

MANUAL OF BENEFITS

Central Pennsylvania and Regional Health and Welfare Fund

COMET MARKETS

PART TIME

U.F.C.W HEALTH AND WELFARE FUND
ROOM 214, 150 S 43RD STREET
HARRISBURG, PA 17111

PHONE 717-561-9932
TOLL FREE 1-800-225-7741

**HEALTH
AND
WELFARE PLAN**

COMET MARKETS
PART TIME EMPLOYEES

BOARD OF TRUSTEES

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Administrator
HEALTHCARE STRATEGIES, INC.

Accountant
JACK COHEN, C.P.A.

Attorney
WILLIG, WILIAMS & DAVIDSON

As a participant you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

- (i) Examine, without charge, at the plan administrator's office and at other locations (worksites and union halls), all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as annual reports and plan descriptions.
- (ii) Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.
- (iii) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary financial report.
- (iv) Obtain, once a year, a statement of the total pension benefits accrued and the nonforfeitable (vested) pension benefits (if any) or the earliest date on which benefits will become nonforfeitable (vested). The plan may require a written request for this statement, but it must provide the statement free of charge.
- (v) File suit in a federal court, if any materials requested are not received within 30 days of the participant's request, unless the materials were not sent because of matters beyond the control of the administrator. The court may require the plan administrator to pay up to \$100.00 for each day's delay until the materials are received.

In addition to creating rights for plan participants, **ERISA** imposes obligations upon the persons who are responsible for the operation of the employee benefit plan.

These persons are referred to as “fiduciaries” in the law. Fiduciaries must act solely in the interest of the plan participants and they must exercise prudence in the performance of their plan duties. Fiduciaries who violate **ERISA** may be removed and required to make good any losses they have caused the plan.

Your employer may not fire you or discriminate against you to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under **ERISA**.

If you are improperly denied a (pension, welfare) benefit in full or in part, you have a right to file suit in a federal or a state court. If a plan fiduciaries are misusing the plan’s money, you have a right to file suit in a federal court or request assistance from the U.S. Department of Labor. If you are successful in your lawsuit, the court may, if it so decides, require the other party to pay your legal costs, including attorney’s fees.

If you have any questions about this statement or your rights under **ERISA**, you should contact the plan administrator or the nearest Area Office of the U.S. Labor-Management Service Administration, Department of Labor.

APPEALS PROCEDURE

When the claim of a Plan participant or beneficiary (hereinafter referred to as “claimant”) is processed, it shall initially be the responsibility of the Administrator of the Fund to decide what benefits the claimant is entitled to, in accordance with the benefits provided by the Plan. In the event that the claim is partially or totally denied, the claimant shall, within a reasonable amount of time, be advised in writing by the Administrator of the reasons for said denial with specific references to pertinent plan provisions and shall be given a copy of this Appeals Procedure. The claimant shall also be given a description of any additional material or information necessary for the claim to be honored and an explanation of why such information or material is necessary. Said information shall be provided in a manner calculated to be understood by the claimant.

If the claimant desires to appeal the said denial of the benefit, he or she shall communicate said desire to appeal to the Administrator of the Fund within sixty (60) days of receipt of the written notice of denial. No special form of appeal is necessary, but said appeal shall be made in writing.

The administrator of the Fund shall refer the appeal to the Board of Trustees. The Board of Trustees shall, if possible, hear the appeal at its next regular meeting, or at a specifically convened meeting. The Board of Trustees may delegate the hearing of the appeal to a panel consisting of one or more Trustees.

The Appellant may review pertinent documents and submit issues and comments in writing to the Board of Trustees. The Appellant also has the right to be represented by counsel, of his own choosing and at his own expense, at the hearing before the Board of Trustees, or its designee, if he so desires. He has the right to testify, to produce witnesses and documentary evidence, and to cross-examine witnesses. The Board of Trustees shall communicate its decision in writing to the Appellant not later than one hundred and twenty days after the request for review of the denial of the claim.

The decision shall include the specific reasons for the decision and specific references to the pertinent plan provisions upon which the decision is based. The decision of the Board of Trustees (subject to the terms and conditions described in the Group Policy) shall be final and binding in the matter of the appeal.

The Plan's Fiscal Year ends on:

June 30

The Plan's Employer Identification Number is:

23-6487659

In addition to Plan Counsel acting as agent for the service process, the Administrator and all Trustees will serve in this capacity as well.

