

UNITED FOOD & COMMERCIAL WORKERS UNION LOCAL 655 WELFARE FUND
PLAN B
SCHEDULE OF BENEFITS

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ELIGIBILITY INFORMATION

Your Plan of benefits – Plan B – includes medical, prescription drug card, vision, dental, weekly disability, life insurance and accidental death and dismemberment (AD&D) benefits. Dependents and Unit 2 Employees should refer to the chart below and to the description of the specific benefits in this Schedule of Benefits to determine whether they are covered by the Plan and whether they are eligible for specific benefits.

INITIAL AND CONTINUING ELIGIBILITY

You should review your Summary Plan Description Booklet for information about eligibility for your spouse and dependent children. Keep in mind that Unit 2 Benefits are only for the employee.

The following chart provides detail on the required number of contribution hours you must work in order to be eligible for either Unit 1 or Unit 2 benefits and in order to continue your eligibility for either Unit 1 or Unit 2 benefits. Eligibility examples are provided on the following pages.

If you Began Working.... To be Eligible for this Level of Benefits		You Must Work this Number of Contribution Hours Each Week for a Calendar Month
*Before November 1, 2003 and have not qualified for coverage prior to September 1, 2007	Unit 1 Benefits: Medical, Prescription Drug, Vision, Dental, Weekly Disability, Life and AD&D Insurance after a consecutive *14-Month Waiting Period	An average of at least 25 hours
	Unit 2 Benefits: Medical, Prescription Drug, Vision, Life and AD&D Insurance after a consecutive * 14-Month Waiting Period	An average of less than 25, but at least 16 hours
*On or After November 1, 2003 and have never qualified for coverage	Unit 1 Benefits: Medical, Prescription Drug, Vision, Dental, Weekly Disability, Life and AD&D Insurance after a consecutive *14-Month Waiting Period	An average of at least 32 hours
	Unit 2 Benefits: Medical, Prescription Drug, Vision, Life and AD&D Insurance after a consecutive * 14-Month Waiting Period	An average of less than 32, but at least 20 hours
* As a Unit 1 Monthly Participant	Unit 1 Monthly Benefits: Medical, Prescription Drug, Vision, Dental, Weekly Disability, Life and AD&D Insurance	Determined by your employer's agreement with the Union

*** This date/time period could vary based on the effective date of your Employer's Collective Bargaining Agreement. Please find your employer on the enclosed list to determine if your employer has a different date.**

Termination of Eligibility

When You Are Eligible for	And You are Credited With	Eligibility Ends on the
Unit 1 or Unit 2 Hourly Benefits	Less than the average of the required number of contribution hours shown above	Last day of the month in which your employer reports your termination of employment or if you did not terminate employment, the last day of the second month following the month for which you last met the hours requirement
Unit 1 Monthly Benefits	No contributions during the month	Last day of the month in which the employer reports your termination of employment or if you did not terminate employment, the last day of the second month following the month for which you last met the hours requirement

Example of employee hired on or after November 1, 2003: The following chart demonstrates how Bill becomes eligible, continues eligibility and stops being eligible for coverage. Bill is hired after November 1, 2003. He is covered under a collective bargaining agreement that does not require contributions for the first twelve months and his employer makes contributions for his credited hours after that period.

Eligibility Example –Hired on or After November 1, 2003			
Month	Monthly Hours	Eligibility Status	Coverage
January, 2008 through December, 2008	Bill hired January 1, 2008	Earning eligibility during the first 12 months of work	None
January, 2009 5 Saturdays	Bill works 160 or more hours	Earning eligibility during this month in which Bill's employer makes contributions for hours worked	None
February, 2009 4 Saturdays	Bill works 128 or more hours	Earning eligibility	None
March, 2009 4 Saturdays	Bill works 128 or more hours	Eligible based on January hours	Unit1
April, 2009 4 Saturdays	Bill works at least 80, but less than 128 hours	Continuing eligibility based on February hours	Unit1
May, 2009 5 Saturdays	Bill works at least 100, but less than 160 hours	Continuing eligibility based on March hours	Unit 1
June, 2009 4 Saturdays	Bill works 128 or more hours	Continuing eligibility based on April hours *	Unit 2
July, 2009 4 Saturdays	Bill works 128 or more hours	Continuing eligibility based on May hours *	Unit 2
August, 2009 5 Saturdays	Bill works 160 or more hours	Continuing eligibility based on June hours **	Unit 1
September 2009 4 Saturdays	Bill works 10 hours and then terminates employment in September	Continuing eligibility based on July hours, but coverage terminates at the end of the month due to termination of employment	Unit 1 until the end of September
October 2009 5 Saturdays	Bill works no hours	Coverage terminated at the end of September due to termination in that month	None – Coverage terminated

This chart assumes that your employer's payroll period (week) runs from Sunday to Saturday. If your employer's payroll period ends on a different day of the week, you should substitute that day for Saturday in this chart.

