this booklet carefully so that you will be familiar with the benefits to which you are entitled and the Plan's eligibility requirements. We hope that you will share our pride in your Plan and the measure of security it provides to those who work in the industry.

Sincerely,

BOARD OF TRUSTEES

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DEFINITION OF TERMS

Accredited Ambulatory Care Center

"Accredited Ambulatory Care Center" means a lawfully operated clinic that maintains and operates facilities similar to a hospital emergency room, or a lawfully operated facility equipped to perform surgeries on a same-day basis, provided such clinic or facility fully meets all of the following tests:

A. It is established, equipped and operated in accordance with the laws of the jurisdiction in which it is located, primarily for the purpose of performing surgical procedures;

B. It is operated under the supervision of a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is devoting full time to such supervision;

C. Its rules permit a surgical procedure to be performed only by a Physician who, at the time the procedure is performed, is privileged to perform such procedure in at least one Hospital in the area;

D. Its rules require in all cases, other than those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetics and remain present throughout the surgical procedure;

E. It has at least two operating rooms and at least one post-anesthesia recovery room; is equipped to perform diagnostic x-ray and laboratory examinations; and has available to handle foreseeable emergencies, trained personnel and necessary equipment, including, but not limited to, a defibrillator, a tracheotomy set, and a blood bank or blood supply;

F. It employs the full-time services of one or more registered nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room;

G. It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications or require post-operative confinement; and

H. It maintains an adequate medical record of each patient, such record to contain admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays and operative report and a discharge summary.

Administrative Manager or Fund Office

"Administrative Manager" or "Fund Office" means the company responsible for administering the day-to-day operations of the Fund, such as receiving Employer contributions, maintaining eligibility records, paying claims and providing information to Covered Persons about the Fund.

The Administrative Manager is Carday Associates, Inc., 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046 (410) 872-9500 or (800) 845-8518.

COBRA

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985. It provides for the continuation of benefits under certain circumstances for Covered Persons.

Co-Payment

"Co-Payment" means a fixed dollar amount that you are required to pay directly to the provider for services or supplies provided under this Plan.

Covered Employment

"Covered Employment" means employment for which your Employer is required to make contributions to the Fund.

Covered Person

"Covered Person" means either the Participant or the Participant's Eligible Dependent, unless specifically stated otherwise.

Deductible

"Deductible" means the annual out-of-pocket amount a Covered Person must pay prior to receiving benefits from the Fund.

Eligible Dependent or Dependent

"Eligible Dependent" means any one of the following persons who is not employed by an Employer:

A. The Participant's legal spouse

B. The Participant's biological children, stepchildren, legally adopted children, children placed for adoption with a Participant, regardless of whether the adoption is finalized, or children under the Participant's legal guardianship, and who are

(1) under 26 years of age, unless the child is eligible for employer-sponsored group health coverage other than through the child's parents; or

(2) Totally and Permanently Disabled, provided the Disability began on or before the child's 26th birthday and while eligible for benefits under the Plan. Disabled means the child is incapable of engaging in gainful employment on account of a medically recognized mental or physical Illness or Injury. However, the Fund

will not provide coverage if the child is able to obtain significant health care benefits from any other source. To Fund coverage, a Participant must apply to the Fund Office and certify the child's initial and continued qualification on a form provided by the Trustees. This coverage shall cease if the child marries, ceases to be Totally and Permanently Disabled, or ceases to be financially dependent upon the Participant for support.

A child will be considered financially dependent upon a Participant for support if he or she is dependent upon the Participant for at least one-half of his/her support. In determining financial dependency, the Trustees may rely on evidence that a child has been claimed as a dependent on the Participant's tax return. In the absence of such evidence or in the event of information raising questions about the accuracy of such evidence, the Trustees may rely on any other information that establishes that the Participant provides at least one-half of the child's support.

The Fund will cover a Participant's child who has not been enrolled in coverage, to the extent required by a Qualified Medical Child Support Order ("QMSCO") as defined by ERISA Section 609. A Qualified Medical Child Support Order is any court judgment, decree or state administrative order that provides for coverage of a Participant's child under a group health plan. To be qualified, the QMCSO must contain specific information, must be submitted to the Fund Office and must be approved by the Trustees. If the Fund receives a QMCSO and the Participant does not enroll the affected child, the Fund will allow the custodial parent or state agency to complete the necessary enrollment forms on behalf of the child.

A QMCSO may require that weekly Accident and Sickness benefits payable by the Fund to a Participant be paid to satisfy child support obligations with respect to a child of a Participant. If the Fund receives such an order and benefits are currently payable or become payable while the order is in effect, the Fund will make payments either to the child support agency or to the individual listed in the order.

Please note that after January 1, 2014, the Fund will cover your Eligible Dependent up to age 26, regardless of whether that dependent is eligible for employer-sponsored group health coverage other than through the dependent's parents.

Employer

"Employer" means an employer who has agreed to make contributions to the Fund in accordance with the terms and conditions of the collective bargaining agreement with the United Food & Commercial Workers of North America, Local No. 400. The term "Employer" also includes the Union in its role as an employer of its employees who participate in the Fund pursuant to a Participation Agreement.

ERISA

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended, and the regulations thereunder.

Experimental

"Experimental" means any drug, device, medical treatment, or procedure for which any of the following are true:

A. The approval of the U.S. Food and Drug Administration for marketing the drug or device has not been given at the time the drug or device is furnished;

B. The drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, medical treatment or procedure, was not reviewed and approved by the treating facility's institutional review board or other such body serving a similar function, if federal law requires such review or approval;

C. Reliable evidence shows that the drug, device, medical treatment or procedure is not the subject of ongoing Phase I or Phase II clinical trials, or the research, experimental study, or investigational arm of ongoing Phase III clinical trials, or is not otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

D. Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent document used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Fund

"Fund" means the Washington Wholesalers Health & Welfare Fund.

Hospice

"Hospice" is a licensed facility primarily engaged in providing a coordinated program of home and inpatient care for terminally ill individuals.

Hospital

"Hospital" means a lawfully operated institution accredited by the American Hospital Association that maintains and operates organized facilities for major surgery, diagnosis, care and treatment, and provides facilities for overnight stay, and that is not, other than incidentally, a clinic, nursing, rest or convalescent home, or similar establishment.

Illness

"Illness" means sickness or disease.

Injury

"Injury" means accidental bodily injury.

Medically Necessary

"Medically Necessary" means a service or supply that is required to identify or treat the Illness or Injury that a Physician has diagnosed or reasonably suspects. In order to be Medically Necessary, a service or supply must be (1) consistent with the diagnosis and treatment of your condition, (2) in accordance with standards of good medical practice, (3) required for reasons other than convenience to you, your Physician, your Hospital, or another provider and (4) the most appropriate supply or level of service which can safely be provided to you. When applied to inpatient care, Medically Necessary means that your symptoms or condition require that those services or supplies cannot be safely provided to you on an outpatient basis. The fact that a service or supply is prescribed by a Physician or another provider alone does not mean that it is Medically Necessary.

Participant

"Participant" is an Employer's employee who has met the Plan's eligibility requirements established by the Trustees.

Participating Dentist

"Participating Dentist" is a dentist who is duly licensed to practice as a dentist in the locality in which he or she performs a dental service and who has contracted with Group Dental Services ("GDS") to provide dental services to Covered Persons.

Participation Agreement

"Participation Agreement" is an agreement that evidences the obligation of the signatory to be bound to the Trust Agreement, the Plan, and the actions of the Trustees and to make contributions to the Fund.

Physician

"Physician" is any person who is recognized by the law of the state in which treatment is received as qualified to treat the type of Illness or Injury causing the expenses or loss for which claim is made.

Total Disability

"Total Disability" is a disability that completely prevents the Covered Person from engaging in any business or occupation for remuneration or profit. Total Disability does not require house-confinement; however, the Covered Person must be under the direct care of a Physician.

Total and Permanent Disability

"Total and Permanent Disability" is a Total Disability that is expected to last the remainder of the Covered Person's lifetime.

Trust Agreement

"Trust Agreement" is the Agreement & Declaration of Trust, as amended from time to time, establishing the Washington Wholesalers Health and Welfare Fund.

Trustees

"Trustees" is the Joint Board of Trustees of the Washington Wholesalers Health and Welfare Fund.

Union

"Union" is the United Food and Commercial Workers of North America, Local No. 400 and any successors resulting from combination, consolidation or merger.

USERRA

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), which provides for the continuation of benefits for Participants who are absent from work due to qualified military service.

Usual, Customary and Reasonable Charges

"Usual, Customary and Reasonable Charges" or "UCR" charges are the prevailing general level of charges made for the same or comparable care or services in the geographical area where the care or services are provided as determined by the Trustees.

Vision Specialist

"Vision Specialist" means a person who provides, through contract with Group Vision Services (GVS), vision care benefits to Covered Persons.

ELIGIBILITY RULES

Initial Eligibility (New Employees)

An employee's initial eligibility for benefits under the Plan begins on the first day of the fourth month after contributions have been received by the Fund from the Employer on behalf of the employee.

Enrolling Yourself and Eligible Dependents in the Plan

In order to receive benefits, you must complete a Fund enrollment form and file it with the Fund Office. You can get an enrollment form from the Fund Office, your Union representative, or your Employer and can enroll an eligible dependent at any time. Failure to enroll promptly will cause a delay in the start of your benefits. Only Eligible Dependent(s) listed on the enrollment form are eligible for dependent coverage. If the Fund receives a "Qualified Medical Child Support Order" ("QMCSO") and a Participant fails to enroll a child covered under the QMCSO, the Fund will allow the custodial parent or state agency to complete the enrollment card. A copy of the Fund's QMSCO Procedures may be obtained from the Fund Office free of charge.

Continuing Eligibility

Once an employee's initial eligibility has been established, the Participant will continue to be eligible for benefits as long as the Participant performs work in Covered Employment, unless participation is terminated for the reasons described below.

Termination of Benefits

Pursuant to the Patient Protection and Affordable Care Act, the Fund cannot rescind your coverage upon enrollment, except in the case of fraud or intentional misrepresentation of material fact that is prohibited by the terms of the Plan. However, benefits will automatically terminate on the earlier of the first day of the month for which your Employer fails to make a contribution due on your behalf or upon your death. Continuation of coverage may be available under COBRA Continuation Coverage, explained below. If you or your Eligible Dependents lose Fund coverage, including COBRA Continuation Coverage, for any reason, the Fund will send you and your Eligible Dependents a Certificate of Coverage that can be presented to your future group health plan to show that you were covered by the Fund and for what period of time. If you need a Certificate of Coverage, write to the Fund Office. The Fund will send you a certificate at any time while you are still covered and up to two years after you lose coverage.

Emergency Continuations

Eligibility for benefits will be extended to Participants who are otherwise eligible for benefits in the following emergency situations.

A. During a period in which the Participant is not working due to Illness or Injury, and written proof is submitted to the Fund Office (signed medical statement from your attending physician), for a maximum period of nine months from the date the Illness or Injury commenced. This provision applies to all Illnesses or Injuries, whether incurred on or off the job.

B. During the first 90 days of a strike or lockout of the Participant's Employer.

C. During a Participant's authorized leave of absence for medical reasons in the family, for a maximum period of three months.

D. As otherwise required by law.

Reinstatement (Participants laid off due to lack of work)

Participants who return to employment with an Employer following a layoff due to lack of work for a period no longer than six months, will have their eligibility for benefits reinstated prospectively upon the Fund's receipt of the first contribution from the Employer. If an employee returns to work for an Employer following a layoff in excess of six months, the employee will have to meet the eligibility requirements for new Participants.

Termination of Dependent Benefits

Benefits for your Dependents will automatically be terminated on the earliest of the following dates:

A. The date your benefits terminate.

B. The date your Eligible Dependent becomes covered as a Participant under the Fund.

C. The Eligible Dependent is a non-Disabled child and:

(1) It is the end of the calendar month during which the child turns 26 years of age; or

(2) Prior to January 1, 2014, the date that the Eligible Dependent less than 26 years of age is eligible for Employer-sponsored coverage other than through the child's parent. After January 1, 2014, Eligible Dependents less than 26 years of age will still be eligible for benefits despite eligibility for coverage under an employer-sponsored health plan.

D. The Eligible Dependent is Totally and Permanently Disabled and:

(1) It is the end of the first calendar month in which the child is no longer Totally and Permanently Disabled and the child is not otherwise eligible for dependent coverage; or

(2) It is the end of the first calendar month in which the child is able to obtain significant health coverage from another source; or

(3) It is the end of the first calendar month in which you fail to properly certify your child's continued eligibility as required by the Trustees.

E. In the case of a spouse, the date your divorce or legal separation becomes final.

F. The date on which the Plan is amended to no longer cover your Eligible Dependents.

Eligible Dependents of a Participant who lose eligibility under the Plan may be entitled to elect to continue coverage under the provisions of COBRA, depending on the reason for their loss of coverage. (See page 11)

SELF-PAY OPTIONS

If you lose coverage for one of the reasons described below, and you elect to waive your COBRA rights, you may be eligible to elect to make monthly contributions to the Fund in order to remain eligible for certain Plan benefits. The amount and conditions under which the monthly contributions are to be paid will be determined by the Trustees. **You must elect the self-pay option and to waive COBRA coverage within the time frames described below. RETROACTIVE ELECTIONS ARE NOT PERMITTED.**

Self Pay Following an Authorized Leave of Absence

If your Employer grants you a leave of absence that extends beyond the period for which your Employer is required to make contributions to the Fund on your behalf, you may elect to make monthly contributions to the Fund in order to remain eligible for all Fund medical benefits, except Accident and Sickness Benefits, for a period not to exceed 12 months from the date your coverage under the Plan terminated. You must submit a written application for extended coverage to the Fund Office prior to the beginning of the authorized leave of absence.

COBRA CONTINUATION COVERAGE RIGHTS

This notice contains important information about your rights under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") to a temporary extension of coverage from the Fund. COBRA requires that the Fund offer eligible participants and their eligible dependents the opportunity to pay for a temporary extension of health coverage at group rates, plus 2% in certain instances in which coverage under the Plan would otherwise end, in accordance with the provisions of federal law.

If you, your spouse and/or your dependent child(ren) are covered under the Plan, you and/or your spouse or children can continue coverage for a time if coverage ends, or if the amount of the premium that you are required to pay to maintain coverage increases, for one of several reasons (called "Qualifying Events"), even if you or they are already covered by another group health plan or Medicare.

A. Right to Elect COBRA Continuation Coverage

(1) Participant's Rights

If any of the following events result in a loss of eligibility Co-payment, the Participant can elect to continue his or her current coverage under the Plan:

(a) termination of employment (other than for gross misconduct); or

(b) reduction in hours of employment.

(2) Spouse's Rights

The dependent spouse of a Participant will have the right to continue his or her current coverage if he or she loses coverage under the Plan Co-payment for any of the following reasons:

(a) the death of the Participant;

(b) termination of the Participant's employment (other than for gross misconduct) or reduction in the Participant's hours of employment;

(c) divorce or legal separation from the Participant; or

(d) the Participant becomes eligible for Medicare.

(3) Dependent Children's Rights

The dependent child of a participant will have the right to continue his or her current coverage if he or she loses eligibility under the Plan for any of the following reasons:

(a) the death of the Participant;

(b) termination of the Participant's employment (other than for gross misconduct) or reduction in the participant's hours of employment;

(c) the Participant becomes eligible for Medicare; or

(d) the Dependent child ceases to satisfy the Plan's eligibility rules.

(4) Who May Elect COBRA Continuation Coverage

Coverage may be continued for any Eligible Dependent who is properly enrolled on the day before the event resulting in loss of eligibility (listed above). Each Eligible Dependent has the independent right to elect or reject COBRA continuation coverage. The Participant may elect coverage on behalf of his or her spouse and family members. An election on behalf of a dependent child can be made by the child's parent or legal guardian.

If one of the Qualifying Events listed above occurs and you and/or your dependent(s) lose coverage and you and/or your dependent(s) do not elect COBRA Coverage or, if applicable, do not elect the self pay option, you and/or your dependent's health coverage will end.