The Plan is maintained pursuant to a Collective Bargaining Agreement. Copies of the Agreement are available upon written request to the Administrator within thirty (30) days.

All participants are entitled to a copy of a list of all contributing employers and can obtain such within thirty (30) days by sending a written request to the Administrator.

Both the Bargaining Agreement and the list of participating employers are also available for inspection at the office of the Administrator.

**SCHEDULE OF BENEFITS
ELIGIBLE PART- TIME EMPLOYEES**

I. LIFE INSURANCE

Length of Service	Amount of Insurance
Under 2 years	\$ 500.00
After 2 years	1,000.00

II. ACCIDENTAL DEATH AND DISMEMBERMENT

Length of Service	Amount of Insurance
Under 2 years	\$ 500.00
After 2 years	1,000.00

III. PPO PLAN A

IV. PRESCRIPTION – Family Coverage after two years of
Employment.

V. DENTAL – MEMBER ONLY – (No Dentures)
(Two year waiting period.)

VI. VISION – Family Coverage after two years
of employment.

Dear Part Time Employee:

This booklet describes the benefits you are eligible to receive through the UFCW Central Penna. and Regional Health & Welfare Fund.

The program offers benefits for Life Insurance, Hospital and Medical, Prescription, Dental and Vision Benefits.

This Fund was established as a result of collective bargaining between your Union and your Employer. Trustees have been appointed by the Union and Employers. The Trustees all serve without compensation and their authority is established by a Trust Agreement, which has been assigned by the Union and the Employers. Under this authority the Trustees have established the rules of eligibility and have provided benefits.

The program adopted by the Board of Trustees is subject to change by them if the experience of the Fund so indicates. In the event there are any changes in any of its features, you will be notified.

Any claimant who feels that he has not received proper benefits may write to the Trustees in care of the Administrator and have his case reviewed.

BOARD OF TRUSTEES

LIFE INSURANCE FOR YOU

DEATH BENEFIT

The amount of your Life Insurance as shown in the Schedule of Benefits will be paid to your beneficiary in the event of your death from any cause. Arrangements may be made to have the proceeds of the insurance paid in installments.

BENEFICIARY

You may name anyone you desire as your beneficiary and you may change your beneficiary at any time, by proper notification to the Welfare Fund Administrator and /or the Insurance Carrier.

WAIVER OF PREMIUM BENEFIT

If you become totally and permanently disabled while insured and before your 60th birthday, your life insurance will be continued in accordance with the Schedule of Benefits without further cost as long as you remain so disabled, provided proofs of disability are furnished as required. The first proof should be filed with the insurance company. Subsequent proofs of disability must be furnished each year.

CONVERSION PRIVILEGE

If your Life Insurance terminates because you leave the employ of one of the participating employers you may exchange your Group Life Insurance for an individual policy in accordance with the "Conversion Privilege" described in your certificate. All you have to do is apply directly to The Life Insurance Company within 31 days after your insurance terminates and pay the premium for your then attained age. No medical examination will be required.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

For You

ACCIDENT BENEFIT

When you have an accident either at or away from work and within 90 days suffer any of the losses shown below, benefits will be paid as follows, except for life, which has no time limitation:

Loss of Life.....	As shown in the Schedule of Benefits The entire amount (Paid to your beneficiary)
Loss of both hands, both feet, the sight of either eyes, or any combination of these.....	The entire amount (Paid to you)
Loss of one hand, one foot, or the sight of one eye.....	One-half the amount (Paid to you)

LIMITATIONS

Benefits will not be paid for suicide or intentionally self-inflicted injury while sane or insane, disease, war or any act of war, committing or attempting to commit a felony.

WHERE TO FILE A CLAIM

All claim forms and bills should be sent
directly to the Welfare Fund Office as follows:

**U.F.C.W HEALTH AND WELFARE FUND
ROOM 214
150 S. 43RD STREET
HARRISBURG, PA 17111**

**PHONE 717 561 9932
TOLL FREE 1 800 225 7741**

VISION BENEFITS

Eligible part-time employees become entitled to the following Vision Care Benefits once every two years.

You may go to any licensed Ophthalmologist, Optometrist, Optician or Oculist for eye examinations and for eyeglasses. The plan will pay upon your receipt of a paid bill up to \$125.00 once in two years for you to be applied any way you desire for the expense of an eye examination or the cost of the eyeglasses.

