SUMMARY PLAN DESCRIPTION

INTRODUCTION

This Summary Plan Description has been prepared by the Local 371 United Food and Commercial Workers Union Amalgamated Welfare Trust Fund (the "Fund") in compliance with the Employee Retirement Income Security Act of 1974 ("ERISA").

The information set forth in this document is provided to you in order to acquaint the Covered Person with the benefits of the Group Health Benefit Plan (the "Plan") that are now available to a Covered Person and Covered Dependents and to describe the procedures to be followed in presenting claims for benefits and remedies that are available for redress of claims that have been denied.

The Plan is paid for entirely and is dependent upon contributions that are made by your Employer under the terms of collective bargaining agreements negotiated with your Employer by United Food and Commercial Workers Union, Local 371.

No oral interpretations can change this Plan. It is the present intention of the Fund and its Board of Trustees to maintain this Plan indefinitely. However, the Fund and its Board of Trustees reserve the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason. Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, co-payments, exclusions, limitations, definitions, eligibility and the like.

You are entitled to coverage if you are eligible in accordance with the terms in this booklet. Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Fund Office or the Claim Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished. If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

DISCLOSURE

This group health plan 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 your plan 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, for example, the elimination of lifetime limits on benefits.

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 (203) 226-4217. 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.

GENERAL INFORMATION

Name of Plan:	Local 371 Amalgamated Welfare Trust Fund ACA Qualified Health Benefit Plan
Plan Sponsor:	Local 371 United Food and Commercial Workers Union Amalgamated Welfare Trust Fund 290 Post Road West - Westport, Connecticut 06881 (203) 226-4217
Employer ID No.:	06-6069081
Plan No.:	503
Plan Administrator:	Board of Trustees of Local 371 United Food and Commercial Workers Union Amalgamated Welfare Trust Fund 290 Post Road West - Westport, Connecticut 06881 (203) 226-4217
Claims Administrator:	Maxon Administrators, Inc. 76 North Broadway Irvington, New York 10533.
Types of Benefits:	The Plan provides life, accidental death and dismemberment benefits on a fully insured basis. The Plan provides disability, hospital, surgical and medical, dental, hearing, vision and prescription benefits on a self-insured basis and the administration is performed by the Fund as well as by a Third Party Claims Administrator.
Agent for Service of Process:	Board of Trustees of Local 371 United Food and Commercial Workers Union Amalgamated Welfare Trust Fund 290 Post Road West Westport, Connecticut 06881 (203) 226-4217

TRUSTEES

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UFCW Local 371

ENROLLMENT

Enrollment Requirements

A person seeking coverage must enroll by filling out and signing an enrollment application within thirty (30) days of becoming eligible for coverage. For Dependent coverage to be effective, the Covered Person is required to enroll for Dependent coverage also.

Enrollment Requirements for Newborn Children

A newborn child or a newly adopted child of a Covered Person who has Dependent coverage is not automatically enrolled in this Plan. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollments" following this section, there will be no payment from the Plan and the covered parent will be responsible for all costs. If the child is required to be enrolled and is not enrolled within thirty (30) days of birth, application for enrollment may be made during Open Enrollment.

Timely Enrollment

1. Timely Enrollment - The enrollment will be "timely" if the completed form is received by the Fund Office or the Claim Administrator no later than thirty (30) days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period. If two Individuals (the mother and father of the child(ren)) are covered under the Plan and the Individual; who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other Covered Person with no Waiting Period as long as coverage has-been continuous.

2. If a husband/wife (or same sex spouses) are both covered under this Plan, and each have single coverage, they may change to a Family Plan at any time. The enrollment form must be returned to the Fund Office, and Dependents not currently covered will be enrolled. Family coverage will be placed under the policy of the higher salaried employee.

Special Enrollment Periods

The enrollment date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

1. Individuals losing other coverage. A Covered Person and/or Covered Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

   (a) The Covered Person or Covered Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

   (b) If required by the Plan Administrator, the Covered Person stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

   (c) The coverage of the Covered Person or Covered Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions towards the coverage were terminated.

   (d) The Covered Person or Covered Dependent requests enrollment in this Plan not later than thirty (30) days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received. If the Covered Person or Covered Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

(2) Dependent beneficiaries. If:

   (a) The Covered Person is a Participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

   (b) A person becomes a Dependent of the Covered Person through marriage, birth, adoption or placement for adoption, then the Dependent (and if not otherwise enrolled, the Covered Person) may be enrolled under this Plan as a covered Dependent of the covered Person. The Dependent Special Enrollment Period is a period of thirty (30) days and begins on the date of the marriage, birth, adoption or placement for adoption. The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

(i) in the case of a Dependent's birth, as of the date of birth; or

(ii) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

ELIGIBILITY EFFECTIVE DATE AND TERMINATION

EMPLOYEE COVERAGE

Eligible Classes of Employees.

All active employees of a contributing Employer who (i) are not considered to be full time employees but regularly scheduled to work more than 30 hours per week by their employer based on its look back period, and (ii) make contributions to the Fund on behalf of the employee.

Eligibility Requirements for Employee Coverage

Coverage begins on the first day of the month in which the Employer begins contributions, which is the first day of the month following completion of the waiting period unless otherwise indicated in the Collective Bargaining Agreement. A "waiting period" is the time between the first day of employment and the first day of coverage under the Plan.

EFFECTIVE DATE

Effective Date of Employee Coverage

An Employee will be covered under this Plan on the first day of the calendar month following the date that the Employee satisfies all of the following:

1. The Eligibility Requirement.

2. The Actively at Work Requirement.

3. The Enrollment Requirements of the Plan

Actively at Work Requirement.

An Employee must be Actively at Work for a benefit or a benefit increase to take effect. An Employee will be considered Actively at Work if the Employee is performing the essential duties of employment on that day either at the Employer's place of business or at some location to which the Employee is required to travel for the Employer's business.

An Employee is considered to be Actively at Work on each day of a regular paid vacation and on each regular non-work day, if the Employee was Actively at Work on the last preceding regular work day. An employee who is absent from work due to illness or injury is not considered Actively at Work.

An Employee may be considered to be Actively at Work while on a leave qualified under the Family and Medical Leave Act of 1993.

The Enrollment Requirement

Before your benefits can become effective you must complete an enrollment form and provide all information necessary for the Fund to determine whether benefits under this Plan are subject to coordination. This form can be obtained from the Fund office.

COVERED DEPENDENT COVERAGE

A Covered Dependent is anyone of the following persons:

1. An Employee's children from birth to the limiting age of 26 years. If the child qualifies for coverage under this Plan, he/she will remain eligible for coverage up to the end of the month in which they attain their 26th birthday (provided that he/she maintains your eligibility for the Fund's benefits), and the appropriate enrollment forms are completed and returned to the Fund Office.

   The term "children" or "child" shall include the following persons up to the age of 26: natural children, adopted children living in the same household as the Employee, or children placed in a covered Employee's home in anticipation of adoption. Also covered are step-children or foster children who reside in the Employee's household and/or a person for whom the Covered Employee is a legal guardian, financially responsible and has furnished the proper legal documentation.

   The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. Coverage of these pre-adoptive children is required by the Federal Omnibus Budget Reconciliation Act of 1993. The child must be available for adoption and the legal process must have commenced.

   As required by the federal Omnibus Budget Reconciliation Act of 1993, any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered, as having a right to Dependent coverage under this Plan.

The phrase "primarily dependent upon" shall mean dependent upon the covered Employee for support and maintenance as defined by the Internal Revenue Code, and the covered employee must declare the child as an income tax deduction. The Plan Administrator may require documentation proving dependency.

The Plan Administrator may require annual verification of whether group health insurance coverage is available to him/her through their employment (or their spouse's employment, where applicable).

2. A Covered Employee's child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, is primarily dependent upon the covered Employee for support and maintenance, is unmarried and was covered under the Plan when reaching the limiting age of 26 years. The Plan Administrator may require at reasonable intervals during the two years following the Dependent's reaching the limiting age subsequent proof of the child's disability and dependency.

   After such two-year period the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: Other individuals living in the Covered Employee's home, but who are not eligible as defined;

1. the Covered Person's spouse as well as the legally separated or divorced former spouse of the Covered Person; any person who is on active duty in any military service of any country.

2. If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

DEPENDENT ELIGIBILITY

Dependents shall become eligible for coverage (i) on the date the Covered Person's own coverage becomes effective, or the date such employee first acquires a dependent, whichever is later, and (ii) the Employee makes the required monthly contribution to the Fund for coverage

At any time, the Plan may require proof that a child qualifies or continues to qualify as a Covered Dependent as defined by this Plan.

TERMINATION OF COVERAGE

When Covered Person Coverage Terminates

Covered Person coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Option):

1. The date the Plan is terminated.

2. The end of the month in which the Covered Person ceases to be in one of the Eligible Classes.

3. The date the Covered Person ceases to be Actively at Work.

When Covered Dependent Coverage Terminates

1. The date that the Covered Person's personal coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Option.)

2. The date Dependent Coverage is terminated under the Plan.

3. The date that the required contribution for Dependent Coverage is not paid to the Fund by the Covered Person.

4. The date that the Covered Dependent ceases to be a Dependent as defined by the Plan. (See the COBRA Continuation Option.)

5. The day the Covered Dependent enters the military, navy or air force of any country or international organization on a full time active duty basis other than scheduled drills or other training not exceeding one month in any calendar year.

6. Coverage for a Dependent Child ends on the last date of the month that the dependent attains age 26 (except as provided in the case of a dependent child suffering from mental retardation, or physical handicap as defined herein).

Continuation During Family and Medical Leave

During any leave taken under the Family and Medical Leave Act of 1993 Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the Covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, limitations or other pre-conditions will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee

A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements, with the exception of an Employee returning to work directly from COBRA coverage. Such an Employee shall have to satisfy the employment waiting period.

Employees on Military Leave

Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights include up to 24 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

Plan exclusions and waiting periods may be imposed for any Sickness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

BENEFITS MANAGEMENT PROGRAM

PREADMISSION REVIEW PROGRAM

When You Must Have Preadmission Review

Preadmission review means that all elective non-emergency, non-urgent and non-maternity inpatient admissions must be reviewed as soon as your doctor determines that you should be admitted as an inpatient. An inpatient admission is when you spend at least one night in a hospital or other approved facility. These admissions include medical, psychiatric and surgical cases.

Elective admissions are defined as those admissions that may be scheduled or are routine. This group includes cases where there is no urgency for immediate or very early medical evaluation or treatment because the possibilities of serious consequences resulting from the lack of medical evaluation are small. The preadmission review process does not apply to emergency, urgent, or maternity hospital admissions. However, notice of emergency, urgent, or maternity admissions are required within 72 hours of admission.

How You Start the Preadmission Review Process

You, a member of your family or your doctor must start the preadmission review process by calling:

** **For (a) inpatient Services while confined in a Hospital or Alcohol/Chemical Dependency Treatment Facility, or (b) services or and supplies furnished by a Hospital, Acute Care Hospital, Ambulatory Surgical Center or a Birthing Center.**

Call: CIGNA/Care Allies
Telephone Number: 1-800-768-4695

** **For all other care and treatment that requires preadmission review.**

Call: Maxon Company
Telephone Number: 1-800-999-3309

As long as the telephone call is made prior to your inpatient admission, you will not be subject to a $300.00 Penalty. You, your doctor and the facility will be notified that the preadmission review requirement has been met.

If You Fail To Call for Preadmission Review

It is your responsibility to make certain that the telephone call is made to meet the preadmission review requirement. If you do not meet the preadmission review requirement, you will be subject to a $300 Penalty, which shall be over and above any other deductibles that are applicable. This means that the first $300 of inpatient charges, in addition to the deductible generally applicable, will be your responsibility to pay. Informing the doctor of the preadmission review requirement does not eliminate the $300 Penalty if the call is not made.

Emergency, urgent or maternity inpatient admissions -- preadmission review not required -- notice of inpatient admission required within 72 hours of admission.

Emergency Admission

Preadmission review is not required for emergency admissions. Emergency admission apply to medical conditions or acute trauma such that life, limb, or the body function of the patient depends on the immediacy of medical treatment. In an emergency admission, tile condition requires immediate medical attention and any delay in receiving treatment would be harmful to the patient. The patient does not have to be admitted via the emergency room to be considered an emergency admission.

Urgent Admission

Preadmission review is not required for urgent admissions. Urgent admissions involve medical conditions or acute trauma such that medical attention, while not immediately essential, should be provided very early in order to prevent possible loss or impairment of life, limb, or body function.

Maternity Admissions

Preadmission review does not apply to maternity admissions. A maternity admission is one in which a pregnant patient is admitted to give birth. Although admissions for incomplete abortion, toxemia and ectopic pregnancy are not considered maternity admissions, these diagnoses will be considered either urgent or emergency admissions.

Need To Give Notice for an Emergency, Urgent, or Maternity Inpatient Admission

All emergency, urgent, or maternity inpatient admissions should be called in by you, a member of your family, your doctor or the facility within 72 hours or 3 business days following an inpatient admission to a hospital or other approved facility, using the same preadmission review toll-free number. This will permit concurrent review to begin. If you

do not call within 72 hours or 3 business days following your admission, concurrent review cannot start and a partial retroactive denial of benefits could result.

