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 Benefit Plan (the "Plan") that are now available to a Covered Person 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.

GENERAL INFORMATION

Name of Plan:	Local 371 Amalgamated Welfare Trust Fund Ancillary Benefits 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.:	502
Plan Year:	January 1 to December 31 of each year.
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 and accidental death and dismemberment benefits on a fully insured basis. The Plan provides disability, hearing, vision and dental benefits on a self-insured basis and the administration is performed by the Fund.
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

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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.

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 a Covered Person does not timely enroll in this Plan, he/she will not be entitled to submit an application for enrollment until such time as there is an Open Enrollment.

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 who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

   (a) The Covered Person 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 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 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 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.

ELIGIBILITY EFFECTIVE DATE AND TERMINATION

EMPLOYEE COVERAGE

Eligible Classes of Employees

All Active Employees of a contributing Employer who has made contributions to the Fund on behalf of the employee to participate in this Plan.

Eligibility Requirements for Employee Coverage

1. A person shall become eligible for coverage provided that coverage under this Plan is afforded pursuant to the terms of the Collective Bargaining Agreement under which the person is working.

2. Coverage shall begin on the first day of the month following completion of the Waiting Period. The Waiting Period is the time between the first day of employment and the first day of coverage.

3. An Active Employee is one who is regularly working for the Employer on a weekly basis, and on whose behalf contributions to the Fund for coverage under this Plan is made by the Employer on behalf of the employee.

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.

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.

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 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 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 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.

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 a

Out of Network Reimbursement Allowance

SERVICE TYPE	REIMBURSEMENT 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 100% of the first $2,500 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 may receive a hearing evaluation and hearing aid benefits once every three years.

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 is 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 Workmen's' Compensation act or law;

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

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 Worker's 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 include 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.

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.

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 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.

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 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.

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 licensed health care provider; or treatment, services or supplies when a Covered Person is not under the regular care of a licensed health provider. Regular care means ongoing 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

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 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, unless such care is specifically covered in the Schedule of Benefits.

17. 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.

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

19. Charges for travel or accommodations, whether or not recommended by a licensed health care provider.

20. For 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.

21. Services, supplies, care or treatment for an injury and/or illness 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.

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

23. No payment will be made for expenses incurred by a Covered Person(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.

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

25. 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.

26. State and municipal provider taxes applied to services or supplies.

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

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

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

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

DEFINITIONS

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

Active Employee - An Active Employee is one who is regularly working for the Employer on a weekly basis, and on whose behalf contributions to the Fund for coverage under this Plan is made by the Employer on behalf of the employee.

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 that 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 Administrator has the right to recover such excess from the person to or from whom such payments were made.

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

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

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

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.

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 day that the Covered Employee submits an application for enrollment in the Plan.

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.

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.

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

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.

Medically Necessary care and treatment is recommended or approved by a health care provider; and is consistent with the patient's condition or accepted standards of good 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 health care provider 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.

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.

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 January 1 and ending on December 31 of each year.

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

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.

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

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.

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.

COORDINATION OF BENEFITS

If a Covered Person t is covered under the Plan and one or more other plans, as defined below, the benefits payable with respect to the Covered Person 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 benefits or services are provided by:

1. Group, blanket or franchise insurance coverage;

2. Any group Hospital service prepayment, group dental/vision 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 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

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 benefits or reimbursement of 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.

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 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 on behalf of the Covered Person

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 may incur charges and/or expenses 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 may have a claim against that Third Party, or insurer, for payment of the charges and/or expenses. Accepting benefits under this Plan for those incurred charges and/or expenses automatically assigns to the Plan any rights the Covered Person 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 has against any Third Party, or insurer, whether or not the Covered Person 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 whether or not designated as payment for charges and/or expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

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 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 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 charges and/or expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those incurred charges and/or expenses automatically assigns to the Plan the Covered Person’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 charges and/or expenses 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 charges and/or expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person 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 benefits to a Covered Person if a Covered Person 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 is a minor, the Plan shall have no obligation to pay any benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person 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.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person 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 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 charges and/or expenses 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 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 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, 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 eligible 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 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 there is a choice among types of coverage under the plan, you are entitled to make a separate election among the types of coverage.

Under the law, 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.

Notice of any of the Qualifying Events listed above must be provided to the Plan in writing and must contain the following information: the Employee's name, the type of Qualifying Event for which the individual is providing notice, the date of the event, the date on which the Employee will lose coverage.

Notice may be provided by the Employee with respect to the Qualifying Event, or any representative acting on behalf of the Employee. Notice from one individual will satisfy the notice requirement for all persons affected by the same Qualifying Event.

Notice of a Social Security Administration determination must be provided to the Plan in writing and must contain the following information: your name as the Employee; the type of Qualifying Event for which the individual is providing notice, and the date of the event. You must submit a copy of the Social Security Administration determination.