Your receipted bills should be sent to your Welfare Fund Administrator for prompt reimbursement.

PRESCRIPTION BENEFITS

Eligible members receive a Drug Identification Card, which must be available to identify themselves to participating pharmacists.

A CLOSER LOOK AT PRESCRIPTION DRUG BENEFITS

The categories of drugs covered by the plan and your copays are shown in this chart.

Prescription Drug Category

What You Pay*

PRESCRIPTION TYPE	RETAIL PHARMACY* (obtain a 34-day supply)	MAIL ORDER PROGRAM (obtain a 100-day supply)
Generic – Non Maintenance	\$3.00 Co-pay	\$3.00 Co-pay
Generic – Maintenance	\$3 co-pay or 10% of the cost of the drug whichever is greater	\$3.00 Co-pay
Brand ** - Non Maintenance	\$5 co-pay (plus the difference in the generic drug and the brand name drug, if applicable)	\$5 co-pay (plus the difference in the cost between the generic drug and the brand name drug, if applicable)
Brand ** - Maintenance	\$5.00 co-pay or 10% of the cost of drug whichever is greater (plus the difference in the cost between the generic drug and the brand name drug, if applicable)	\$5.00 co-pay or 10% of the cost of drug whichever is greater (plus the difference in the cost between the generic drug and the brand name drug, if applicable)

*You can now obtain your maintenance drugs up to a 34-day supply for a one co-payment at retail.

**If there is no generic available, there will be no difference in cost between brand and generic.

PRIOR AUTHORIZATION REQUIRED FOR SOME DRUGS

A small number of prescriptions require advance approval before they will be covered by the plan. **For Prior Authorization, you, your doctor or your pharmacist must call 1-800-467-2006. If you do not obtain pre-approval, the drug may not be covered.**

Mail – Order Prescriptions

The mail-order program offers a convenient, cost-saving and timesaving way to order prescriptions that you take on a regular basis, such as high blood pressure medicine. These drugs are also called “maintenance drugs” because they are used to maintain your health and/or control a chronic medical condition for a long period of time. Maintenance drugs are usually prescribed for 100 days.

Your doctor can write your maintenance prescription with refills for up to one year.

The mail-order program is administered by Remote Express Distribution Network (RxDN). You simply send your prescription and copayment to RxDN. They mail the medicine to you, usually within 7 business days (try to leave 2 weeks for delivery).

Getting a New Mail-Order Prescription Filled for the First Time

Fill out the mail-order form and send it to RxDN along with the prescription from your doctor and the applicable copayment. The copayments for mail-order drugs are \$3 generic and \$5 brand name plus the difference in the cost between generic drug and the brand name drug, if applicable.

Questions About Mail-Order?

**Call RXDN
1-800-800-8769**

Refilling Mail-Order Prescriptions

Your Doctor can write your mail-order prescription with refills for up to one year. If you already have a prescription on file with RxDN, you can refill the prescription over the phone instead of sending another form. RxDN will bill you directly.

Getting Prescriptions Filled While Away From Home

NPA has over 50,000 pharmacies nationwide. You should have no problem filling a prescription at a participating pharmacy no matter where you are traveling. Simply present your I.D. card. NPA pharmacies are online via computer with NPA and will submit your claim electronically at the time the prescription is filled. You pay only your applicable co-payment.

If you do not use a participating pharmacy, you must pay the full cost of the prescription, usually at the full retail cost – you will not benefit from the “plan discount.” Call the Fund office to see if you can be reimbursed, and the eligible amount. If the prescription is reimbursable, the Fund office will send you a claim form. You must complete and send the form to NPA no later than 30 business days from the date the prescription was dispensed.

DESCRIPTION OF DENTAL BENEFITS

PAYMENT OF BENEFITS

Benefits will be provided for Eligible Dental Services when billed by the licensed Dentist in charge of the case. Unless otherwise indicated, payment will be made whether services are performed in or out of the hospital.

Payment for services performed by a Dentist will be made to the Dentist on the basis of the Prevailing Fee Allowance (whichever is lower). Should the Contract call for a payment of less than 100 percent Prevailing Fee, any balance will be the Employee-Subscriber's responsibility.

Unless otherwise indicated, payment for all services provided under this Program will be limited to \$500.00 maximum per person per year.

