SCHEDULE OF LIFE INSURANCE

PART TIME CONTINUOUS SERVICE

$2000.00 AFTER ELIGIBILITY REQUIREMENTS ARE SATISFIED

Accidental death and dismemberment benefit is provided

TELEPHONE
203-226-4217

SEE PLAN BOOKLET FOR ELIGIBILITY REQUREMENTS AND MORE DETAILED INFORMATION

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

.PRINTED 1/1/14

DISABILITY BENEFITS
MEMBER ONLY

Commencement date
7th day due to sickness or accident

Maximum payment period
26 weeks in any 52 week period

Benefits payable
$100.00 PER WEEK
Based on a 7 day work week

- Must be actively at work on the date benefits go into effect in order to be eligible
- Must be totally disabled and continuously under a doctors care
- Must be disabled due to a condition covered by the plan
- Must submit proof of ongoing disability as requested

LOCAL 371 UFCW

Amalgamated Welfare Trust Fund

290 Post Road West
P.O. Box 470
Westport, CT
06881

1-203-226-4217

Thomas a. Wilkinson
President

Ronald M. Petronella
Secretary-Treasurer

BENEFIT SCHEDULES
PART TIME
&
ACA QUALIFIED

MEMBER ONLY

EFFECTIVE 1/1/2014

WEEKLY DISABILITY, DENTAL, OPTICAL, LIFE INSURANCE

DENTAL SCHEDULE OF BENEFITS– MEMBER ONLY
Effective 1/1/2014

DIAGNOSTIC & PREVENTATIVE

DENTAL CODE 0120, 0150EXAM(1 EVERY 6 MO)	$ 60.00
DENTAL CODE 1110 ADULT PROPHY(1 EVERY 6 MO)	$105.00
DENTAL CODE 1120 CHILD PROPHY (1 EVERY 6 MO)	$ 76.00
FULL SERIES XRAY INC BW(FREQ 3YRS)	$ 100.00
2 BITEWING XRAYS	$ 40.00
4 BITEWING XRAYS(MAX CAL YR)	$ 50.00
PERIAPICAL XRAYS(EACH)	$ 20.00
TOPICAL FLUORIDE(UNDER 18 YRS)	$ 45.00
SEALANTS(UNDER 18 YRS)	$ 42.00

ORAL SURGERY

SIMPLE EXTRACTION	$125.00
SURGICAL EXTRACTION	$150.00
COMPLETE BONY IMPACTION	$300.00
PARTIAL BONY IMPACTION	$275.00
SOFT TISSUE IMPACTION	$225.00
REMOVAL OF CYST	$140.00

GENERAL ANESTHESIA

PER 1/2 HR OR FRACTION THEREOF	$ 76.00

FILLINGS

ONE SURFACE FILLING	$ 62.00
TWO SURFACE FILLING	$ 80.00
THREE OR MORE SURFACE FILLING	$ 98.00
REINFORCEMENT PINS(UP TO 4 PER TOOTH)	$ 28.00
POST	$100.00
POST & CORE	$175.00

PALLIATIVE SERVICES

EMERGENCY SERVICE BENEFIT	$ 75.00
DENTAL CODE 0140	$ 82.00

INLAYS/ONLAYS

ONE SURFACE	$120.00
TWO SURFACE	$160.00
THREE OR MORE SURFACE	$200.00

CROWNS/ABUTMENTS/PONTICS

DENTAL CODE 2710	$410.00
DENTAL CODE 2720	$600.00
DENTAL CODE 2740	$600.00
DENTAL CODE 2750	$600.00
DENTAL CODE 2752	$600.00
DENTAL CODE 2790	$600.00
DENTAL CODE 2792	$600.00

ROOT CANAL THERAPY

ONE CANAL	$450.00
TWO CANAL	$500.00
THREE OR MORE CANAL	$600.00
APICOECTOMY	$250.00

**ABOVE SERVICES INCLUDE FILLINGS

DENTURES(available once every 3 yrs)

FULL UPPER OR LOWER(EACH)	$525.00
CAST PARTIAL UPPER/LOWER(EACH)	$550.00
UNILATERAL PARTIAL/NESBIT	$240.00

**ABOVE SERVICES INCLUDE 6 MONTHS AFTERCARE

RELINE OR REBASE	$150.00

DENTAL SCHEDULE OF BENEFITS—MEMBER ONLY

DENTURE REPAIR

REPAIR BODY BROKEN DENTURE	$ 70.00
REPLACE BROKEN TOOTH	$ 60.00
ADD TOOTH TO REPLACE EXISTING TOOTH	$ 60.00
REPLACE CLASP OR REST	$ 68.00

PERIDONTIA

GUM TREATMENT(PER VISIT)	$ 50.00
PERIODONTAL SPLINT/ARCH	$ 70.00
GINGEVECTOMY/GINGIOPLASTY(PER QUAD)	$200.00
GINGEVAL CURRETAGE/ROOT PLANING(PER QUAD)	$ 50.00
GINGEVAL FLAP(PER QUAD)	$200.00
OSSEOUS SURGERY(PER QUAD)	$300.00
OCCLUSAL ADJUSTMENT	$ 50.00
**MAXIMUM PERIODONTAL BENEFIT PER CAL YR	$1200.00

ORTHODONTICS/SPACE MAINTAINERS

FIXED SPACE MAINTAINER(BAND TYPE)	$135.00
REMOVABLE SPACE MAINTAINER WITH STAINLESS STEEL ROUND WIRE REST	$125.00
STAINLESS STEEL WIRES AND CLASPS	$ 27.00
STUDY MODELS	$ 45.00
REMOVABLE APPLIANCE(PER JAW)	$180.00
FIXED APPLIANCE(PER JAW)	$200.00
MONTHLY ADJUSTMENTS (BEGINNING 6 MONTHS AFTER PLACEMENT)	$ 18.00

**MAXIMUM 36 MONTHS

ANNUAL DENTAL BENEFIT LIMIT $2500

- EXCEPTIONS AND LIMITATIONS
- This program does not cover cosmetic services
- Allowance includes local anesthesia and analgesia
- Services not shown in the schedule are not covered
- Pretreatment estimates are required for all services in excess of $500.00

OPTICAL PROGRAM BENEFITS
MEMBER ONLY
COVERAGE IS PROVIDED THROUGH THE EYEMED VISION CARE NETWORK

In Network Coverage

Service	Member Cost
Exam with Dilation	$0
Standard Single Vision Plastic Lens	$0
Standard Bifocal Plastic Lens	$0
Standard Trifocal Plastic Lens	$0
Standard Progressive Lens	$65
Premium Progressive Lens	$65, 80% of charge less $120 allow-ance
Contact lenses conventional	$0 copay up to $90 allowance
Contact lenses disposable	$0 copay up to $90 allowance
Frames	$0 copay up to $75 allowance

Frequency:
Examination—Once every 12 months
Lenses or Contact Lenses—Once ever 12 months
Frames—Once every 24 months

Out of Network reimbursement is as follows

Once every 12 months

Eye Exam with Dilation up to $40
Standard Plastic Single Vision Lenses up to $35
Standard Plastic Bifocal Lenses up to $55
Standard Plastic Trifocal Lenses up to $90
Standard Progressive Lenses up to $55
Premium Progressive Lenses up to $55
Contact lenses conventional or disposable up to $90.00

Once every 24 months

Frames once every 24 months up to $42

Forms for out of network reimbursement can be obtained on our website www.ufcw371.org or by calling the Fund office