The notice must be sent to the Fund Office no later than 60 days after the latest of:

- the date of the disability determination by the Social Security Administration; or
- the date on which the Qualifying Event occurs; or

and before the end of the first 18 months of continuation coverage.

If you are providing notice of a Social Security determination that disability has ended, notice must be sent to the Fund Office no later than 30 days after the date of the final determination by the Social Security Administration that the disability has ended.

Notice may be provided by you with respect to the Qualifying Event, or any representative acting on behalf of you. Notice from one individual will satisfy the notice requirement for all persons affected by the same Qualifying Event.

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 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 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 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 an employee 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 qualifying 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.

How to Elect COBRA Continuation Coverage

Once the Fund Office has been notified that a Qualifying Event has occurred, you will be notified within 14 days in writing of your COBRA rights, if any. If you are eligible to continue coverage, you must notify the Fund Office of your decision to elect to continue coverage within 60 days after your coverage terminates or you receive the notice, whichever is later.

COBRA continuation coverage may be elected for some members of the family and not others. In addition, one or more Dependents may elect COBRA even if the Employee does not elect it. However, in order to elect COBRA Continuation Coverage, the members of the family must have been covered by the Plan on the date of the Qualifying Event. A parent may elect or reject COBRA Continuation Coverage on behalf of Dependent children living with him or her.

A Qualified Beneficiary who elects COBRA continuation coverage will be entitled to the same Medical Benefits coverage that he had when the Qualifying Event occurred, but the Qualified Beneficiary must pay for it. See the section on COBRA Self-Pay Premium, below. If there is a change in the health coverage provided by the Plan to similarly situated Employees and their families, the same change will be made in your COBRA continuation coverage.

COBRA Self-Pay Premium

The Fund Office will set premium payments according to federal law, which allows the premium to cover 100% of the cost to the Plan of providing such coverage to similarly situated persons plus 2% to cover administrative expenses. If the 18-month COBRA continuation period has been extended because of Disability, the premium may be set at 150% of the Plan's cost for the 11-month period following the 18-month COBRA continuation period.

If the cost changes, the Fund will revise the charge you are required to pay, but no more often than once every year unless the Plan of benefits is changed significantly. In addition, if the benefits change for Active Employees, your coverage will change as well.

The initial payment for the COBRA continuation coverage is due 45 days after COBRA continuation coverage is actually elected. If this initial payment is not made when due, COBRA continuation coverage will not take effect. After that, payments are due on the first day of each month, but there will be a 30-day grace period to make those payments. If payments are not made to the Fund Office by the last day of the grace period, COBRA continuation coverage will be cancelled as of the due date. Payment is considered made when it is postmarked.

Confirmation of Coverage to Health Care Providers

Under certain circumstances, federal rules require the Fund to inform your health care providers as to whether you have elected and/or paid for COBRA continuation coverage. This rule only applies in situations where the health care provider is requesting confirmation of coverage and you are eligible for, but have not yet elected, COBRA coverage, or you have elected COBRA coverage but have not yet paid for it.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should COBRA be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Office.

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 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 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.

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 care. 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 a request for payment under the Plan for covered 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

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 that 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 that 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 intends 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

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights:

Receive Information about Your Plan and Benefits.

You have the right to:

- Examine, without charge, at the Fund Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including any relevant insurance contracts and collective bargaining agreements, and 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 Employee Benefits Security Administration.

- Obtain, upon written request to the Fund Administrator, copies of documents governing the operation of the Plan, including any relevant insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Fund Administrator may make a reasonable charge for the copies.

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

Continue Dental Coverage.

You have the right to:

- Continue dental coverage for yourself if there is a loss of coverage under the Plan as a result of a Qualifying Event. You may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your dental plan, if you have creditable coverage from another dental plan or group health plan. You should be provided a certificate of creditable coverage, free of charge, from your dental plan, group health plan or health insurance issuer: 1) when you lose coverage under the plan; 2) when you become entitled to elect COBRA continuation coverage; 3) when your COBRA continuation coverage ceases; 4) if you request it before losing coverage; or 5) if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Fund Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Fund Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

However, in all cases including those described in the above paragraph, a person must first exhaust his administrative remedies under the Plan, by following the Plan's Claims and Appeals Procedures described in the summary plan description, before the person may file a suit in any court. The person will then have one year from the date a final decision on appeal is reached under the Plan in which to start a lawsuit. In no event may legal action be brought in court, by or on behalf of the person, later than this one-year period.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Fund Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Administrator, you should: (1) contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory; or (2) call the EBSA's Toll-Free Employee & Employer Hotline at 1-866-444-EBSA (3272); or 3) write to the EBSA's Office of Participant Assistance at the following address:

Office of Participant Assistance
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW,
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the EBSA's Toll-Free Employee & Employer Hotline at 1-866-444-EBSA (3272).