* Because Bill has now worked an average of 20 hours per week but less than 32, he is eligible for Unit 2 benefit coverage when he experiences a reduction in hours.

** Bill's Unit 1 Benefit coverage is reinstated based on his hours worked in June.

UNIT 1 MONTHLY COVERAGE – ELIGIBILITY EXAMPLE

For Example: The following chart demonstrates how Mary becomes eligible and continues eligibility. Mary is covered under a collective bargaining agreement that does not require contributions for the first twelve months and her employer makes contributions for her credited hours. Unit 1 Monthly plan participants are not eligible for Unit 2 benefits, so coverage ends when Unit 1 Monthly participants do not work the number of hours required by the collective bargaining agreement.

Month	Monthly Hours	Eligibility Status	Coverage
January 4 Saturdays	Mary hired January 1 of Prior Year Mary works the number of hours required by collective bargaining agreement	Earning eligibility during the first 12 months of work and during this first month in which Mary's employer begins making contributions for hours worked	None
February 4 Saturdays	Mary works the number of hours required by collective bargaining agreement	Earning eligibility during this month in which Mary's employer makes contributions for hours worked	None
March 4 Saturdays	Mary does not work the number of hours required by collective bargaining agreement	Eligible based on January hours	Unit 1
April 5 Saturdays	Mary does not work the number of hours required by collective bargaining agreement	Continuing eligibility based on February hours	Unit 1
May 4 Saturdays	Mary works the number of hours required by collective bargaining agreement	Mary is not eligible, based on March hours	None
June 4 Saturdays	Mary works the number of hours required by collective bargaining agreement	Mary is not eligible, based on April hours	None
July 5 Saturdays	Mary works the number of hours required by collective bargaining agreement	Mary is eligible again, based on May hours	Unit 1
August 4 Saturdays	Mary works the number of hours required by collective bargaining agreement	Continuing eligibility based on June hours	Unit 1
September 4 Saturdays	Mary works only a few hours and terminates employment in September	Continuing eligibility based on July hours, but coverage ends at the end of September due to termination of employment	Unit 1 until the end of September
October 5 Saturdays	Mary works no hours	Coverage terminated at the end of September due to termination in that month	None - Coverage terminated

This chart assumes that your employer's payroll period (week) runs from Sunday to Saturday. If your employer's payroll period ends on a different day of the week, you should substitute that day for Saturday in this chart.