If it is Determined the Admission was not an Emergency, Urgent, or Maternity Admission

If you are admitted to a hospital or other approved facility, and it is later determined that such admission was not either an emergency, urgent, or maternity admission and you followed the emergency procedures described in this Booklet, you will incur the $300 Penalty.

Concurrent Review

If you called the preadmission review number prior to your elective inpatient admission or within 72 hours or 3 business days after an emergency, urgent or maternity inpatient admission, a review process will be conducted to determine whether an inpatient setting is medically necessary for your care or, if medically necessary, how long you need to be an inpatient. Once you enter a hospital or other approved facility, concurrent review helps to assure that you are not an inpatient longer than is medically necessary. The goal of concurrent review is to encourage the appropriate use of inpatient care. When the review process determines that inpatient care is no longer medically necessary, you, your doctor and the facility will be notified not less than the day before inpatient benefits cease.

Pre-Surgical Review

All surgical procedures that are performed in a Hospital, Acute Care Hospital, Ambulatory Surgical Center or a Birthing Center as well as all surgical procedures that are performed in a physician's office that cost in excess of $1,000.00 require pre-surgical review unless the procedure is performed under emergency circumstances.

Documentation showing the necessity for certain proposed surgery must be submitted by the attending doctor. This must be done before the surgery takes place. The necessity for the proposed surgery will be determined based on the documentation submitted. It will also be determined whether hospital confinement is required for the surgery. You may be required to obtain a second surgical opinion from a board certified specialist in your area designated by the Plan Supervisor on our behalf. If you do not obtain the required second surgical opinion and surgery is performed, covered charges for all expenses associated with the surgery will be limited to 50% of the amount that would have been considered covered charges.

Benefits for expenses incurred as a result of surgery are shown in the Schedule of Coverage.

Prospective Review for Miscellaneous Services

Documentation showing the necessity for certain proposed services must be submitted by the attending physician prior to the services being provided. The necessity for the proposed services will be determined based upon the documentation submitted. The services which are subject to this prospective review are:

- Home Care
- Durable Medical Equipment
- Sleep Studies\
- Physical Therapy
- Outpatient Surgical
- All Injections, including but not limited to all injectables, infusions as well as all services that are related to or associated with Pain Management.

SCHEDULE OF BENEFITS

All benefits described in this Schedule are subject to the exclusions, limitations and other provisions of the Plan, described more fully herein including, but not limited to, the Claim Administrator's determination that care and treatment is Medically Necessary; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE BENEFITS

Life Insurance after 1 year of service	$2,000.00
Accidental Death and Dismemberment Insurance after 1 year of service	$2,000.00
Life Insurance after 2 years of service	$4,000.00
Accidental Death and Dismemberment Insurance after 2 years of service	$4,000.00

WEEKLY DISABILITY BENEFITS

Disability Benefit**

Benefit is payable after 7 consecutive days of disability

Benefit

Weekly Benefit	$150.00
Maximum Benefit Period	26 weeks in any 52 week period.

**** Assuming that your collective bargaining agreement provides for this benefit.**

DENTAL BENEFITS

Note: See Schedule "1" for Reimbursement Schedule and Rules/Limits

Annual Benefit Maximum $2,500 per Covered Person

Annual Periodontal Maximum is $1,200 per Covered Person

Lifetime Orthodontic Maximum is $2,500 per Covered Person

VISION COVERAGE

Note: **Routine Vision Coverage is Provided through the Eyemed Vision Care Network**

In Network Coverage

SERVICE TYPE	**MEMBER COST**
Exam with Dilation	$0
Standard Single Vision Plastic Lenses	$0
Standard Bifocal Vision Plastic Lenses	$0
Standard Trifocal Vision Plastic Lenses	$0
Standard Progressive Lenses	$65.00
Premium Progressive Lenses	$65.00, 80% of charge less $120.00 Allowance
Conventional Contact Lenses Allowance	$0 Copay up to $90.00
Disposable Contact Lenses Allowance	$0 Copay up to $90.00
Frames allowance	$0 Copay up to $75.00

Out of Network Reimbursement Allowance

SERVICE TYPE	**REIMBURSMENT ALLOWANCE**
Exam with Dilation	$40.00
Standard Single Vision Plastic Lenses	$35.00
Standard Bifocal Vision Plastic Lenses	$55.00
Standard Trifocal Vision Plastic Lenses	$90.00
Standard Progressive Lenses	$55.00
Premium Progressive Lenses	$55.00
Conventional or Disposable Contact Lenses	$90.00
Frames	$42.00

Frequency:

Examination – Once every 12 months
Lenses or Contact Lenses – Once every 12 months
Frames – Once every 24 months age 16 & over
Frames – Once every 12 months age 16 & under

HEARING CARE SERVICE BENEFITS

The Fund provides coverage for up to 100% of the first $2500 and up to 80% of the next $2500 in charges that are related to the evaluation of a hearing loss (including the evaluation, examination and molds) and for the fitting and dispensing of a hearing aid or aids

Eligible participants and their dependents may receive a hearing evaluation and hearing aid benefits once every three years.

PRESCRIPTION DRUGS

Retail Pharmacy

** For each 30-day supply or part thereof

Classification	**Coinsurance/Co-payment**
Generic	$10.00
Preferred Brand-Name	30% (Minimum - $20.00) (Maximum - $100.00)
None Preferred Brand-Name	30% (Minimum - $40.00) (Maximum - $200.00)

Mail Order Distribution

** For each 90-day supply

Classification	**Coinsurance/Co-payment**
Generic	$25.00
Preferred Brand - Name	30% (Minimum - $40.00) (Maximum - $200.00)
None Preferred Brand-Name	30% (Minimum - $80.00) (Maximum - $400.00)

** **Generic is mandatory when available.**

** **Coverage is not provided for prescriptions that are filled at non-participating pharmacies. Check you benefit provider summary for the names and addresses of participating pharmacies.**

MEDICAL SURGICAL AND HOSPITAL EXPENSE BENEFIT

Participating Provider Organization

The Plan is a plan that contains a Participating Provider Organization.

PPO name: CIGNA (Connecticut General Life Insurance Company)
Address: P.O. Box 188004
Chattanooga, TN 37422-8004

Telephone: 1-800-768-4695
Website: https://sarhcpdir.cigna.com

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, through CIGNA, which are called Participating Providers. Therefore, when a Covered Person and/or Covered Dependent uses a Participating Provider, that Covered Person will receive a higher payment from the Plan than when a Non-Participating Provider is used.

Health Services Rendered By Non-Participating Providers

Emergency Health Services

The Plan will pay those Medically Necessary services and supplies for Covered Services, for emergency health services rendered to a Covered Person by Non-Participating Providers, subject to the terms and conditions and to all limitations and exclusions of this Plan. The emergency health services required must be:

1. of such an immediate nature that a prudent layperson would reasonably believe that use of a Participating Provider would result in a delay that would worsen the emergency; or

2. if a provision of federal, state or local law requires the use of a specific provider; or

3. provided under circumstances under which the Covered Person is unable, due to his or her condition, to request treatment at a location where the services of a Participating Provider would be available.

The Covered Person must notify the Fund Office and CIGNA within one (1) business day after emergency health services are initially provided by a Non-Participating Provider, or as soon thereafter as is reasonably possible.

Full details for the emergency health services rendered shall be made available to the Fund and/or CIGNA at their request. Continuation of care through the Non-Participating

Provider after initial emergency care is rendered shall require the authorization of the Fund and/or CIGNA. If the Covered Person is hospitalized with a Non-Participating Provider, he or she may be transferred to a Participating Provider, upon request by the Fund or CIGNA, as soon as, in the opinion of CIGNA's Medical Director, it is medically appropriate to do so. Eligible expenses for emergency health services are the Maximum Allowable for Network Services less applicable Co-payments, Deductibles and Coinsurance, and any charge made by the provider in excess of the Maximum Allowable. The health services must be ordered by a Physician and are subject to the limitations, exclusions, and other provisions of this Plan.

Non-Emergency Health Services

Subject to the conditions below, the Plan will pay those Medically Necessary services and supplies rendered by a Non-Participating Provider for non-emergency services, subject to the following:

1. Such services shall be subject to all limitations and exclusions of this Plan.

2. The Covered Person and/or Covered Dependent shall pay any Co-payment, Deductible, and Coinsurance for which the Covered Person and/or Covered Dependent would otherwise be responsible if the service or supply were rendered by a Participating Provider.

3. The Plan shall pay the lesser of the Non-Participating Reimbursement amount or the Maximum Allowable, as determined by the Fund and/or CIGNA, less any applicable Co-payment amount after credit is given for payment of any applicable Deductible.

4. The Covered Person shall pay to the provider of the service the Non-Participating Reimbursement amount or Maximum Allowable, any applicable Copayment amount, and any charge made by the provider in excess of the Maximum Allowable.

If a Participating Provider recommends a Covered Person must receive Medically Necessary services and supplies from a Non-Participating Provider and the Fund and/or CIGNA authorizes the referral to a Non-Participating Provider, the amount payable by the Plan for Medically Necessary services and supplies shall be determined as follows:

1. Such services shall be subject to all limitations and exclusions of this Plan.

2. The Covered Person shall pay any Co-payment, Deductible, and Coinsurance for which the Covered Person would otherwise be responsible if the service or supply were rendered by a Participating Provider.

3. The Plan shall pay the lesser of the billed charge or the Maximum Allowable, as determined by CIGNA, less any applicable Copayment, Deductible, and Coinsurance amount.
4. The Covered Person shall pay to the provider of the service any applicable Co-payment, Deductible, and Coinsurance amount and any charge made by the provider in excess of the Maximum Allowable.

Co-payments/Deductibles/Coinsurance payable by Plan Participants

Co-payments/Deductibles/Coinsurance are dollar amounts that the Covered Person must pay before the Plan pays. A deductible is an amount of money that is paid once a Plan Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services. Each January 1st, a new deductible amount is required. A co-payment is a smaller amount of money that is paid each time a particular service is used. Typically, there may be co-payments on some services and other services will not have any co-payments. Co-payments do not accrue toward the 100% maximum out-of-pocket payment.

The individual for whom coverage has been extended by the Fund is entitled to health services to the extent provided below.

****All benefits listed under this section are subject to the following annual deductibles and annual out of pocket maximums:**

Annual Deductible (January 1 to December 31)

$300.00 per Covered Person or Covered Dependent - $700.00 per Family Unit

Note: For Participants who are employed by Stop and Shop and were hired/promoted into the classification of Full Time Clerk after May 1, 2016 the Annual Deductible is:

$400.00 per Covered Person or Covered Dependent - $800.00 per Family Unit

Annual Maximum Out of Pocket Expenses

In-Network: $2,500.00 Per Covered Person and/or Covered Dependent
$5,000.00 Per Family Unit

HOSPITALIZATION

Includes emergency room services and services provided on an in-patient or outpatient basis in hospitals and/or surgical centers:

	Network	Out of Network
Deductible	Applies	Applies
Co-payment	$200.00	$200.00
Benefit	80% of Allowable Charges	60% of Allowable Charges
Maternity Confinement**	100% of Allowable Charges	80% of Allowable Charges

**** Emergency room includes all services billed by the Hospital and Emergency Room Physician.**

**** Maternity confinement that leads to delivery shall be paid at 100% (in network) and 80% (out of network) once the co-payment is made and the annual deductible is reached. Maternity confinement that does not lead to delivery is payable at the same rate as a normal hospital admission.**

X-RAY AND LABORATORY SERVICES

Regardless of whether provided in a hospital or non-hospital setting:

	Network	Out of Network
Deductible	Applies	Applies
Benefit	80% of Allowable Charges	60% of Allowable Charges

PHYSICIAN SERVICES

	Network	Out of Network
Deductible	Applies	Applies
Physician Office Visits*	80% of Allowable Charges	60% of Allowable Charges

Chemotherapy/Radiation**	80% of Allowable Charges	60% of Allowable Charges
Colonoscopy***	80% of Allowable Charges	60% of Allowable
Diagnostic Screening	80% of Allowable Charges	60% of Allowable Charges
Durable Medical**** **Equipment, Surgical Equipment, Prosthetics and Orthotics**	80% of Allowable Charges	60% of Allowable Charges
Well Care Visits***** **(Children – Up to 16)**	100% of Allowable Charges **$25 Copay applies**	80% of Allowable Charges **$25 Copay applies**

*** Benefits are payable for 1 routine physical per calendar year, payable at 100% of Allowable Chargesand are not subject to co-payment or deductibles.**

**** Benefits payable for chemotherapy and/or radiation therapy are subject to an additional co-payment of $200.00 per 6-week treatment regimen.**

***** Benefits payable for a routine colonoscopy are limited to those individuals who are over the age of 50. Benefits are limited to 1 test and an additional test 10 years later.**

****** Benefits will be paid for durable medical equipment and surgical equipment only after authorized by the Plan.**

******* The Plan will pay for well-care visits, as follows:**

(a)	**birth to 6 months**	**1 visit every 2 months**
(b)	**9 months to 18 months**	**1 visit every 3 months**
(c)	**ages to 16**	**1 visit per year**

OTHER MEDICAL SERVICES

	Network	Out of Network
Ambulance	80% of Allowable Charges	60% of Allowable Charges
Skilled Nursing*	80% of Allowable Charges	60% of Allowable Charges
Home Health Care*	80% of Allowable Charges	60% of Allowable Charges
Hospice Care*	80% of Allowable Charges	60% of Allowable Charges

*** Benefits payable for skilled nursing care, home health care and hospice care are subject to prior approval by the Plan.**

REHABILITATION SERVICES

	Network	Out of Network
Deductible	Applies	Applies
Speech Therapy*	80% of Allowable Charges	60% of Allowable Charges
Occupational Therapy*	80% of Allowable Charges	60% of Allowable Charges
Physical Therapy*	80% of Allowable Charges	60% of Allowable Charges
Acupuncture**	$500.00 per calendar year	$500.00 per calendar year
Chiropractor***	80% of Allowable Charges 20 visits per year	60% of Allowable Charges 20 visits per year
Podiatry****	80% of Allowable Charges	60% of Allowable Charges

***** **Speech Therapy, Occupational Therapy or Physical Therapy are only covered where services are rendered (a) as a result of surgery for correction of a congenital condition of the involved part of a person; (ii) to treat an Injury; or (iii) to treat a Sickness that is other than a learning or Mental Disorder. The benefit payable is for services rendered within 90 consecutive days following the first date of treatment.**

The Plan does not cover aquatic therapy or massage therapy.