THE BASIC PROGRAM (100% Prevailing Fee)

This is the foundation of the dental care program and is required because it meets basic needs before they become major problems. Eligible procedures consist of diagnostic, preventive and restorative services – all essential to good dental health.

1. Routine oral examinations and prophylaxis (including cleaning, scaling and polishing of teeth), but not more than once in any period of six (6) consecutive months.
2. Periapical and bitewing x-rays as required.
3. Full mouth x-rays, but not more than once in any period of thirty-six (36) consecutive months, unless special need is shown.
4. Topical application of Fluoride for children under age 19.
5. Repair to broken dentures.
6. Space maintainers (not made of precious metals) that replace prematurely lost teeth for children under 19 years of age.
7. Palliative emergency treatment for dental pain.
8. Simple extractions.
9. Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth. Gold foil restorations are not eligible.
10. Endodontics, including pulpotomy, pulp capping and root canal treatment.

11. Anesthetic services performed by (or under the direct personal supervision of) and billed for by a Dentist other than the operation Dentist or his assistant in connection with the performance of covered oral surgical services. Anesthetic services consist of the administration of an anesthetic agent or an anesthetic drug by injection or inhalation. The administration of a local infiltration or block anesthetic is not covered.
12. Consultations, limited to one consultation per consultant during any one period of hospitalization, when the subscriber is an inpatient and his dental condition requires such consultation.

THE SUPPLEMENTAL BENEFIT (100% Prevailing Fee)

This is the logical extension of the Basic Program. It covers complex dental procedures that are important to preventive dentistry. Covered services, if prescribed by a treatment outline approved by The Plan, consist of:

1. Inlays and Crowns – not part of a bridge. (No payment will be made for precious metal restorations unless the teeth cannot be restored with another material).
2. Oral surgery consisting of surgical removal of teeth and maxillary or mandibular intrabony cysts and procedures performed for the preparation of the mouth for dentures.
3. Apicoectomy (dental root resection).

THE PERIODONTIC BENEFIT (50% Prevailing Fee)

After age 35, the greatest single cause of tooth loss is gum disease. At least 50% of the Pennsylvania population over 50 years of age already has some gum problems. Rarely painful in its early stages, gum disease, if left unattended, can cause gums to recede and form pockets of bacteria and infection. Teeth become loose and essential bone may be lost. This rider can help improve a person's health, appearance and emotional well-being. It provides for treatment of periodontal disease, including:

1. Periodontal examinations.
2. Gingival curettage.
3. Gingivectomy and gingivoplasty.
4. Osseous (bone) surgery in connection with periodontal disease, including flap entry and closure.
5. Mucogingivoplastic surgery.

PREAUTHORIZATION

Preauthorization is used by The Fund to determine eligibility of the subscriber and to review the treatment plan to determine the extent of coverage. This assures both the subscriber and the Dentist that the particular service that will be performed is a covered service. It also allows the subscriber to plan for any additional liability that he may have. Finally, it allows The Fund to review proposed services relative to propriety and quality. Preauthorization is required for:

1. All treatment plans of \$100.00 or more;
2. The extraction of six or more teeth;
3. Space maintainers;
4. Periodontics.

GENERAL PROVISIONS

1. In the event a Subscriber transfers from the care of one Dentist to that of another Dentist during the course of treatment, or if more than one Dentist performs services for one dental procedure, The Fund shall be liable for not more than the amount it would have been liable for had but one Dentist performed the Service.
2. In all cases involving Covered Services in which the Dentist and Patient select a more expensive course of treatment than is customarily provided by the Dental Profession, consistent with sound professional standards of dental practice for the dental condition concerned, the Plan will pay only the charge allowed for the lesser procedure.
3. A contract between Patient and Dentist, prior to the effective date of coverage under this contract, is not invalidated by a date of coverage under this contract, is not invalidated by a subsequent contract made between The Fund and/or Patient and/or Dentist. The Patient shall be liable for any difference due to the Dentist under such a contract after The Fund liability has been satisfied.
4. Any additional treatment that is necessitated by lack of patient cooperation with the Dentist or non-compliance with prescribed dental care that results in additional liability will be the responsibility of the patient.
5. Appliances or restorations necessary to increase vertical dimension or restore the occlusion are considered optional and their cost remains the responsibility of the patient.

The Group Number is 395.