SCHEDULE OF BENEFITS AS OF JANUARY 1, 2010 -- PLAN B

Eligibility For Current Plan Participants with up to 60 months (5 years) of service (based on hire date) that have never qualified for Health and Welfare benefits and New Hires (hired on or after September 1, 2007)	Unit 1: 32 hours average per week; after 14-month waiting period Unit 1 coverage (Family, medical, prescription drug, vision, dental, weekly disability, life and AD&D Insurance) Unit 2: 20 hours average per week; after 14-month waiting period (employee-only medical, prescription drug, vision, life, and AD&D insurance)	
Coordination Of Benefits For Spousal Coverage	A working spouse must elect medical and prescription coverage if available and subsidized through his or her employer. The Fund will coordinate benefits as secondary provider.	
Medical Benefits		
Calendar Year maximum benefit	\$100,000 per person	
Benefit And Payment Provisions	In-Network	Out-of-Network
Medical Benefits		
Annual deductible	\$300 per person; \$900 per family	\$450 per person; \$1,350 per family
Out-of-pocket maximum	\$1,500 per person; \$3,750 per family	\$3,000 per person; \$7,500 per family
In-Office Physician Care		
Office visit fee for illness or injury	<i>Family practice physician, internist, pediatrician, or OB/GYN: You pay \$15 copay per visit Specialist: You pay \$20 copay per visit</i>	Plan pays 60% of reasonable & customary after deductible
Pre- and post-maternity care (only employee/spouse covered)	Plan pays 80% after deductible	Plan pays 60% of reasonable & customary after deductible
X-ray and lab (outpatient)	Plan pays 80% after deductible	Plan pays 60% of reasonable & customary after deductible
Chiropractic Services — limit maximum: 20 visits per calendar year		
Chiropractic manipulations and other covered related services	You pay \$20 copay per visit, then Plan pays 80% no deductible	You pay \$20 copay per visit, then Plan pays 60% of reasonable & customary
X-ray & lab prescribed in connection with chiropractic care	Plan pays 80% after deductible <i>Benefits payable up to \$200 maximum per calendar year</i>	Plan pays 60% of reasonable & customary after deductible <i>Benefits payable up to \$200 maximum per calendar year</i>
Other Services — limit maximum: 20 visits per calendar year		
Physical, speech, and occupational therapy (preventive and maintenance care not covered)	You pay \$20 copay per visit, then Plan pays 80% no deductible	You pay \$20 copay per visit, then Plan pays 60% of reasonable & customary
Hospital Inpatient		
Hospital care, includes emergency room physician, radiologist, anesthesiologist, and pathologist care	Plan pays 80% after deductible	Plan pays 60% of reasonable & customary after deductible
Emergency Room / Urgent Care Services		
Emergency room	You pay \$100 copay, then Plan pays 90% no deductible (copay waived if admitted from ER)	You pay \$100 copay, then Plan pays 60% of reasonable & customary no deductible (copay waived if admitted from ER)
Urgent care facility	You pay \$50 copay, then Plan pays 90% no deductible	You pay \$50 copay, then Plan pays 60% of reasonable & customary – no deductible
Outpatient Surgery		
Surgery and related services (on same day)	Plan pays 80% after deductible	Plan pays 60% of reasonable & customary after deductible when services are rendered in an out-patient hospital facility only
** Special note – <u>Non-network</u> out-patient surgical centers are <u>not</u> covered by the Fund **		

SCHEDULE OF BENEFITS PLAN B (CONTINUED)

Medical Benefits (continued)		
Benefit And Payment Provisions	In-Network	Out-of-Network
Outpatient Care		
Diagnostic tests and X-rays Radiation therapy Dialysis treatment Cardiac and pulmonary rehabilitation (for certain diagnoses) Chemotherapy and infusion (please call the Fund Office)	Plan pays 80% after deductible	Plan pays 60% of reasonable & customary after deductible
Ambulance service	Plan pays 80% after deductible	Plan pays 60% of reasonable and customary after deductible. Plan pays In-Network percentage in the event of emergency
Home care, includes home respiratory, infusion therapy, and physical therapy (please call the Fund Office) <i>Limited to 40 visits per 12-month period</i>	Plan pays 80% after deductible	Plan pays 60% of reasonable & customary after deductible
Skilled nursing facility care (per episode of treatment) <i>Limited to 60 days per calendar year</i>	Plan pays 80% after deductible	Plan pays 60% of reasonable & customary after deductible
Hospice Care- In-patient or Home Patient must have life expectancy of less than 6 months to be eligible	Plan pays 80% after deductible	Plan pays 60% of reasonable & customary after deductible
Durable medical equipment, prosthetics and orthotics (\$1,000 lifetime maximum per piece of equipment; Wigs and prosthesis for hair loss due to a medical diagnosis or treatment covered by the Plan is limited to \$150 lifetime maximum per person)	Plan pays 80% after deductible	Plan pays 60% of reasonable & customary after deductible
Hearing aid benefit	Covered only if they are recommended by a network provider and pre-approved by the Board of Trustees. Contact Fund office for instructions The plan allows up to a maximum of \$500 per ear every 5 years Hearing exam and hearing aids must be provided through a network provider.	
Smoking Cessation Programs (Smoking Cessation benefits payable up to \$200.00 per calendar year and \$400 per lifetime maximum per person)	Plan pays 80% after deductible * after completion of behavioral modification program	Plan pays 60% after deductible * after completion of behavioral modification program
Weight Loss Programs	Plan pays 80% after deductible	Plan pays 60% of reasonable & customary after deductible
<i>Weight loss benefits payable up to \$1,500 per lifetime maximum per person, including prescription drugs for weight loss</i>		
Mental health and substance abuse benefits	There is a \$25 copay per visit fee	
Mental Health Benefits	Maximum per calendar year; 30 days inpatient care; 30 office visits (including outpatient or partial daycare visits with the physician); 16 days residential care	
Chemical dependency benefits	Maximum per calendar year: 30 office/outpatient days; 21 days of inpatient hospitalization; 16 days of residential care; Lifetime maximum of 10 episodes of chemical dependency benefits	
<i>ALL treatment must be referred through the Member Assistance Program (MAP), People Resources. You need to call (800) 765-9124 for a referral for any mental health and substance abuse treatment. There is a \$25 copay per office visit. Plan pays 80% after deductible of all other covered charges.</i>		
Organ/tissue transplant benefits	Plan pays 80% after deductible	Plan pays 60% of reasonable & customary after deductible
<i>Organ/tissue transplant benefit maximum: \$100,000 combined calendar year maximum regardless of transplant performed (up to a lifetime maximum of \$250,000); Benefit maximum starts 5 days prior to date of transplant.</i>		

