SCHEDULE OF DEATH BENEFITS

FULL TIME CONTINUOUS SERVICE

1ST YEAR $2000
2ND YEAR $4000
3RD YEAR $6000
4TH YEAR.....$8000
5TH YEAR.....$10000
6TH YEAR.....$12000
7TH YEAR.....$14000
8TH YEAR.....$16000
9TH YEAR.....$18000
10TH YEAR.....$25000

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT IS PROVIDED

DISABILITY BENEFITS

MEMBER ONLY

COMMENCEMENT DATE

1ST DAY DUE TO ACCIDENT
5TH DAY IF DUE TO SICKNESS

MAXIMUM PAYMENT PERIOD

26 WEEKS IN ANY 52 WEEK PERIOD

BENEFITS PAYABLE

75% OF WEEKLY EARNINGS
UP TO A MAXIMUM OF $400

- MUST BE ACTIVELY AT WORK ON THE DATE BENEFITS GO INTO EFFECT IN ORDER TO BE ELIGIBLE
- MUST BE TOTALLY DISABLED AND UNDER A DOCTORS CARE
- MUST BE DISABLED DUE TO A CONDITION COVERED BY THE PLAN
- MUST SUBMIT PROOF OF ONGOING DISABILITY AS REQUESTED

ONLY THE FULL BOARD OF TRUSTEES IS AUTHORIZED TO INTERPRET THE PLAN DESCRIBED IN THIS BOOKLET. NO EMPLOYER OR UNION NOR ANY REPRESENTATIVE OF ANY EMPLOYER OR UNION, IS AUTHORIZED TO INTREPRET THIS PLAN NOR CAN ANY SUCH PERSON ACT AS AGENT OF THE TRUSTEES. IF YOU WISH ANY INFORMATION REGARDING THE PLAN, SUCH INFORMATION CAN BE COMMUNICATED TO YOU ON BEHALF OF THE FULL BOARD OF TRUSTEES EITHER BY THE TRUSTEES OR IF AUTHORIZED BY THE TRUSTEES IN WRITING, SIGNED BY THE FUND ADMINSTRATIVE MANAGER

LOCAL 371
UFCW

AMALGAMATED WELFARE TRUST FUND

290 POST ROAD WEST
WESTPORT, CT 06881

THOMAS A. WILKINSON
PRESIDENT

RONALD M. PETRONELLA
SECRETARY-TREASURER

FULL TIME EMPLOYEES HEALTH & WELFARE

WEEKLY DISABILITY, DENTAL, VISION AND DEATH BENEFIT SCHEDULES

SEE SUMMARY PLAN DESCRIPTION FOR MEDICAL & RX COVERAGE INFORMATION

LOCAL 371 AWTF PARTICIPATES WITH

CIGNA PPO NETWORK FOR MEDICAL
1-800-768-4695
EXPRESSCRIPTS FOR RX
1-800-711-0917
EYEMED VISION CARE FOR ROUTINE VISION
1-866-723-0514

FUND OFFICE- 203-226-4217

DENTAL SCHEDULE OF BENEFITS

ANNUAL BENEFIT MAXIMUM
$5000 PER COVERED PERSON
EFFECTIVE JANUARY 1, 2014

DIAGNOSTIC & PREVENTATIVE	
PERIODIC DENTAL EXAM ESTAB	$60
DENTAL EXAM FOCUSED ON PROBLEM	$82
COMP DENTAL EXAM NEW/ESTAB PATIENT	$100
ADULT PROPHY	$105
CHILD PROPHY	$76
FLUORIDE-UNDER AGE 18	$45
FULL SERIES XRAY	$100
2 BITEWING XRAYS	$40
4 BITEWING XRAYS(MAX 4 PER YEAR)	$50
PERIAPICAL XRAY	$20
SEALANTS PER TOOTH(UNDER AGE 18)	$42
ORAL SURGERY	
SIMPLE EXTRACTION	$125
**SURGICAL EXTRACTIONS COVERED UNDER MAJOR MEDICAL BENEFITS	
GENERAL ANESTHESIA	
PER 1/2 HOUR OR FRACTION THEREOF	$76
*(IN CONNECTION WITH ORAL SURGER COVERED UNDER THE MAJOR MEDICAL BENEFIT, ANESTHESIA WILL ALSO BE PAYABLE UNDER MAJOR MEDICAL BENEFITS)	
FILLINGS	
ONE SURFACE FILLING	$100
TWO SURFACE FILLING	$120
THREE SURFACE FILLING	$150
REINFORCEMENT PINS(UP TO 4 PER TOOTH)	$28
POST	$100
POST & CORE	$175
PALLIATIVE SERVICES	
EMERGENCY SERVICE BENEFIT	$ 75
INLAYS & ONLAYS	
ONE SURFACE	$120
TWO SURFACE	$160
THREE SURFACE	$200
CROWNS/PONTICS/ABUTMENTS	
INDIRECT RESIN BASED CROWN	$410
RESIN BASED CROWN OVER METAL	$600
ALL CERAMIC CROWN	$600
PORCELAN CROWN OVER METAL	$600
CERAMIC/PORCELAIN CROWN OVER METAL	$600
ALL METAL CROWN(HIGH CONTENT [PRECIOUS METAL)	$600
ALL METAL CROWN(MEDIUM CONTENT PRECIOUS METAL)	$600