Where Speech Therapy, Occupational Therapy or Physical Therapy are provided on an in-patient basis, they will be paid up to a maximum of 60 consecutive days per Injury and/or Illness and only where such therapy cannot be provided in an outpatient or home setting.

****** **Benefits for acupuncture are payable only for services rendered by a licensed physician having an M.D. degree.**

******* **Benefits payable for chiropractic services include all core and ancillary services, including but not limited to examinations and x-rays. .**

******** **The Plan will pay for custom-fitted orthotic devices prescribed by a podiatrist once every three years and are subject to the co-payment and deductibles set forth above, subject to a maximum of $350.00.**

SURGICAL SERVICES

Includes services provided at hospitals and out-patient surgical centers:

	Network	**Out of Network**
Deductible	Applies	Applies
Benefit	80% of Allowable Charges	60% of Allowable Charges

OUTPATIENT MENTAL HEALTH SERVICES

	Network	**Out of Network**
Deductible	Applies	Applies
Co-payment	$200.00	$200.00
Outpatient	80% of Allowable charges	60% of Allowable charges

SUBSTANCE ABUSE BENEFITS

	Network	Out of Network
Deductible	Applies	Applies
Co-payment	$200.00	$200.00
Inpatient*	80% of Allowable charges	60% of Allowable charges
Outpatient	80% of Allowable charges	60% of Allowable charges

To the extent that you seek out of network healthcare services that are comparable and available within a 100 mile radius of your residence, you are obligated to have such services performed locally – to the extent that you elect to use a provider outside of this geographical limitation, no benefits will be paid by the Fund.

*** Benefits for inpatient treatment require pre-authorization from the Fund.**

DESCRIPTION OF BENEFITS

LIFE INSURANCE

Qualification

These benefits are provided to you only if the collective bargaining agreement under which you are employed provides for these benefits.

Benefit

In the event of your death, the amount shown in the Schedule of Benefits will be paid to the beneficiary named by you.

Continuation of Benefits if Disabled

If, because of total disability you should terminate your employment before age 60, your insurance will remain if force without payment of premium for a period of twelve months and thereafter as long as you are continuously totally disabled, subject to yearly proof of continuance of such disability.

Rights to an Individual Policy of Life Insurance (Conversion Privilege)

In the event you are insured for Life Insurance Benefits and such insurance is terminated because your employment terminated or you cease to be within the classes eligible for such insurance, you may apply for an individual policy of Life Insurance on any of the forms of policy customarily issued by the Insurance Company in an amount equal to, or at your option less than, the amount for which you are insured prior to date of termination of insurance. No evidence of insurability or medical examination will be required.

Your application must be made and the required premium paid within 31 days following termination of your insurance. The premium will be that applicable to the form and amount at your then attained age.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Qualification

These benefits are provided to you only if the collective bargaining agreement under which you are employed provides for these benefits.

Benefits

If you suffer any of the losses shown below as a result of bodily injuries caused directly and exclusively by accident, the benefit shown for that loss will be payable:

A. The full amount shown in the Schedule of Benefits will be paid for loss of: (1) life, (2) two hands, or (3) two feet, or (4) sight of two eyes, or (5) one hand and one foot, or (6) one hand and sight of one eye, or (7) one foot and sight of one eye.

B. One-half of the amount shown in the Schedule of Benefits will be paid for loss of: (1) one foot or one hand, or (2) sight of one eye.

Loss of hands or feet means loss by severance at or above the wrist or ankle joints. Loss of sight means total and irrecoverable loss of the entire sight.

The total amount payable for all losses suffered in anyone accident may not exceed the full amount for which you are insured.

Payment for loss of life will be made to the beneficiary you have named. Payment for any other losses will be made to you.

Losses Not Covered

1. Loss occurring more than 90 days after the accident.

2. Loss caused directly or indirectly, wholly or partly or contributed to, by:

   (a) bodily or mental infirmity;
   (b) illness, disease or medical or surgical treatment;
   (c) the commission of or attempt to commit a crime;
   (d) the use or ingestion of alcohol;
   (e) the use or ingestion of illegal drugs or narcotics unless administered on the advice of a physician;
   (f) service, travel or flight in any aircraft except as a passenger on a regularly

scheduled commercial passenger flight; or

(g) suicide or attempted suicide.

Change of Beneficiary for Life and AD&D Insurance

You may change your beneficiary at any time by making written request to the Fund Office. The change will take effect as of the date you signed the request.

WEEKLY DISABILITY BENEFITS

Qualification

These benefits are provided to only of the collective bargaining agreement under which you are employed provides for these benefits.

Benefits

If you are disabled so as to be incapable of performing the regular duties of your occupation, then after the completion of the elimination period, you will be paid the Weekly Benefit as set forth in the Schedule of Benefits subject to the limitations that are set forth in this Plan.

Weekly Benefits commence on the day following the completion of the elimination period shown in the Schedule of Benefits.

The maximum payment period for a disability is 26 weeks in any 52-week period.

Weekly Benefits will be paid on a regular basis subject to medical certification. With each payment, a form will be included which must be completed by your doctor and returned in order that payment of benefits be continued to you. The Plan, at its own expense, reserves the right to have an independent medical examination conducted as a condition of continuing benefits.

Limitations

No benefits will be payable:

1. for any period during which the employee is not under the care of a physician;

2. for a disability caused by or resulting from the use or ingestion of alcohol unless the Covered Person is enrolled in an inpatient alcohol/substance abuse program. In that event, the benefit shall be limited to 30 days during the lifetime of the Covered Person;

3. for a disability caused by or resulting from the use of drugs or narcotics unless administered on the advice of a physician unless the Covered Person in enrolled in an inpatient alcohol/substance abuse program. In that event, the benefit shall be limited to 30 days during the lifetime of the Covered Person;

4. in connection with any accidental bodily injury arising out of or in the course of any occupation or employment for wage or profit or any sickness compensable under any Workmens' Compensation act or law;

5 for any period where a member is away from employment because of a leave of absence;

6 for a disability caused by the commission of or attempt to commit a crime.

DENTAL EXPENSE BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

Covered Procedures

The Procedures covered by the Plan are set forth in the Schedule of Dental Benefits.

Maximum Benefit Amounts

The Maximum Benefit Dental Benefit Amounts that the Plan will pay for each procedure covered by this Plan is set forth in the Schedule of Dental Benefits.

Predetermination of Benefits

Before starting a dental treatment for which the charge is expected to be $500 or more, a predetermination of benefits form must be submitted.

A regular dental claim form is used for the predetermination of benefits. The Covered Person fills out the Participant section of the form and then gives the form to the Dentist. The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form. The dental claim form should then be sent to the Fund Office at the following address:

Local 371 Amalgamated Welfare Trust Fund
290 Post Road West - P.O. Box 470
Westport, Connecticut 06881

The Dentist will be notified of the amounts payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed, x-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

Dental Limitations

In addition to the General Limitations of this Plan, Dental Expense Benefits are not provided for:

1. Charges as a result of dental disease, defect or Injury:

    (a) Which arises out of or in the course of any occupation or employment for wage or profit; or

    (b) For which the Covered Person is entitled to benefits under any Workers' Compensation or Occupational Disease Law;

2. Charges for services that are furnished by or for the United States Government or any other Government, unless payment is legally required;

3. Charges for services to the extent provided under any governmental program or law under which the individual is or could be covered. (This exclusion does not apply to a state plan under Medicaid or to any plan when, by law, its benefits are in addition to any private or non-governmental insurance program);

4. Charges not included in the schedule of Dental Benefits;

5. Charges in excess of the benefits payable according to the Schedule of Dental Benefits;

6. Charges for treatment by other than a Dentist, except x-rays ordered by a Dentist or services performed by a licensed dental hygienist, under the supervision and direction of a Dentist;

7. Charges for a crown, gold restoration, or a denture or fixed bridge or addition of teeth to one, if the work involves a replacement or modification of a crown, gold restoration, denture or bridge installed less than five (5) years before;

8. Charges for the replacement of a lost or stolen appliance;

9. Charges for dentures of fixed bridgework involving replacement of teeth missing before the individual was a Covered Person, unless it also replaces a tooth that is extracted while such individual is a Covered Person, and such tooth was not an abutment for a denture or fixed bridge installed during the preceding three (3) years;

10. Charges for services performed solely for cosmetic reasons, unless made necessary by an accident occurring while covered. Facings on molar crowns or pontics are always considered cosmetic;

11. Charges for appliances, restorations or procedures for the purpose of splinting or correcting attrition or abrasion;

12. Charges for appliances, restorations, or procedures whose primary purpose is to alter vertical dimension or restore occlusion.

13. The maximum payments listed in the Schedule of Dental Benefits includes local anesthesia and analgesia.

Verification of Services, Necessity and Alternative Procedures

The Plan may at its discretion, request as proof of services rendered, clinical reports, charts and x-rays and may request an examination of the claimant by a Dentist appointed by the Fund.

The Plan may, at its discretion, consider a procedure, upon which you and your Dentist agree in place of a procedure listed in the Schedule of Dental Benefits. The payment, if the procedure is approved, will be no greater than the Maximum Payment listed in the Schedule of Dental Benefits for the procedure it is replacing.

Integration With Medical Benefits

In the event benefits are available for the same expenses under both the medical and dental provisions of this Plan, such charges will first be considered for payment as a medical expense, with any remaining (eligible) balance of expenses considered for payment under the Dental Expense Benefit. There will be no duplication of benefits.

OPTICAL EXPENSE BENEFITS

Covered Procedures/Expenses

The Plan will only pay for those procedures and/or expenses covered by the Plan are set forth in the Schedule of Optical Expense Benefits.

The Plan will not pay for sunglasses, even if prescribed or provided by an optician, optometrist or ophthalmologist.

Maximum Benefit Amounts

The Plan will not pay for more than one examination, complete pair of lenses with frames, or contact lenses in a calendar year for each Covered Person and/or Covered Dependent.

The maximum benefit that the Plan will pay for each procedure and/or expense covered by this Plan is set forth in the Schedule of Optical Expense Benefits.

HEARING CARE SERVICE BENEFITS

Qualification

These benefits are provided to a Participant and their eligible dependents only if the collective bargaining agreement under which you are employed provides for these benefits.

Limitations of Service

All hearing care services must be received at the University of Connecticut Speech and Hearing Clinic in Storrs, Connecticut. No expenses for the fitting and dispensing of hearing aid or aids will be covered except those recommended, provided or dispensed by a University of Connecticut Speech and Hearing Clinic audiologist. Hearing aids will be provided only through the Hearing Clinic.

In accordance with federal law, children must receive medical clearance by a physician, preferably an otolaryngologist, in order to be fitted for hearing aids, unless a waiver is signed by a guardian. The cost of the appointment to clear a Participant's child for the fitting of hearing aids is **not** covered by this benefit. In the case of children, a parent or other responsible adult must accompany the child to all appointments

Participants interested in an evaluation must first contact the Fund Office to verify eligibility. After eligibility has been established, the Fund Office will assist in scheduling an appointment with the University of Connecticut Speech and Hearing Clinic in Storrs.

Eligible Participants and their eligible dependents may receive a hearing evaluation and hearing aid benefits once every three years.

Covered charges for hearing aids include the full range hearing appliances, including any necessary accessories, such as ear molds and an initial supply of batteries, provided the hearing aid or aids are deemed appropriate for the individual with the hearing loss by an audiologist at the Hearing Clinic. This benefit also includes all the follow-up sessions for the individual with the hearing loss to adjust to the hearing appliance at the Hearing Clinic for the first twelve months after purchase.

The Fund will not replace lost, stolen, or damaged hearing aids or appliances. Hearing appliances, however, do have warranties. The typical warranty covers at least one year. The warranty will be explained to Participants by the staff at the Hearing Clinic and is part of the program the Fund arranges with the Hearing Clinic and the manufacturers of the hearing aids.