SCHEDULE OF BENEFITS PLAN B (CONTINUED)

Preventive Care (In Physician's Office)

Benefit And Payment Provisions	In-Network	Out-of-Network
Physician's office visit (1 per calendar year) Routine physicals (1 per calendar year) Gynecological exams (1 per calendar year) Well-child care visit (birth to one year)	<i>Family practice physician, internist, pediatrician, or OB/GYN: You pay \$15 copay per visit</i> <i>Specialists: You pay \$20 copay</i>	Plan pays 60% of reasonable & customary after deductible
Hearing exams (1 per calendar year) Immunizations Pap smear Routine mammograms (covered as outlined by American Cancer Society)	Plan pays 80% no deductible	Plan pays 60% of reasonable & customary after deductible
Family planning Infertility lab work Infertility treatment <i>Benefits payable up to \$10,000 lifetime maximum</i>	Plan pays 50% no deductible	Plan pays 50% of reasonable & customary after deductible

InformedRX Prescription Drug Card Program

Annual deductible	\$50 per person	
Type Of Medication	Participating Network Retail Pharmacy (up to 30-day supply)	Mail Order Program ** (up to a 90-day supply)
Generic drugs	You pay 15% or \$10 copay (whichever is greater); with \$25 maximum copay	You pay 10% or \$20 copay (whichever is greater); with \$75 maximum copay
Single source brand name drugs (no generic available)	You pay 25% or \$20 copay (whichever is greater); with \$50 maximum copay	You pay 25% or \$40 copay (whichever is greater); with \$150 maximum copay
Multi-source brand name drugs	You pay 25% of generic cost or \$20 copay (whichever is greater), plus the difference between the brand name and generic price	You pay 25% of generic cost or \$40 copay (whichever is greater), plus the difference between the brand name and generic price

** You may also fill your maintenance prescriptions (up to 90-day supply) at all Schnucks, Dierbergs, Shop'n Save and Kroger stores that have pharmacies. You must have filled at least one 30 day supply of the prescription at retail before you are eligible to fill the 90 day supply. The same mail order co-pay's shown above apply.

Vision Care Benefits

Benefits are payable every other calendar year for eye exam and 1 pair of eyeglasses or contact lenses

Call VSP Vision Care at 1-800-877-7195 or visit their web site at www.vsp.com whenever you need to locate a vision care provider in your area. When you call to make an appointment, tell the doctor you are a VSP member. Your ID card will not be needed.

VSP Choice Providers	Benefits Payable Every Other Calendar Year
Well Vision Exam (eye exam related to illness or injury covered under medical benefits)	Plan covers 100% after you pay a \$35 copayment
Prescription lenses- single vision, lined bifocal and lined trifocal, and Polycarbonate lenses for dependent children	Plan covers 100% after you pay a \$50.00 copayment
Allowance for frames	Plan covers a maximum of \$100.00: you receive 20% off the amount over your allowance
Allowance for contact lenses and contact lens exam (fitting and evaluation)	Plan covers a maximum of \$150.00
Non-VSP Service Providers	Benefits Payable Every Other Calendar Year
Well Vision Exam (eye exam related to illness or injury covered under medical benefits)	Plan covers up to \$50
Pair of lenses (eyeglass)	
Single vision	Plan covers up to \$50
Bifocal	Plan covers up to \$60
Trifocal	Plan covers up to \$70
Frames	Plan covers up to \$40
Contact Lenses	Plan covers up to \$150

SCHEDULE OF BENEFITS PLAN B (CONTINUED)

Dental Benefits

Only Unit 1 Unit 1 employees and dependents are eligible for dental benefits

You have access to the Anthem Blue Cross and Blue Shield (BCBS) dental network. To find a provider in your area, log onto www.655hw.org. By selecting an Anthem BCBS dental provider your out-of-pocket costs will be lower since the providers have agreed to offer their services at discounted rates. This means you will pay a percentage of a lower cost.

