National IAM Benefit Trust Fund

Health and Welfare Plan

Dental Plan

Summary Plan Description

Effective May 1, 2021

For More Information, Visit www.iambfo.org

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TO ALL PARTICIPANTS AND ELIGIBLE DEPENDENTS:

On September 6, 1966, the Executive Council of The International Association of Machinists and Aerospace Workers established a nationwide Trust Fund known as the IAM National Health and Welfare Plan. On October 1, 1979, it became a part of the National IAM Benefit Trust Fund (Fund).

We are pleased to provide you with this Summary Plan Description (SPD), which describes in detail the dental benefits available to active and eligible retired employees and their eligible dependents through the National IAM Benefit Trust Fund effective May 1, 2021.

We urge you to read this SPD carefully so that you may fully understand the benefits available to you and your family. We also suggest that you keep this SPD with your important papers so it will be readily available for future reference. Here are some things to keep in mind:

This SPD replaces all other SPDs previously published by the Fund. If any changes are made to the Fund's plans of benefits (Plan), they will be communicated to you via a notice that will be sent to the last known mailing address the Fund Office has on file for you. Therefore, it is extremely important that you notify the Fund Office if you change your mailing address.

The benefits described in the SPD are not guaranteed (vested). All benefits may be changed, reduced or eliminated at any time by the Board of Trustees, to the extent allowed by law. The Board reserves the right to set the effective date of any Plan change.

The information set forth in the SPD is effective for the health and welfare benefits provided by the Fund with respect to all claims incurred on or after May 1, 2021, unless otherwise stated.

The administration of these benefits and accompanying claims is subject to the terms of any agreements executed between the Trustees and third-party providers of benefits and or services under the terms of the Plan.

The Board solely is authorized to interpret the terms of the Plan and has discretion to decide all questions about the Plan, including questions about your eligibility for benefits, the amount and type of benefits payable to you, and the application of any Plan term or provision. Your employer or union representative does not have the authority to interpret and/or apply the Plan on behalf of the Board or to act as an agent of the Board.

If you have any questions about your benefits, please write or call the Fund Office. Our staff will be pleased to assist you.

Sincerely,

THE BOARD OF TRUSTEES

Welcome!

Welcome to your Dental Plan. We know that your benefits are important to you, and that's why we work hard to provide you with the best comprehensive, cost-effective, high quality coverage we can. This SPD provides you with a detailed description of your dental benefits under the Plan. SPDs for medical, vision, and short-term disability benefits, and life and accidental death and dismemberment insurance are provided separately if you are eligible for such benefits.

Dental benefits are self-funded, which means that claims are paid directly from Fund rather than an outside insurance company. Your employer contributes to the Fund on your behalf, according to the terms of your collective bargaining agreement or other participation agreement.

Being self-funded also means that you have a responsibility to be an informed, conscientious health care consumer. Your individual efforts to conserve Fund resources have a direct effect on the cost of health care benefits provided to you and your family, as well as future benefit availability. It's in everyone's best interest to use the savings measures the Trustees have put into place, like using network providers whenever possible and taking advantage of preventive care benefits on a routine basis.

This SPD explains the general provisions of the Plan. It includes legally required notices, an overview of your coverage, information about eligibility requirements for you and your family, claims and appeals procedures, and a glossary of terms used in this SPD. However, this SPD is only a summary of your Plan's provisions. Full details are contained in the documents that establish the Plan provisions, including the Plan Document. If there is a discrepancy between the wording here and the documents that establish the Plan, the Plan Document language will govern. The Trustees reserve the right to amend, modify or terminate the Plan, and to modify contribution rates at any time and from time to time.

If you have any questions about your Plan, the Trustees have authorized the Fund Office to respond in writing to any written questions you may have. In addition, as a courtesy to you, the Fund Office may respond informally to oral questions. However, oral information and answers are not binding on the Trustees and cannot be relied upon in any dispute concerning your benefits.

NOTE: Neither the Fund, the Board of Trustees, nor any of their designees are engaged in the practice of medicine or dentistry, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided to you by any doctor, dentist or other provider. Neither the Fund, Trustees, nor any of their designees will have liability whatsoever for any loss or injury caused to you by any doctor, dentist, or provider by reason of negligence, by failure to provide care or treatment, or otherwise.

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Schedule of Benefits

The Fund offers four (4) unique Dental Plans with varying levels of coverage through Delta Dental of Georgia.

Please do not rely only on these tables to determine your benefits. Important coverage details, limitations, exclusions, and definitions that may affect claims for you, your spouse, and your dependent children are found later in this SPD.

Please Note: Possession of this SPD, a dental ID card, or a dental claim form does not establish your eligibility for benefits under this Plan. If you want to confirm which of these schedules applies to you or verify your eligibility for dental benefits, you should call Delta Dental Customer Service toll-free at 1-800-521-2651. Or you can register at www.deltadentalins.com to review your benefits and eligibility online. You may also contact the Fund Office for eligibility confirmation at 1-800-457-3481.

