

**MANUAL
OF
BENEFITS**

Central Pennsylvania and Regional Health and Welfare Fund

COMET MARKETS

FULL 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
FULL TIME EMPLOYEES

BOARD OF TRUSTEES

EMPLOYER 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 or 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 or 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 FULL - TIME EMPLOYEES**

I. LIFE INSURANCE

Length of Service	Amount of Insurance
Under 2 years	\$ 500.00
2 years to 5 years	\$ 1,000.00
After 5 years	\$ 3,500.00

II. ACCIDENTAL DEATH AND DISMEMBERMENT

Length of Service	Amount of Insurance
Under 2 years	\$ 500.00
2 years to 5 years	\$ 1,000.00
After 5 years	\$ 3,500.00

III. ACCIDENTAL AND SICKNESS WEEKLY BENEFITS

A maximum of \$125.00 for a period of up to 13 weeks. (66-2/3% of regular straight time pay up to a maximum of \$125. Payment beginning with the 8th day of disability.

IV. MEDICAL / HOSPITAL
PPO 100 PLAN

V. PRESCRIPTION – Family Coverage
Drug Identification Card

VI. VISION – Family Coverage

VII. DENTAL – Family Coverage – 2 Year Waiting period.
(No Denture allowance)

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 both 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.

ACCIDENT AND SICKNESS BENEFITS

Non-Occupational Benefits For You

WEEKLY BENEFITS

When you are absent from work because of a non-occupational accident, or because of sickness, “weekly” payments as shown in the Schedule of Benefits will be made to you beginning:

1. with the 1st day of disability due to an accident or
2. with the 8th day of disability due to sickness unless hospital confinement occurs earlier in which case, payments for disability due to sickness will begin with the first day of hospital confinement.

To receive benefits, you must be under a doctor’s care.

SUCCESSIVE DISABILITIES

Successive disabilities due to injuries received in the same accident or due to the same or a related sickness will be considered as one disability unless the disabilities are separated by your return to work for at least 2 consecutive weeks.

PAYMENT PERIOD

Weekly payments will continue while you are unable to work up to a maximum of 13 weeks.

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 full-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 receipt of a paid bill up to \$125.00 once in two years for you to be applied anyway 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

See Insert

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.

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

¶
Mandatory Generic Drug Program – A generic drug is one that is chemically equivalent to the original brand name drug, but costs substantially less. Many brand name prescription drugs are available in FDA approved generic equivalents. When a generic drug is dispensed, there is no patient co-pay. However, if a brand name drug is dispensed and a FDA approved generic equivalent is available, you must pay the difference between the cost of the generic drug and the cost of the brand name drug. If a FDA - approved generic equivalent is not available, you will not be required to pay the difference in cost. You just pay the \$2.00 co-pay.¶

¶
If it is medically necessary that you receive a brand name drug when a generic equivalent is available, you may apply for a medical necessary exception. Your doctor will be required to certify in writing the medical reason for use of the brand name drug. If your request is approved, you may receive the brand name drug without paying the difference in cost.¶

¶
Maintenance Drug Policy – A maintenance drug is any medication that your doctor prescribes regularly over an extended period of time for the control or treatment of a chronic illness. All maintenance drugs must be filled through the Mail Order Program in order to be covered. There is no patient co-pay when you use the Mail Order Program.¶
If you do not use the Mail Order Program and instead have your prescription filled elsewhere, you must pay the full cost of the prescription. The enclosed brochure will give you information and instructions on how to use the Mail Order Program.
Please note, the mandatory generic policy is still in effect when you use the Mail Order Program.¶

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 perform 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 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.