If a Participant is dissatisfied with the hearing aids dispensed, the Participant can return the hearing aid or aids within 30 days to the Hearing Clinic and the Participant will reimburse the cost of the hearing aid less (a) $100.00 per aid, (b) the cost of all earmolds and (c) batteries Any fees you paid for the balance of the charges for the hearing aid or aids will be refunded to you as the Fund is responsible for all the charges associated with the evaluation and fittings.

PRESCRIPTION DRUGS

Participating pharmacies have contracted with the Plan through OptumRx, Inc. to charge Covered Persons and Covered Dependents reduced fees for covered Prescription Drugs. The Plan does not provide coverage for prescriptions that are filled at non-participating pharmacies. Check you benefit provider summary for the names and addresses of participating pharmacies.

Co-payments

The co-payment is applied to each covered pharmacy drug or mail order drug charge. The co-payment amount is not a covered charge under the Medical Plan. Co-payment amounts are as shown in the Schedule of Benefits. If a drug is purchased from a participating pharmacy when the Covered Person's ID card is not used, reimbursement shall be limited to the Maximum Allowable Charge.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, OptumRx, Inc., the mail order pharmacy, is able to offer Covered Persons significant savings on their prescriptions.

Covered Prescription Drugs

1. All drugs prescribed by a Physician that require a prescription either by federal or state law.

2. Insulin and other diabetic supplies when prescribed by a Physician.

3. Prenatal Vitamins.

Limits To This Benefit

This benefit applies only when a Covered Person and/or Covered Dependent incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a Physician.

2. Refills up to one (1) year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

1. Any charge for the administration of a covered Prescription Drug.

2. Any charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

3. Any drug or medicine that is consumed or administered at the place where it is dispensed.

4. Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin-A or medications for hair growth or removal.

5. Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

6. Experimental drugs and medicines, even though a charge is made to the Covered Person and/or Covered Dependent

7. Any drug not approved by the Food and Drug Administration.

8. Immunization agents or biological sera.

9. Drugs or medicines labeled: "Caution - limited by federal law to investigational use."

10. Charges excluded under Medical Plan Exclusions.

11. Charges for Prescription Drugs that may be properly received without charge under local, state or federal programs.

12. Charges for FDA-approved drugs that are prescribed for non-FDA-approved uses.

13. Drugs or medicines that can legally be bought without a written prescription. This does not apply to injectable insulin.

14. Any refill that is requested more than one (1) year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

15. Replacement of lost or stolen prescription medications covered under this Summary Plan Description.

16. Charges for Prescription Drugs that are dispensed by non-participating pharmacies.

17. Charges for Brand Name Prescription Drugs where generic replacements were available.

18. Charges for all compounded prescriptions, i.e. the mixture of two or more ingredients when at least one of the ingredients in the preparation is a Federal or State legend drug in a therapeutic quantity.

MEDICAL SURGICAL AND HOSPITALIZATION BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person and/or Covered Dependent for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

Deductible

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Plan Year a Covered Person and/or Covered Dependent must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Plan Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that Plan Year.

Benefit Payment

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person and/or Covered Dependent that are in excess of the deductible and any co-payments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount, in excess of any listed limit of the Plan nor will benefits be paid for any services that are subject to exclusions of the Plan.

Out-Of-Pocket Limit

Covered Charges are payable at the percentages shown each Plan Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at one hundred percent (100%) (except for the charges excluded) for the rest of the Plan Year. When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at one hundred percent (100%) (except for the charges excluded) for the rest of the Plan Year.

Maximum Benefit Amount

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person.

Extension of Benefits

If a total and continuous disability exists on the date Major Medical Expense Benefits are terminated, benefits for Covered Expenses incurred for the treatment of the injury or disease causing such disability will be payable, provided the disability is total and continuous through the date such treatment is received, except that no benefits will be payable for Covered Expenses incurred more than twelve months after such termination of benefits and further excepted that no payment of benefits will be made beyond the date the individual becomes eligible for similar benefits under any other group medical coverage.

Allowable Charges

Allowable charges are the per service charges that CIGNA has contracted with participating hospitals, physicians, laboratories and other health care providers to pay for the following items of service and supply. These charges are subject to the "Benefit Limits" of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

1. **Hospital Care.** The medical services and supplies furnished by a Hospital, Acute Care Hospital, Ambulatory Surgical Center or a Birthing Center if prescribed or approved by a Physician and upon preauthorization by CIGNA/Care Allies. Covered charges for room and board will be payable as shown in the Schedule of Benefits.

    (a) Inpatient Services:

        (i) Room and Board in a Hospital, Acute Care Hospital, Ambulatory Surgical Center or a Birthing Center on a semi-private accommodation basis as stated in the Schedule of Benefits.

        (ii) Services and supplies other than Room and Board that are pre-authorized by CIGNA/Care Allies.

    (b) Outpatient Services:

        (i) Services and supplies furnished by a Hospital, Acute Care Hospital, Ambulatory Surgical Center or a Birthing Center. Services and supplies in connection with procedures that require pre-authorization must be pre-authorized by Maxon Company.

2. **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility;

(b) the confinement starts within 15 days of a Hospital confinement or is in lieu of a Hospital confinement of at least three days;

(c) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

(d) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered charges for a Covered Person's care in these facilities is limited to the allowable charge limit shown in the Schedule of Benefits and subject to prior approval by the Plan.

3. **Physician Care**. The professional services of a Physician for surgical or medical services.

Multiple Surgeries; Assistant Surgeries.

Charges for multiple surgical procedures will be a covered expense subject to the following provisions:

(i) If bilateral or multiple surgical procedures are performed during the same surgical setting, payment shall be made for only the primary surgical procedure plus fifty percent (50%) of the Maximum Allowable physician's fee for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(ii) if multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Maximum Allowable physician's fee for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Maximum Allowable for that procedure; and

(iii) if an assistant surgeon is required, the assistant surgeon's covered charge will not exceed twenty percent (20%) of the surgeon's Maximum Allowable physician's fee.

Emergency Room Physician Services

Services provided by emergency room physicians are considered to be part of the total charges provided in relation to that visit and subject to the deductible and co-payment requirements for emergency room charges.

4. **Private Duty Nursing Care**. The private-duty nursing care by licensed nurse (R.N., L.P.N. or L.Y.N.).

Covered charges for this service will be included to this extent:

(a) Inpatient Nursing Care. Charges are covered only when care is Medically Necessary or not Custodial in nature.

(b) Outpatient Nursing Care. Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for outpatient nursing care are those shown below, under Home Health Care Services and Supplies.

5. **Home Health Care Services and Supplies**. Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required.

Benefit payment for nursing, home health aide and therapy service is subject to the Home Health Care limit shown in the Schedule of Benefits and requires prior approval from the Plan.

A home health care visit will be considered a periodic visit by either a nurse (R.N. or L.P.N.) or therapist, as the case may be or four hours of home health aide services.

6. **Hospice Care Services and Supplies**. Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered charges for Hospice Care Services and Supplies are payable for both inpatient and outpatient services.

Charges for bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Dependent Children). Bereavement services must be furnished within six months after the patient's death.

7. **Reconstructive Surgery**. Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges subject to the Schedule of Benefits. Mammoplasty coverage will include reimbursement for:

   (a) reconstruction of the breast on which a mastectomy has been performed,

   (b) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

   (c) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

8. **Second Surgical Opinion**. The Plan will pay all eligible expenses for a second surgical opinion as stated in the Schedule of Benefits. If the second doctor does not confirm the need for surgery, the Plan will pay the same benefit for a third doctor's opinion.

9. **Treatment of Mental Disorders**. Covered charges for care, supplies and treatment of Mental Disorders will be limited as follows:

   (a) All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.

   (b) Inpatient services under the direction of a physician, as stated in the Schedule of Benefits. Inpatient services must be pre-authorized by CIGNA/Care Allies.

   (c) Physician's visits are limited to one (1) treatment per day.

   (d) Outpatient psychiatric, diagnostic and therapeutic services provided by a Participating Physician or Licensed Psychologist.

10. **Other Medical Services and Supplies.** The following services and supplies not otherwise included in the items above:

(a) Anesthetic; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(b) Diagnostic x-rays and/or MRI studies prescribed and performed in accordance with accepted medical practice.

(c) Laboratory studies prescribed and performed in accordance with accepted medical practice.

(d) Radiation or chemotherapy and treatment with radioactive substances. The materials and services of technicians are included.

Benefits payable for chemotherapy and/or radiation therapy are subject to an additional co-payment of $200.00 per 6-week treatment regimen.

(e) Rental or purchase of durable medical or surgical equipment to be used only for therapeutic care. The determination whether items are purchased rather than rented will be made by the Plan Administrator.

Benefits for durable medical equipment and surgical equipment are subject to prior approval by the Plan.

(f) Local Medically Necessary professional land or air ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided, but in any event, no more than 50 miles from the place of pickup, unless the Claim Administrator finds a longer trip was Medically Necessary.

(g) Surgical dressings, splints, casts and other devices used in the reduction of fractures and dislocations.

(h) The initial purchase, fitting, repair and replacement of orthotic appliances such as braces, splints or other appliances that are required for support for an injured or deformed part of the body.

The Plan will pay benefits for custom fitted orthotic devices prescribed by a podiatrist once every three years, subject to the co-payment and deductibles set forth in the Schedule of Benefits and up to a maximum of $350.00.

(i) The initial purchase, fitting, repair and replacement of fitted prosthetic devices. Prosthetics are to include devices following the

performance of a covered mastectomy and two bras per year which are prescribed to fit the prosthesis.

Benefits for the purchase, fitting, repair and replacement of prosthetic devices are subject to prior approval by the Plan.

(j) Physical therapy by a licensed physical therapist, occupational therapy by a licensed occupational therapist, speech therapy by a licensed speech therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and to improve a body function, and follow either; (i) surgery for correction of a congenital condition of the involved part of a person born while covered under the plan; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.

The benefit payable is for services rendered within 90 consecutive days following the first date of treatment.

(k) Initial contact lenses required following cataract surgery.

(l) Chiropractic care. Such care must be in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral columns and must be provided by a licensed M.D., D.O., or D.C.

Benefits payable for chiropractic services include all core and ancillary services, including but not limited to examinations and x-rays.

(m) Charges incurred for treatment of any type of allergy.

(n) Charges incurred for a licensed or certified midwife, nurse midwife, or nurse practitioner for medical care.

(o) Charges for well child care to age 16 subject to the limits set forth in the Schedule of Benefits, including regularly scheduled pediatric visits, immunizations and vaccinations as well as newborn nursery and physician charges and circumcisions.

(p) Cardiac rehabilitation as deemed Medically Necessary provided services are rendered under the supervision of a Physician. The benefits shall be limited to Covered Persons and/or Covered Dependents who (1) have completed a documented diagnosis of

myocardial infarction within the preceding twelve (12) months; or (2) have had recent coronary bypass surgery and/or (3) have stable angina pectoris. Requests for outpatient cardiac rehabilitation sessions must be preauthorized by Cigna/Care Allies.

(q) Acupuncture services rendered by a licensed Physician having an M.D. degree.

(r) Services provided in connection with sterilization procedures. However, there is no coverage for the care and treatment for reversal of surgical sterilization

11. **Substance Abuse**. Services required to treat alcohol and/or chemical dependency shall be payable according to the Schedule of Benefits, subject to the following:

(a) Inpatient Services while confined in a Hospital or Alcohol/Chemical Dependency Treatment Facility as stated in the Schedule of Benefits. These services must be preauthorized by Cigna/Care Allies.

(b) Outpatient services provided by an Outpatient Treatment Facility as stated in the Schedule of Benefits. These services must be preauthorized by Cigna/Care Allies.

12. **Pregnancy Care**. Medical and Hospital Services, including prenatal and postnatal care provided under the direction of a Physician. Benefits are payable in accordance with the Schedule of Benefits.

Group health plans 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 forty-eight (48) hours following a vaginal delivery, or less than ninety-six (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 forty eight (48) hours (or ninety-six (96) hours as applicable).

13. **Well Newborn Nursery/Physician Care.** Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge. This coverage is only provided if a parent is a Covered Person at the time of the birth and the newborn child is an eligible Dependent and is neither injured nor ill.

Group health plans 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 forty eight (48) hours following a vaginal delivery, or less than ninety-six (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 forty-eight (48) hours (or ninety-six (96) hours as applicable).

14. **Routine Preventive Care.** Covered charges are payable as described in the Schedule of Benefits in order to cover routine physical exams, pap smears, mammograms, lab tests (including PSA tests), well baby care, check-ups and immunizations. Routine Preventative Care is limited to 1 routine physical per year, payable at 100% of Allowable Charges.

15. **Organ transplant limits**. Organ Transplant Services and expenses incurred within the transplant benefit period as defined below. These services must be preauthorized by CIGNA/Care Allies and shall be available only at Hospitals designated by CIGNA/Care Allies.

    (a) Health services directly related to the transplanting of a natural kidney, kidney/pancreas, cornea, liver, heart, heart/lung, lung, and bone marrow (allogeneic and autologous) and stem cell transplants for certain conditions.