Plan D001

Dental Services	All Providers
Deductible	$0
Diagnostic and Preventive	100%
Basic	100%
Major	80%
Implants	50%
Dental Calendar Year Maximum	None
Orthodontics	50%
Orthodontic Lifetime Maximum	$7,000

Plan D002

Dental Services	In-Network Providers	Out-of-Network Providers
Deductible • Individual	$0	$50
• Family	$0	$150
Diagnostic and Preventive	100%	90%
Basic	85%	75%
Major	75%	50%
Implants	50%	50%
Dental Calendar Year Maximum	$2,500	
Orthodontics	85%	75%
Orthodontic Lifetime Maximum	$2,000	

Plan D003

Dental Services	In-Network Providers	Out-of-Network Providers
Deductible • Individual	$0	$50
• Family	$0	$150
Diagnostic and Preventive	90%	80%
Basic	80%	50%
Major	60%	50%
Implants	50%	50%
Dental Calendar Year Maximum	$2,000	
Orthodontics	50%	50%
Orthodontic Lifetime Maximum	$1,500	

Plan D004

Dental Services	In-Network Providers	Out-of-Network Providers
Deductible • Individual	$0	$50
• Family	$0	$150
Diagnostic and Preventive	90%	80%
Basic	80%	50%
Major	60%	50%
Implants	50%	50%
Dental Calendar Year Maximum	$1,500	
Orthodontics	Not Covered	

Additional Information

The following provisions apply to the above schedules:

- Diagnostic and preventive services are not subject to the deductible;
- Diagnostic and preventive services do not add to the dental calendar year maximum;
- Both in-network and out-of-network dental benefits add to the dental calendar year maximum (except diagnostic and preventive services and orthodontics);
- Orthodontic treatment is not subject to the deductible; and
- Both in-network and out-of-network dental benefits for orthodontic treatment add to the orthodontic lifetime maximum.

Eligibility Provisions

Initial Eligibility

Active Employees

You are eligible for coverage if you are an active employee of an employer that is participating in the Plan, you are working in a position for which coverage is provided under the terms of the applicable collective bargaining agreement and/or participation agreement, and your employer is making the required monthly contributions to the Plan on your behalf.

Please note that eligibility under the Plan also is subject to any further requirements and limitations in the applicable collective bargaining agreement or other participation agreement. Whenever the coverage language in the applicable collective bargaining agreement or other participation agreement is inconsistent with the language in this document, the language in the applicable collective bargaining agreement or participation agreement will prevail, if language has been accepted by the Fund.

Employees on a Leave of Absence

Employees who are on an approved leave of absence, where an extension of coverage is being provided under the terms of the applicable collective bargaining agreement and/or participation agreement, are also considered to be active employees by the Plan on the condition that the extension of coverage language was approved in advance by the Plan, and the employer continues to make the required monthly contributions to the Plan on the employee's behalf.

Effective Date of Coverage for Active Employees

Your coverage will become effective on the first day of the month in which you become an eligible employee, you enroll in the Plan, and your employer contributes to the Fund on your behalf.

Determination of Eligibility for Coverage

Your eligibility for coverage under this Plan is determined each month, based on the contributions received from your employer. After the initial determination of your eligibility, your eligibility and coverage will terminate on the last day of any month in which you no longer qualify as an employee, and your employer does not remit the required contribution for your coverage.

If your coverage terminates because of your death, your dependents will continue coverage as if you had remained a participant until the end of the month of your death. After that, your dependents are eligible to elect COBRA continuation coverage.

Eligibility for Retiree Coverage

To be eligible for retiree coverage where provided, you must retire from active employment with a participating employer while you are eligible for benefits under this Plan, and your employer must continue to make the required monthly contributions to the Plan. Retiree coverage is only available where the collective bargaining agreement and/or participation agreement provide for retiree dental care coverage, and the covered employee meets the eligibility rules for retiree coverage under the terms of such agreements.

Continuation of Eligibility

Eligibility During Family Medical Leave (FMLA)

Your eligibility for coverage while on FMLA will be determined by your contributing employer. However, you are eligible for leave under the FMLA if you:

- Have worked for a covered employer for at least 12 months;
- Have worked at least 1,250 hours over the previous 12 months; and
- Work at a location where at least 50 employees are employed by the employer within 75-mile radius.

The Fund Office will maintain your prior eligibility until the end of the leave, provided your contributing employer properly grants the leave under federal law, notifies the Fund, and continues to make monthly contributions on your behalf while you are on an approved leave.

If you and your employer have a dispute over your eligibility under FMLA, your benefits will be suspended pending resolution of the dispute, in the absence of the required contribution. The Board of Trustees will have no direct role in resolving the dispute. Coverage under this Plan will continue during the FMLA leave on the same basis as other similarly situated employees.

Call your employer to determine if you are eligible for the FMLA leave. Then, contact the Fund Office if you are planning to take the FMLA leave so that the Fund is aware of your employer's responsibility to make contributions during your absence. The Board of Trustees cannot enforce collection of contribution from your employer while you are out on leave; however, federal authorities may assist you regarding your continued coverage.