(5) Newborn or Adopted Children

If you marry, have a child born, or if a child is placed for adoption with you, during a period of COBRA coverage, you may elect COBRA continuation coverage for that spouse or child for the remainder of your COBRA coverage period provided you enroll the spouse or child in accordance with the Plan's rules. Coverage for the spouse, newborn or adopted child will continue for the same time as coverage for dependent children who were properly enrolled in the Plan on the day before the Qualifying Event. Spouses, newborn or adopted children added to your COBRA coverage also become qualified beneficiaries.

B. Length of COBRA Coverage

(1) General Length of Coverage

Coverage may continue under COBRA as follows:

(a) Coverage for you and your Dependent(s) may be continued for up to 18 months, if coverage is terminated due to the Participant's:

(i) termination of employment (other than for gross misconduct); or

(ii) reduced work hours.

(b) Coverage for your eligible Dependent(s) may be continued up to a maximum of 36 months, if coverage is terminated due to:

(i) the Participant's death;

(ii) the Participant's divorce or legal separation;

(iii) a dependent child's ceasing to satisfy rules for dependent status; or

(iv) the Participant becomes entitled to Medicare benefits (under Part A, Part B, or both).

(c) If a Participant becomes entitled to Medicare, and within 18 months of becoming entitled to Medicare, he/she becomes entitled to COBRA due to termination of employment (other than for gross misconduct) or reduction in work hours, coverage for the participant's dependent may be continued for up to 36 months from the date the participant became entitled to Medicare.

(2) Extension of Coverage - Second Qualifying Event

If you become eligible for COBRA Continuation Coverage, the 18-month coverage period may be extended for your spouse or beneficiaries for an additional 18 months if a second qualifying event occurs within the 18-month period of COBRA Continuation Coverage. However, in no event will COBRA Continuation Coverage extend beyond 36 months. Such second qualifying events may include the death of the Participant, divorce or separation from the Participant, the Participant becoming entitled to Medicare benefits (under Part A, Part B, or both), or a Dependent child's ceasing to be eligible for coverage as a dependent under the Plan. However, these events are second qualifying events only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Fund in writing and in accordance with the notification procedures described below in order to extend the period of continuing coverage.

(3) Extension of Coverage - Disability Extension

If you become eligible for COBRA Continuation Coverage, the 18-month COBRA Continuation Coverage period may be extended an additional 11 months if you or your Dependent(s) are determined to be disabled by the Social Security Administration ("SSA") as of or during the first 60 days of COBRA Continuation Coverage. The extended COBRA Continuation Coverage period applies to you and your Dependents, regardless of who is disabled. You must notify the Administrative Manager in writing and in accordance with the notification procedures described below in order to extend the period of continuing coverage. If, during the initial 18-month period, the Social Security Administration determines that the person is no longer disabled, the 11-month extension does not apply. If the Social Security Administration determines that the person is no longer disabled after the initial 18-month period, the period of continuation coverage ends with the first month that begins more than 30 days after the date of the Social Security Administration's determination, provided the period of continuation coverage does not exceed 29 months.

C. Notification Requirements

The Fund will offer COBRA coverage to qualified beneficiaries only after it has been timely notified of the occurrence of a Qualifying Event.

(1) Employer Notices and Procedures

The Employer must notify the Fund, in writing, within 30 days of the Participant's death, termination of the Participant's employment, reduction in working hours, the Participant's entitlement to Medicare, or the Employer's initiation of bankruptcy proceedings. The Employer's failure to provide timely notice may subject the Employer to federal excise taxes.

(2) Participant and Dependent Notices and Procedures

The Participant or Eligible Dependent must notify the Fund, in writing, within 60 days of the following Qualifying Events in order to maintain the right to COBRA Coverage: divorce or legal separation of a Participant or a Dependent child's loss of dependent status as defined by the Plan. Both the Participant and the affected Dependent are jointly responsible for this notice. If you or your dependent fails to give written notice to the Administrative Manager within the required 60 day period, the affected person will lose the right to COBRA Coverage.

All notifications under COBRA must comply with these provisions. Notice should be mailed or hand delivered to the Fund at:

Washington Wholesalers Health and Welfare Fund.
c/o Carday Associates, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

The written notice of a Qualifying Event must include the following information: name and address of affected Participant and/or Dependent, Participant's Social Security number, date of occurrence of the Qualifying Event, and the nature of the Qualifying Event. In addition, you must enclose evidence of the occurrence of the Qualifying Event (for example, a copy of: divorce decree, separation agreement, death certificate, dependent's birth certificate). Once the Administrative Manager receives timely notification that a Qualifying Event has occurred, COBRA coverage will be offered to the Participant and Dependents, as applicable.

(3) Notice of Second Qualifying Event or Disability

Participants and Dependents covered under COBRA Continuation Coverage must provide notice of a second Qualifying Event or Disability to the Fund Office within 60 days of the date of occurrence of the second Qualifying Event or the date of disability determination, and before the end of the 18-month COBRA Continuation Coverage period. The written notice must conform to the requirements for providing notices in the section titled "Participant and Dependent Notices." The notice must include evidence of the second Qualifying Event or

disability (for example, a copy of: divorce decree, separation agreement, death certificate, Medicare eligibility/enrollment, dependent's birth certificate, SSA disability determination).

Failure to provide the Fund Office with notice of a disability or second Qualifying Event within 60 days will result in the loss of the right to extend coverage.

(4) Financial Responsibility for Failure to Give Notice

If a Participant or Dependent does not give written notice within 60 days of the date of the Qualifying Event, or a participating Employer within 30 days of the Qualifying Event, and as a result, the Fund pays a claim for a person whose coverage terminated due to a Qualifying Event, then that person or the participating Employer, as applicable, must reimburse the Fund for any claims that should not have been paid. If the person fails to reimburse the Fund, then all amounts due may be deducted from other benefits payable on behalf of that individual or on behalf of the Participant, if the person was his or her Dependent, to the extent permitted by law.

In addition, you or your Eligible Dependent must notify the Fund Office immediately if you become covered by any other plan of group health benefits whether through your employment or your spouse's employment or otherwise. You must repay the Fund for any claims paid in error as a result of your failure to notify the Fund of any other health coverage.

(5) Notice of Change of Participant's and Dependent's Address

It is crucial that Participants and Dependents keep the Fund Office informed of their current addresses. If you or a covered family member experiences a change of address, immediately inform the Fund Office in writing.

(6) Plan's Notice of COBRA Rights

Within 14 days of receiving notice of any of these Qualifying Events, the Fund will notify the Participant or Eligible Dependent, as applicable of the right to continue coverage. The Participant or eligible Dependent must elect COBRA continuation coverage within 60 days of the date that coverage would otherwise end, or if later, within 60 days from the date that the Fund first sent notice of the right to elect COBRA continuation coverage to the Participant or Eligible Dependent. This election must be made in writing and returned to the Fund Office within the 60-day election period. Failure to timely notify the Fund will result in forfeiture of COBRA rights.

D. Termination of COBRA Coverage

Continuation coverage will terminate on the first of the following dates:

(1) The date a required premium is due and is not paid on time or during the applicable grace period.

(2) The date you or your Eligible Dependent becomes covered by another group health plan (as an employee or otherwise) that does not contain any pre-existing exclusion or limitation affecting you or your Eligible Dependent. This includes coverage under a spouse's plan or, in the case of children, coverage under another parent's plan. You or your Dependent must notify the Fund when you or your Dependent becomes covered under another group health plan.

(3) You or your Dependent becomes entitled to Medicare benefits. This does not apply in situations where the "Qualifying Event" is the participating employer's bankruptcy proceeding under the United States Bankruptcy Code.

(4) The Plan is terminated or no longer provides group health plan coverage for similarly situated Participants or Dependents.

(5) The date the applicable period of continuation coverage is exhausted.

(6) The first month that begins more than 30 days after the date of the Social Security Administration's determination that you or your Eligible Dependent is no longer disabled, in situations where coverage was being extended for 11 months, provided the period of continuation coverage does not exceed 29 months.

E. Benefits Under COBRA Coverage

Under COBRA, the Participant or Eligible Dependent may only elect to continue benefits that were already in place at the time of the event resulting in the loss of eligibility. However, you may not elect to continue the Life Insurance, Accidental Death and Dismemberment, or the Accident and Sickness benefits. Only those services which would otherwise have been payable under the Plan of benefits will be covered under COBRA. If the level of benefits provided by the Fund to similarly situated employees change, your coverage also will change.

F. Cost of COBRA Coverage and Payment

(1) Cost

The cost that you must pay to continue benefits under COBRA is 102% of the cost of coverage, as determined annually by the Fund's Board of Trustees. The cost will be specified in the notice of right to elect continuation of coverage sent to you by the Fund. However, the COBRA premium for the 11-month disability extension period (if applicable) is increased to 150% of the cost of coverage.

The Trustees will determine the premium for the continued coverage. The premium will not necessarily be the same as the amount of the monthly contribution that a participating employer makes on behalf of a covered employee. The premium will be fixed, in advance, for a 12-month period. The COBRA premium will be changed every year for all COBRA beneficiaries.

(2) Payment of Premiums

The initial payment must be made either at the time of the election or within 45 days of the election. The initial payment must include retroactive payments to the date of loss of eligibility. Ongoing payments are due on the first of each month for which coverage is to be continued. However, you will have grace period of 30 days after the first of the month in which to make a payment. For example, if you want coverage for October, payment is due on October 1 but must be made no later than October 31. If you fail to make your premium payment within 30 days of the due date, COBRA coverage is terminated. Payment must actually be received by the Fund Office within the 30-day grace period to be timely. It is not enough to have your payment postmarked by the 30th day.

You will not be billed; it is your responsibility to remit payments to the Fund Office in a timely manner. Payments received after the applicable grace period will result in termination of coverage.

Claims incurred following the date of the event that resulted in the loss of eligibility, but before the eligible Participant or Dependent has elected continuation coverage, will be held until the election has been made and premiums have been paid in full. If the Participant or Eligible Dependent does not make a timely election and pay the premiums, no Fund coverage will be provided. Coverage will remain in effect only while the monthly premiums are paid fully and on time.

G. Other

(1) Trade Act Rights

The Trade Adjustment Assistance Act of 2002 ("Trade Act") created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation ("PBGC") (eligible individuals). In 2011, the Trade Adjustment Assistance Extension Act was passed which changed the group eligibility requirements, and individual benefits and services available under the Trade Adjustment Assistance program. Under these tax provisions, eligible individuals can receive assistance in obtaining health insurance coverage, including COBRA continuation coverage. If you have questions about these tax provisions, you may call the Department of Labor's Office of Trade Adjustment Assistance toll free 1-888-365-6822. More information about the Trade Act is also available at www.doleta.gov/tradeact. This program is offered by the federal government and the Plan has no role in its administration.

(2) Other Rights

This notice describes your rights under COBRA it is not intended to describe all of the rights available under ERISA, the Health Insurance Portability and Accountability Act ("HIPAA"), Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), the Trade Act, and other laws.

(3) Contact for Additional Information

If you have questions or wish to request additional information about COBRA coverage, or your rights available under ERISA, HIPAA, HITECH, or the Trade Act, please contact the Fund Office.

CONTINUATION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act of 1993 ("FMLA") generally requires Employers with 50 or more employees to provide eligible employees with up to 12 weeks per year during any 12 month period due to:

- The birth or adoption of a child or the placement with you of a child for adoption;
- To provide care for a lawful spouse, child or parent who is seriously ill;
- Your serious illness;
- A qualifying exigency that arises in connection with the active military service of your spouse, child or parent. A qualifying exigency includes: (1) notification of military deployment within 7 days of the deployment date; (2) attending military events and related activities, such as formal ceremonies, or military-sponsored family support and assistance meetings; (3) childcare and school activities, such as arranging for or providing childcare or attending school meetings; (4) making financial and legal arrangements; (5) attending counseling sessions; (6) up to five days of rest and recuperation; and (7) attendance at post-deployment activities.

You also may be entitled to up 26 weeks of FMLA leave during a 12 month period to care for a family member who is injured during military service.

For questions about whether you are eligible for FMLA leave, pleases contact your Employer.

During your FMLA leave, you can continue your coverage with the Fund, provided your Employer properly notified the Fund and timely makes its required payments. Your coverage under the FMLA will cease once the Fund Office is notified or otherwise determines that you have terminated Covered Employment, exhausted your FMLA leave entitlement, or you inform the Fund Office of your intent not to return to Covered Employment from leave. Your coverage will also cease if your Employer fails to maintain coverage on your behalf.

Once the Fund Office is notified or otherwise determines that you are not returning to Covered Employment following a period of FMLA leave, you may elect continued coverage under the COBRA continuation of coverage rules. Your COBRA period will commence on the last day of your FMLA leave.

If you fail to return to Covered Employment following your leave, the Fund may recover the value of benefits it paid during the period of FMLA leave, unless your failure to return was based upon the continuation, recurrence, or onset of a serious health condition that affects you or a family member and which would normally qualify you for leave under the FMLA. The Fund reserves the right to offset payment of outstanding medical claims incurred prior to the period of FMLA leave against the value of the benefits paid on your behalf during the period of FMLA leave, to the extent permitted by law.

CONTINUATION OF COVERAGE UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 ("USERRA")

If you are absent from employment by reason of service in the uniformed services, you can elect to continue coverage for yourself and your Eligible Dependent(s) under the provisions of the USERRA. The period of coverage for you and your Eligible Dependent(s) begins on the date of your absence from employment due to military service and ends on the earlier of:

A. the end of the 24-month period beginning on the date on which your absence begins;

B. the day after the date on which you are required to but fail to apply for or return to a position of employment for which coverage under this Plan would be extended. (For example, for periods of service over 180 days, generally you must reapply for employment within 90 days of discharge.); or

C. If you fail to Pay the required premium to continue your coverage under USERRA.

The right to temporarily continue coverage from the Fund does not include the right to receive any non-health benefits provided from the Fund. In addition to your right to continue coverage under USERRA, you and your Dependents also may have rights to elect continuation coverage under COBRA if they experience a qualifying event.

If you wish to elect USERRA coverage, you must notify the Fund Office of your absence from Covered Employment due to military service, unless giving notice is precluded by military necessity or unless, under all relevant circumstances, notice is impossible or unreasonable. In addition, your election to receive USERRA coverage must be received within 60 days of the last day of Covered Employment, otherwise you lose your right to continue coverage under COBRA.

You may be required to pay all or a portion of the cost of coverage. If the period of military service is less than 31 days, coverage under the Plan will continue as if you were still working in Covered Employment. If the military service extends more than 31 days, you must pay 102% of the cost of coverage unless the Employer pays for the coverage under its leave policy. The cost of USERRA coverage will be determined in the same manner as the cost for COBRA coverage. You should contact the Fund Office for the current cost.

USERRA requires timely monthly payments. The payment due date is the first day of the month in which USERRA coverage begins. For example, payments for the month of November must be paid on or before November 1. The payment due for the initial period of USERRA coverage must include payment for the period of time dating back to the date that coverage would have terminated if you had not elect USERRA coverage. There is an initial grace period of 45 days to pay the first premium due, starting with the date USERRA coverage was elected. After that, there is a grace period of 30 days to pay any subsequent amounts due. If you timely elect and pay for USERRA coverage, coverage will be provided retroactive to the date of your departure for military service. If payment is not received by the end of the applicable grace period, USERRA coverage will terminate as of the end of the last period which payment was received. If you fail to pay the full payment by each due date (or within the 30-day grace period), you will lose all USERRA coverage and it cannot be reinstated.

Once a timely election of USERRA coverage has been made, it is your responsibility to make timely payments. The Fund will not send notice that a payment is due or that it is late or that USERRA coverage is about to be terminated due to untimely payment.

When you return to Covered Employment after receiving an honorable discharge within the time periods required by law, you will be eligible to continue your coverage from the Fund.

IMPORTANT INFORMATION ABOUT YOUR BENEFITS

Selection of Your Physician, Hospital Or Other Service Provider

If you choose a service provider (for example, a Hospital, Physician or Vision Care Specialist) with which the Fund has contracted, you will receive in-network benefits. The Fund will not judge the qualifications of service providers. It does not promise that any particular provider is appropriate for you or your condition. Selecting providers is the exclusive responsibility of Participants, Eligible Dependents and their medical advisors.

Charges Covered by The Fund

The Life and Accidental Death and Dismemberment Benefits cover you for Injuries that occur both on and off the job. All other benefits cover you only for non-work related Injuries and Illnesses that are not covered by Workers Compensation or similar legislation. However, under specified circumstances, benefits may be advanced to you pending a determination of Workers' Compensation coverage. In addition to the other limitations and restrictions found elsewhere in this booklet, no benefits are provided for charges which you are not legally obligated to pay--such as for U.S. Government hospital confinement and services--and charges payable as Workers' Compensation claims.