Service	Benefits Payable
Calendar year maximum payable for coverage A, B, and C combined	\$3,000 per person
Coverage A: routine exams, prophylaxis, fluoride treatment and X-rays – allowed twice per year (no 6 month clause)	Plan pays 100% of usual and customary
Coverage B: restorative, basic dental care, periodontics, (veneers - must be pre-authorized)	Plan pays 80% of usual and customary
Coverage C: crowns, bridges, dentures, partials (5 year replacement clause)	Plan pays 50% of usual and customary
Orthodontia (covered only for eligible dependent children)	Plan pays 80% up to \$2,000 lifetime per child

Employee-Only Benefits

Level Of Coverage	Unit 1	Unit 2
Life Insurance Benefit		
In the event of your death	Hire date at least one year but less than 10 years \$10,000 at least 10 years but less than 15 years \$15,000 at least 15 years but less than 20 years \$20,000 20+ years ----- \$25,000	Hire date at least one year but less than 10 years \$ 2,000 at least 10 years but less than 15 years \$ 5,000 at least 15 years but less than 20 years \$10,000 20+ years ----- \$15,000
Accidental Death and Dismemberment Benefit		
In the event your death is a result of an accident your beneficiary will receive the following in addition to the Life Insurance Benefit	Hire date at least one year but less than 10 years \$10,000 at least 10 years but less than 15 years \$15,000 at least 15 years but less than 20 years \$20,000 20+ years ----- \$25,000	Hire date at least one year but less than 10 years \$ 2,000 at least 10 years but less than 15 years \$ 5,000 at least 15 years but less than 20 years \$10,000 20+ years ----- \$15,000
Loss of any one of: hands, feet, or sight of an eye	Hire date at least one year but less than 10 years \$ 5,000 at least 10 years but less than 15 years \$ 7,500 at least 15 years but less than 20 years \$10,000 20+ years ----- \$12,500	Hire date at least one year but less than 10 years \$ 1,000 at least 10 years but less than 15 years \$ 2,500 at least 15 years but less than 20 years \$ 5,000 20+ years ----- \$ 7,500
Loss of any two of: hands, feet, or sight of an eye	Hire date at least one year but less than 10 years \$10,000 at least 10 years but less than 15 years \$15,000 at least 15 years but less than 20 years \$20,000 20+ years ----- \$25,000	Hire date at least one year but less than 10 years \$ 2,000 at least 10 years but less than 15 years \$ 5,000 at least 15 years but less than 20 years \$10,000 20+ years ----- \$15,000
Weekly Disability Income Benefit		
Eligibility begins on	The 1 st day of an accident or the 4 th day of an illness	No coverage
Percentage of payment	70% of average weekly wage for the 4-week period immediately preceding the disability	N/A
Maximum weekly benefit amount	at least one year but less than 10 years \$ 250 at least 10 years but less than 20 years \$ 300 20+ years ----- \$ 350	N/A
Maximum period of pay	13 weeks	N/A
Reinstatement of weekly disability benefit	Benefits are restored when you return to work for 5 days within a 7-day period and work <i>your average weekly hours</i> (minimum of 25-32 hours per week based on your Unit 1 eligibility qualification)	

FOR MORE INFORMATION

FUND OFFICE

Contact the Fund Office, Monday through Friday, 8 a.m. – 5:30 p.m., CST, if you have questions about your benefits. Phone: (314) 835-2700 (in the St. Louis area) or (866) 565-2700 (outside St. Louis)

ANTHEM

Refer to your provider directories or go online to www.anthem.com if you have questions about the providers that participate in the Anthem Blue Access Choice PPO network.

INFORMEDRX

Contact InformedRX if you have questions about participating retail pharmacies or for information about using the mail order program. Phone: (888) 354-0090 (for information about participating retail pharmacies) or (800) 881-1966 (for information about the mail order program) or visit their website at www.sxc.com.

PEOPLE RESOURCES (MEMBER ASSISTANCE PROGRAM)

Contact People Resources before receiving mental health or substance abuse treatment. Phone: (800) 765-9124 or (314) 222-4012 or visit their website at www.worklifetools.com. Please enter UFCW as employer name.

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