Eligibility for Coverage During Leave Under USERRA (Military Leave)

If you enter qualified military service (such as active or inactive duty training or active duty in the United States armed forces or National Guard), and you have sufficient hours in previous work periods to continue eligibility for one or more months following the month you enter the Uniformed Services, you have the option of continuing your eligibility in the Plan under the Plan's Continuation of Eligibility rules or freezing your eligibility as of the end of the month in which you enter the Uniformed Services, or as of the date you enter the Uniformed Services if you enter on the first of the month. In addition, you may elect coverage for yourself and eligible dependent(s) under COBRA continuation coverage. However, in accordance with the Uniformed Services Employment and Reemployment Rights Act (USERRA), you must return to work or seek reemployment with an employer following a discharge, under not less than honorable conditions, within the minimum time period allowed.

If you do not return to work in covered employment or seek reemployment in covered employment within the minimum time period allowed, you will forfeit your continued eligibility rights under the Plan. In order to ensure protection of your rights under the USERRA, you must notify the Fund Office as soon as you are called up for qualified military service.

If you are covered under the Plan at the time your qualified military service leave begins, your health coverage will be continued by the Fund for your first 30 days of military service providing monthly contributions are made by your contributing employer. If you are on uniformed services for more than 30 days, you will be permitted to continue health coverage for yourself[1] and your eligible dependents under the options set forth herein:

[1] See option to elect coverage for yourself (not your spouse or eligible dependents) discussed in the SPD.

- **Coverage options for your eligible dependent(s):** Coverage for your eligible dependents may be elected under COBRA continuation coverage. You will be required to self-pay for this coverage. In the alternative, coverage may be provided through the military.
- **Coverage options for yourself:** you may elect coverage under the Plan's continuation of coverage benefit[1] and continue coverage for yourself for up to 24 months. However, the right to elect this continuation coverage is available only to you, not your dependents.

If you freeze your eligibility at the beginning of your qualified military leave (effective after your automatic 30-day coverage) you may reclaim this eligibility when you return to work for an employer under the criteria set forth in USERRA. You must notify the Fund Office of your selection, i.e., whether you will freeze your eligibility; elect continuation of coverage for yourself; or elect COBRA coverage for yourself, and/or your spouse and eligible dependent children. If you do not notify the Fund Office, your eligibility will be automatically extended until it is exhausted.

If you are honorably discharged from the Uniformed Services, Plan coverage for you, your spouse and your eligible dependent child will be reinstated on the day you begin work with an employer participating in the Plan, provided that you comply with the notice on return to work requirements of USERRA. These requirements and additional information on USERRA can be found at the DOL's website at: http://www.dol.gov/vets/programs/userra/userra_fs.htm.

Your right to maintain and reinstate coverage by reason of qualified military service will be administered and interpreted by the Plan in accordance with the requirements of USERRA, employer contributions, if any, credited to you will be kept on the Plan's records during the qualified military service leave of absence, and your coverage, as well as coverage for your spouse, and your eligible dependent child will be reinstated, provided you return to work in covered employment or seek reemployment with an employer within the time period protected under USERRA.

Eligibility for Your Spouse and Eligible Dependent Children

Your eligible dependents include:

- Your spouse[2] to whom you are legally married pursuant to state and federal law, and with whom you can file an income tax return, until the last day of month in which a divorce, dissolution of marriage, annulment or legal separation is obtained.
- Your biological children, foster children, children placed for adoption, adopted children, stepchildren, and/or children for whom you or your covered spouse are; (a) legal guardian, or (b) required to provide medical coverage under a Qualified Medical Child Support Order (QMCSO), until the last day of the month in which the child reaches age 26.
- Unmarried children of any age provided they are incapable of self-sustaining employment because of a physical or mental disability that occurred when they were covered by this Plan and turned age 26 with such disability present.

A dependent must qualify as a dependent as set forth either in the Affordable Care Act (ACA) or the Internal Revenue Code (Code), and the contributing employer must make contributions to the Plan for such coverage, where required. All eligible dependents must complete the enrollment process to ensure coverage.

[1] This coverage is similar to but is not COBRA continuation coverage.
[2] The term dependent does not include a spouse who is on active duty in any armed forces.

Employees are required to submit a completed eligible dependent certification (EDC) form for any child whose last name differs from the employee's last name, for stepchildren, or for other covered children. Adoption and/or placement papers are required for coverage of legally adopted children and children placed for adoption. Coverage of stepchildren requires submission of the child's birth certificate and proof of the employee's marriage to the child's biological or adoptive parent. Coverage of other dependents requires submission of guardianship papers or other papers confirming the legal relationship between the employee and child. employees must provide a marriage certificate to enroll a spouse. The Fund Office also may ask you for other related information it needs to evaluate the terms of your relationship with a dependent and may periodically request verification of the covered dependent's status on an ongoing basis.

Eligibility for Disabled Children

If a dependent child, age 26 or older, is incapable of self-sustaining employment because of mental or physical disability, and the child relies on you for more than one-half of his or her financial support and maintenance, and maintains a permanent residence with you during more than one-half of the calendar year, the child's coverage may be continued under this Plan if his or her disability began when the child was covered by this Plan, and he or she turned age 26 with the disability.