Changes in Benefits

Benefit levels are maintained at a level the Trustees feel is practical. However, benefits must be reviewed from time to time, as economic circumstances indicate, and adjustments will be made as required. Any change in benefits will affect claims incurred on or after the effective date of the change.

No Assignment

If a Hospital, Physician, Dentist or other health care provider that has an agreement with the Fund provided your services (in-network providers), the Fund will make payment to them directly. Otherwise, only you can receive reimbursement from the Fund. You cannot assign any reimbursement due to any person, corporation or organization except as otherwise required by law. Any assignment by you (other than to a care provider or as required by law) will be void. Assignment means transferring your right to collect money for those services to another person or organization.

Plan Interpretation and Determinations

With respect to all uninsured benefits offered by the Fund, such as hospital and major medical benefits, the Board of Trustees shall have exclusive authority and discretion to determine when a claimant is eligible for any payments under this Plan; to make factual determinations about any matter under the Plan; to determine the amount of payment, if any, a claimant is entitled to under this Plan; to interpret all of this Plan's provisions; and to interpret all of the terms used in this Plan. With respect to insured coverage, such as vision and dental, the Board of Trustees shall have authority and discretion to determine whether a claimant is eligible for benefits under the Plan, and all other questions concerning coverage shall be resolved pursuant to the contract between the Fund and the relevant insurer.

Recovery of Payments

If any incorrect payment is made by the Fund, the Board of Trustees has the right to recover any such amount from the Participant or Dependent on whose behalf the payment was made or from the service provider that received the payment. Such amount may be deducted from any future benefit payment to which a person may be entitled from the Fund, to the extent permitted by law. If any incorrect payment is made to or on behalf of a Participant or Dependent, the Participant and the Dependent are both responsible for the overpayment and the Fund has the right to recover any overpayment from either or both individuals.

IMPORTANT! The following represents a general description of the benefits provided through the Fund. You must check the Summary of Benefits at the end of this booklet to determine the level of benefits applicable to your coverage.

LIFE INSURANCE

Insured by Prudential

Your life insurance benefits are insured by Prudential. The amount of coverage is noted in the Summary of Benefits at the end of this booklet. Detailed information about this benefit, including filing claims and appeals and designating a beneficiary, is included in the booklets provided by Prudential. If you have any questions about your coverage or need a copy of your insurance booklet, please contact Prudential at 888-598-5671; www.prudential.com. If there is any conflict between the provisions in this SPD and the Prudential booklet, the terms of the Prudential booklet will always govern.

ACCIDENTAL DEATH & DISMEMBERMENT

Insured by Prudential
Participant ONLY

Your accidental death and dismemberment benefits are insured by Prudential. The amount of coverage for is noted in the Summary of Benefits at the end of this booklet. Detailed information about this benefit, including filing claims and appeals and designating a beneficiary, is provided in the booklets provided by Prudential. If you have any questions about your coverage or need a copy of your insurance booklet, please contact Prudential at 888-598-5671; www.prudential.com. If there is any conflict between the provisions in this SPD and the Prudential booklet, the terms of the Prudential booklet will always govern.

ACCIDENT AND SICKNESS BENEFITS

(Weekly Income Benefits)
Participants ONLY

Weekly Accidental and Sickness benefits are payable to eligible Participants up to the maximum amount shown in the Summary of Benefits in the event you are Totally Disabled. This benefit is not available for Dependents. Benefits are not payable for any Injury or Illness arising out of or in the course of employment that is payable under any Workers' Compensation Law or similar law. However, under certain circumstances, benefits may be advanced to you pending a determination of Workers' Compensation coverage.

Weekly benefits begin on the fourth day of Total Disability and continue for a maximum of 26 weeks during one period of Total Disability. One period of Total Disability includes all periods of Total Disability due to the same or related cause or causes, separated by less than two weeks of continuous, full time, active work. If you return to continuous full time work for at least two weeks, any subsequent Total Disability will be considered a new period of disability, irrespective of its causes and the three-day waiting period will apply.

There is no reduction or restriction on benefits because of age.

Filing a Claim

Accident and Sickness Claims must be filed within 30 days of the beginning of your Total Disability. Contact the Fund Office for the proper forms to be completed by the doctor who is treating you for your Total Disability. Please refer to the Claims and Appeals section of this SPD for more information on the claims procedures.

Accident and Sickness Benefits: Maternity

Accident and Sickness Benefits for maternity reasons are paid on the same basis as any other Total Disability.

If a Participant continues to work throughout the pregnancy, Accident and Sickness Benefits can commence two weeks prior to delivery, if indicated by the Physician. Benefits may begin prior to that date, if the Participant is determined to be Totally Disabled.

Benefits may continue for up to six weeks after delivery for a normal delivery, and for up to eight weeks after delivery for a caesarean section. Benefits may continue beyond these time periods following the birth of a child, if the Participant provides written medical evidence to the Trustees of continued Total Disability.

PREFERRED PROVIDER ORGANIZATION

The Fund has contracted with CareFirst Blue Cross/Blue Shield to help reduce employee health care cost. CareFirst Blue Cross/Blue Shield is a managed care network of Hospitals, Physicians and other health care providers, commonly referred to as a Preferred Provider Organization (PPO) that offer in-network benefits at reduced rates. When you use a CareFirst Blue Cross/Blue Shield preferred Physician or Hospital for your medical benefits, you will pay lower out of pocket expenses, and the Fund's costs also will be reduced. You may participate in this program by visiting one of the Preferred Providers listed in the directory, which is available at www.carefirst.com. If you are in Maryland, DC or Northern Virginia you may also contact CareFirst Blue Cross/Blue Shield at 1-800-235-5160. The CareFirst Blue Cross/Blue Shield Directory lists all the participating physicians and hospitals. It is a guide to assist you in identifying providers and is organized by specialty and geographical location

CareFirst Blue Cross/Blue Shield discounts claims when you use a participating Physician or Hospital, but CareFirst is not your insurance carrier. Your coverage is provided through the Fund.

Participants outside the CareFirst Blue Cross/Blue Shield network (outside Maryland, DC or Northern Virginia – considered "FlexLink" out of Local Area) should call 1-800-810-BLUE (2583) or 1-888-444-8115 for assistance in locating a doctor or to verify if your provider is in the Blue Cross/Blue Shield Network. You may also access this information on-line by going to www.carefirst.com, click on "Members and Visitors", then "Find a Doctor." You can then search by provider type (medical or facilities) depending on your needs. Under the heading at the bottom of the page which says "Other Networks" click on the "PPO-National/International Blue Cross/Blue Shield Directory" link.

The following instructions have been compiled to assist you when using a Preferred Provider:

- Select any CareFirst Blue Cross/Blue Shield PPO Provider.

- When you make an appointment with a Preferred Provider, identify yourself as a CareFirst Blue Cross/Blue Shield participant. When you arrive at the provider's office, present your group health identification card which displays the "CareFirst Blue Cross/Blue Shield" logo.

- To take advantage of lower hospital costs, you may seek services from any of CareFirst Blue Cross/Blue Shield's participating Hospitals. You are required to pre-certify prior to admission. Check your I.D. card for the number you are required to call.

- Send claims to the P.O. Box number that appears on your I.D. card.

- If you have questions about your eligibility, benefit coverage or reimbursement of a claim, contact the Fund Office.

- CareFirst Blue Cross/Blue Shield service telephone numbers are:

Maryland, DC or Northern Virginia: 1-800-235-5160
All Other Areas: 1-800-810-BLUE (2583)

The list of health care providers participating in the PPO network is subject to change without notice. Since some listed providers may no longer be a PPO Provider. You must check with your provider each time you request health care services. This will ensure that your provider is still participating so that you will be afforded the appropriate discounts.

CERTIFIED ADMISSIONS REVIEW AND EVALUATION

InforMed

Hospital Pre-Admission Certification

The Trustees have retained InforMed, to administer the Fund's hospital pre-admission certification program for all hospital admissions. The purpose of this program is to protect your health and the financial integrity of the Fund by preventing unnecessary medical treatment.

Procedures

When you need to be admitted to the hospital for:

A. Scheduled Admission

You must call the InforMed office before your admission.

B. Emergency Admission

You must call the InforMed office within two (2) business days of your admission.

Contact InforMed at 1-866-347-1676. If you fail to contact InforMed within these time periods, the Fund will not pay for your Hospital stay or for any of the services related to your Hospital stay.

InforMed's certification is required to determine whether a hospital stay is Medically Necessary. InforMed does NOT certify that you are eligible for benefits, that the procedures or Hospital stay is covered by the Fund, or the amount of coverage provided by the Fund. You must verify eligibility and coverage with the Fund Office.

COMPREHENSIVE MEDICAL BENEFITS

BASIC HOSPITAL BENEFIT

Room and Board

Payment for the charges incurred per day for room and board is provided up to the amount of daily benefit and maximums shown in the Summary of Benefits at the end of this booklet.

Room and Board in The Intensive Care Unit

Charges are payable up to two (2) times the base allowance for regular Room and Board for a maximum of 10 days, beginning with the 11th day, the regular Room and Board rate shown in the Summary of Benefits at the end of this booklet is payable in full as long as maximum number of days per calendar year has not been exhausted. If you are readmitted to the Hospital within 60 days after your previous hospitalization, the readmission will be considered part of the first hospitalization.

Any charges in excess of the base allowance for the Basic Hospital Benefit or that occurs after the expiration of this benefit are payable under your Major Medical Benefits, if applicable.

MAJOR MEDICAL BENEFIT

Payment of Benefits

After any applicable Deductible is met, the Fund will provide benefits in accordance with the Summary of Benefits at the back of this booklet. In case of a common accident in which two or more family members are involved, only one Deductible must be satisfied. Payment by the Fund will constitute full and final payment, except as may otherwise be provided or limited here. Charges made by a Physician in excess of these amounts are the responsibility of the patient.

The maximum amount payable under the Plan also is set forth in the Summary of Benefits.

The following services are covered under the major medical benefit. All benefits cover both Participants and their Eligible Dependents, unless otherwise indicated.

Surgical Services

Benefits for surgical services are available when performed by a Physician. This benefit covers operative and cutting procedures, procedures to reduce fractures and dislocations, as well as major endoscopic and other surgical-diagnostic procedures.

Inpatient Medical Services

Benefits for inpatient medical services are available up to the maximum number of days allowed under the Basic Hospital Benefit. Successive hospital confinements will be considered continuous and constitute a single confinement if discharge from and readmission to a hospital occurs within a 60-day period. This benefit includes (1) general nursing care; (2) use of the operating, delivery, recovery, or treatment room; (3) anesthesia, radiation, and x-ray therapy when administered by an employee of the hospital; (4) dressings, plaster casts, and splints provided by the hospital; (5) laboratory examinations; (6) basal metabolism tests; (7) x-ray examinations; (8) electrocardiograms and electroencephalograms; (9) physiotherapy and hydrotherapy; (10) oxygen provided by the hospital; (11) drugs and medicines in general use; (12) administration of blood and blood plasma and intravenous injections and solutions.

Maternity Benefits

All female Participants or spouses entitled to dependent coverage are eligible to receive the inpatient hospital services described above up to the maximum number of days allowed under the Basic Hospital Benefit for any one pregnancy. Maternity benefits include nursery care of the newborn child or children while the mother is receiving benefits.

The services of maternity centers are covered under your normal plan of benefits.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurance issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Admissions for Diagnostic Study

Inpatient admissions solely for the purpose of diagnostic study directed toward the diagnosis of a definite condition or disease will, in most instances, not be covered. Please have your Physician contact InforMed should complicated diagnostic testing be required. InforMed will determine the medical appropriateness of an inpatient stay in these instances. Benefits are not provided for inpatient admissions for the following services: Audiometric testing, eye refractions, examinations for the fitting of eye glasses or hearing aids, psychiatric examinations; psychological testing; dental examinations; premarital examinations; research studies; allergy testing; screening; routine physical examinations; or checkups for fluoroscopy without films. This list is by way of example only and is not intended to be exhaustive.

Pre-Admission Testing

Benefits are available for preoperative laboratory tests and x-ray examinations performed in the outpatient department of a Hospital prior to a scheduled admission for an inpatient stay, provided the tests would have been available under the Plan to a Hospital inpatient and are Medically Necessary in connection with the inpatient stay.

Obstetrical Services

Benefits for obstetrical services are available to all female Participants or wives of Participants entitled to dependent coverage. Benefits include prenatal and postnatal care. If a Participant takes an approved leave of absence because of pregnancy and no contributions are received by the Fund on the Participant's behalf, the Participant will continue to be eligible for benefits related to her pregnancy until the birth of her child.

In lieu of obstetrical services provided by a Physician, you may elect to receive benefits for non-surgical obstetrical care, services provided by a nurse midwife who is a licensed and registered nurse certified by the American College of Nurse Midwives, or services of a licensed maternity center providing comprehensive birth services.

Pediatric Services

Benefits for pediatric services are available for any properly enrolled Eligible Dependent children. Benefits are provided for a visit to a Physician for routine history and necessary examination.

Major Human Organ Transplants

Benefits are available for hospital services, supplies and Physician services for kidney, cornea, and bone marrow transplants. If you are a recipient of the transplant, benefits cover both you and the donor. If you are a donor, only you are covered, but only to the extent that the recipient does not cover you.

In addition, certain benefits are available for the recipients of human heart, heart-lung, liver and pancreas transplants. However, benefits are not available for any transplants considered Experimental. Charges for evaluation, room & board, Hospital services and supplies, and Physician services are covered up to the limits of the Plan. The Hospital must meet certain criteria and be approved by the Fund. There are other conditions and exclusions including notice requirements. If you are a candidate for any transplant, contact the Fund Office. The maximum amount paid under basic for lifetime is $50,000. NOTE: All amounts paid for transplants are applied to Major Medical lifetime maximum.

Anesthesia Services

Benefits for anesthesia services are available when performed by a Physician anesthesiologist (other than the operating surgeon or his assistant) or a nurse anesthetist in conjunction with surgical or obstetrical services.

Consultation Services

Benefits for inpatient consultation services, except for staff consultation required by Hospital rules or regulations, are available when performed in conjunction with surgical or medical services and when the consultation is requested by the attending Physician. Benefits will be provided for one consultation per consultant during any Hospital confinement.

Surgical Assistant Services

Benefits are available for the services of a licensed Physician who actively assists the operating surgeon in the performance of surgical services when the condition of the patient and type of surgical performance require assistance and when interns, residents, or house staff are not available.

Outpatient Emergency Care

Benefits are available for care received within 72 hours of an accidental Injury wherever rendered by a Physician or for care received within 72 hours as a result of a medical emergency when performed in the outpatient department of a Hospital by a Physician. However, emergency care received in conjunction with work-related injuries that are otherwise covered by Workers' Compensation or other similar legislation are not covered.

Oral Surgical Services

Benefits are available for oral surgical services consisting of the reduction or manipulation of fractures or bones; excision of the mandible joints and lesions of the mandible, mouth, lip, or tongue; incision of the accessory sinuses, mouth, salivary glands, or ducts; manipulations of dislocations of the jaw; removal of impacted teeth only when Hospital confinement is required or when rendered in the outpatient department of a Hospital; plastic reconstruction or repair of the mouth or lips necessary to correct accidental injury, but not for care of the teeth, dental structures, alveolar processes, dental caries, extractions, corrections of impactions, gingivitis, orthodontia, and prostheses.

Temporomandibular Joint Syndrome ("TMJ")

Charges are covered for treatment of TMJ under the Major Medical Benefit. The lifetime maximum amount payable for treatment of TMJ is $1,000.

Ambulance Services

Benefits are provided for emergency ambulance service, both air and ground, under major medical, subject to applicable co-insurance and annual per person Deductibles. The Covered Person's condition must be of such nature that any other method of transportation would not be medically advisable.

Radiation Therapy

Benefits are provided for the following services when administered by a Physician:

A. X-rays for the treatment of neoplasms, lymphoid hyperplasia of the nose and pharynx, and disorders of the female genital system. The maximum payable in any one calendar year will be 25 treatments for any and all such conditions.