    Access Requirements:

    The Fund requires all transplants be preauthorized prior to receiving any services, including evaluation. It is the Participant's responsibility to obtain preauthorization for all transplant-related services. Failure to obtain preauthorization for any transplant-related services will result in non-coverage of benefits. All transplant-related services shall be available only at designated transplant facilities. The medical criteria for the type of approved transplant will be applied and each potential transplant must be deemed by CIGNA/Care Allies to be Medically Necessary and appropriate for the medical condition for which the transplant is proposed.

Approved Transplant Services:

Services and supplies for transplant-related services, when ordered by a Participating Physician, provided at or arranged by a designated transplant facility. Such services include, but are not limited to, Hospital charges, Physician charges and ancillary services rendered during the benefit period. Unless otherwise excluded in the "Plan Exclusions" Section coverage is provided for cornea, kidney, kidney/pancreas, liver, heart, heart/lung, lung and bone marrow (allogeneic and autologous) and stem cell transplants for certain conditions, when such transplants are Medically Necessary, medically appropriate and rendered in a designated transplant facility in accordance with CIGNA/Care Allies's guidelines for transplantation health services. The Participant should contact the Fund Office for information on designated transplant facilities and guidelines on transplantation.

Benefit Period:

The period of time from the date the Participant receives preauthorization and has an initial evaluation for the transplant procedure until the earliest of (a) one (1) year from the date the transplant procedure was actually performed; or (b) the date of the Participant's death. Benefits under this organ transplant coverage do not include services or supplies related to any transplant of inter-species organs or xenograft or any transplant involving a mechanical organ.

16. **Medical Care for Mouth, Teeth and Gums.** Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

(a) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth not incidental to the fitting or continued use of dentures.

(b) Emergency repair if due to accidental bodily injury to sound natural teeth that occurred while covered under this Plan, excluding any injury caused by chewing or dentures, and such services are rendered within one (1) year of such injury.

(c) Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth. Services must be rendered within one (1) year of such surgery.

(d) Excision of benign bony growths of the jaw and hard palate.

(e) External incision and drainage of cellulitis.

(f) Incision of sensory sinuses, salivary glands or ducts.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

For all Benefits shown in the Schedule of Benefits, charges for the following are not covered:

1. Care, treatment, or supplies for which a charge was incurred before a person was Covered under this Plan, or after coverage ceased under this Plan, except for an on-going dental procedure which will be completed within 30 days from the date of termination, and except as described under the Plan's Extension of Benefits provisions.

2. Charges excluded or limited by the terms and conditions of the Plan as set forth in this document.

3. Charges incurred for which the Plan has no legal obligation to pay.

4. Care and treatment of an Injury or Sickness that, in either case, is occupational - that is, arises from work for wage or profit including self-employment.

5. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when a Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment that is appropriate care for the Injury or Sickness.

6. Care and treatment for which there would not have been a charge if no coverage had been in force.

7. Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

8. Care and treatment that is either Experimental/Investigational or not Medically Necessary.

9. The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual Customary Reasonable Charge.

10. Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance, unless the injury or sickness is (i) a result of an unrelated medical condition, or (ii) a result of being a victim of an act of domestic violence..

11. Any charge for a loss that is due to a declared or undeclared act of war.

12. Any charges for medical services resulting from a self-inflicted injury unless such self-inflicted injury is a result of a diagnosed mental health or alcohol/substance abuse condition.

13. Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, child, brother, or sister, whether the relationship is by blood or exists in law.

14. Care and treatment provided for cosmetic reasons, including services performed to change appearance or to reconstruct an external body part, including reconstructive or cosmetic surgery for psychological reasons or necessitated by congenital abnormalities, panniculectomy or removal of excess skin following surgery for morbid obesity. This exclusion will not apply if the care and treatment is for repair of damage from an accident that occurred while the person was covered under the Plan; or is for correction of an abnormal congenital condition in a child born while one of the parents was covered under the Plan.

    Reconstructive mammoplasty will be covered after Medically Necessary surgery, providing the reconstruction is performed within five years of the mastectomy and providing the Covered Person was covered under the Plan at the time of the mastectomy. Reconstructive Mammoplasty includes any necessary surgery and reconstruction of the breast on which a mastectomy was not performed in order to produce a symmetrical appearance.

15. Except as provided by the optical benefits provided by the Plan, routine eye examinations, including refractions, lenses for the eyes and exam for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages. Radial keratotomy is also excluded.

16. Charges for services or supplies in connection with hearing aids or exams for their fitting.

17. Charges for routine or periodic examinations, screening examinations evaluation procedures, preventive medical care, or treatment or service not directly related to the diagnosis or treatment of a specific Injury or Sickness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.

18. In excess of 20 visits per year for Chiropractic treatment.

19. Services or supplies provided mainly as a rest cure, maintenance or Custodial Care, Convalescent or Sanitorial Care.

20. Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations); and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

21. Replacement of braces of the leg, arm, back, neck, artificial arms, legs, eyes or lenses for the eyes, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

22. Services for educational, vocational testing, self-help training, bio-feedback services or training or counseling in life management skills.

23. Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

24. Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, allergy-free pillows, blanket or mattress covers, electric heating units, swimming pools, orthopedic mattresses, exercising equipment, vibratory equipment, elevators or stair lifts, electric wheel chairs, scooters, blood pressure instruments, stethoscopes, clinical thermometers, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and non-hospital adjustable beds.

25. Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness.

26. Care and services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change, This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

27. Care and treatment for reversal of surgical sterilization.

28. Charges incurred for care and treatment or testing for infertility, artificial insemination or in vitro fertilization.

29. Care and treatment for hair loss including wigs (except when as a result of cancer treatment), hair transplants or any drug that promises hair growth, whether or not prescribed by Physician.

30. Care and treatment for smoking cessation programs, including smoking deterrent patches.

31. Care and treatment for sleep disorders unless deemed Medically Necessary.

32. Exercise programs, except for Physician-supervised cardiac rehabilitation, occupational, or physical therapy covered by this Plan.

33. Care, services or treatment required as a result of complications from a treatment not covered under the Plan.

34. Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.

35. For medical services not performed by a practitioner of the healing arts duly licensed or certified by the proper authorities of the jurisdiction in which he practices to render services within the scope of such license or certificate.

36. Services, supplies, care or treatment for an injury and/or illness sustained by Covered Person(s) and/or Covered Dependent(s) that do not suffer from a documented alcoholism/substance abuse dependency that is caused by or directly related to the ingestion of or being under the influence of alcohol or any controlled substance, drug, hallucinogen or narcotics not administered on the advice of a Physician.

37. Services, treatments, and supplies that are not specified as covered under this Plan.

38. No payment will be made for expenses incurred by a Covered Person(s) and any Covered Dependent(s) for expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law.

39. Services related to molecular genetic testing (specific gene identification) or related genetic counseling, except for purposes of determination of therapy.

40. Any services, supplies medications or programs relating to weight loss including but not limited to those rendered in connection with gastric restrictive procedure for morbid obesity.

41. Care, treatment or supplies out of the U.S., if travel is for the sole purpose of obtaining medical services.

42. Food, food supplements or special diets and liquids unless provided in an inpatient Hospital setting.

43. Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical and/or psychiatric treatment.

44. All costs associated with blood storage services.

45. Services for disorders in which the main symptoms are caused by, or in response to, exposure to common life stressors of a non-medical origin; marital relationship problems, social, marital or occupational maladjustment.

46. Any services rendered for any Covered Person or Eligible Dependent who is the genetic mother, genetic father, surrogate mother, putative mother, or birth mother of any child who is the product of a surrogacy agreement or arrangement, or for any otherwise Covered Dependent, associated within any manner with any type of surrogacy agreement or arrangement, including, but not limited to, traditional surrogacy, artificial insemination related to a surrogacy agreement or arrangement, or gestational or invitrofertilization surrogacy. This exclusion does not apply to services provided to a child who is legally adopted by a Covered Person.

47. State and municipal provider taxes applied to medical services or supplies.

48. All diagnostic and treatment services related to the treatment of jaw problems including temporomandibular joint (TMJ) syndrome.

49. Examination, treatment, or testing that is received pursuant to an order or judgment issued by a court administrative, or regulatory body.

50. Charges associated with failure to keep a scheduled appointment, phone consultations, completion of claim forms, or return to work or school forms.

51. Charges for aquatic therapy or massage therapy.

52. Charges for out of network healthcare services that are comparable and available within a 100 mile radius of your residence, unless such charges are a result of you being physically beyond the 100 mile radius at the time of the occurrence of the injury and/or illness requiring the services.

53. Multiple office visits billed by the same healthcare provider for the same category of service on the same date of service.

54. Drug testing, other than drug testing that is administered as part of an established program to care for a diagnosed alcohol/substance abuse condition.

DEFINITIONS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee - is an Employee who performs all of the duties of his job with the Employer on a regularly scheduled basis and is categorized as a Full-Time employee under the collective bargaining agreement that covers his/her employment.

Active Service or Actively at Work - A Covered Employee will be considered in "Active Service" on a day which is a scheduled work day, if he is performing in the customary manner all of the regular duties of his employment on a full time basis, either at his customary place of employment, or at some location to which that employment requires him to travel, or if he is absent from work solely by reason of vacation and at the time his coverage would otherwise become effective, he has not been absent from work for a period of more than three consecutive weeks. A Covered Employee will be considered "Actively at Work" on a day which is not a scheduled work day only if he was performing in the customary manner all of the regular duties of his employment on the last day preceding scheduled work day.

Allowable Charges/Expenses means any necessary, usual, customary and reasonable expenses incurred while eligible for benefits under this Plan. Whenever payments have been made by the Plan in amounts in excess of those necessary to satisfy the intent of the Plan, the Plan Supervisor has the right to recover such excess from the person to or from whom such payments were made.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Baseline shall mean the initial test results to which the results in future years will be compared in order to detect abnormalities.

Birthing Center means any freestanding health facility, place, professional office or institution whicl1 is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located. The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery (no more than 24 hours); provide care under the full-time supervision of a Physician and either a registered graduate nurse or a certified nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre-or post-delivery confinement.

Calendar Year means January 1st through December 31st of the same year.

Chemical Dependency/ Alcoholism is the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco or ordinary caffeine-containing drinks.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Cosmetic Surgery means surgery to change (a) the texture or appearance of the skin or any part of the body; or (b) the relative size or position of any part of the body, when such surgery is not needed to correct or improve a bodily function; except that, Cosmetic Surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

Covered Person is an Employee who is covered under this Plan.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Deductible is the amount of covered charges for which no benefit will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible (the dollar amount indicated) shown in the Schedule of Benefits.

If all or any portion of the amount applied to the deductible accumulated by the application of the charges incurred during the last three consecutive months of a calendar year, then the deductible amount for the next ensuing calendar year will be reduced to the extent to such application.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury.

Employee means a person who is an Active, regular Employee of an Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer means an employer that has entered into a collective bargaining agreement with the Union to make contributions in order to provide benefits under this Plan.

Enrollment Date is the first day of coverage, or if there is a waiting period, the first day of the waiting period.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational means care, treatment, services, or supplies which do not constitute accepted medical practice, properly within the range of appropriate medical treatment, under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Foster Child means an unmarried child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a Covered Employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the Covered Employee's; the child depends on the Covered Employee for primary support; the child lives in the home of the Covered Employee; and the Covered Employee may legally claim the child as a federal income tax deduction.

A covered foster Child is not a child temporarily living in the Covered employee's home; one placed in the Covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Generic Drug means a Prescription Drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

HIPAA means The Health Insurance Portability and Accountability Act of 1997.

Home Health Care Agency is an agency that meets all of these tests: its main function is to provide Home Health Care Services and supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed every 30 days; it must certify that the home health care is in place of Hospital confinement; and it must specify the type and extent of home health care required for the treatment of the Patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an agency where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises,

The definition of "hospital" shall be expanded to include the following:

1. A facility operating legally as a psychiatric Hospital and licensed as such by the state in which the facility operates.

2. A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the

staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Alcoholism and Drug Abuse.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit". It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Annual/Maximum Benefit is a word that appears in this Plan in reference to benefit maximums and limitations. Annual is understood to mean during the course of a Plan year.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments, or any type of Skilled Nursing Facility.

Medical Emergency means the sudden and unexpected onset of serious symptoms, which would include acute chest pain such as found in heart attacks, cardiovascular accidents, loss of consciousness or respiration, convulsions, poisonings, acute abdominal pain, or other such medical conditions.

Medically Necessary care and treatment is recommended or approved by a Physician; and is consistent with the patient's condition or accepted standards of good medical practice; and is medically proven to be effective treatment of the condition; and is not performed mainly for the convenience of the patient or provider; and is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International

Classification of Diseases, Published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments to injured persons for medical care without determining fault in connection with automobile accidents.

Outpatient Care is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), Licensed Professional Physical Therapist, Physiotherapist, Licensed Professional Counselor, Psychiatrist, Audiologist, Speech Language Pathologist, Midwife and any other practitioner of the healing arts that is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means the Plan of Benefits described in this document.