You must submit proof of your dependent child's disability to the Fund Office before the child turns 26 and may be required periodically thereafter (proof may be required more often during the first two (2) years).

Important Rules for Dependent's Eligibility

The Fund will not provide coverage for other relatives living in your household (e.g., mother, father, siblings, etc.) regardless of whether they are dependent upon you financially, or for non-biological children living in your household for whom you are not legally responsible. Also note:

- If your eligible dependent child is employed and becomes covered under a group health plan connected to his or her employment, the plan under which he or she is an employee will be considered the primary plan for coverage. This Plan will be secondary.
- For adopted children, children placed with you for adoption, or foster children to be considered eligible dependents, you must provide the Fund Office with appropriate legal documentation, satisfactory to the Plan in its sole discretion, such as adoption papers or a court order appointing you as the legal guardian for the child.
- For a stepchild to be considered an eligible dependent, the Fund requires that the employee provide a copy of the child's birth certificate and proof of the employee's marriage to the child's biological or adoptive parent. The Fund may also require any and all documentation, including paternity papers, court order, state order and/or divorce decree setting forth the relationship with the child.
- If a dependent spouse is eligible for benefits under this Plan as an active employee, benefits will be payable for the spouse first as an employee, then as a dependent. In no event will benefits exceed 100% of covered Charges incurred.
- If a dependent child loses eligibility status, the child may regain eligibility only by satisfying all of the requirements included in the Plan's definition of an eligible dependent, and these dependent eligibility requirements.

The Fund Office will require all participants to provide documentation substantiating an individual's right to status as an eligible dependent. Documentation required by the Fund Office may include:

- A marriage certificate (in the English language);
- Birth certificate of biological child showing both parents' names;

- Court (legal) documents showing legal guardianship or adoption;
- Acknowledgement of paternity;
- Receipt of a Qualified Medical Child Support Order pursuant to terms of the Fund; or
- Notarized affidavits.

The date a person becomes a dependent means:

- With respect to a newborn child, the date of birth;
- With respect to a stepchild, the date of your marriage to your stepchild's parent;
- With respect to a foster child, the date the child is placed with you for foster care;
- With respect to a child named in a QMCSO, the later of the date specified in the court order or the date it is qualified;
- With respect to an adopted child, the date of adoption or placement for adoption; or
- With respect to a spouse, the date of the marriage;
- With respect to a child for whom you are legal guardian, the date the guardianship papers are signed by the Court.

Effective Date of Coverage for Eligible Dependents

On the day you become eligible for coverage under the Plan, your eligible dependents also become eligible, provided they are enrolled in the Plan within 30 days of your eligibility effective date, and meet all the requirements for coverage.

If you marry after the date you initially become covered under the Plan, your spouse becomes covered on the day of marriage provided you give the Fund Office timely notice of the marriage, and complete the required paperwork within the permissible time period as set forth under the subsection "Special Enrollment During Mid-Coverage Period."

If, after the date you initially become covered under the Plan, you have a newborn biological child, an adopted child, a stepchild, a child placed with you for adoption, or a foster child, such child will become covered on the date of their birth (for a newborn biological child) or on the date the child is adopted or placed in your home (for step, adopted, or foster children).

To ensure a new dependent receives coverage, you must notify the Fund Office within 30 calendar days of the date you acquire a new dependent through marriage, birth, foster placement, or adoption. You must also submit all required paperwork, and your employer must make the required contribution for dependent coverage (e.g., employee plus spouse, employee plus children, family).

Eligibility Pursuant to a Qualified Medical Child Support Orders

The Plan is required to recognize Qualified Medical Child Support Orders (QMCSOs). QMCSOs require health plans to recognize state court orders that the Plan finds to be Qualified Medical Child Support Orders, as defined in the Social Security Act, directing a participant to provide health care coverage for dependent children, even if the participant does not have custody of the children. The Plan will honor any medical child support order, which it finds to be a Qualified Medical Child Support Order (QMCSO) under the procedures set forth under the Plan, and as set forth in ERISA.

Under federal law, a QMCSO is a child support order of a court or state administrative agency that has been received by the Fund Office, and that:

- Designates one parent to pay for a child's health plan coverage;

- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is determined; and
- States the period for which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide. For a state administrative agency order to be a QMCSO state law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to health care coverage for any of your dependent children, the Plan Administrator will determine if that order is a QMCSO as defined by ERISA, and under the terms of the Plan. The Plan Administrator's determination will be binding on you, the other parent, the child and any other party acting on behalf on the child. If an order is determined to be a QMCSO, the Plan Administrator will notify the parents of each child and advise them of the Fund's procedures that must be followed to provide coverage to the dependent children.

Coverage of the dependent children will be subject to all terms and provisions of the Plan, including any limits on the selection of providers, and requirement for authorization of services, insofar as is permitted by applicable law.

No coverage will be provided for any dependent child under a QMCSO unless all the Plan's requirements for coverage of that dependent child have been satisfied. Coverage of a dependent child under a QMCSO will terminate when your coverage terminates for any reason, subject to the dependent child's right to elect COBRA continuation coverage (if that right applies).