B. Application or implementation of radium or radon.

Benefits are not provided for the cost of radiation therapy materials used.

Accredited Ambulatory Care

In place of a Hospital, benefits will be paid for services and supplies provided by an Accredited Ambulatory Care Facility.

Chemotherapy

Benefits are available for chemotherapy materials and for the administration of anti-cancer chemotherapeutic agents when provided under the supervision of a Physician. The maximum payable in any one calendar year shall be 20 treatments for any and all such conditions.

Tonograms

Tonograms are covered, whether rendered on an inpatient or outpatient basis, provided they are performed by a Physician and directly related to an Illness.

Cleft Lip or Cleft Palate Conditions

Benefits are available to cover medical expenses for the treatment of cleft lip and cleft palate conditions. The various covered services include: expenses arising from orthodontics, oral surgery, otologic, audiological, and speech/language treatment.

Alcohol and Chemical Dependency

Benefits are available to Participants ONLY for the treatment of alcohol and chemical dependency. The benefit provided is the same as any other benefit provided for Illness or Injury.

Mental and Nervous Benefits

Benefits are available to Participants ONLY to cover both inpatient and outpatient medical expenses incurred for the treatment of mental and nervous conditions. The benefit provided is the same as any other benefit provided for Illness or Injury.

The following services or supplies are not covered under the mental health benefit, in addition to the general exclusions under the Plan.

A. Treatment of chronic pain. However, psychotherapy and/or pharmacotherapy, biofeedback or hypnotherapy treatment rendered in connection with psychiatric disorders are covered.

B. Charges for services, supplies or treatment that are covered elsewhere under the Plan.

C. State hospital treatment. However, non-custodial state hospital treatment that is determined by the Trustees to be Medically Necessary is covered.

D. Treatment for stress. However, treatment for stress is covered when rendered in connection with a psychiatric disorder.

E. Treatment that is not Medically Necessary.

F. Treatment or consultations provided via telephone.

G. Marriage counseling.

H. Psychiatric or psychological examinations, testing or treatments for purposes of obtaining or maintaining employment or insurance or related to judicial or administrative proceedings.

I. Psychological testing, except where conducted for purposes of diagnosing a psychiatric disorder or when rendered in connection with a diagnosed psychiatric disorder.

J. Private duty nursing, except as Medically Necessary. Evaluations, consultations, or therapy for educational professional training or investigational purposes relating to employment.

K. Treatment for personal growth/development, or professional certification.

L. Prescription drugs (covered under a separate program).

M. Treatment for smoking cessation, obesity or weight reduction.

N. Academic education during residential treatment.

O. Aversion therapy.

Diagnostic X-Ray and Laboratory Services

Benefits for diagnostic x-ray and laboratory services (including pathological examination of tissue, electrocardiograms, electroencephalograms, and basal metabolism tests) are available when administered in the outpatient department of a Hospital or a Physician's office and when such exams are required for the diagnosis or treatment of Illness or Injury.

Benefits shall be available for pap smears and mammograms as noted below. This benefit is not subject to the annual Deductible.

From age 35 through 39:	One baseline mammogram
From age 40 through 49:	One mammogram and one clinical examination every one or two years, depending upon the recommendation of your attending Physician.
Age 50 and over:	One mammogram each year.

If you require any of the above services, you should present your ID card to the Physician. Benefits do not include services for any examinations in connection with care of teeth, research studies, screening, premarital exams, fluoroscopy without films, or an exam not incidental to or necessary for the diagnosis of a disease or injury. Also, payment will not be made to both a Hospital and Physician for the same service.

Physical Exam and Vaccines

Benefits shall be available for vaccines including but not limited to, pneumonia, flu and polio, and physical exams, including laboratory and x-ray expenses, up to $200 per person in any one calendar year. These benefits are not subject to the annual Deductible.

Mastectomy

Notwithstanding any limitations in this Plan to the contrary, consistent with federal law, the Plan covers the following benefits related to mastectomy: (1) reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and physical complications at all stages of mastectomy, including lymphedemas. Such benefits are subject to the Plan's annual Deductible, coinsurance, and maximums.

Gastric Bypass

Bariatric surgery for eligible Participants and Dependents will only be covered when pre-certified by InforMed as follows:

- BMI equal to or greater than 50kg/m;

- Careful review of pertinent history and physical findings;
- No serious psychological disorder which would make it difficult for the patient to receive informed consent;
- Ability to be personally responsible for maintaining good medical follow-up to ensure proper nutritional assessments and to receive vitamin injections when necessary; and
- Previous failed attempts at losing weight using more conservative therapies.

Other Covered Medical Expenses

In addition to the services described above, the following services are covered under the Major Medical Benefit, provided they are performed or prescribed by a Physician.

A. Services of Physicians, including specialists, provided in a Hospital, in the home, and in the Physician's office;

B. X-ray, radon, radium, and radioactive isotope treatments or therapy;

C. Blood transfusions, including the cost of blood and blood plasma (except when donated or replaced);

D. Services of a licensed physical therapist;

E. Services of an actively practicing private duty nurse when Medically Necessary as follows:

(1) in or out of the Hospital, services of a registered professional nurse (R.N.) or a licensed practical nurse (L.P.N.);

(2) the technical proficiency and scientific skills of an R.N. or L.P.N. are required and skilled services are actually rendered;

(3) the services cannot be rendered by the Hospital's general nursing staff;

F. Rental or, at the discretion of the Plan, purchase, of a wheelchair, hospital type bed, or other durable equipment necessary for therapeutic use;

G. Local professional ambulance services for the outpatient hospital care for accidental bodily injury and for inpatient admissions (donations for the services of a voluntary ambulance are ineligible for coverage);

H. Services for cosmetic purposes for the correction of congenital defects or conditions resulting from traumatic injuries;

I. Prosthetic appliances such as casts, splints, crutches, braces, or artificial limbs, when prescribed by a Physician;

J. Services or appliances for dental care resulting from accidental bodily injury (although services for the replacement or correction of false teeth as a result of accidental injury are ineligible for coverage);

K. Blood sugar monitors and other medical paraphernalia are covered up to $100 once every five years for those who suffer from Diabetes Mellitus;

L. Injuries resulting from an act of domestic violence or from a medical condition, including mental health medical conditions.

Exclusions and Limitations

In addition to the Plan's General Limitations, the Major Medical Benefit does not cover the following:

A. Services or supplies provided as a result of any Injury or Illness arising out of or in the course of any employment that is compensable under any Workers' Compensation or occupational disease act or law or employer's liability law, except for Life, or Accidental Death and Dismemberment Benefits. However, under specified circumstances, benefits may be advanced to you pending a determination of Workers' Compensation coverage;

B. Services or supplies furnished to you or your Eligible Dependent under the laws of the United States or any political subdivision thereof;

C. Services or supplies to the extent that the cost may be recoverable by or on behalf of you or your Eligible Dependent in any action by law and in compromise and settlement of any claims against any party other than your insurer;

D. Services or supplies not Medically Necessary for the treatment of Illness or Injury;

E. Services or supplies covered under any federal or state program of health care for the aged, including but not limited to Medicare;

F. Services or supplies or medications rendered in a nursing home or extended care facility;

G. Services or supplies received from a Physician for medical expenses in excess of the UCR as determined by the Trustees;

H. Services or supplies of any kind that are Experimental in nature or not generally accepted medical practice by the medical community practicing in the state of Maryland;

I. Services performed by interns, residents, or Physicians who are employees of a Hospital and whose fees are charged for, by, or payable to a Hospital or other institution;

J. Services or supplies provided through a medical department or clinic, or similar services maintained by the employer;

K. Benefits to the extent paid or would have been paid under Title XVIII (Parts A and B) of the Social Security Act of 1965 and amendments thereto;

L. Consultation services related to medical or surgical services when they are rendered by the same Physician during the same Hospital admission;

M. Illness or Injury resulting from war, declared or undeclared;

N. Services, supplies, or care of any kind other than those otherwise defined as covered medical expenses under the Plan;

O. Hydrotherapy, dietary control, or any combination thereof, or when services rendered to the Covered Person are primarily hydrotherapy, dietary control, or any combination thereof;

P. Services or supplies for cosmetic or plastic surgery, unless performed to correct functional disorders or conditions resulting from traumatic injuries; or as otherwise required by law;

Q. Transsexual operations or any care or services associated with this type of operation;

R. Sterilization reversals;

S. Injections of a medication that would be covered under the Prescription Drug Benefit in its oral form unless administered on an emergency basis;

T. Care of corns, bunions, (except capsular or bone surgery therefore), calluses, nails of the feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet, except when major surgery is performed or the Participant or Eligible Dependent has diabetes or a medical condition which requires that routine foot care be administered by a Physician;

U. Pulmonary tuberculosis and quarantinable disease in special institutions except as specified herein;

V. Dental care and treatment to the natural teeth and gums; dental surgery or dental appliances to replace the natural teeth and gums, unless such treatment is made necessary by accidental Injury;

W. Hearing aids and the examination for them;

X. Eyeglasses and the examination for prescription or fitting, except when necessary as a result of eye surgery;

Y. Services, supplies, or care of any kind related to the pregnancy of a person other than the Participant or the Participant's legal spouse;

Z. Custodial, milieu, sanitaria care, rest cures, or travel, whether or not recommended by a Physician;

AA. All rehabilitative therapy including, but not limited to, speech, occupational, recreational, or educational therapy, or forms of non-medical self care or self help training; and any related diagnostic testing provided on an outpatient basis;

BB. Air conditioners, humidifiers, dehumidifiers, purifiers, and all similar equipment;

CC. Services or supplies provided prior to the effective date or subsequent to the termination date of a Covered Person's coverage under the Plan.

How to File A Claim for Medical Benefits

All Hospital and Major Medical benefit claims must be filed within (12) months from the date of service. Any claims submitted after that date will be denied as untimely.

For a PPO Provider:

You complete the claim form in the provider's office. The provider will submit the claim directly to CareFirst for processing. You will be notified when processing is complete.

For a Non-PPO Provider:

A. Obtain a claim form from the Fund Office claims department by telephone or in person. The telephone number is 410-872-9500 or 1-800-845-8518.

B. Complete the front section of the claim form. Be sure to sign the Authorization and Certification box and the Assignment of Benefits section if you wish payment to go directly to the provider.

C. The provider must complete the back section of the form OR provide you with a fully itemized bill to attach to the claim form. A diagnosis must be included for the claim to be processed.

D. The completed claim form and itemized bill must be submitted to the Fund Office:

Washington Wholesalers Health & Welfare Fund
c/o Carday Associates, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

When submitting your claim, you must submit an original of the bill. Photocopies of bills are not acceptable except when one of the following situations occur:

A. When other group insurance is involved and the Fund is the secondary carrier;

B. The billing is a Physician's itemized, running list of all charges and payments;

C. The original bill has been lost. If this is the case, the photocopy must be submitted with a signed statement by the Participant stating that the original was lost.

When submitting a claim for "Secondary" payment, you must attach a copy of the other insurance's explanation of benefits to the claim. This information is necessary to process your claim. Without this information, the processing of your claim will be delayed.

For general rules and more information on filing a claim, see the Claims for Benefits section in this SPD.

VISION CARE BENEFITS

The purpose of the Vision Care Benefit is to provide Participants and their Eligible Dependents with vision care service to maintain visual efficiency, prevent the development of conditions which might result in serious loss of sight, and maintain each person's ability to see safely on and off the job.

Although Vision Care Benefits are provided through the Fund, they are provided by Group Vision Services. Group Vision Services offers vision care through a closed panel of Vision Specialists. That means that the Fund will provide you and your Eligible Dependents the following Vision Care Benefits only when performed by a Vision Specialist.

A. Vision Survey - a survey of principal visual functions to determine the condition of your or your Eligible Dependent's vision. Available to each Participant and Eligible Dependent once every 24 months.

B. Visual Analysis - Whenever a Participant or Eligible Dependent seeking care has symptoms of a vision problem or when the vision screening indicates the need for further care, a complete visual analysis will be made, including but not limited to:

(1) Case History

(2) Examination for pathology (disease) or abnormalities

(3) Job visual analysis

(4) Refraction

(5) Coordination measurements

(6) Near point visual functions analysis

(7) Visual field examinations

(8) Prescription of proper lenses if indicated

(9) Tonometry and/or field tests given for glaucoma for participants over age 35, or if history of glaucoma in family.

Visual analysis is available to each Covered Person once every 24 months, if Medically Necessary.

C. Lenses and Frames - when the visual analysis indicates that lenses and/or frames are necessary for the proper visual health and welfare of the Covered Person the lenses and/or frames will be supplied together with the necessary professional services, which include but are not limited to:

(1) Prescribing and ordering proper lenses;

(2) Assisting in the selection of a frame where indicated;

(3) Verifying the accuracy of the finished glasses;

(4) Proper fitting and adjustment of the glasses;

(5) Progress or follow-up work as necessary;

(6) Subsequent adjustments of frames to maintain comfort and efficiency;

(7) Supplying lenses and frames. Lenses and frames to be supplied by the Fund will be fabricated in laboratories approved by the Standards Committee of Group Vision Services.

Second Pair of Glasses

D. If at the time of the initial examination, the Covered Person requests a second pair of glasses, the Group Vision Services doctor will provide the extra pair and charge the Covered Person the Group Vision Services established laboratory cost for the second pair of glasses, plus materials services fee.

E. If after the initial examination, the covered person at a later time requests a second pair of glasses, the Group Vision Services doctor will provide the Covered Person with the second pair, but the patient will pay the Group Vision Services established UCR for such second pair and not the laboratory cost.

Exclusions and Limitations

In addition to the Plan's General Limitations, the Vision Care Benefit does not cover the following:

A. Sunglasses, plain or prescription;

B. Special procedure such as orthoptics, vision training, contact lenses (except for therapeutic reasons), subnormal vision aids, aniseikonia, etc.;

C. Medical or surgical treatment of the eyes (already covered under existing medical and surgical benefits);

D. Services or materials for which the Covered Person may be compensated under the Workers' Compensation Law; Employer's Liability Law, regardless of jurisdiction; or services for which the patient without cost may obtain the needed care from any federal governmental organization, county, municipality or special service district;

E. Replacement of lost, stolen or broken glasses;

F. The cost of photosensitive lenses in excess of the cost of white lenses;

G. All tints other than Pink #1 or #2;

H. The cost of plastic multifocal lenses in excess of the cost of glass multifocal lenses;

I. The cost of frames in excess of the plan allowance;

J. The cost of oversize lenses in excess of the cost of normal size lenses.

How to Get Vision Care Under This Program

A. Call Group Vision Services at 1-866-265-4626 for the name of a participating Vision Specialist or via internet at www.gvsmd.com.

B. Call the Vision Specialist to make an appointment. Inform the Vision Specialist that you participate in this Plan.

C. Keep the appointment. If cancellation is necessary, notify the Vision Specialist's office at least 24 hours in advance.

D. The Vision Specialist will inform you or your Eligible Dependents what other appointments are necessary.

E. You will be responsible for paying a $10 Co-payment toward the exam and a $25 Co-payment toward the materials. If you choose frames not in the regular selection available, you will be charged the wholesale cost plus $10.00.

Filing a Claim

Claims will be made in the following manner:

A. The Vision Specialist shall present the completed claim and billing form to Group Vision Services for processing.

B. Payment shall be made directly to the Vision Specialist by Group Vision Services.

C. DO NOT PAY THE VISION SPECIALIST FOR ANY SERVICES, FRAMES OR LENSES COVERED UNDER THIS PLAN, AS NO CHECKS CAN BE PAID DIRECTLY TO A PARTICIPANT OR HIS ELIGIBLE DEPENDENT.

See the Claims for Benefits section of this SPD for more information on filing a claim or appeal.

PRESCRIPTION DRUG BENEFITS

The Fund will pay for Medically Necessary prescription drugs which require compounding, legend drugs, insulin and related diabetic supplies and certain contraceptive drugs. The prescriptions must be written by a Physician legally licensed to practice medicine. Prescription benefits are processed through informedRx. You will pay a 5% Co-payment for each prescription filled at an "in network" retail participating informedRx pharmacy. Current "in network" participating pharmacies are:

Giant Food	Shoppers Food Warehouse
Kroger	Metro Pharmacy
Tidewater Pharmacy	Safeway

You will pay a 10% Co-payment for each prescription filled at other retail pharmacies affiliated with informedRx. If you live outside a 25-mile radius of an "in network" informedRx participating pharmacy, the 5% Co-payment will apply. After you pay the Co-payment, the Fund will pay the balance, subject to the Limitations and Exclusions on pages 46-47 of this SPD. Each prescription and refill obtained from a retail pharmacy will be limited to a 34-day supply.