Plan Participant means a Covered Person.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year, which is a short Plan Year.

Pregnancy is the condition associated with childbirth and conditions associated with Pregnancy.

Prescription Drug means any of the following: a drug or medicine which, under federal law, is required to bear the legend: "Caution: Federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription by a licensed Physician. Such a drug must be Medically Necessary in the treatment of a Sickness or Injury.

Residential/Detoxification Facility means an institution that is licensed, certified or approved pursuant to state and local laws as a facility for the treatment of alcoholism.

Right of Recovery this Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Semi Private means "semi-private" room accommodations of at least two beds.

Special Care Facility means a licensed institution (other than a Hospital as defined) which:

1. Specializes in physical rehabilitation,
2. Specializes in the diagnosis and treatment of mental illness, or

3. Qualifies as a skilled nursing facility or provider of services under Medicare; but only if that institution (a) maintains on the premises facilities necessary for medical treatment; (b) provides such treatment for compensation, under the supervision of Physicians; and (c) provides nurses' services.

Sickness is a person's illness, or disease or Pregnancy.

Skilled Nursing Facility is a facility that fully meets all of these tests:

1. It is licensed to provide for persons convalescing from Injury or Sickness, and provides professional nursing services on an inpatient basis. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities must be provided.

2. Its services are provided for compensation from its patients and under the full-time supervision of a Physician or a registered nurse.

3. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

4. It maintains a complete medical record on each patient.

5. It has an effective utilization review plan.

6. It is not, other than incidentally, a place for: rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

7. It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to distortion, misalignment or subluxation of, or in, the vertebral column.

Surgical Expense Benefit means the Benefit paid For Surgery upon receipt of proof satisfactory to the Plan Supervisor that a Covered Person has incurred necessary expenses for surgical services that were recommended and approved by a physician.

Temporomandibular Joint (TMJ) Syndrome is the set of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled) means: In the case of an Active Employee, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness. In the case of a Covered Dependent it means the complete inability to perform the normal activities of a person of like age and sex in good health.

Union means Local 371, United Food and Commercial Workers Union.

Usual, Customary, and Reasonable Charge is a charge that is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same geographical area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual, Customary, and Reasonable. The Plan Administrator has further approved of HIAA schedules at the 80th percentile as the basis for determining the Usual, Customary, and Reasonable level of reimbursement.

COORDINATION OF BENEFITS

If a Covered Person or Covered Dependent is covered under the Plan and one or more other plans, as defined below, the benefits payable with respect to the Covered Person and/or Covered Dependent under the Plan will be either the Plan's benefits or benefits reduced by the amount the other carrier pays for any eligible expenses, so the benefit payment is up to, but not exceeding the benefits ordinarily provided by the Plan if it were the only Health Care Benefit Plan in force.

Benefit Plan: The term "Benefit Plan" means this Plan or any other plan under which medical benefits or services are provided by:

1. Group, blanket or franchise insurance coverage;

2. Any group Hospital service prepayment, group medical service prepayment, group practice or other group prepayment coverage;

3. Group coverage under labor-management trusted plans, union welfare plans, Employer organization plans or Employee benefits plans;

4. Coverage under governmental programs or coverage required or provided by any statute (including no-fault auto insurance), except Medicare. (Refer to the Effect of Medicare provision for treatment of this coverage under This Plan.)

Allowable Charges/Expenses

For a charge to be allowable it must be a usual, customary and reasonable charge, and at least part of the charge must be covered under this Plan. In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

For an expense to be allowable, it must be a necessary, reasonable and customary expenses incurred while eligible for benefits under this Plan, part or all of which would be payable under any of the Plans coordinated with this one.

The Plan Administrator and/or Claims Administrator have the right to release to, or obtain from, any other organization or person, any information necessary for the administration of this provision.

Obligation of Covered Persons/Dependents to Provide Information

When a Covered Person and/or Covered Dependent claims benefits under this Plan, he/she must furnish the Plan Administrator and the Claims Administrator with all information

about other coverage which may be involved in applying this coordination provision. In the event that a Covered Person and/or Covered Dependent refuses to comply with the obligation under this provision, the Plan may delay enrollment, re-enrollment and/or payment of benefits until such time as there has been compliance.

Effect of State Mandated Automobile Insurance

This Plan shall have secondary liability for those medical expenses incurred as a result of a motor vehicle accident, on behalf of a Covered Person subject to any state automobile insurance law, regardless of the terms and conditions of any specific automobile policy. Furthermore, if a Covered Person has no Personal Injury Protection, in a state where such coverage is mandated, coverage under this Plan shall be reduced by the minimum coverage requirement of the state with jurisdiction.

In addition to the above, for those Covered Persons subject to the State of New Jersey no-fault automobile insurance law, or the law of any other state which permits issuance of a state mandated motor vehicle policy with an optional high Personal Injury Protection deductible, this Plan shall not recognize as a covered expense the Personal Injury Protection deductible, selected by a Covered Person. Such deductible amount shall be the direct responsibility of the Covered Person.

Order of Benefit Determination

A plan without a provision to limit payment made by one or more plans (either by coordination or integration) will always be primary. If both or all plans involved have such a provision, the order of benefit determination will be as follows:

1. An automobile medical payment plan or no-fault insurance policy.

2. A federal, state, local government, or community program, excluding Medicaid, providing medical benefits or reimbursement of medical costs, unless statutes or regulations governing such programs provide otherwise.

3. Student coverage obtained through an educational institution above the high school level.

4. If a plan has no provision for coordination of benefits or integration, that plan will have primary responsibility.

5. The benefits of the plan that covers the person as an Employee or Member (that is, other than as a dependent) are determined before those of the plan that covered the person as a dependent.
6. A plan that covers a person as an active Employee or as a dependent of that Employee determines its benefits before those of a plan that covers the

person as a laid-off or retired Employee. The same rule applies to dependents of laid-off or retired Employees. A plan that covers a person as a retiree pays before the plan that covers the person as a dependent. Except as stated below, when this Plan and another plan cover the same child as a dependent of different persons, called "parent":

(i) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

(ii) If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan contains the gender rule, and if, the plans differ on the order of benefits, then the gender rule is used to determine the order of benefits. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(i) the plan of the parent with custody;

(ii) the plan of the Spouse of the parent with custody;

(iii) the plan of the parent without custody;

(iv) the plan of the Spouse of the parent without custody.

However, if the terms of a court decree specify that one of the parents is responsible for the health care expenses of the child, then the benefit of the plan of the parent with financial responsibility will be determined first. The plan of the other parent will then be the secondary payer. If the terms of the court decree specify that the parents will share joint custody and neither parent is specified as responsible for the health care expenses of the child, the rules which apply to parents who are not separated or divorced will be used to determine which plan pays first. If the above rules do not establish primary responsibility, then the Plan that has covered the person for a longer period of time will have primary responsibility.

Claims Determination Period

Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to Receive or Release Necessary Information.

To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person and/or Covered Dependent is required to give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of Payment

This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of Recovery

This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan, the Covered Person or the Covered Dependent

That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this Provision Applies

The Covered Person and/or Covered Dependent may incur medical or dental charges due to Injuries that may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person and/or Covered Dependent may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person and/or Covered Dependent may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person and/or Covered Dependent has against any Third Party, or insurer, whether or not the Covered Person and/or Covered Dependent chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person and/or Covered Dependent whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person and/or Covered Dependent:

1. automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

2. must repay to the Plan the benefits paid on his or her behalf out of the recovery made from the Third Party or insurer.

Amount Subject to Subrogation or Refund

The Covered Person and/or Covered Dependent agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a one hundred percent (100%), first dollar priority over any and all recoveries and funds paid by a Third Party to a Covered Person and/or Covered Dependent relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person and/or Covered Dependent may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person and/or Covered Dependent’s Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make,

payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to recover payment for medical or dental expenses from the Covered Person and/or Covered Dependent. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person and/or Covered Dependent is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage

The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person and/or Covered Dependent if a Covered Person and/or Covered Dependent refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person and/or Covered Dependent is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person and/or Covered Dependent or his/her authorized legal representative obtains valid court recognition and approval of the Plan's one hundred percent (100%), first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms

"Covered Person" means anyone that is covered under the Plan.

"Covered Dependent" means all persons that are covered as Dependents under the Plan, including minors.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person and/or Covered Dependents by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery From Another Plan Under Which the Covered Person and/or Covered Dependent is Covered

This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator/Claim Administrator

The Plan Administrator and/or Claim Administrator has a right to request reports on all settlements. The Plan Administrator has the right to approve of all settlements.

CONTINUATION OF COVERAGE BENEFITS (COBRA)

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end.

This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

Note: Special COBRA rights apply to employees who have been terminated or experienced a reduction of hours and who qualify for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 1974. These employees must have made petitions for certification to apply for TAA on or after November 4, 2002. The employees, if they do not already have COBRA coverage, are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members, but only within a limited period of sixty (60) days or less and only during the six (6) months immediately after their group health plan coverage ended. Any employee who qualifies or may qualify for assistance under this special provision should contact his or her Plan Administrator for further information.

If you are an employee covered under the Plan, you have the right to choose this continuation coverage if you lose your group health coverage for any of the following reasons (qualifying events):

1. A reduction in your hours of employment;

2. The termination of your employment (for reasons other than gross misconduct on your part), including resignation and/or retirement;

3. Your enrollment for benefits under Title XVIII of the Social Security Act (i.e. the Medicare program)

4. A proceeding in bankruptcy under Title II, commencing after July 1, 1986, with respect to an Employer from whose employment a covered employee retired at any time.

If you are the dependent child of an employee, you have the right to choose continuation coverage for yourself if you lose group health coverage for any of the following reasons (qualifying events):

1. The death of your parent;

2. A termination of your parent's employment (for reasons other than gross misconduct) or reduction in your parent's hours of employment;

3. Divorce or legal separation of your parents; or

4. Your parent becomes eligible and enrolls for benefits under Title XVIII of the Social Security Act (i.e. the Medicare program) Medicare.

Reason 5 applies to dependent children only:

5. The dependent ceases to be a "dependent child" as defined by the terms of the Plan.

If you are one of these people you are considered a "Qualifying Beneficiary." The term Qualifying Beneficiary includes a child born to or placed for adoption with the covered employee during the period of COBRA coverage.

If there is a choice among types of coverage under the plan, each of you who is eligible for continuation coverage is entitled to make a separate election among the types of coverage. Thus, a dependent child is entitled to elect continuation coverage even if the covered employee does not make that election. Similarly, a dependent child may elect a different coverage from the coverage that the employee elects.

Under the law, the employee or a family member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing dependent status. The employer has the responsibility to notify the Plan Administrator of the employee's death, termination of employment or reduction in hours, or Medicare eligibility.

In addition, the employee or a family member must inform The Plan Administrator of a determination by the Social Security Administration that the individual concerned was disabled at the time or within 60 days of the employee's termination of employment or reduction in hours of employment, within 60 days of the determination. If, during continued coverage, the employee is later determined by the Social Security Administration as no longer being disabled, the individual must inform the Plan Administrator of this re-determination within 30 days of the date it was made.

When the Plan Administrator is notified that one of these events has happened, he will in turn notify you that you have the right to choose continuation coverage. Under the law, you

have at least 60 days from the date you would lose coverage because of one of the events described above to inform the Fund that you want continuation coverage. If you do not choose continuation coverage, your group health insurance coverage will end.

If you choose continuation coverage, you are entitled to coverage that as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. This means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified.

The law requires that you be afforded the opportunity to maintain continuation coverage for three years unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months.

For an employee or family member who is disabled at the time of the employee's termination or reduction in hours, or within the first sixty days of COBRA coverage, the continuation coverage period is 29 months. The disability that extends the continuation coverage period must be determined under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided within 18 months of the employee's termination or reduction of hours in employment, and the affected individual must have elected continuation coverage within the 60 days election period and must inform Plan Administrator of the determination of disability within 60 days of the date of the notice.

If you are a qualified beneficiary and a second qualifying event occurs within 18 months after a termination or reduction in hours, you have three years of continuing coverage from the date of the termination or reduction in hours. If an employee or family member is disabled (as determined at the time of the employee's termination or reduction il1. hours under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act, and another qaalifying event (other than bankruptcy) occurs within the 29-month continuation period, then the continuation coverage period is 36-months after the termination of employment or reduction in hours. For the 36-months continuation coverage period to apply, notice of determination of disability under the Social Security Act must be provided within 18 months of the employee's termination or reduction of hours in employment.

However, the law also provides that your continuation coverage may be terminated for any of the following five reasons:

1. Your Employer no longer provides group health coverage to any individuals;

2. The premium for your continuation coverage is not timely paid;

3. You become covered under another group health plan (whether or not as an employee);

4. You become entitled to Medicare; however, for family members other than the employee, the continuation coverage period begins on the date on which the employee becomes entitled to Medicare (or, if applicable, the date of an earlier qualifying event) and extends for 3 years; or

5. You were divorced from a covered employee and subsequently remarry and are covered under your new spouse's group health plan.

You do not have to show that you are insurable to choose continuation coverage. However, you will have to pay the premium for your continuation coverage.