You may obtain a copy of the Plan's procedures governing QMCSOs without charge from the Fund Office. If you have any questions about QMCSOs contact the Fund Office.

Benefits Upon Your Death - Eligibility of Your Surviving Spouse

Surviving spouse coverage is available for existing contributing employers only if the collective bargaining agreement and/or participation agreement provide for surviving spouse coverage, and the employee or retiree meets any required age and/or years of service rules specified in such agreements at the time of death.

To be eligible for surviving spouse coverage where provided, the death of an employee or retiree must occur while eligible for benefits under the applicable Plan, and the contributing employer must continue to make the required monthly contributions to the Plan.

There is otherwise no coverage for surviving spouses under this Plan. However, your covered surviving spouse and surviving dependent children may have rights under this Plan to make payments for continuation of coverage under COBRA as described later in this SPD.

Please check your applicable collective bargaining agreement, participation agreement, and all information provided to you by your employer for more details on whether a surviving spouse benefit is available under the terms of the applicable Plan.

How to Enroll in Coverage Under the Plan

You must apply for coverage for yourself and your dependents by completing an enrollment form and providing the completed form to your employer. Your employer will process the form and initiate any

necessary payroll deduction, indicate the effective date of coverage, and provide the form to the Fund Office. Coverage for you, your spouse, and/or eligible dependent children will not be effective until the Fund Office receives and processes the form. Enrollment forms should be received by the Fund Office prior to your initial effective date for coverage. If submission prior to your effective date is not possible, your form must be received by the Fund Office before the end of the initial coverage month.

If you acquire a new dependent, you should notify your employer and enroll the new dependent within 30 days to ensure coverage for your dependent. If you do not enroll your dependent within 30 calendar days, unless you experience a special enrollment event, enrollment for coverage will be delayed until your employer's open enrollment period. If your employer does not have an open enrollment period, the Fund Office can assign an annual enrollment period during which changes will be allowed. Please contact the Fund Office if you have any questions about when a dependent can be enrolled and the date the individual will qualify as a dependent.

If you fraudulently enroll someone who is not eligible for coverage, that person's coverage will be terminated immediately. The Fund has a right to be reimbursed of any claims that were paid based on the fraudulent enrollment. You also may be subject to criminal penalties.

Special Enrollment During Mid-Coverage Period

If you, your spouse, or your eligible dependent children are declining coverage because of other health insurance coverage, in the future you may be able to enroll yourself, your spouse, or your dependents in this Plan, provided you request enrollment within 30 calendar days after coverage under the other plan ends. The dependent's loss of coverage must be due to exhaustion of continuation coverage under another plan, termination resulting from the loss of eligibility under the other plan, termination as a result of increase in cost of coverage under the other plan, or termination because employer contributions under the other plan were reduced or terminated.

Loss of coverage for this purpose does not include a loss due to the individual or participant's failure to make payments on a timely basis under the applicable terms, or termination of coverage for cause.

If you have a new dependent as a result of marriage, birth, or placement for adoption, you may enroll your new dependent, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you fail to enroll your new dependent within the Special Enrollment time period, you may enroll your new dependent during your employer's next open enrollment period. If your employer does not have an open enrollment period, the Fund Office can assign an annual enrollment period during which changes will be allowed. Please contact the Fund Office if you have any questions about when a dependent can be enrolled and the date the individual will qualify for dependent coverage under the Plan.

A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption. If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

Please contact the Fund Office if you have any questions about Special Enrollment.

Termination and Continuation of Coverage

Termination of Coverage

Termination of Coverage for Employees

Your coverage under this Plan will terminate on the earliest of the following dates:

- The date your employer ceases to be a contributing employer;
- The date this Plan is discontinued or the National IAM Benefit Trust Fund is terminated;
- The last day of the month for which you made a contribution for coverage, if it is required, or for which contributions were made on your behalf by your employer; or
- The last day of the month during which your employment terminates. Your employment will terminate if you are not actively engaged in work in a covered position for your employer. However, if you are no longer actively engaged in work in a covered position due to any of the following reasons your employment will be deemed to continue provided your employer does not terminate you, and continues to make the required payments for your coverage:
  - Paid vacation;
  - Retirement, but only if your Employer provides retiree coverage;
  - Disability due to accident or illness; but only if your Employer provides such coverage, and limited to no more than 12 months unless otherwise approved by the Board; or
  - Layoff; but only if your Employer provides for such coverage and limited to no more than 12 months unless otherwise approved by the Board.

Termination of Coverage for Dependent Children

The coverage for children will terminate on the earlier of the following dates:

- The date your coverage terminates;
- The last day of the month in which the person no longer qualifies as a dependent;
- The last day of the month for which contributions were made for dependent coverage; or
- The last day of the month during which you die.

Termination of Coverage for your Spouse

The coverage for your spouse will terminate on the earlier of the following dates, as applicable:

- The date your coverage terminates;
- The last day of the month during which you divorce or legally separate from your spouse; or
- The last day of the month during which you die.