Mandatory Mail Order for Maintenance Drugs

The mail order program is mandatory for maintenance drugs. "Maintenance drugs" are drugs which are prescribed for a long period of time to control a chronic condition where medication therapy is not considered curative. A list of Maintenance Drugs is available from the informedRx web site (http://www.myinformedrx.com) or from the Fund office.

When a maintenance drug is prescribed, you should ask the Physician to provide two prescriptions. One prescription should be for a 30-day supply which you may have filled at a local participating retail pharmacy. The second prescription should be for a larger supply (maximum 90 days) which should be used to order through the mail order program. You will be allowed to have the initial prescription filled, plus one refill, by a local participating retail pharmacy. All additional refills must be purchased through the informedRx mail order service:

RxDN
P.O. Box 137
Bristol, PA 19007
1-800-800-8769

The Co-payment for all mail order prescriptions and refills is 5%. Mail order forms are available from the RxDN web site (http://www.rxdn.com) or from the Fund office.

Generic Drugs

The Fund will pay the cost of a brand name drug only when a generic drug equivalent does not exist. If you or your Physician insists on a brand name drug when there is a generic equivalent,

you must pay the difference between the cost of the generic drug and the brand name drug, in addition to the applicable Co-payment.

Use of over-the-counter and generic drugs will save you money. You may be eligible for additional savings with your prescription drug program by switching to an over-the-counter or generic product used to treat the same medical condition as the brand medication you are currently taking. Over-the-counter and generic alternatives offer the more cost-effective way to manage many common medical conditions at a fraction of the price of brand medications. Obviously, any change in your medication(s) should be coordinated with and approved by your doctor.

Omeprazole is a generic proton pump inhibitor that is prescribed for the same medical condition as the brand drug Nexium at a much lower cost and therefore lower Co-payment for you. Prilosec OTC (Omeprazole) is an over-the-counter proton pump inhibitor that is prescribed for the same medical condition as the brand drug Nexium at a much lower cost to you than Nexium. Keep in mind that these are not generic equivalents to Nexium, but rather a generic and over-the-counter for similar medications used to treat the same medical conditions.

To avoid paying a higher Co-payment, you may want to speak with your Physician to see if a generic alternative medication is right for you. This will result in reduced out-of-pocket expense to you through lowered Co-payments. Any change in your drug therapy is on a voluntary basis and should be decided between you and your Physician.

Step Therapy

Step Therapy is a process that requires the use of a preferred product or specific criteria to be met before a particular drug can be approved. If a prescription for a medication requiring Step Therapy is presented to the pharmacy, your prescription profile is instantly reviewed when the claim is electronically submitted to informedRx. Based on the history in your file, the prescription claim may be approved automatically. If the prescription rejects, two options exist. The pharmacist may call the Physician to obtain a prescription for the preferred product, or you may pursue approval of the prescription via the Prior Authorization process. The preferred product must be used before a prescription requiring Step Therapy can be obtained.

To avoid an extra trip to the pharmacy before filling a prescription for the types of drugs described below, first determine whether you need to try an alternative first, or to obtain prior-authorization. If you are unsure of if you need a prior-authorization form, contact informedRx at 1-888-354-0090.

You will benefit by having lower prescription Co-payment. For example, when your pharmacy submits a prescription for Nexium to informedRx, the system will look back at your prescription profile to determine if you have tried Prilosec OTC in the past. If the system finds that to be true, the claim will automatically be processed without any inconvenience to you. If not found in your history, the claim will reject with a message to the pharmacy that Prilosec OTC must first be used. If you have used Prilosec OTC but did not submit the claim through informedRx, you need to pursue Prior Authorization by contacting informedRx at 1-888-354-0090. Although

informedRx has provided Step Therapy Program descriptions, it is important to talk with your Physician before making any changes in your medication therapy.

If you are on a medication affected by Step Therapy and have not tried the preferred agent, get a prescription from your doctor for the preferred agent or contact InforMed to begin the prior authorization process.

The table below indicated medications included in the Step Therapy Program:

Drug Class	Preferred Product	Medication(s) Affected by Step Therapy
Proton Pump Inhibitors	Prilosec OTC **	Aciphex, Nexium, Prevacid, Protonix
Non-Sedating Anti-histamines	Claritin OTC **	Allegra, Allegra-D, Clarinex, Clarinex-D, Zyrtec, Zyrtec-D
Anti-inflammatory Cox-2 Inhibitors	Traditional NSAIDS (ibuprofen, naproxen)	Celebrex
Angiotension II Receptor Blockers (ARBS) *	ACE Inhibitors (Captopril, Enalopril, Fosinopril, Lisininopril, Quinapril, etc.)	Diovan,, Teveten, Atacand, Benicar, Micardis, Avapro
Allergic Rhinitis (Runny nose, itchy/ tearing eyes) *	Steroid Nasal Spray and an Antihistamine	Singulair ***
Statins (Treatment of High Cholesterol)	Pravastatin, Simvastatin, Lovastatin	Lipitor (10, 20 & 40 mg strengths only), Crestor (5 & 10 mg strengths oly), altoprev, Lescol & Lescol XL
Gliptins and TZDs (Oral medications for the treatment of diabetes)	Metformin	Januvia, Janumet, Actos, Avandia, Actoplus Met, Avandamet & Avandaryl
Attention Deficit Hyperactivity Disorder (ADHD)	Amphetamine/ Dextroamphetamine, Dextroamphetamine, Methylphenidate	Adderall, Concerta, Daytrana, Desoxyn, Dexedrine, Focalin, Liquadd, Metadate Methlyn, Ritalin, Strattera, Vyvanse
Osteoporosis Agents	Alendronate	Boniva, Fosamax, Actonel
Antidepressants	Fluoxetine, Paroxetine, Citalopram, Fluvoxamine, Sertraline	Lexapro

* Grandfathering: Members taking this medication in the past 120 days are automatically approved.
** Prilosec OTC and Claritin OTC will be available with your prescription drug card with a valid prescription.
*** Members who use Singulair for asthma control would be exempt from this requirement. Members less than 18 years of age would also be exempt from this requirement.

Quantity Limitations

Medications for insomnia will be limited to 15 tablets/capsules per 30 days. This limitation is based on use and safety guidelines from the FDA. These guidelines support the indication for short-term treatment of sedatives since tolerance and dependency can develop. The drugs affected by this limitation are Ambien, Sonata and Lunesta.

Medications for migraines will be limited based on use and safety guidelines from the FDA. These guidelines are for your safety since over use of these medications can increase the risk of serious side effects. The drugs affected by this limitation are Amerge, Axert, Frova, Imitrex, Maxalt, Zomig, and Relpax. The table below specifies the standard quantity limits for a 30-day supply:

Drug Name	Retail Quantity Limits
Amerge	9/30 days
Axert	6/Rx; 12/30 days
Frova	12/30 days
Imitrex Tabs	9/30 days
Imitrex Nasal Spray	12 sprays/30 days
Imitrex Injectable	5ml/10 syringes/30 days
Imitrex Injectable Kits	4 boxes/8 syringes/30 days
Maxalt	12/30 days
Zomig	6/30 days
Relpax	6/30 days

Prescription Drug Coverage Under Medicare

Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The Washington Wholesalers Health and Welfare Fund has determined that the prescription drug coverage offered by the Fund is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15th through December 31st. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your Washington Wholesalers Health and Welfare Fund prescription drug coverage, be aware that you and your Dependents may not be able to get this coverage back.

Please contact the Fund Office for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with The Washington Wholesalers Health and Welfare Fund and don't enroll in a Medicare prescription drug program after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov.

- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help.

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov or you can call them at 1-800-772-1213 (TTY 1-800-325-0778).

Claims Procedure

A. All Participants and their Eligible Dependents will receive a medical/prescription ID card which must be shown to the participating pharmacist. This card will be issued when you become eligible.

B. Take your Physician's prescription to a participating pharmacy.

C. Identify yourself by presenting your ID card.

D. Pay the required Co-payment to the pharmacist.

See the Claims for Benefits section of this SPD for more information on filing a claim.

If You Forget Your Card

If you forget your ID card when you have your prescription filled, you must pay the full cost of the prescription to the pharmacy and request a reimbursement. Contact the Fund Office for the proper forms to complete. When your reimbursement is processed, the check will be made out to you. Claims for reimbursement will be considered only for prescriptions filled within one year of the date the claim was submitted.

Limitations and Exclusions

In addition to the General Limitations and Exclusions section found elsewhere in this booklet, the Prescription Drug Benefit does not cover the following:

A. Charges not listed as covered prescription drug charges;

B. Charges for a non-legend, patent or proprietary medicine or medication not requiring a prescription;

C. Charges for canes, crutches, wheelchairs or any means of conveyance or locomotion;

D. Charges for braces, splints, dressings, bandages, sick room equipment or supplies, heat lamps, respiratory therapy supplies or similar items;

E. Charges for abdominal supports, trusses, oxygen;

F. Charges for immunizing agents, biological sera, blood or blood plasma;

G. Charges for vitamins, vitamin prescriptions, cosmetics, dietary supplements, health or beauty aids;

H. Charges for medication which is to be taken or administered, in whole or part, to the individual while he is a patient in a hospital, rest home, sanitarium, extended care facility, convalescent hospital nursing home or similar institution;

I. Charges for any drugs or medicines delivered or administered to the Covered Person by the prescriber;

J. Charges for any drug labeled "Caution-Limited by Federal Law to Investigational Use" or Experimental Drugs, even though a charge is made to the Covered Person;

K. Prescriptions for erectile dysfunction drugs are limited to eight pills per month, per Participant when Medically Necessary;

L. Charges for Relenza or Tamiflu;

M. Charges for contraceptive material or devices, except NorPlant, Depo-Provera, NuvaRing and oral contraceptive drugs are covered for Participant or spouse only;

N. Charges for infertility medication;

O. Some drugs may require preauthorization;

P. Charges payable under any of the other benefits of the plan to the extent of the portion of such charges so paid.

Prescription Benefit Questions

Generally, questions regarding your pharmacy benefits should be directed to informedRx Customer Service at 888-354-0090. However, you should contact the Fund office with any questions concerning your eligibility for prescription benefits or for any additional assistance you may need.

DENTAL BENEFITS

Dental Benefits are provided through Group Dental Services ("GDS") and Participating Dentists. You must choose a Participating Dentist as your primary care dentist by notifying GDS's Administrative Office at 1-800-242-0450 or 301-770-1480. A GDS Member Service Representative will provide you with a list of Participating Dentists who are close to where you live or work. You and each of your covered Dependents are free to choose the same or a different Participating Dentist as your primary care dentist, or to change your selection at any time by calling GDS.

This dental program provides coverage for the least costly, professionally adequate procedure to treat a condition. If you agree to a more costly procedure, the Fund will only cover the less costly procedure and you will be responsible for the difference in cost.

If you do not live or work within 20 miles or 30 minutes of a Participating Dentist and you seek treatment from a nonparticipating dentist where you live or work, GDS will reimburse you upon written proof of receipt of Covered Services in the amount GDS would have paid to a Participating Dentist for rendering the service. You will be responsible for any additional charges. You should contact GDS's Administrative office prior to seeking treatment to determine the amount that GDS pays for the services and you must submit your written proof of the services to GDS.

You may seek a referral from GDS to a nonparticipating specialist who agrees to accept GDS's rates if you have a condition requiring specialized care and GDS does not have a specialist in the network with the training and expertise to treat the condition. Contact GDS for more information.

The Fund will provide the following Covered Services only when performed by a Participating Dentist (with limited exceptions listed on pages 50-51):

A. Basic services; provided at no charge

(1) Oral examination;

(2) Prophylaxis, including sealing and polishing, limited to once every six months;

(3) Dental X-rays as required, including bite wing and periapical X-rays;

(4) Fluoride treatments to patients under age 19;

(5) Local anesthesia;

(6) Palliative emergency treatment;

(7) Dental fillings of all types, except gold;

(8) Routine extractions provided by the general dentist.

B. Oral surgery: provided at no charge

(1) All extractions (including simple, surgical, multiple and impactions);

(2) Local or general anesthesia;

(3) X-rays and alveolectomies associated with extraction.

C. Prosthetics service; provided at no charge

(1) Simple denture repairs;

(2) Denture rebase;

(3) Nesbits (one tooth partials);

(4) Denture reconstruction

D. Additional services

The following services will be available from the Participating Dentists after a patient Co-payment according to the fee schedule set forth below:

(1) Full denture; limited to one set in any five-year period $30.00

(2) Partial denture; limited to one set in any five-year period $30.00

(3) Space maintainer (unilateral) $10.00

(4) Bilateral fixed space maintainer $20.00

E. Orthodontia coverage is available after a Co-payment of $1,500, and is limited to:

(1) Diagnosis, including models, photographs, x-rays, and tracings.

(2) Active fully banded treatment, including necessary appliances and progress x-rays.

(3) Retention treatment following active treatment (not to exceed ten visits in any 18-month period.).

(4) Phase I (interceptive orthodontic treatment) is not covered.

(5) Benefits will not be provided beyond a period of 24 consecutive months of active treatment nor beyond a period of 18 consecutive months of retention treatment.

(6) The Plan will not be liable for the replacement and/or repair of any appliance which was not initially furnished by GDS.

(7) Benefits will be provided to a Covered Person not more than once within a five-year period.

(8) Patients must be age 11 or older.

Certain specialized dental services, namely periodontia and pedodontia, are not included in the services provided for in this program. Endodontia (root canal) is also excluded. See Limitations and Exclusions below.

Important! Any services rendered by a nonparticipating dentist will not be covered by this Plan (except as described below).

Limitations and Exclusions

In addition to the General Limitations and Exclusions section found elsewhere in this booklet, the Dental Benefit does not cover the following:

A. Prophylaxis, including sealing and polishing, more than once every six months. See A above.

B. More than one partial or complete denture per arch within a five-year period. See D. above.

C. Orthodontia, except as provided in E above.

D. Covered Services provided by a Participating Dentist, except in the following circumstances:

(1) when authorized by GDS;

(2) in the case of a Dental Emergency, occurring further than fifty miles from the Covered Person's primary dentist if the Covered Person is temporarily away from home and outside the GDS service area; or

(3) You do not live or work within 20 miles or 30 minutes of a Participating Dentist and you submit written proof of receipt of Covered Services. You will be reimbursed only for the cost GDS would have paid a Participating Dentist for the same Covered service.

E. Cosmetic services. Cosmetic services are those services that are elective and that are not necessary for good dental health. Cosmetic services include, but are not limited to:

(1) alteration or extraction and replacement of sound teeth;

(2) any treatment of the teeth to remove or lessen discoloration except in connection with endodontic treatment.

F. Examination, evaluation and treatment of temporomandibular joint (TMJ) pain dysfunction, unless incidental to another appointment.

G. Replacement of dentures, bridgework or any other dental appliances previously supplied by GDS, due to loss or theft is not covered, unless the Covered Person received such appliance prior to the immediately preceding five-year period.

H. Any service or treatment started before the Covered Person was covered by GDS, for example, orthodontic work in progress, teeth prepared for crowns, and root canal therapy in progress. Please contact the Fund Office or GDS for details.

I. Hospitalization for any dental procedure.

J. Drugs obtainable, whether with or without a prescription.

K. Dental implants.

L. Services rendered by prosthodontic specialists and that are necessary for complete oral rehabilitation or reconstruction.

M. Services for injuries or conditions that are covered under Workers' Compensation or employer's liability laws; services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision.

N. Periodontia, pedodontia, and endodontia (root canal).

To Make an Appointment With A Participating Dentist

All Covered Persons must first register at one of the registration centers before beginning treatment by a Participating Dentist. Subsequent dental appointments are made by calling GDS directly at (301) 770-1480 or 1-800-242-0450. Requests for appointments will be taken in the order they are received. When calling, have pencil and paper ready to take down the name and address of the dentist and the appointment time. Be ready to give your Social Security number.