DENTAL SCHEDULE OF BENEFITS

ANNUAL BENEFIT MAXIMUM
$5000 PER COVERED PERSON
EFFECTIVE JANUARY 1, 2014

ROOT CANAL	
ONE CANAL	$450
TWO CANAL	$500
THREE CANAL	$600
APICOECTOMY	$250
ABOVE SERVICES INCLUDE FILLINGS	
DENTURES	
FULL UPPER OR LOWER(EACH)	$525
CAST PARTIAL UPPER OR LOWER(EACH)	$550
UNILATERAL PARTIAL, NESBIT	$240
RELINE OR REBASE	$150
DENTURES AVAILABLE ONCE EVERY THREE YEARS. ABOVE SERVICES INCLUDE SIX MONTHS AFTERCARE	
DENTURE REPAIR	
REPAIR BODY OF BROKEN DENTURE	$70
REPLACE BROKEN TOOTH	$60
ADD TOOTH TO EXISTING TOOTH	$60
REPLACE CLASP OR REST	$68
PERIODONTIA	
GUM TREATMENT(PER VISIT)	$50
PERIODONTAL SPLINT/ARCH	$70
GINGEVECTOMY/GINGIOPLASTY(PER QUAD)	$200
GINGIVAL CURRETTAGE, ROOT PLANING(QUAD)	$50
GINGIVAL FLAP(QUAD)	$200
OSSEOUS SURGERY(QUAD)	$300
OCCLUSAL ADJUSTMENT	$50
MAXIMUM PER CALENDAR YEAR PERIODONTAL BENEFIT	$1200
ORTHODONTIC/SPACE MAINTAINERS	
REMOVABLE APPLIANCE(ONE PER JAW LIFETIME)	$200
FIXED APPLIANCE(ONE PER JAW LIFETIME)	$500
MONTHLY ADJUSTMENTS(BEGINNING 6 MONTHS AFTER PLACEMENT)	$100
MAXIMUM LIFETIME ORTHODONTIC TREATMENT	$2500

EXCEPTIONS AND LIMITATIONS

- THIS PROGRAM DOES NOT COVER COSMETIC SERVICES
- ALLOWANCES INCLUDE LOCAL ANESTHESIA AND ANALGESIA
- SERVICES NOT SHOWN IN SCHEDULE ARE NOT COVERED
- PRETREATMENT ESTIMATES ARE REQUIRED FOR ALL SERVICES IN EXCESS OF $500
- ALL SERVICES MAY BE SUBJECT TO FREQUENCY LIMITATIONS

EYE MED VISION CARE NETWORK

EFFECTIVE JULY 1, 2013
Vision Care Services Member Cost Reimbursement

In-Network

Exam With Dilation as Necessary	$0 Copay
Frames $0 Copay; $75 allowance; 20% off retail price over $75	
Standard Plastic Lenses	
Single Vision $0 Copay	
Bifocal $0 Copay	
Trifocal $0 Copay	
Standard Progressive Lens $65 Copay	
Premium Progressive $65, 80% of charge less $120 Allowance	
Contact Lenses	
Conventional $0 Copay; $90 allowance; 15% off retail price over $90	
Disposable $0 Copay; $90 allowance; plus balance over $90	
Medically Necessary $0 Copay, Paid in Full	
MEMBER COSTS/DISCOUNTS ON OTHER SERVICES IN NETWORK	
Standard Contact Lens Fit & Follow up	Member Cost $40
Lens Options	
(paid by the member and added to the base price of the lens)	
UV Treatment	Member Cost $15
Tint (Solid and Gradient)	Member Cost $15
Standard Plastic Scratch Coating	Member Cost $15
Standard Polycarbonate	Member Cost $40
Standard Anti-Reflective Coating	Member Cost $45
Polarized 20% off retail price	
Other Add-Ons and Services 20% off retail price	
Premium Contact Lens Fit & Follow-Up	10% off
Laser Vision Correction	
Lasik or PRK from U.S. Laser Network 15% off retail price or 5% off promotional price N/A	

Vision Care Services OUT OF NETWORK
Member Reimbursement

Exam With Dilation as Necessary	Up to $40
Frames	Up to $42
Standard Plastic Lenses	
Single Vision	Up to $35
Bifocal	Up to $55
Trifocal	Up to $90
Standard Progressive Lens	Up to $55
Premium Progressive	Up to $55
Contact Lenses	
Conventional	Up to $90
Disposable	Up to $90
Medically Necessary	Up to $200

Frequency	
Examination	Once every 12 months
Lenses	Once every 12 months
Frames(16 years of age and older)	Once every 24 months
Frames(Under age 16)	Once every 12 months