You must provide proof satisfactory to the Fund Office of your divorce or legal separation.

Termination of Coverage for Surviving Spouse

Survivor benefits, if allowed, will terminate on the earliest of the following:

- The date your surviving spouse dies;
- The last day of the month in which your surviving spouse remarries;

- The last day of the month in which a monthly contribution is received for coverage; or
- The expiration of the applicable continuation of coverage period under the Plan, including COBRA continuation coverage.

Options Under Which Your Coverage Can Be Extended

COBRA Continuation Coverage Benefit

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you otherwise lose your group health coverage. It also can become available to your spouse and eligible dependent child who are covered under the Plan at the time they would otherwise lose their coverage. This continuation of coverage under the Plan is a temporary extension of coverage, with a period of coverage that is determined by the type of event (qualifying event) that would otherwise trigger your loss of coverage (or loss of coverage for your spouse and/or eligible dependent child). This continuation of coverage is provided in addition to the Plan Provided Continuation of Coverage Benefit noted on the next page.

After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your eligible dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event, and you, your spouse, or eligible dependent children were enrolled in coverage under the Plan at the time the qualifying event occurred. To be enrolled in the Plan under COBRA continuation coverage, you, your spouse or eligible dependent child must elect to continue coverage, complete the election form, and submit the completed form to the Fund Office within the applicable time period. In addition, the monthly premiums must be paid on a timely basis and sent directly to the Fund Office, on or before the due date.

You, as the participant/employee will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events occur:

- A reduction in your work hours which causes a loss of eligibility under the Plan; or
- Your employment ends for any reason other than your gross misconduct.

Your spouse will become a qualified beneficiary if coverage under the Plan is lost because any of the following qualifying events:

- Your death;
- You experience a reduction in work hours, which causes a loss of eligibility under the Plan;
- Your employment ends for any reason other than your gross misconduct; or
- You become divorced or legally separated from your spouse.

Your eligible dependents will become qualified beneficiaries if they lose coverage under the Plan because of any of the following qualifying events:

- Your death;
- You experience a reduction in work hours, which causes a loss of eligibility under this Plan;
- Your employment ends for any reason other than your gross misconduct;
- You and your spouse become divorced or legally separated; or
- Your dependent child no longer meets the eligibility requirements under the Plan. For example, the dependent child reaches age 26 and no longer meets the eligibility definition as of the end of the month of his or her 26th birthday.

Who is a Qualified Beneficiary?

A "qualified beneficiary" under COBRA is any participant or eligible dependent who, on the day before the qualifying event, has coverage under the Plan, who would otherwise lose such coverage due to the qualifying event, and timely elects to receive COBRA continuation coverage. The term qualified beneficiary includes any eligible dependent who is born to, or placed for adoption with, you during the period of COBRA continuation coverage. Adding a dependent to your coverage may cause an increase in your COBRA premiums.

If a qualified beneficiary with COBRA continuation coverage acquires an eligible dependent, the eligible dependent may be added to the coverage for the remainder of the COBRA Continuation coverage period. If a qualified beneficiary has a dependent who was eligible, but not enrolled in the Plan at the time the qualified beneficiary enrolled for COBRA continuation coverage because the dependent had other group health coverage at that time, and the dependent loses the coverage under the other group health plan due to exhaustion of COBRA continuation coverage, you may add the dependent to your coverage for the remainder of the COBRA continuation coverage period. The addition must be completed within 30 calendar days after the dependent's loss of the other coverage.

Who Must Give Notice of the Qualifying Event?

Employer's Responsibility

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office has determined, or been notified, that a qualifying event has occurred. Your contributing employer must notify the Fund Office if:

- You experience a reduction in work hours that causes a loss of eligibility under the Plan;
- Your employment ends for any reason other than your gross misconduct; or
- You die.

Your Responsibility

You are responsible for providing the Fund Office with timely notice of the following qualifying events:

- You and your spouse are divorced or are legally separated;
- An eligible dependent has ceased to meet the eligibility requirements;
- If there is an occurrence of a "second qualifying event" experienced by you or any other qualified beneficiary after you, or the other qualified beneficiary who previously became entitled to COBRA with a maximum duration of 24 (or 35) calendar months. This second qualifying event could include your death, your divorce or legal separation, or your dependent losing eligibility status under the Plan. (More information about second qualifying events is provided later in this section.);
- If a qualified beneficiary entitled to receive COBRA continuation coverage with a maximum of 24 calendar months has been determined by the Social Security Administration to be disabled. If this determination is made at any time that an individual is disabled during the first 60 calendar days of COBRA continuation coverage, the qualified beneficiary may be eligible for an 11-calendar month extension of the original 24-calendar month maximum coverage period, for a total of 35 calendar months of COBRA continuation coverage; and
- If the Social Security Administration determines that a qualified beneficiary is no longer disabled.

Failure to provide the proper notice within the required timeframes, as set forth below, may prevent you from obtaining or extending COBRA continuation coverage.

The Fund Office will determine whether a qualifying event has occurred for purposed of COBRA continuation coverage. However, you should promptly notify the Fund Office of any of these qualifying events listed herein. This will allow the Fund Office to process your election for continuation of coverage more efficiently, with little or no interruption your coverage and the handling of your claims.