Broken or Late Appointments

Many Covered Persons need dental services, and a broken appointment will deprive someone else of treatment, since available dental time is limited. Therefore, any broken appointment will

be charged to the patient at a rate of $10 for each half hour of the missed appointment unless you cancel the appointment at least 24 hours in advance. Unless the broken appointment fee is paid, no further dental work will be done. Plan to be at a Participating Dentist's office ten minutes in advance of an appointment. If you arrive more than thirty (30) minutes late for a scheduled appointment, the Participating Dentist may treat the tardiness as a failure to keep a scheduled appointment and the missed appointment fee will apply.

Filing A Claim

A description of procedures to file a claim and GDS' grievance and appeals procedures, as well as a more detailed description of the dental program, is included in the attached GDS Certificate of Coverage. GDS' grievance procedure in no way limits your right to appeal to the Fund's Board of Trustees, described later in this booklet. See the Claim Review and Appeal Procedures section of this SPD for more information.

COORDINATION OF BENEFITS

It is the Fund's intent to help pay your medical bills, but your benefits are not meant to exceed the charges you incur. Therefore, if you or your Eligible Dependents are covered under one or more Other Plans, as defined below, the Fund will coordinate benefits so that total benefits payable by both plans will not exceed the applicable UCR for the service or supply in question. When duplicate coverage exists, the primary plan normally pays its benefits according to its schedule of benefits, and the secondary plan pays a reduced amount. The Fund will never pay, either as the primary or the secondary plan, benefits which, when added to the benefits payable by the Other Plan for the same service, exceed 100% of the UCR charge. Benefits payable under an Other Plan include the benefits that would have been payable if proper claim had been made for them.

All benefits provided by the Fund are subject to this provision.

For purposes of this provision, the term "Other Plan" means any plan providing benefits or services for or by reason of medical care or treatment, or dental care or treatment, under (1) group, blanket, or franchise insurance coverage; (2) hospital or medical service organizations and other group prepayment coverage; (3) labor-management trusted plans, union welfare plans and/or employer organization plans; (4) governmental programs or plans required or provided by any statute; (5) schools or other educational institutions; (6) any Health Maintenance Organization; and (7) any other plan or program of health benefits, regardless of whether funded by insurance or otherwise.

The following rules apply:

A. The plan that covers the Covered Person as an employee (or, if applicable, former employee) is primary; the plan that covers the covered person as a Dependent is the secondary plan.

B. When a child whose parents are not legally separated or divorced is covered as an Eligible Dependent under this Plan and an Other Plan, the primary plan is the plan of the parent whose birthday falls earlier in the year.

C. When a child whose parents are legally separated or divorced is covered as an Eligible Dependent under this Plan and an Other Plan, and there is a court decree that establishes financial responsibility for health care expenses with respect to the child, the plan of the parent with such financial responsibility is primary.

D. When a child whose parents are legally separated or divorced is covered as an Eligible Dependent under this Plan and an Other Plan, and there is no court decree establishing financial responsibility for the child's health care expenses, the plan of the parent with legal custody of the child (or the stepparent if the parent with custody has remarried) is primary.

E. When rules A-D do not establish an order of benefit determination, the benefits of the plan which has covered the person for the longer period of time shall be primary.

For the purposes of Coordination of Benefits, the Fund may:

A. Release to or obtain from any insurance company or other organization or person any information and may require information to be furnished by any person claiming benefits under the Fund;

B. Have the right to pay to any organization any amount determined to be warranted, if payments that should have been made under the Fund have been made by such other organization;

C. Have the right, if overpayment is made, to recover such overpayment from any person or any insurance company or organization.

Medicare - Coordination of Benefits

All active Participants over age 65 and spouses over age 65 of active Participants of any age will be entitled to receive coverage under this Plan under the same conditions as a Participant or Participant's spouse under age 65. The Plan cannot be "secondary" to Medicare for employees and spouses over age 65 by paying only those medical expenses Medicare does not cover. Absent an election (described below), the Plan will be the primary payor of medical costs for active Participants over 65 and spouses over 65 of active Participants of any age, with Medicare providing secondary coverage. This means you will be reimbursed first under this Plan (except in the case of End Stage Renal Disease ("ESRD") as set forth below). If there are covered expenses not paid by the Plan, Medicare may reimburse you if the expenses are covered by Medicare. To get reimbursement from Medicare, you must enroll for Medicare. In addition, to get coverage under Part B of Medicare, you must enroll and pay a monthly premium.

If you are age 65 or older, you are entitled to elect Medicare as your primary insurance coverage in lieu of the Plan. However, an active Participant over age 65 or an active Participant's spouse over age 65 will automatically continue to be covered by this Plan as the primary insurer unless you (1) notify the Administrative Manager, in writing, that you do not want coverage under this Plan to continue or (2) you cease to be eligible for coverage under this Plan. If you elect coverage under Medicare, the Plan will not pay benefits secondary to Medicare. If you have any questions about the coordination of benefits under this Plan with Medicare benefits, contact the Fund Office.

In order to ensure that you begin to receive Medicare benefits at age 65, you must contact the Social Security Administration office regarding these benefits at least three months prior to your attaining age 65.

Disabled Participants under age 65

If you or your spouse, while under age 65, is entitled to Medicare solely on the basis of total and permanent disability as defined by the Social Security Administration, other than for End Stage Renal Disease ("ESRD"), the Plan will be primary for meeting your medical expenses provided you are covered under this Plan as an active employee or Eligible Dependent. Medicare will provide coverage on a secondary basis.

If your disabled spouse has other group coverage, the benefits are payable in the following order:

A. This Plan, up to the limits of the benefits provided in the Plan.

B. Spouse's coverage.

C. Medicare.

ESRD

If you or your Eligible Dependent(s) become entitled to Medicare based on ESRD, the Plan will remain primary for the first 30 months of your entitlement to Medicare due to ESRD, to the extent required by law. If you or your Eligible Dependent(s) are entitled to Medicare on the basis of age or disability and the Plan is currently paying benefits secondary, the Plan will remain secondary upon your entitlement to Medicare due to ESRD.

GENERAL EXCLUSIONS AND LIMITATIONS

Limitations that apply only to certain services have been described in the appropriate sections. The following General Exclusions apply to all benefits, except Life Insurance and Accidental Death and Dismemberment.

Benefits are not payable for the following:

A. Services, supplies or care provided as a result of any Injury or Illness arising out of or in the course of any employment that is compensable under any Workers' Compensation or occupational disease act or law or employer's liability law, except those covered by the Life or Accidental Death and Dismemberment Benefits. However, under specified circumstances, benefits may be advanced to you pending a determination of Workers' Compensation coverage;

B. Services, supplies or care rendered in a Veteran's Administration or other Federal, State, County or Municipal Hospital;

C. Supplies, services or care for which no charge is made, or which are furnished by or at the expense of the U.S. Government or any of its agencies, including benefits paid under "Medicare";

D. Medical expenses caused or contributed to by warfare, injury occurring or illness contracted while in the Armed Forces;

E. Treatment, services, supplies or care deemed not Medically Necessary;

F. Charges in excess of the UCR charges with respect to the price of any treatment, service or supply;

G. Services, supplies or care related to treatment of Injuries incurred during aviation on other than regular commercial flights;

H. Services, supplies or care for Illnesses, Injuries or conditions related to alcohol abuse or alcoholism for Eligible Dependents;

I. Services, supplies or care for conditions related to drug addiction or substance abuse for Eligible Dependents;

J. Services, supplies or care in a nursing home, skilled nursing home or extended care facility;

K. Cosmetic or elective surgery, except as expressly covered under Major Medical benefits;

L. Service, supplies or care related to pregnancy for persons other than the Participant or the Participant's legal spouse;

M. Services, supplies or care related to weight control and treatment of obesity not caused by an organic condition;

N. Treatment for sexual impairment or inadequacy, except as provided for under the Prescription Drug Benefit;

O. Dental services and supplies, except as covered under Dental Benefits;

P. Vision Care services and supplies, except as covered under Vision Care Benefits;

Q. Prescription drugs except as covered under Prescription Drug Benefits;

R. Services, supplies, care or treatment, the cost of which may be recoverable by, or on behalf of, you or your Dependent in any action at law, any judgment, compromise, settlement of any claims against any party, or any other payment, you, your Dependent or your attorney may receive as a result of an Injury, no matter how these amounts are

characterized or who pays these amounts, as provided under Subrogation and Reimbursement Section of this SPD;

S. Services, supplies, care or treatment resulting from you or your Eligible Dependent's participation in an illegal or criminal act or while in police custody. This exclusion is not affected by any subsequent official action or determination with respect to prosecution of the Covered Person (including acquittal or failure to prosecute) in connection with the acts involved;

T. Services, supplies or care provided prior to the effective date or subsequent to the termination date of the Covered Person's coverage under the Plan;

U. All services, supplies, care and treatment not expressly covered in this SPD.

CLAIMS FOR BENEFITS

To file a claim for benefits, please follow the instructions in the section of this SPD describing the particular benefit. In addition, please read the following information carefully.

Hospital, Major Medical, Prescription Drug, and Accident and Sickness Benefits

Hospital, Medical, Prescription Drug, and Accident and Sickness benefits are provided directly by the Fund. The general claim filing rules and the Claim Review and Appeal Procedures described below apply to these benefits.

Life Insurance, AD&D, Dental and Vision Benefits

Claims for Life Insurance, AD&D, Dental and Vision benefits are provided under insurance agreements between the Fund and specific insurers. For claims and appeals rules for these benefits, please consult with your insurance booklets. However, because the Fund is still responsible for determining your eligibility for these benefits, you may follow the appeal procedures provided below for eligibility denials.

When You File a Claim – General Rules

A. Present your Fund identification card when seeking service from a Hospital, Physician or Pharmacist.

B. You (or the Hospital, Physician or other provider) must submit an itemized bill or file a claim for you or your Dependent to be eligible for benefits. A provider may submit a bill directly to the Fund when you sign the "Assignment to Pay Benefits to Provider" on your claim form. Then the Fund may pay the fee for covered services directly to the Hospital or Physician. If your provider has not billed the Fund directly, you must submit an itemized bill or file a claim for benefits with the Fund Office. Bills must be fully itemized and on the letterhead stationery of the provider of the service. Bills must show the patient's name, type of service, diagnosis, dates of service, and charge per service. Canceled checks, cash register slips, and personal itemizations are not acceptable.

C. If bills are submitted for more than one family member at a time, a separate itemized bill must be submitted for each individual member.

D. Several benefits have deadlines to file a claim. For example, Hospital and major medical claims or itemized bills must be filed within 12 months of the date of service. Please refer to the section in the SPD concerning the specific benefit for this important information.

E. The fact that a claim for benefits from a source other than the Fund has been filed or is pending does not excuse these claims filing requirements. Likewise, lack of knowledge of coverage does not excuse these requirements.

F. If you receive Hospital care in a Veterans', Marine, or other federal Hospital or elsewhere at government (federal, state, or municipal) expense, no benefits are provided under this Plan. However, to the extent required by law, the Fund will reimburse the VA Hospital for care of a non-service related disability if the Fund would normally cover charges for such care and if the claim is properly filed within the appropriate Fund time periods.

G. The Fund reserves the right and opportunity to examine the person whose Injury or Illness is the basis of a claim as often as it may reasonably require during pendency of the claim.

H. You will receive an Explanation of Benefits ("EOB") or other notice from the Fund when your claim is processed as explained below. Please keep the EOB or notice and refer to it when you have questions regarding your claim.

I. Keep copies of all bills submitted for your records. Original bills will not be returned.

J. You may name a representative to act on your behalf during the claims procedure. To do so, you must notify the Fund in writing of the representative's name, address, and telephone number and authorize the Fund to release information (which may include medical information) to your representative. Please contact the Fund Office for a form to designate a representative. In the case of an Urgent Care claim, defined below, a health care professional with knowledge of your medical condition will be permitted to act as your representative.

K. The Fund does not impose any charges or costs to review a claim or appeal; however, regardless of the outcome of an appeal, neither the Board of Trustees nor the Fund will be responsible for paying any expenses that you might incur during the course of an appeal.

L. The Fund and Board of Trustees, in making decisions on claims and on appeal, will apply the terms of the Plan and any applicable guidelines, rules and schedules, and will periodically verify that benefit determinations are made in accordance with such documents, and where appropriate, applied consistently with respect to similarly situated claimants. Additionally, the Fund and Trustees will take into account all information you submit in making decisions on claims and on appeal.

M. If your claim is denied in whole or in part, you are not required to appeal the decision. However, you must exhaust your administrative remedies by appealing the denial to the Board of Trustees before you have a right to bring an action in federal or state court. Failure to exhaust these administrative remedies will result in the loss of your right to file suit, as described in the ERISA Rights statement in this SPD.

N. The Fund's procedures and time limits for processing claims and for deciding appeals will vary depending upon the type of claim, as explained below. However, the Fund may also request that you voluntarily extend the period of time for the Fund to make a decision on your claim or your appeal.

Claim Inquiries

If you have a question regarding coverage for services not specifically stated in the Summary Plan Description, submit it in writing to the Fund Office. Do not rely on a verbal statement; request a written statement before proceeding with the contemplated medical service.

Fraudulent Claims

If a fraudulent claim is knowingly submitted, all benefits will be denied. If any benefits should be paid on any fraudulent claim, the Participant and his Eligible Dependents may be denied all further benefits under the Fund until restitution of the money improperly obtained is made to the Fund. Fraudulent claims include accepting benefits not covered under the Plan. The Participant will be advised by mail of any action taken with regard to a fraudulent claim. This procedure supplements any remedies available in a court proceeding against the Participant.

CLAIM REVIEW AND APPEAL PROCEDURES

A. Life Insurance and Accidental Death & Dismemberment Benefits

If your claim for AD&D benefits, or your beneficiary's claim for life insurance benefits, is denied by Prudential Insurance you must appeal directly to Prudential. However, if your (or your beneficiary's) claim is denied on the basis of your eligibility for benefits from the Fund, you may appeal to the Board of Trustees using the procedures outlined in Section (2) below.

For claims and appeals rules regarding the Plan's life insurance and accidental death dismemberment benefits, please see your booklet from Prudential

However, if your claim for benefits is denied on the grounds you are not eligible for benefits, in whole or in part, you will receive a written explanation of the reason(s) it was denied usually within 90 days after your claim has been received by the Fund Office. If additional time of up to 90 days is required because of special circumstances, you will be notified in writing of the reason for the delay, and the date that the Fund expects to issue a final decision. A decision will be made with respect to your claim no more than 180 days from the date your claim is first filed with the Fund Office.

If your claim is denied, you will receive a written explanation that describes the specific reason for the denial, the specific provisions of this SPD on which the decision was based, any additional information necessary to reconsider your claim, the Fund's appeal procedures, and also your right to bring an action under ERISA if you decide to appeal and that appeal is denied.

You can appeal the claim denial based on ineligibility for benefits directly to the Board of Trustees. If you decide to appeal to the Board of Trustees, you must make written request for a review within 60 days after you receive written notice your claim has been denied. You must include in your written appeal all the facts regarding your claim as well as the reason(s) you feel

the denial was incorrect. You may receive, upon request and free of charge, reasonable access to and copies of documents relevant to your claim. You may submit issues and comments in writing, and documents, relating to your claim.

The Board of Trustees will take into account all information you submit in making its decision. The Board of Trustees will make its decision at the next regular meeting following receipt of your appeal, unless there are special circumstances, such as the need to hold a hearing, in which case the Board of Trustees will decide the case at its next regular meeting. If you submit your appeal less than 30 days before the next scheduled Board of Trustees meeting, the Board of Trustees will then decide the case at the second scheduled meeting, or, if there are special circumstances, the third meeting after it receives your appeal. If the Board of Trustees requires a postponement of the decision to the next meeting, you will receive a notice describing the reason for the delay and an expected date of the decision.

The Board of Trustees will send you a notice of its decision within five days of the decision. If the Board of Trustees denies your appeal, the notice will contain the reasons for the decision, specific references to the plan provisions on which the decision was based, notice that you may receive, upon request and free of charge, reasonable access to and copies of all documents and records relevant to the claim, and a statement of your right to bring a lawsuit under ERISA.

The decision of the Board of Trustees is final and binding.