CLAIMS PROVISIONS

Physical Examination and Autopsy

The Plan, at its own expense, will have the right and opportunity to examine the person of any Covered Person and/or Covered Dependent whose Injury or Illness is the basis of a claim when and as often as it may reasonably require during the pendency of a claim, and to have an autopsy performed in case of death where it is not forbidden by law.

Assignment

Any Covered Employee may authorize the Plan Administrator or Claims Administrator to pay benefits for coverage against expenses for medical care and treatment directly to the institution(s) or person(s) on whose charge a claim is based.

When Claims Should Be Filed

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them. Claims should be filed with the Claims Administrator within ninety (90) days of the date charges for the services were incurred.

Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time; and

(b) the claim is submitted within one (1) year from the date incurred. This one (1) year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

Claims Procedure

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is

filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. If you have any questions regarding this procedure, please contact the Claim Administrator.

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim. A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination. In the case of a Claim involving Urgent Care, the following timetable applies:

1. Notification to claimant of benefit determination 72 hours

2. Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

    (a) Notification to claimant, orally or in writing 24 hours

    (b) Response by claimant, orally or in writing 48 hours

    (c) Benefit determination, orally or in writing 48 hours

3. Ongoing courses of treatment, notification of:

    (a) Reduction or termination before the end of treatment 72 hours

4. Determination as to extending course of treatment 24 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification. Please see the

Cost Management section of this booklet for further information about Pre-Service Claims. In the case of a Pre-Service Claim, the following timetable applies:

1. Notification to claimant of benefit determination - 15 days

2. Extension due to matters beyond the control of the Plan - 15 days

3. Insufficient information on the Claim: Notification of - 15 days

4. Response by claimant - 45 days

5. Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim - 5 days

6. Ongoing courses of treatment:

    (a) Reduction or termination before the end of the treatment - 15 days

    (b) Request to extend course of treatment - 15 days

    (c) Review of adverse benefit determination - 30 days

    (d) Reduction or termination before the end of the treatment - 15 days

    (e) Request to extend course of treatment - 15 days

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant. In the case of a Post-Service Claim, the following timetable applies:

1. Notification to claimant of benefit determination - 30 days

2. Extension due to matters beyond the control of the Plan - 15 days

3. Extension due to insufficient information on the Claim - 15 days

4. Response by claimant following notice of insufficient information - 45 days

5. Review of adverse benefit determination - 60 days

Notice to Claimant of Adverse Benefit Determinations

Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three (3) days of the oral notification, the Claim Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the adverse determination.

(2) Reference to the specific Plan provisions on which the determination was based.

(3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(4) A description of the Plan's review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an adverse benefit determination on review.

(5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office.

(6) If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

(7) If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Appeals

When a claimant receives an adverse benefit determination, the claimant has one hundred eighty (180) days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing. A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by the Board of Trustees who were neither the individual who made the adverse determination nor a subordinate of that individual. If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Board of Trustees shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

Voluntary Appeals, Including Voluntary Arbitration

During voluntary dispute resolution, any statute of limitations or other defense based on timeliness is tolled during the time any voluntary appeal is pending. The Plan waives any

right to assert that a claimant has failed to exhaust administrative remedies because he or she did not elect to submit a benefit dispute to the voluntary appeal provided by the Plan. A claimant may elect a voluntary appeal after exhaustion of appeals of an adverse benefit determination as explained in the section above, entitled, "Appeals." The Plan will provide to the claimant, at no cost and upon request, sufficient information about the voluntary appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal. This information will include a statement that the decision will have no effect on the claimant's rights to any other benefits under the Plan; will list the rules of the appeal; state the claimant's right to representation; enumerate the process for selecting the decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker. No fees or costs will be imposed on the claimant as part of the voluntary level of appeal, and the claimant will be told this.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

Plan Administrator

This Plan is to be administered by the Plan Administrator in accordance with the provisions of ERISA. The Plan Administrator is the Board of Trustees.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Duties of the Plan Administrator

1. To administer the Plan in accordance with its terms.

2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

3. To decide disputes which may arise relative to a Plan Participant's rights.

4. To prescribe procedures for filing a claim for benefits and to review claim denials.

5. To keep and maintain the Plan documents and all other records pertaining to the Plan.

6. To appoint a Claims Administrator to pay claims.

7. To perform all necessary reporting as required by ERISA.

8. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609.

9. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

Plan Administrator Compensation

The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

Fiduciary

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Duties

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Covered Persons and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

1. with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

2. by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

3. in accordance with the Plan documents to the extent that they agree with ERISA.

The Named Fiduciary

A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

1. the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

2. the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

Claims Administrator Is Not A Fiduciary

A Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

Funding The Plan And Payment Of Benefits

The Plan is paid for entirely and is dependent upon contributions that are made by Employers under the terms of collective bargaining agreements negotiated between them and United Food and Commercial Workers Union, Local 371.

Benefits are paid directly from the Plan through the Claims Administrator.

Plan Is Not An Employment Contract

The Plan is not to be construed as a contract for or of employment.

Clerical Error

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered. If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

Amending and Terminating The Plan

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination. The Board of Trustees intend to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CERTAIN PLAN PARTICIPANT RIGHTS UNDER ERISA

Covered Employees in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

3. Continue health care coverage for a Plan Participant or other Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or Dependents may have to pay for such coverage.

4. Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

If a Covered Employee's claim for a benefit is denied or ignored, in whole or in part, the Participant has 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 a Covered Employee can take to enforce the above rights. For instance, if a Covered Employee requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within thirty (30) days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he/she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If the Covered Employee has a claim for benefits that is denied or ignored, in whole or in part, the Participant may file suit in state or federal court. In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries.

No one, including the Employer or any other person, may fire a Covered Person (i.e. Plan Participant) or otherwise discriminate against a Covered Person in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), that Plan Participant should contact either the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, at 200 Constitution Avenue, N.W., Washington, DC 20210.

Schedule "1"

Dental Benefit Schedule

Code	Description	AGE LIMIT	ALLOWED AMOUNT	FREQUENCY/ OTHER LIMITS
D0110	INITIAL ORAL EXAMINATION	0	$60.00	1 Per 6 Months
D0120	PERIODIC ORAL EVALUATION	0	$60.00	1 Per 6 Months
D0130	EMERGENCY ORAL EXAMINATION	0	$75.00	
D0140	LIMITED ORAL EVALUATION - PROBLEM - FOCUSED	0	$82.00	
D0150	COMPREHENSIVE ORAL EVALUATION	0	$100.00	1 Per 12 Months
D0160	EXTENSIVE ORAL EXAM	0	$100.00	1 Per 12 Months
D0180	COMPREHENSIVE PERIODONTAL EVALUATION	0	$60.00	1 Per 6 Months
D0210	INTRAORAL-COMPLETE SERIES (INCLUDING BITEWINGS)	0	$100.00	1 Per 36 Months
D0220	INTRAORAL PERIAPICAL - FIRST FILM	0	$20.00	
D0230	INTRAORAL PERIAPICAL - EACH ADDITIONAL FILM	0	$20.00	
D0240	INTRAORAL OCCLUSAL	0	$20.00	
D0270	BITEWING - SINGLE FILM	0	$20.00	Max - 4 BW Per 6 Months
D0272	BITEWING XRAYS - 2 FILMS	0	$40.00	Max - 4 BW Per 6 Months
D0273	BITEWING XRAY 3 FILMS	0	$37.50	Max - 4 BW Per 6 Months
D0274	BITEWING XRAYS - 4 FILMS	0	$50.00	Max - 4 BW Per 6 Months
D0330	PANORAMIC FILM	0	$100.00	1 Per 36 Months
D1110	PROPHYLAXIS-ADULT	0	$105.00	1 Per 6 Months
D1120	PROPHYLAXIS-CHILD	0	$76.00	1 Per 6 Months
D1201	TOPICAL FLUORIDE W/PROPHY - CHILD	17	$45.00	1 Per 6 Months
D1203	TOPICAL FLUORIDE W/O PROPHY - CHILD	17	$45.00	1 Per 6 Months
D1204	FLUORIDE	17	$45.00	1 Per 6 Months
D1206	TOPICAL FLUORIDE	17	$45.00	1 Per 6 Months
D1208	TOPICAL APPLICATION OF FLUORIDE	17	$45.00	1 Per 6 Months
D1351	TOPICAL SEALANTS PER TOOTH	17	$42.00	
D2140	AMALGAM-ONE SURFACE, PERMANENT	0	$100.00	1 Per 36 Months
D2150	AMALGAM-TWO SURFACES, PERMANENT	0	$120.00	1 Per 36 Months
D2160	AMALGAM-THREE SURFACES, PERMANENT	0	$150.00	1 Per 36 Months
D2161	AMALGAM-FOUR OR MORE SURFACES, PERMANENT	0	$150.00	1 Per 36 Months
D2330	RESIN-ONE SURFACE, ANTERIOR	0	$100.00	1 Per 36 Months
D2331	RESIN-TWO SURFACES, ANTERIOR	0	$120.00	1 Per 36 Months

D2332	RESIN - 3 SURFACES, ANTERIOR	0	$150.00	1 Per 36 Months
D2334	REINFORCEMENT PINS (UP TO 4 PER TOOTH)	0	$28.00	1 Per 36 Months
D2335	RESIN - 4 OR MORE SURFACES, ANTERIOR	0	$150.00	1 Per 36 Months
D2391	RESIN-BASED COMPOSITE- ONE SURFACE,POSTERIOR	0	$100.00	1 Per 36 Months
D2392	RESIN-BASED COMPOSITE- TWO SURFACES, POSTERIOR	0	$120.00	1 Per 36 Months
D2393	RESIN - 3 SURFACES, POSTERIOR	0	$150.00	1 Per 36 Months
D2394	RESIN - 4 OR MORE SURFACES, POSTERIOR	0	$150.00	1 Per 36 Months
D2510	ONE SURFACE INLAY METALLIC	0	$120.00	1 Per 36 Months
D2520	TWO SURFACE INLAY METALLIC	0	$160.00	1 Per 36 Months
D2530	THREE SURFACE INLAY METALLIC	0	$200.00	1 Per 36 Months
D2542	TWO SURFACE ONLAY METALLIC	0	$160.00	1 Per 36 Months
D2543	THREE SURFACE ONLAY METALLIC	0	$200.00	1 Per 36 Months
D2544	FOUR SURFACE ONLAY METALLIC	0	$200.00	1 Per 36 Months
D2610	ONE SURFACE INLAY PORCELAIN/CERAMIC	0	$120.00	1 Per 36 Months
D2620	TWO SURFACE INLAY PORCELAIN/CERAMIC	0	$160.00	1 Per 36 Months
D2630	THREE SURFACE INLAY PORCELAIN/CERAMIC	0	$200.00	1 Per 36 Months
D2642	TWO SURFACE ONLAY PORCELAIN/CERAMIC	0	$160.00	1 Per 36 Months
D2644	FOUR SURFACE ONLAY PORCELAIN/CERAMIC	0	$200.00	1 Per 36 Months
D2650	ONE SURFACE INLAY COMP/RESIN	0	$120.00	1 Per 36 Months
D2651	TWO SURFACE INLAY COMP/RESIN	0	$160.00	1 Per 36 Months
D2652	THREE SURFACE INLAY COMP/RESIN	0	$200.00	1 Per 36 Months
D2662	TWO SURFACE ONLAY COMP/RESIN	0	$160.00	1 Per 36 Months
D2663	THREE SURFACE ONLAY COMP/RESIN	0	$200.00	1 Per 36 Months
D2664	FOUR SURFACE ONLAY COMP/RESIN	0	$200.00	1 Per 36 Months
D2710	CROWN - RESIN BASED COMPOSITE INDIRECT	0	$410.00	1 Per 60 Months
D2712	CROWN - 3/4 RESIN BASED COMPOSITE INDIRECT	0	$410.00	1 Per 60 Months
D2720	CROWN - RESIN WITH HIGH NOBLE METAL	0	$600.00	1 Per 60 Months
D2721	CROWN - RESIN WITH PREDOMINANTLY BASE METAL	0	$600.00	1 Per 60 Months
D2722	CROWN - RESIN WITH NOBLE METAL	0	$600.00	1 Per 60 Months
D2740	CROWN - ALL CERAMIC	0	$600.00	1 Per 60 Months
D2750	CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	0	$600.00	1 Per 60 Months