Procedures for Notifying the Plan of a Qualifying Event

To notify the Fund Office of any of the qualifying events listed above, a qualified beneficiary can send a notice via U.S. First Class mail, fax or email to request continued coverage under the Plan within the later of 60 calendar days from the date of the qualifying event or the date coverage was lost under the Plan due to the qualifying event. The notice must be in a form that documents the date sent (e.g., if sending by mail, the request must be postmarked no later than 60 calendar days after the date described above). In the event of divorce or legal separation, you must also submit a copy of the divorce decree or written proof of the legal separation.

In the event of a Social Security Administration determination of disability, you must submit a copy of the Social Security disability determination. If you are providing notice of a Social Security Administration determination of disability, the notice must be postmarked no later than 60 calendar days after the latest of:

- The date of the disability determination by the Social Security Administration;
- The date on which the qualifying event occurs; or
- The date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event.

Notice of a Social Security disability determination must be submitted to the Fund Office *before* the end of the first 18 calendar months of the COBRA continuation coverage.

If you are providing notice of a Social Security Administration determination that a qualified beneficiary is no longer disabled, the notice must be postmarked no later than 30 calendar days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled.

Notice may be provided by the participant or qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the participant or qualified beneficiary. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event.

Address to Notify Plan Administrator of Qualifying Event
National IAM Benefit Trust Fund
99 M Street, SE, Suite 600
Washington, DC 20003

Determining the Duration of COBRA Continuation Coverage

Once the Fund Office determines or receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Participants may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Generally, under COBRA, an employee may elect to continue coverage by making timely self-payments for up to 18 months for COBRA qualifying events. However, under this Plan, except where otherwise noted below, coverage may be continued by making timely self-payments for up to 24 months if the loss

of coverage is for any termination of employment or loss of hours in employment covered by the Plan. Consequently, continuation of coverage with respect to termination of employment or loss of hours in employment will be collectively referred to as continuation of coverage.

In the case where the qualifying event is your death, you and your spouse divorce or are legally separated, or your covered dependent is losing eligibility under the Plan, the length of COBRA continuation coverage may be in effect up to a total of 36 calendar months for each qualified beneficiary.

In the case where the qualifying event is the termination of your employment or reduction of your hours of employment to result in failure to meet the eligibility requirements under the Plan, the COBRA continuation coverage period generally will last up to a total of 24 calendar months (see above). However, this 24-calendar month period of COBRA continuation coverage may be extended in the following two instances:

- **Extension of 24-Calendar Month Period of Continuation Coverage Due to Disability**

  If you, your spouse or your eligible dependent child covered under the Plan is determined by the Social Security Administration to be disabled, and you notify the Fund Office in a timely fashion, you and your covered dependents may be entitled to receive up to an additional 11 calendar months of COBRA continuation coverage (for a total maximum of 35 months). The disability must be determined some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 24-calendar month of the original period of continuation coverage.

- **Extension of 24-Calendar Month Period of Continuation Coverage Due to a Second Qualifying Event**

  If you, your spouse or eligible dependent child covered by the COBRA continuation coverage experiences another qualifying event (a “second qualifying event”) while already covered under a 24-calendar month continuation coverage that includes the 6-month continuation coverage period provided under the Plan plus the 18-month period under COBRA (or a 35-calendar month period of coverage if disabled), you and your covered qualified beneficiaries may be eligible for additional months of COBRA continuation coverage for a maximum period of COBRA continuation coverage of up to 36 calendar months. Timely notice of the second qualifying event must be given to the Fund Office.

  This extension may be available to any eligible dependents (if they are qualified beneficiaries) receiving continuation coverage if the employee or former employee dies, or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as an eligible dependent child.

In no event will any spouse, or eligible dependent child be eligible for more than 36 total months of continuation coverage.

This extended period of continuation coverage is not available to anyone who became your spouse after the termination of employment or reduction in hours. However, this extended period of continuation coverage is available to any child born to, adopted by, or placed for adoption with you (the active employee) during the 24-month period of continuation coverage.

In no case are you entitled to continuation coverage for more than a total of 24 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional continuation coverage period on account of disability). Therefore, if you experience a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event and continuation coverage may not be extended beyond 24 months from the initial, qualifying event.

COBRA Continuation Coverage and Disability

If you are a covered employee and you lose coverage due to termination of employment as the result of your disability, you may elect to enroll in COBRA Continuation coverage. As in the case of all COBRA continuation coverage, you must self-pay for the premiums during the coverage period. Your coverage will continue until the earliest of:

- The date you cease to be disabled or return to active work;
- The occurrence of other applicable termination events described in the Termination of COBRA Continuation Coverage section.