B. Accident and Sickness (Loss of Time) or Disability Benefits

If your claim for Accident and Sickness benefits is denied by the Fund, in whole or in part (or your benefits reduced or terminated), you will receive a written explanation of the reason(s) it was denied usually within 45 days after your claim has been received by the Fund Office. The Fund may require an additional 30 days, and occasionally another 30 days beyond that, for reasons beyond the control of the Fund, including your failure to properly file your claim or submit sufficient information for the Fund to process it. If extra time is required, you will be notified in writing explaining the reason for the delay, the standards for entitlement to a benefit, any unresolved issues and additional information required, and the date that the Fund expects to issue a final decision. If the Fund requests additional information, you will have 45 days to respond. The Fund will not decide your claim until you respond or the 45 days expires, whichever comes first. If you do not submit the requested information, the Fund will deny your claim.

If your claim is denied, you will receive a written explanation that describes the specific reason for the denial, the specific provisions of the plan document on which the decision was based, any additional information necessary to reconsider your claim, the Fund's appeal procedures, and also your right to bring an action under ERISA if you decide to appeal and that appeal is denied. If the Fund relied on an internal rule, guideline or protocol in making the decision, you will receive either a copy of the rule, etc., or a statement that it was relied upon and is available upon request and free of charge. If the Fund based its decision on medical necessity, experimental treatment or a similar exclusion or limit, you will receive either an explanation of the decision related to your condition or a statement that such an explanation is available upon request and

free of charge. If the Fund received the advice of any medical or vocational expert with respect to your claim, the Fund will identify the expert upon your request.

You can appeal the claim denial directly to the Board of Trustees. If you decide to appeal to the Board of Trustees, you must make a written request for a review within 180 days after you receive written notice your claim has been denied. You must include in your written appeal all the facts regarding your claim as well as the reason(s) you feel the denial was incorrect. You may receive, upon request and free of charge, reasonable access to and copies of documents relevant to your claim. You may submit issues and comments in writing, and documents, relating to your claim.

The Board of Trustees will take into account all information you submit in making its decision. If the initial decision was based in whole or in part on a medical judgment, the Board of Trustees will consult with a health care professional in the appropriate field who was not consulted in the initial determination (or a subordinate of such person). The Board of Trustees did not initially review your claim, and will not give deference to the initial decision. The Board of Trustees will make its decision at the next regular meeting following receipt of your appeal, unless there are special circumstances, such as the need to hold a hearing, in which case the Board of Trustees will decide the case at its next regular meeting. If you submit your appeal less than 30 days before the next scheduled Board of Trustees meeting, the Board of Trustees will then decide the case at the second scheduled meeting, or, if there are special circumstances, the third meeting after it receives your appeal. If the Board of Trustees requires a postponement of the next meeting, you will receive a notice describing the reason for the delay and an expected date of decision.

The Board of Trustees will send you a notice of its decision within five days of the decision. If the Board of Trustee denies your appeal, the notice will contain the reasons for the decision, specific references to the plan provisions on which the decision was based, notice that you may receive, upon request and free of charge, reasonable access to and copies of all documents and records relevant to the claim, and a statement of your right to bring a lawsuit under ERISA. If the Fund relied on an internal rule, guideline or protocol in making the decision, you will receive either a copy of the rule, etc., or a statement that it was relied upon and is available upon request and free of charge. If the Fund based its decision on medical necessity, experimental treatment or a similar exclusion or limit, you will receive either an explanation of the decision related to your condition or a statement that such an explanation is available upon request and free of charge. If the Fund received the advice of any medical or vocational expert with respect to your claim, the Fund will identify the expert upon your request.

The decision of the Board of Trustees is final and binding.

C. Hospital, Major Medical and Prescription Drug Benefits

All claims for Hospital, Major Medical and Prescription Drug benefits are decided by the Fund. The procedures and time periods for processing claims depends on the type of claim as explained below.

(1) Claim Review

Pre-Service Claim

A pre-service claim is any claim for benefits under the Plan, the receipt of which is conditioned, in whole or in part, on the Fund's approval of the benefit before you receive the medical care. For example, a request for services for which pre-certification is required, is a pre-service claim.

If your pre-service claim is filed improperly, the Fund will notify you of the problem (either orally or in writing, unless you request it in writing) within five (5) days of the date you filed the claim. The Fund will notify you of its decision on your pre-service claim (whether approved or denied) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after the claim is received by the Fund. The Fund may extend the period for a decision for up to fifteen (15) additional days due to matters beyond the control of the Fund, provided that the Fund gives you a written notice of such extension before the end of the initial fifteen (15) day period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which the Fund expects to make a decision. If an extension is necessary due to your failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information, and you will be given at least forty-five (45) days from receipt of the notice to provide the requested information.

If you do not provide the information requested, or do not properly refile the claim, the Fund will decide the claim based on the information it has available, and your claim may be denied.

Urgent Care Claim

An Urgent Care claim is a pre-service claim that requires shortened time periods for making a determination because a longer determination period (i) could seriously jeopardize your life or health or your ability to regain maximum function or (ii) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. It is important to note that the rules for an Urgent Care claim apply only when the Fund requires approval of the benefit before you receive the services; these rules do not apply if approval is not required before health care is provided, for example in the case of an emergency. See the Section of your SPD entitled "Certified Admissions Review and Evaluation" for more information on the Plan's pre-approval and pre-certification requirements and whom you should contact for pre-approval and pre-certification.

If your Urgent Care claim is filed improperly, the Fund will notify you of the problem (either orally or in writing, unless you request it in writing) within 24 hours of the date you filed the claim. The Fund will notify you of the decision on your Urgent Care claim (whether approved or denied) as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after the claim is received by the Fund, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered. If the Fund needs more information, the Fund will notify you of the specific information necessary to complete the claim as soon as possible, but not later than twenty-four (24) hours after receipt of

the claim by the Fund. You will be given a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the requested information. The Fund will notify you of its decision as soon as possible, but not later than forty-eight (48) hours after the earlier of (i) the Fund's receipt of the specified information or (ii) the end of the period given to you to provide the specified information. Due to the nature of an Urgent Care claim, you may be notified of a decision by telephone, which will be followed by a written notice of the same information within three (3) days of the oral notice.

If you do not provide the information requested, or do not properly refile the claim, the Fund will have to decide the claim based on the information it has available.

Concurrent Care Claim

A Concurrent Care claim is a request for the Fund to approve, or to extend, an ongoing course of treatment over a period of time or number of treatments, when such approval is required. If you have been approved by the Fund for Concurrent Care treatment, any reduction or termination of such treatment (other than by amendment to the program of benefits or termination of the Plan) before the end of the period of time or number of treatments will be considered denial of a claim. The Fund will notify you of the denial of the claim at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a decision on review of the denial of the claim before the benefit is reduced or terminated.

Your request to extend a course of treatment beyond the previously approved period of time or number of treatments that constitutes an Urgent Care claim will be decided as soon as possible, taking into account medical circumstances, and will be subject to the rules for Urgent Care claims (see above), except the Fund will notify you of the decision (whether approved or denied) within twenty-four (24) hours after the Fund's receipt of the claim, provided that the claim is made to the Fund at least twenty-four (24) hours before the end of the previously approved period of time or number of treatments.

Post-Service Claim

A post-service claim is any claim that is not a pre-service claim. Typically, a post-service claim is a request for payment by the Fund after you have received the services.

If the Fund denies your post-service claim, in whole or in part, the Fund will send you a notice of the claim denial within a reasonable period of time, but not later than thirty (30) days after the claim is received by the Fund. The Fund may extend the period for a decision for up to fifteen (15) additional days due to matters beyond the control of the Fund, provided that the Fund gives you a written notice of such extension before the end of the initial thirty (30) day period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which the Fund expects to make a decision. If an extension is necessary due to your failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information, and you will be given at least forty-five (45) days from receipt of the notice to provide the requested information. If you do not provide the information

requested, the Fund will decide the claim based on the information it has available, and your claim may be denied.

(2) Fund Decision

If the Fund denies the claim, in whole or in part, the Fund will send you a written notice of the denial, unless, as noted above, your claim is for Urgent Care, then this notice may be oral, followed in writing. The notice will provide (a) the specific reason or reasons for denial; (b) reference to specific SPD provisions on which the denial is based; (c) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (d) an explanation of the claims review procedures and the time limits applicable to such procedures, including the expedited review process applicable to Urgent Care claims; (e) a statement of your right to bring a civil action under Section 502(a) of ERISA following a denial of your appeal; (f) if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim, a statement that the specific rule, guideline, protocol, or other similar criterion was relied upon in denying the claim and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and (g) if the denial is based on a determination of medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment related to your condition will be provided free of charge upon request.

(3) Appeal Procedure

You have the right to appeal a denial of your benefit claim to the Fund's Board of Trustees. Your appeal must be in writing and must be sent to the Board of Trustees at the following address:

Board of Trustees
Washington Wholesalers Health and Welfare Fund
c/o Carday Associates
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

An appeal of an Urgent Care claim (see above) may also be made by telephone by calling 1-410-872-9500 or by faxing a letter to 1-410-872-9527. If your claim is denied, you (or your authorized representative) may, within 180 days from receipt of the denial, request a review by writing to the Board of Trustees. Pursuant to your right to appeal, you will have the right (a) to submit written comments, documents, records, and other information relating to your claim for benefits; and (b) upon request, reasonable access to, and free copies of, all documents, records, and other information relevant to your claim for benefits. In making a decision on review, the Board of Trustees or a committee of the Board of Trustees will review and consider all comments, documents, records, and all other information submitted by you or your duly authorized representative, without regard to whether such information was submitted or considered in the initial claim determination. In reviewing your claim, the Board of Trustees will not automatically presume that the Fund's initial decision was correct, but will

independently review your appeal. In addition, if the initial decision was based in whole or in part on a medical judgment (including a determination whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the Board of Trustees will consult with a healthcare professional in the appropriate medical field who was not the person consulted in the initial claim (nor a subordinate of such person) and will identify the medical or vocational experts who provided advice to the Fund on the initial claim.

In the case of an appeal of a claim involving Urgent Care as defined above, the Board of Trustees will notify you of the decision on your appeal as soon as possible, taking into account the applicable medical exigencies, but not later than seventy-two (72) hours after the Fund's receipt of your appeal. In the case of an appeal of a pre-service claim, the Board of Trustees will notify you of the decision on your appeal within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after the Fund's receipt of your appeal. The Fund may also request that you voluntarily extend the period of time for the Board of Trustees to make a decision on your appeal.

In the case of an appeal of a post-service claim, the Board of Trustees or a committee of the Board of Trustees will hear your appeal at their next scheduled quarterly meeting following receipt of your appeal, unless your appeal was received by the Fund within 30 days of the date of the meeting. In that case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. If special circumstances require an extension of the time for review by the Trustees, you will be notified in writing, before the extension, of the circumstances and the date on which a decision is expected. In no event will a decision be made later than the third quarterly meeting after receipt of your appeal. The Trustees will send you a written notice of their decision (whether approved or denied) within five days of the decision.

If the Board of Trustees has denied your appeal, the notice will provide (a) the specific reason or reasons for the denial; (b) references to specific SPD provisions on which the denial is based; (c) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and (d) a statement of your right to bring an action under Section 502(a) of ERISA. In addition, the notice will state that (a) if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your appeal, a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and (b) if the denial of your appeal was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation will be provided free of charge upon request.

The Board of Trustees has the power and sole discretion to interpret, apply, construe and amend the provisions of this SPD and make all factual determinations regarding the construction, interpretation and application of the SPD. The decision of the Board of Trustees is final and binding.

For certain benefits, before filing an appeal with the Board of Trustees as described above, you may wish to contact the appropriate Fund provider identified below with any questions or concerns that you have regarding the claim denial. If you choose to do so, please contact the

provider directly for important information regarding the appropriate procedures, including any time limits.

Whether or not you choose to address your concerns to the provider, you have the right to appeal a benefit denial to the Board of Trustees as described above. However, if you choose to address your concerns to the provider, you must do so before you appeal to the Board of Trustees. If you are not satisfied with the results through the provider and wish to file an appeal to the Board of Trustees, you must do so within 180 days from the day you received the original claim denial from the Fund Office or the provider. If you do not choose to address your concerns to the provider and wish to appeal directly to the Board of Trustees, you must do so within 180 days from the day you received the claim denial from the Fund Office or the provider. Please remember that if you are not able to resolve your concerns by contacting the appropriate provider named below, you must appeal to the Board of Trustees before filing a suit against the Fund.

- For certification of denials made by InforMed, you may contact InforMed at 1596 Whitehall Road, Annapolis, MD 21409 or 1-866-347-1676.

- For denied Prescription Drug benefit claims, you may contact informedRx at 20 Valentine Road, New Providence, NJ 07974 or 1-888-354-0090.

D. Vision and Dental Benefits

If your claim for Dental or Vision benefits is denied by the insurer on the basis of the insurance contract, you must follow the procedures outlined in the Dental or Vision insurer's booklet. If, however, you (or your Dependent's) claim is denied on the basis of your eligibility for benefits from the Fund, you may appeal to the Board of Trustees using the procedures for Hospital, Major Medical and Prescription Drug Benefits in Section C above.

Special Rule Regarding Appeals of Dental Benefit Claims

If you appeal your dental claim denial to GDS and GDS denies your appeal, the Fund offers an additional level of appeal by the Board of Trustees that is entirely voluntary. This means that you are not required to file this additional appeal with the Board of Trustees in order to file suit under Section 502(a) of ERISA. Please note the following about the Fund's voluntary level of appeal for dental claims:

A. Upon request and free of charge, the Fund will provide you with sufficient information relating to the voluntary level of appeal to enable you to make an informed judgment about whether to submit a dental benefit dispute to the voluntary level of appeal, including a statement that your decision as to whether to submit your dental benefit dispute to the voluntary level of appeal will have no effect on your right to any other benefits under the Plan and information about the applicable rules, your right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as financial or personal interests in the result or any past or present relationship to any party to the review process.

B. You may elect to file a voluntary appeal to the Board of Trustees only after a denial of your appeal by GDS.

C. The Fund will not impose any fees or costs on you as part of the voluntary appeal.

D. During this voluntary appeal process, the time that it takes to decide your appeal will not be counted against you in determining whether any lawsuit that you file afterward is brought in a timely manner.

Your voluntary appeal must be submitted in writing to the Board of Trustees within forty-five (45) days of the date you receive your appeal denial from GDS. The Board of Trustees or a committee of the Board of Trustees will hear your appeal at their next scheduled quarterly meeting following receipt of your appeal, unless your appeal was received by the Fund within thirty (30) days of the date of the meeting. In that case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. If special circumstances require an extension of the time for review by the Trustees, you will be notified in writing, before the extension, of the circumstances and the date on which a decision is expected. In no event will a decision be made later than the third quarterly meeting after receipt of your appeal. The Trustees will send you a written notice of their decision (whether approved or denied) within five (5) days of the decision.

ADVANCE BENEFITS FOR WORKERS' COMPENSATION CLAIMS

(Participant ONLY)

If you suffer an Injury or Illness that is work-related, you must file a claim for Workers' Compensation benefits with your Employer. The Fund does not cover any expenses related to an Illness or Injury that is work-related. However, if you apply for Workers' Compensation and your claim is denied by either your Employer or your Employer's insurance carrier, you may apply to the Fund for Accident & Sickness or Medical Benefits. This benefit is not available to Dependents.

The Fund will pay benefits provided that:

A. You file a timely claim with the Fund – that is, within 12 months of the date of service for Hospital and Major Medical claims (for other claims, check the section of this SPD for applicable claims filing deadlines).

B. You submit a copy of the written denial of your workers' compensation claim from your Employer or your Employer's insurance carrier. The denial must state that the claim is not compensable under Workers' Compensation.

C. You agree in writing to timely appeal the denial of your Workers' Compensation claim to the Workers' Compensation Commission for final adjudication.

D. If you fail to file an appeal within 30 days from the date the original claim is denied, all benefits terminate and payments made by the Fund to you and your provider must be immediately returned.

E. You obtain approval from the Fund Office prior to any settlement of your claim.

F. If the Workers' Compensation Commission denies your claim, for a reason other than your failure to appear, failure to file a timely appeal or failure to file supplementary materials if requested to do so, and you do not appeal, you may keep any payments advanced to you. However, if you decide to pursue your claim after that denial and you receive any recovery, whether by judgment, settlement, or compromise, you must repay the Fund the payments advanced to you.

G. If the Workers' Compensation Commission determines that your claim is work related, but denies your claim for another reason, you must repay the Fund the payments advanced to you.