Claims should be submitted to:

DELTA DENTAL
ONE DELTA DRIVE
MECHANICSBURG, PA 17055

SERVICES NOT PROVIDED

1. Charges for services for which benefits are otherwise provided or for which the patient incurs no charge.
2. Charges for treatment by other than a Dentist, unless the treatment is rendered under the direct supervision of the Dentist.
3. Charges for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.
4. Charges for the replacement of a lost, missing, or stolen prosthetic device, for the replacement or repair of an orthodontic device or for any duplicate device or appliance.
5. Charges for failure to keep a scheduled visit with the Dentist.
6. Charges for services or supplies which are not necessary according to accepted standards of dental practice or which are not recommended or approved by the attending Dentist or do not meet accepted standards of dental practice, including charges for services or supplies which are experimental in nature.
7. Charges for sealants and for oral hygiene and dietary instruction.
8. Charges for plaque control programs.
9. Charges for implantology.
10. Unusual procedures and techniques and services other than specifically covered herein.
11. Services, the cost of which has been or is later recovered in any action at law or in compromise or settlement of any claim.
12. Services in a hospital performed by a Dentist who is compensated by the hospital for the services.
13. Services performed prior to the effective date of the contract.

December 1986

“VERY IMPORTANT NOTICE”

As of January 1, 1987, a new Federal law which was enacted April 7, 1986, (Public Law 99-272, Title X) requiring that Health and Welfare Funds under the joint trust between the Union and the Employers, as provided in the Taft Hartley Act, offer participants and their families the opportunity for a temporary extension of certain health coverage (called “Continuation Coverage”) at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the new law. (Both you and your spouse should take the time to read this notice carefully.)

If you are a participant in the United Food and Commercial Workers Health and Welfare Fund, you have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part.)

If you are the spouse of an employee covered by the United Food and Commercial Workers Health and Welfare Fund, you have the right to choose continuation coverage for yourself if you lose group health coverage under U.F.C.W. Health and Welfare fund for any of the following four reasons:

1. The death of your spouse;
2. A termination of your spouse’s employment (for reasons other than gross misconduct) or reduction in your spouse’s hours of employment;
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes eligible for Medicare.

In the case of a dependent child of an employee covered by the United Food and Commercial Workers Health and Welfare Fund, he or she has the right to continuation coverage if group health coverage under U.F.C.W. Health and Welfare Fund is lost for any of the following five reasons:

1. The death of a parent;
2. The termination of a parent’s employment (for reasons other than gross misconduct) or reduction in a parent’s hours of employment with his company;
3. Parents’ divorce or legal separation;
4. A parent becomes eligible for Medicare; or

5. The dependent ceases to be a “dependent child” under the United Food and Commercial Workers Health and Welfare Fund.

Under the new law, the employee or a family member has the responsibility to inform the office of the Administrator of a divorce, legal separation, or a child losing dependent status under U.F.C.W. Health and Welfare Fund. 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.

When the Administrator is notified that one of these events has happened, the Administrator will in turn notify you that you have the right to choose continuation coverage. Under the new law, you have at least 60 days from the date you would lose coverage because of one of the events described above to inform the Administrator that you want continuation coverage.

If you do not choose continuation coverage, your group health insurance coverage will end.

If you choose continuation coverage, the U.F.C.W. Health and Welfare Fund is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. The new law requires that you be afforded the opportunity to maintain continuation coverage for 3 years unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. However, the new law also provides that your continuation coverage may be cut short for any of the following five reasons:

1. Your employer no longer provides group health coverage to any of its employees.
2. The premium for your continuation coverage is not paid;
3. You become an employee covered under another group health plan;
4. You become eligible for Medicare;
5. You were divorced from a covered employee and subsequently remarry and are covered under your new spouse’s group health plan.

You do not have to show that you are insurable to choose continuation coverage. However, under the new law, you will have to pay a premium, which is 102% of the cost for your continuation coverage. (The new law also says that, at the end of the 18-month or 3-year continuation coverage period, you will be offered the opportunities to enroll in and pay the cost for those benefits that are convertible.)

This new law applies to the United Food and Commercial Workers Health and Welfare Fund beginning on January 1, 1987. If you have any questions about the new law, please contact the office of the Administrator, Room 214, 150 S. 43rd Street, Harrisburg, PA

17111. Also, if you have changed marital status, or you or your spouse change addresses, please notify the Administrator at the above address.