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	$60.00	1 Per 12 Months
D0160	EXTENSIVE ORAL EXAM	0	$60.00	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	$62.00	1 Per 36 Months
D2150	AMALGAM-TWO SURFACES, PERMANENT	0	$80.00	1 Per 36 Months
D2160	AMALGAM-THREE SURFACES, PERMANENT	0	$98.00	1 Per 36 Months
D2161	AMALGAM-FOUR OR MORE SURFACES, PERMANENT	0	$98.00	1 Per 36 Months
D2330	RESIN-ONE SURFACE, ANTERIOR	0	$62.00	1 Per 36 Months
D2331	RESIN-TWO SURFACES, ANTERIOR	0	$80.00	1 Per 36 Months

D2332	RESIN - 3 SURFACES, ANTERIOR	0	$98.00	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	$98.00	1 Per 36 Months
D2391	RESIN-BASED COMPOSITE- ONE SURFACE,POSTERIOR	0	$62.00	1 Per 36 Months
D2392	RESIN-BASED COMPOSITE- TWO SURFACES, POSTERIOR	0	$80.00	1 Per 36 Months
D2393	RESIN - 3 SURFACES, POSTERIOR	0	$98.00	1 Per 36 Months
D2394	RESIN - 4 OR MORE SURFACES, POSTERIOR	0	$98.00	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	$150.00	
D7220	SOFT TISSUE IMPACTION	0	$225.00	
D7230	PARTIAL BONY IMPACTION	0	$275.00	
D7240	REMOVAL OF IMPACTED TOOTH	0	$300.00	
D7241	REMOVAL OF IMPACTED TOOTH UNUSUAL SURGICAL COMP	0	$300.00	
D7250	SURGICAL REMOVAL ROOT TIP - APICOECTOMY	0	$250.00	

D7286	BIOPSY OF ORAL TISSUE	0	$140.00	
D7310	ALVEOLOPLASTY	0	$25.00	
D7410	RADICAL EXCISION-LESION DIAMETER UP TO 1.25 CM	0	$140.00	
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM	0	$140.00	
D7412	EXCISION OF BENIGN LESION, COMPLICATED	0	$140.00	
D7413	EXCISION OF MALIGNANT LESION UP TO 1.25 CM	0	$140.00	
D7414	EXCISION OF MALIGNANT LESION GREATER THAN 1.25 cm	0	$140.00	
D7415	EXCISION OF MALIGNANT LESION, COMPLICATED	0	$140.00	
D7440	EXCISION OF MALIGNANT LESION DIAM <= 1.25 CM	0	$140.00	
D7441	EXCISION OF MALIGNANT LESION DIAM > 1.25 CM	0	$140.00	
D7450	REMOVAL OF ODONTOGENIC LESION DIAM <= 1.25 CM	0	$140.00	
D7451	REMOVAL OF ODONTOGENIC LESION DIAM > 1.25 CM	0	$140.00	
D7460	REMOVAL OF NONODONTOGENIC LESION DIAM <= 1.25 CM	0	$140.00	
D7461	REMOVAL OF NONODONTOGENIC LESION DIAM > 1.25 CM	0	$140.00	
D7953	BONE REPLT GRFT RIDGE	0	$37.50	
D8060	INTERCEPTIVE ORTHO APPLICANCES & TX	0	$200.00	Per Jaw - 1 Per Jaw Per Lifetime - Includes 6 Months Aftercare
D8080	COMPREHENSIVE ORTHO ADOLESCENT	0	$200.00	Per Jaw - 1 Per Jaw Per Lifetime - Includes 6 Months Aftercare
D8090	COMPREHENSIVE ORTHODONTIC - ADULT	0	$200.00	Per Jaw - 1 Per Jaw Per Lifetime - Includes 6 Months Aftercare
D8210	REMOVABLE APPLIANCE	0	$125.00	Per Jaw - 1 Per Jaw Per Lifetime - Includes 6 Months Aftercare
D8220	FIXED OR CEMENTED APPLIANCE	0	$200.00	Per Jaw - 1 Per Jaw Per Lifetime - Includes 6 Months Aftercare

D8670	PERIODIC ORTHODONTIC TREATMENT VISIT	0	$18.00	1 Per Month - May Require Proof of Visit - Starts 6 Months After Placement
D8690	ORTHODONTIC TREATMENT	0	$18.00	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	$76.00	
D9220	GENERAL ANESTHESIA-FIRST 30 MINUTES	0	$76.00	
D9221	GENERAL ANESTHESIA-EACH ADDITIONAL 15 MINUTES	0	$38.00	
D9223	GEN ANESTH - EACH 15 MIN	0	$38.00	
D9230	ANALGESIA,ANXIOLYSIS,INHALATION OF NITROUS OXIDE	0	$76.00	
D9240	INTRAVENOUS SEDATION	0	$76.00	
D9241	IV SEDATION 1ST 30 MIN	0	$76.00	
D9242	IV SED ADDT'L UNIT	0	$38.00	
D9243	IV SEDATION 15 MINUTES	0	$38.00	
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	