SUBROGATION AND REIMBURSEMENT

The Fund does not provide benefits to the extent of any recovery received from a third party. FOR INSTANCE, IF YOU OR YOUR ELIGIBLE DEPENDENT IS INJURED IN AN AUTOMOBILE ACCIDENT OR OTHER ACCIDENT, INCLUDING MALPRACTICE, FOR WHICH A THIRD PARTY IS LIABLE TO PAY YOU DAMAGES, THEN THAT PERSON (OR HIS/HER INSURANCE) IS RESPONSIBLE FOR PAYING YOUR OR YOUR ELIGIBLE DEPENDENT'S ELIGIBLE MEDICAL EXPENSES, AS WELL AS YOUR ACCIDENT AND SICKNESS BENEFITS. It is recognized that legal proceedings to recover from a third party can take a long time and are not always successful in the end. For this reason, the Fund will advance benefits on your behalf based on the understanding that you are required to reimburse the Fund in full from any recovery you or your Eligible Dependent may receive no matter how characterized. The Fund extends benefits to you and your Eligible Dependents only as a service to you. The Fund expects to be reimbursed if you obtain recovery from another person or entity or their insurance coverage, regardless of the provisions of that insurance with respect to the coordination of benefits.

You and/or your Dependent are required to notify the Fund within ten (10) days of any accident, Illness or Injury for which someone else may be liable. Further, the Fund must be notified within ten (10) days of the initiation of any lawsuit arising out of the accident, Illness or Injury and of the conclusion of any settlement, judgment or payment relating to the accident, Illness or Injury in any lawsuit initiated to protect the Fund's claims.

If you or your Dependent receive any benefit payments from the Fund for an Injury or Illness and you or your Dependent recover any amount from any third party or parties in connection with such Injury or Illness, regardless of how such recovery is characterized, you or your Dependent must reimburse the Fund from that recovery the total amount of all benefit payments the Fund made or will make on your or your Dependent's behalf in connection with such Injury or Illness.

In addition, if you or your Dependent receive any benefit payments from the Fund for any such Injury or Illness, the Fund is subrogated to all rights of recovery available to you or your Dependent arising out of any claim, demand, cause of action or right of recovery which has accrued, may accrue or which is asserted in connection with such Injury or Illness, to the extent of any and all related benefit payments made or to be made by the Fund on your or your Dependent's behalf. This means that the Fund has an independent right to bring an action in connection with such Injury or Illness in your or your Dependent's name and also has a right to intervene in any such action brought by you or your Dependent, including any action against an insurance carrier under any uninsured or under-insured motor vehicle policy.

The Fund's right of reimbursement and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable to any extent for the Injury or Illness, and regardless of whether you or your Dependent actually obtain the full amount of such judgment, award, settlement, compromise, insurance or order.

The Fund's rights of reimbursement and subrogation provide the Fund with first priority to any and all recovery in connection with the Injury or Illness, whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified. Such recovery includes amounts payable under you or your Dependent's own uninsured motorist insurance, under-insured motorist insurance, or any medical pay or no-fault benefits payable. The "make-whole" doctrine does not apply to the Fund's rights of reimbursement and subrogation. The Fund's rights of reimbursement and subrogation are for the full amount of all related benefit payments; this amount is not offset by legal costs, attorneys' fees or other expenses incurred by you or your Dependent in obtaining recovery. The Fund shall have a lien on any amount received by you, your Dependent or a representative of you or your Dependent (including an attorney) that is due to the Fund under this Section, and any such amount shall be deemed to be held in trust by you or your Dependent or representative for the benefit of the Fund until paid to the Fund.

The Fund requires that you, your Eligible Dependent, and your attorney, complete, sign, and return to the Fund a Subrogation and Reimbursement Agreement that includes a questionnaire about the accident. The Fund will send the Subrogation/Reimbursement Agreement to its lawyer, who arranges to recover payment for the Fund. Under the Fund's Subrogation and Reimbursement Agreement, you have the following obligations:

A. Show the Subrogation and Reimbursement Agreement to your attorney if you retain an attorney to represent you in your claim. The attorney must sign the Subrogation Agreement or all benefit payments will cease.

B. Notify the Fund Office within ten (10) days of the date you file suit.

C. Take such action and cooperate with the Fund Office or Fund Counsel, as necessary or appropriate, to recover from any third party, as damages, those payments made by the Fund.

D. Reimburse the Fund in full from any money recovered from third persons, as described above.

E. Not do anything to impair, prejudice, or discharge the Fund's right of subrogation.

Benefit payments are not payable until you sign a Subrogation and Reimbursement Agreement. Your or your Dependent's claims will not be considered filed and will not be paid until the fully signed Agreement is received by the Fund. This means that, if you file a claim and your Subrogation and Reimbursement Agreement is not received promptly, the claim will be untimely and will not be paid if the period for filing claims passes before your Subrogation and Reimbursement Agreement is received.

Further, the Fund excludes from coverage for any charges, any medical or other treatment, service or supply to the extent that the cost of the professional care or hospitalization may be recoverable by, or on behalf of, you or your Dependent in any action at law, any judgment,

compromise or settlement of any claims against any party, or any other payment you, your Dependent, or your attorney may receive as a result of the accident, Illness or Injury, no matter how these amounts are characterized or who pays these amounts, as provided in this Section.

Under this provision, you and/or your Dependent are obligated to take all necessary action and cooperate fully with the Fund in its exercise of its rights of reimbursement and subrogation, including notifying the Fund of the status of any claim or legal action asserted against any party or insurance carrier and of your or your Dependent's receipt of any recovery. You or your Dependent also must do nothing to impair or prejudice the Fund's rights. For example, if you or your Dependent choose not to pursue the liability of a third party, you or your Dependent may not waive any rights covering any conditions under which any recovery could be received. If you are asked to do so, you must contact the Fund Office immediately. Where you or your eligible Dependent choose not to pursue the liability of a third party, the acceptance of benefits from the Fund authorizes the Fund to litigate or settle your claims against the third party. If the Fund takes legal action to recover what it has paid, the acceptance of benefits obligates you and your Dependent (and your attorney if you have one) to cooperate with the Fund in seeking its recovery, and in providing relevant information with respect to the accident.

You or your Eligible Dependent also must notify the Fund before accepting any payment prior to the initiation of a lawsuit. If you do not, and you accept payment that is less than the full amount of the benefits that the Fund has advanced you, you will still be required to repay the Fund, in full, for any benefits it has paid. The Fund may withhold benefits if you or your Eligible Dependent waives any of the Fund's rights to recovery or fail to cooperate with the Fund in any respect regarding the Fund's subrogation rights.

If you or your Eligible Dependent refuses to reimburse the Fund or refuses to cooperate with the Fund regarding its Subrogation and Reimbursement rights, the Fund has the right to recover amounts you or your Eligible Dependent owes by methods that include offsetting them against future benefits, if necessary. "Non-cooperation" includes the failure of any party to execute a Subrogation and Reimbursement Agreement and the failure of any party to respond to the Fund's inquiries concerning the status of any claim or any other inquiry relating to the Fund's right of reimbursement and subrogation.

This Reimbursement and Subrogation program is a service to you or your Eligible Dependent. It provides for the early payment of benefits. It also saves the Fund money (which saves YOU money, too) by making sure the responsible party pays for your injuries.

Please contact the Fund Office if you have any questions about Subrogation.

GENERAL PLAN INFORMATION

The following information is provided to let you know how the Fund is operating on a day-to-day basis, and who is responsible for basic decisions.

Plan Name

Washington Wholesalers Health and Welfare Fund.

Plan Sponsor

The Board Trustees of the Washington Wholesalers Health and Welfare Fund, 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046, (410) 872-9500 or (800) 845-8518, is the plan sponsor. A list of participating employers and employee organizations is available from the Fund Office and is available for examination.

Type of Plan

This is an employee welfare benefit plan and group health plan designed to provide health care benefits such as hospitalization, medical, surgical, prescription drug, dental, vision, accident & sickness, life and accidental death and dismemberment benefits.

Name of Plan Administrator

The Board of Trustees of the Washington Wholesalers Health and Welfare Fund at the above address and telephone numbers is the plan administrator.

Type of Administration

Contract administration - The Board of Trustees has contracted with Carday Associates, Inc., at 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046, (410) 872-9500 or (800) 845-8518, to provide day-to-day administrative management services.

Employer Identification Number and Plan Number

The Employer Identification Number assigned by the Internal Revenue Service effective March 15, 1952 to the Board of Trustees is 52-6057761. The Plan number assigned by the Board of Trustees is 501.

Plan Year

For purposes of maintaining the Fund's fiscal records, the year end date is March 31.

Agent for Service of Legal Process

The Fund's Contract Administrator has been designated as the agent for the service of legal process. Service of legal process may also be made on a member of the Board of Trustees.

Funding Medium

Benefits are provided from the Fund's assets which are held in trust by the Board of Trustees for the purpose of providing benefits to Participants and their Eligible Dependents and paying reasonable administrative expenses. The Fund has liability for all benefits other than Life, Accidental Death and Dismemberment, Dental and Vision benefits, and determines benefit payments in accordance with rules promulgated by the Board of Trustees. Life and Accidental Death and Dismemberment benefits are insured under the Fund's contract with Prudential. The address for Prudential is 2101 Welsh Road, Dresher, PA 19025. Dental benefits are provided and insured pursuant to the Fund's contract with Group Dental Service of Maryland, Inc. The address for Group Dental Service of Maryland, Inc. is 111 Rockville Pike, Suite 950, Rockville, MD 20850. Vision benefits are provided and insured pursuant to the Fund's insurance contract with Group Vision Services. The address for Group Vision Services is 111 Rockville Pike, Suite 735, Rockville, MD 20850. These insurers pay claims for benefits under the Fund.

Contribution Source

The Fund is maintained pursuant to collective bargaining agreements between the Union and Employers, and contributions to the Fund are made by Employers in accordance with the applicable collective bargaining agreement. These agreements provide that Employers contribute to the Fund on behalf of each covered employee on the basis of a fixed rate per hour. The Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this Fund on behalf of participants working under the collective bargaining agreement. A copy of the collective bargaining agreements may be obtained by writing to the Fund Office and are available for examination.

Plan Amendment and Termination

The Trustees intend to continue the Plan described in this booklet as long as contributions permit. Nevertheless, the Trustees reserve the right, in their sole judgment, to terminate or amend the Plan, or any part of it, at any time. The Trustees also reserve the right to amend the eligibility rules. Participants do not have a vested right to benefits under the Plan.

In the event the Plan is terminated, the Trustees will use remaining assets of the Fund to provide benefits, pay administration expenses and otherwise to carry out the purposes of the Plan in an equitable manner until the entire remainder of the Fund has been disbursed.

Board of Trustees

The names and business addresses of the Trustees are:

EMPLOYER TRUSTEES

Scott Habermehl
Boar's Head Provisions Company, Inc.
1819 Main Street, Suite 800
Sarasota, FL 34236

Brad Harris
A.M. Briggs Company, Inc.
2130 Queens Chapel Road, NE
Washington, DC 20018

Brian Willard
Metropolitan Poultry
1920 Stanford Court
Landover, Maryland 20785

UNION TRUSTEES

Thomas P. McNutt
UFCW Local 400
4301 Garden City Drive
Landover, Maryland 20785

Lawrence "Tony" Perez
UFCW Local 400
4301 Garden City Drive
Landover, Maryland 20785

C. James Lowthers
266 Cape St. John Road
Annapolis, MD 21401

Eligibility and Benefits

The Fund's requirements pertaining to eligibility for participation, the conditions pertaining to eligibility to receive benefits, and a description or summary of the benefits are set forth in this booklet and/or certificates of insurance incorporated by reference herein.

Circumstances That May Affect Benefits

Circumstances that may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of any benefits are contained in the preceding pages of this booklet and/or certificates of insurance incorporated by reference herein.

Plan Interpretation

The Trustees shall have the sole power and discretion to construe the provisions of the Plan and the terms used herein. Any construction adopted by the Trustees in good faith shall be binding on the Union, the Employers and all Fund Participants and Dependents.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA")

As a Participant in the Washington Wholesalers Health & Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as union halls and work sites, all Plan documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly, the Pension and Welfare Benefit Administration).

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Care Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Action by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Health Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan

participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a health benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a qualified medical child support order, you may file suit in Federal court. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly, the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (formerly, the Pension and Welfare Benefits Administration), U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (formerly, the Pension and Welfare Benefits Administration).

GRANDFATHERED PLAN

The Washington Wholesalers Health and Welfare Fund believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Washington Wholesalers Health and Welfare Fund may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, as described below.

The Affordable Care Act requires that all plans: 1) provide coverage for dependent children up to the age of 26 regardless of marital status, financial dependency, residency, or student status; 2) eliminate lifetime limits on essential health benefits; 3) phase out annual dollar limits on essential health benefits over a three-year period; 4) eliminate exclusions for pre-existing conditions; and 5) prohibit the rescission of coverage except in cases of fraud or misrepresentation. The Fund has made the required amendments to the Plan in order to comply with these requirements, such as providing coverage for dependent children up to the age of 26 (with some restrictions) and clarifying that coverage will not be rescinded by the Plan (without just cause).

The Fund does not have any lifetime limits on benefits and it does not have any pre-existing condition exclusions for individuals under the age of 19 years. The Fund does have an annual dollar limit on benefits of $250,000.00 per year plus Basic Hospital Benefits. The Affordable Care Act requires that annual limits on coverage of key benefits be no lower than $750,000.00. However, the Fund received a waiver from the U.S. Department of Health and Human Services based on the Fund's representation that providing $750,000.00 in coverage for key benefits would result in a significant increase in the cost of premiums or a significant decrease in the provision of benefits. This waiver is valid from April 1, 2011 through March 31, 2012. The Fund applied for an extension of this waiver, which will extend the waiver through December 31, 2013.

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 at 410-872-9500 or 800-845-8518. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

SUMMARY OF BENEFITS FOR PARTICIPANTS AND ELIGIBLE DEPENDENTS

This summary is intended to provide general information concerning the benefit program. Payment for specific claims is subject to the descriptions, exclusions and limitations regarding benefits set out in this SPD, and the rules, regulations, and limitations that have been or may be adopted by the Board of Trustees.

Benefits	Description of Coverage
BASIC HOSPITAL SERVICES:	Pre-Certification Required See page 26
Room & Board	Up to $120 per day up to a 70-day maximum for all causes in a calendar year. Charges in excess of basic benefit limits are subject to Major Medical.
Intensive Care Unit	Up to $240 per day for first 10 days for all causes in a calendar year. Beginning on the 11th day, up to $120 per day up to 70-day maximum for all causes in a calendar year. Charges in excess of basic benefit limits are subject to Major Medical.
MAJOR MEDICAL:	
Individual Annual Deductible Family Annual Deductible Maximum Co-Insurance Fund Pays You Pay	$250 $625 80% of PPO Negotiated Rate* 20% of PPO Negotiated Rate* *If PPO provider not used, percentage of UCR
Annual Out of Pocket Expense Maximum	$2,500 Coverage rises to 100% of PPO Negotiated Rate after out of pocket maximum has been incurred for the calendar year.
Annual Maximum	$250,000
PRESCRIPTION DRUG	5% - In Network Giant, Safeway, Shoppers, Kroger, Metro Pharmacy, Tidewater Pharmacy 10% - Out of Network Mandatory Generic Mandatory Mail Order for Maintenance Drugs

Benefits	Description of Coverage
VISION:	Coverage through Group Vision Services. Vision analysis provided once every two years - $10 Co-pay for the exam and $25 Co-pay for all covered materials (see pages 38 to 40).
DENTAL	Coverage through Group Dental Services (GDS) as described on pages 48 to 52.
LIFE INSURANCE (PARTICIPANT ONLY)	Death Benefit - $10,000
ACCIDENTAL DEATH & DISMEMBERMENT (AD & D) (PARTICIPANT ONLY)	Accidental Death - $2,500 Accidental Dismemberment - $2,500 for two limbs, eyes or any combination; $1,250 for one limb
ACCIDENT & SICKNESS: (PARTICIPANT ONLY)	Commencing with the fourth day you are disabled from work due to a non-occupational injury or illness, benefits will be paid at (1) 66 2/3% of weekly earnings (straight time only) or (2) a maximum of $253 per week, whichever is less, up to a maximum of 26 weeks in a calendar year.