D2751	CROWN - PROCELAIN FUSED TO PREDOMINANTLY METAL	0	$600.00	1 Per 60 Months
D2752	CROWN - CERAMIC/PORCELAIN OVER METAL	0	$600.00	1 Per 60 Months
D2780	CROWN - 3/4 CAST HIGH NOBLE METAL	0	$600.00	1 Per 60 Months
D2781	CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	0	$600.00	1 Per 60 Months
D2782	CROWN - 3/4 CAST NOBEL METAL	0	$600.00	1 Per 60 Months
D2783	CROWN - 3/4 PORCELAIN/CERAMIC	0	$600.00	1 Per 60 Months
D2790	CROWN - FULL CAST HIGH NOBLE METAL	0	$600.00	1 Per 60 Months
D2791	CROWN FULL CAST BASE METAL	0	$600.00	1 Per 60 Months
D2792	CROWN - FULL CAST NOBEL METAL	0	$600.00	1 Per 60 Months
D2794	CROWN - TITANIUM	0	$600.00	1 Per 60 Months
D2920	RECEMENT CROWN	0	$75.00	
D2940	SEDATIVE FILLING	0	$75.00	
D2950	CORE BUILDUP INC ANY PINS	0	$175.00	
D2951	PIN RETENTION IN ADDITION TO RESTORATION	0	$100.00	
D2952	CAST POST AND CORE IN ADDITION TO CROWN	0	$175.00	
D2953	CAST POST (PART OF CROWN)	0	$175.00	
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	0	$175.00	
D2957	CAST POST AND CORE PREFAB ADDITIONAL SAME TOOTH	0	$175.00	
D3220	PULPOTOMY	0	$75.00	
D3221	PULPAL DEBRIDEMENT	0	$75.00	
D3240	PULPAL THERAPY	0	$75.00	
D3310	ONE CANAL (EXCLUDING FINAL RESTORATION)	0	$450.00	
D3320	TWO CANALS (EXCLUDING FINAL RESTORATION)	0	$500.00	
D3330	THREE CANALS (EXCLUDING FINAL RESTORATION)	0	$600.00	
D3347	RETREATMENT BICUSPID	0	$250.00	
D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY	0	$250.00	
D3410	APICOECTOMY - ANTERIOR	0	$250.00	
D3420	APICOECTOMY WITH ENDODONTIC PROCEDURE PER ROOT	0	$250.00	
D3425	APICOECTOMY - MOLAR - FIRST ROOT	0	$250.00	
D3426	APICOECTOMY - EACH ADDITIONAL ROOT	0	$250.00	
D4210	GINGIVECTOMY OR GINGIVOPLASTY - PER QUADRANT	0	$200.00	

D4211	GINGIVECTOMY/PLASTY<4	0	$50.00	
D4212	GINGIVECTOMY	0	$50.00	
D4220	GINGIVAL CURETTAGE- PER QUADRANT	0	$50.00	
D4240	GINGIVAL FLAP PROC W/ PLANING - PER QUADRANT	0	$200.00	
D4241	GINIVAL FLAP 1 TO 3 TEETH PER QUAD	0	$25.00	
D4250	MUCO-GINGIVAL SURGERY - PER QUADRANT	0	$200.00	
D4260	OSSEOUS SURGERY - 4 OR MORE TEETH PER QUADRANT	0	$300.00	
D4261	OSSEOUS SURGERY - 3 TEETH PER QUADRANT	0	$200.00	
D4263	BONE REPLACEMENT GRAFT - FIRST SITE	0	$37.50	
D4264	BONE REPLACEMENT GRAFT - EACH ADDITIONAL	0	$37.50	
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE-PER QUAD	0	$200.00	
D4271	FREE SOFT TISSUE GRAFT PROCEDURE - PER QUADRANT	0	$200.00	
D4273	SUPEPITHELIAL CONNECTIVE TISSUE GRAFT	0	$40.00	
D4320	PROVISIONAL SPLINTING, INTRACORONAL	0	$70.00	
D4321	PROVISIONAL SPLINTING, EXTRACORONAL	0	$70.00	
D4341	PERIODONTAL SCALING\ROOT PLANNING-4 OR MORE TEETH	0	$50.00	
D4342	PERIOSCALE&RTPLAN 1-3 TEETH/QUAD	0	$50.00	
D4355	FULL MOUTH DEBRIDEMENT	0	$50.00	
D4910	PERIODONTAL MAINT PROCEDURES	0	$50.00	
D5110	COMPLETE DENTURE - MAXILLARY	0	$525.00	1 Per 36 Months
D5120	COMPLETE DENTURE - MANDIBULAR	0	$525.00	1 Per 36 Months
D5130	IMMEDIATE DENTURE - MAXILLARY	0	$525.00	1 Per 36 Months
D5140	IMMEDIATE DENTURE - MANDIBULAR	0	$525.00	1 Per 36 Months
D5211	PARTIAL RESIN UPPER	0	$550.00	1 Per 36 Months
D5212	PARTIAL RESIN LOWER	0	$550.00	1 Per 36 Months
D5213	UPPER PARTIAL-CAST METAL BASE	0	$550.00	1 Per 36 Months
D5214	MANDIBULAR PARTIAL CAST DENTURE	0	$550.00	1 Per 36 Months
D5218	LOWER - WITH TWO CHROME CLASP	0	$550.00	1 Per 36 Months
D5225	MAXILLARY PARTIAL DENT FLEX BASE	0	$550.00	1 Per 36 Months
D5226	MANDIBULAR PARTIAL DENTURE	0	$550.00	1 Per 36 Months

D5230	LOWER - WITH GOLD LINGUAL BAR	0	$550.00	1 Per 36 Months
D5231	LOWER - WITH CHROME LINGUAL BAR	0	$550.00	1 Per 36 Months
D5240	LOWER - WITH GOLD LINGUAL BAR	0	$550.00	1 Per 36 Months
D5241	LOWER - WITH CHROME LINGUAL BAR	0	$550.00	1 Per 36 Months
D5250	UPPER - WITH GOLD PALATAL BAR	0	$550.00	1 Per 36 Months
D5261	UPPER - WITH CHROME PALATAL BAR	0	$550.00	1 Per 36 Months
D5280	PARTIAL REMOVABLE UNILATERAL	0	$240.00	1 Per 36 Months
D5281	PARTIAL REMOVABLE UNILATERAL	0	$240.00	1 Per 36 Months
D5292	FULL CAST PARTIAL - WITH TWO	0	$550.00	1 Per 36 Months
D5293	FULL CAST PARTIAL - WITH TWO	0	$550.00	1 Per 36 Months
D5294	FULL CAST PARTIAL - WITH TWO	0	$550.00	1 Per 36 Months
D5510	REPAIR DENTURE BASE	0	$70.00	
D5600	REPAIR BODY OF BROKEN DENTURE	0	$70.00	
D5610	REPAIR ACRYLIC SADDLE OR BASE	0	$70.00	
D5620	REPAIR CAST FRAMEWORK	0	$60.00	
D5630	REPAIR OR REPLACE BROKEN CLASP	0	$60.00	
D5640	REPLACE BROKEN TEETH - PER TOOTH	0	$60.00	
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	0	$60.00	
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE	0	$60.00	
D5670	REPLACE TEETH AND ACRYLIC ON METAL FRAMEWORK	0	$68.00	
D5680	REPLACE BROKEN CLASP	0	$68.00	
D5710	REBASE COMPLETE UPPER DENTURE	0	$150.00	
D5711	REBASE COMPLETE LOWER DENTURE	0	$150.00	
D5720	REBASE PARTIAL UPPER DENTURE	0	$150.00	
D5721	REBASE PARTIAL LOWER DENTURE	0	$150.00	
D5730	RELINE COMPLETE UPPER DENTURE - OFFICE	0	$150.00	
D5731	RELINE COMPLETE LOWER DENTURE - OFFICE	0	$150.00	
D5740	RELINE PARTIAL UPPER DENTURE - OFFICE	0	$150.00	
D5741	RELINE PARTIAL LOWER DENTURE - OFFICE	0	$150.00	
D5750	RELINE FULL UPPER DENTURE	0	$150.00	
D5751	RELINE COMPLETE MANDIBULAR	0	$150.00	
D5760	RELINE MAXILLARY PARTIAL(UPPER)	0	$150.00	
D5761	RELINE MANDIBULAR PARTIAL(LOWER)	0	$150.00	

D5860	OVERDENTURE - COMPLETE MAXILLARY	0	$525.00	1 Per 36 Months
D5865	OVERDENTURE COMPLETE MANDIBULAR	0	$525.00	1 Per 36 Months
D6057	CUSTOM ABUTMENT INCLUDES PLACEMENT	0	$600.00	1 Per 60 Months
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	0	$600.00	1 Per 60 Months
D6059	ABUTMENT SUPP PFM	0	$600.00	1 Per 60 Months
D6060	ABUTMENT PORCELAIN PREDOM METAL CROWN	0	$600.00	1 Per 60 Months
D6071	FPD ABUTMENT RETAINER	0	$600.00	1 Per 60 Months
D6240	PONTIC PORCELAIN FUSED TO HNOB	0	$600.00	1 Per 60 Months
D6241	PORCELAIN FUSED TO NOBLE METAL	0	$600.00	1 Per 60 Months
D6242	PONTIC - PORCELAIN FUSED TO NOBLE METAL	0	$600.00	1 Per 60 Months
D6245	PONTIC PORC CERAMIC	0	$600.00	1 Per 60 Months
D6520	INLAY - METALLIC TWO SURFACES	0	$160.00	1 Per 36 Months
D6602	INLAY CAST HIGH NOBLE METAL TWO SURFACE	0	$160.00	1 Per 36 Months
D6740	ABUT ALL PORC CERAMIC	0	$600.00	1 Per 60 Months
D6752	CROWN - PORCELAIN FUSED TO NOBLE METAL	0	$600.00	1 Per 60 Months
D6930	RECEMENT FIXED PARTIAL DENTURE	0	$60.00	
D6980	FIXED PARTIAL DENTURE REPAIR	0	$60.00	
D7111	SINGLE TOOTH EXTRACTION	0	$125.00	
D7120	EACH ADDITIONAL TOOTH EXTRACTION	0	$125.00	
D7140	EXTRACTION ERUPTED TOOTH OR ROOT REMOVAL	0	$125.00	
D7210	SURGICAL EXTRACTION	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D7220	SOFT TISSUE IMPACTION	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D7230	PARTIAL BONY IMPACTION	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D7240	REMOVAL OF IMPACTED TOOTH	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D7241	REMOVAL OF IMPACTED TOOTH UNUSUAL SURGICAL COMP	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D7250	SURGICAL REMOVAL ROOT TIP - APICOECTOMY	0	$250.00	

D7286	BIOPSY OF ORAL TISSUE	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D7310	ALVEOLOPLASTY	0	$25.00	
D7410	RADICAL EXCISION-LESION DIAMETER UP TO 1.25 CM	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D7412	EXCISION OF BENIGN LESION, COMPLICATED	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D7413	EXCISION OF MALIGNANT LESION UP TO 1.25 CM	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D7414	EXCISION OF MALIGNANT LESION GREATER THAN 1.25 cm	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D7415	EXCISION OF MALIGNANT LESION, COMPLICATED	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D7440	EXCISION OF MALIGNANT LESION DIAM <= 1.25 CM	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D7441	EXCISION OF MALIGNANT LESION DIAM > 1.25 CM	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D7450	REMOVAL OF ODONTOGENIC LESION DIAM <= 1.25 CM	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D7451	REMOVAL OF ODONTOGENIC LESION DIAM > 1.25 CM	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D7460	REMOVAL OF NONODONTOGENIC LESION DIAM <= 1.25 CM	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D7461	REMOVAL OF NONODONTOGENIC LESION DIAM > 1.25 CM	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D7953	BONE REPLT GRFT RIDGE	0	$37.50	
D8060	INTERCEPTIVE ORTHO APPLICANCES & TX	0	$500.00	Per Jaw - 1 Per Jaw Per Lifetime - Includes 6 Months Aftercare
D8080	COMPREHENSIVE ORTHO ADOLESCENT	0	$500.00	Per Jaw - 1 Per Jaw Per Lifetime - Includes 6 Months Aftercare

D8090	COMPREHENSIVE ORTHODONTIC - ADULT	0	$500.00	Per Jaw - 1 Per Jaw Per Lifetime - Includes 6 Months Aftercare
D8210	REMOVABLE APPLIANCE	0	$200.00	Per Jaw - 1 Per Jaw Per Lifetime - Includes 6 Months Aftercare
D8220	FIXED OR CEMENTED APPLIANCE	0	$500.00	Per Jaw - 1 Per Jaw Per Lifetime - Includes 6 Months Aftercare
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT	0	$100.00	1 Per Month - May Require Proof of Visit - Starts 6 Months After Placement
D8690	ORTHODONTIC TREATMENT	0	$100.00	1 Per Month - May Require Proof of Visit - Starts 6 Months After Placement
D9110	PALLIATIVE TREATMENT OF DENTAL PAIN	0	$75.00	
D9200	GENERAL ANESTHESIA	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D9220	GENERAL ANESTHESIA-FIRST 30 MINUTES	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D9221	GENERAL ANESTHESIA-EACH ADDITIONAL 15 MINUTES	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D9223	GEN ANESTH - EACH 15 MIN	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D9230	ANALGESIA,ANXIOLYSIS,INHALATION OF NITROUS OXIDE	0	$76.00	Per Half an Hour or Fraction Thereof
D9240	INTRAVENOUS SEDATION	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D9241	IV SEDATION 1ST 30 MIN	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D9242	IV SED ADDT'L UNIT	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D9243	IV SEDATION 15 MINUTES	0	$0.00	Payable Under Major Medical - Payable at 80% of Usual & Customary Once Deductible Has Been Satisfied
D9310	CONSULTATION	0	$82.00	
D9940	OCCLUSAL GUARD	0	$180.00	
D9951	OCCLUSAL ADJUSTMENT - LIMITED	0	$50.00	
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	0	$50.00	