Summary of Periods of Continuation Coverage

Qualifying Event Resulting in Loss of Coverage	Qualified Beneficiary	Maximum Continuation Coverage Period
1. Termination of employee (for reasons other than gross misconduct	Employee, spouse, and dependent children	24 months after the date of the qualifying event[1]
2. Employee's reduction in work hours (making the employee ineligible for the coverage in place prior to reduction)	Employee, spouse, and dependent children	24 months after the date of the qualifying event[1]
3. Death of employee	Surviving spouse and dependent children	36 months after the date of the qualifying event
4. Divorce or legal separation	Spouse or dependent children	36 months after the date of the qualifying event
5. Dependent child ceases to qualify for benefits under the Plan	Child aging out of eligibility	36 months after the date of the qualifying event
6. Disability as certified by Social Security Administration of any COBRA covered qualified beneficiary	Employee, spouse or dependent child with the disability	35 months after the date of the qualifying event or longer in certain circumstances[2]
7. Termination of employment due to retirement	Employee	Indefinite[3]

[1] This 24-month maximum period includes the 18-month statutory COBRA period plus an additional 6 months self-pay, as provided under the Plan.

[2] Refer to above sections concerning Duration of COBRA Coverage and COBRA Continuation Coverage and Disability.

[3] Refer to following sections concerning Termination of COBRA Continuation Coverage and Application of Continuation Coverage to Retirees.

Benefits While on COBRA Continuation Coverage

If you choose to elect COBRA continuation coverage, the Plan will provide an extension of your coverage that was in effect the day before the qualifying event occurred and that is identical to similarly situated participants under the Plan.

Following receipt of a notice or after an employee's loss of eligibility due to a termination of employment or reduction in hours of employment, the Plan will notify the employee, spouse and their eligible dependent child of their rights to purchase COBRA continuation coverage and the cost of such coverage that you will self-pay.

Making the Election for COBRA Continuation Coverage

When the Fund Office receives information concerning the loss of health care coverage due to a qualifying event, the employee or eligible family member will be sent a notice explaining their right to elect COBRA continuation coverage. The notice provides you (or eligible family member) with information regarding your coverage options and the cost to you associated with each option. The Notice also will include an election form you must complete and return to the Fund Office within the applicable time in order to activate your coverage under COBRA. The completed election form must be submitted to the Fund Office, within 60 days after the later of; (1) the date coverage would otherwise end, or (2) the date the qualified beneficiary receives the notice of the right to elect continuation coverage.

Each qualified beneficiary who elects continuation coverage must be named on the election form, or a separate election form must be submitted for any person not named on the form. If, for any reason, the Fund Office does not receive a completed election form within the 60-day period for any particular qualified beneficiary, the eligibility period for that qualified beneficiary to elect COBRA continuation coverage will expire and his or her health benefits will terminate as of the date on which he or she first became a qualified beneficiary (i.e., when coverage under the Plan terminated).

Neither the Fund Office nor the Plan will be responsible if a parent or guardian, acting on behalf of a minor qualified beneficiary, does not inform the minor qualified beneficiary of his or her right to elect COBRA continuation coverage within the 60-day period.

Cost of COBRA Continuation Coverage

The cost of coverage under COBRA is paid totally by you or the other qualified beneficiary covered under the Plan. The monthly rates you will self-pay reflect the cost of dental benefits under the Plan, plus a 2% administration fee as allowed under COBRA. In the event that your coverage is based on a Social Security Administration or Railroad Retirement Board disability award, your monthly premium may include a surcharge. Also, the rate for COBRA coverage may change due to changes in the benefits offered by the Plan and, in certain circumstances, to reflect changes in the cost of the Plan's benefits. Absent these restrictions or conditions, your COBRA rate generally will remain in effect for a period of 12-months.

Under the law, you are required to pay the full cost for this coverage. More details are included in the individual COBRA election notice you will receive. The initial payment must be received by the Plan within 45 days after the date of your election for COBRA continuation coverage. The initial premium must be paid to cover the period of coverage from the date of the election, retroactive to the date of the loss of coverage due to the qualifying event. Subsequent premiums amounts will be due on the first day of each calendar month for the duration of the applicable period of coverage.

It is the responsibility of each qualified beneficiary or person acting on behalf of a qualified beneficiary, to ensure that the Fund Office receives the correct payment on a timely basis. Nether the Plan or the

Fund Office is responsible if the qualified beneficiary causes himself or herself to lose the continuation coverage through a failure to submit the correct payment in a timely fashion.

Termination of COBRA Continuation Coverage

Continuation coverage will terminate as noted above, or the earliest of:

- The date of death for the covered individual;
- The last day of the applicable maximum continuation period;
- The last day of the month for which you made a timely self-payment for COBRA continuation coverage;
- The date you (as a spouse) remarry or marry and obtain coverage under another group health plan;
- The date you obtain coverage as an employee under another employer-sponsored group health plan;
- The date the Social Security Administration or Railroad Retirement Board makes a determination that you are no longer disabled;
- The date the Plan terminates; or
- The date your employer ceases to be a contributing employer, except as noted below.

If your employer stops participating in the National IAM Benefit Trust Fund, the Fund will continue to carry the COBRA continuation coverage benefits for you, your spouse, and your eligible dependent children only if the employer does not substitute another plan. If the employer establishes one or more group health plans, or starts contributing to another multi-employer group health plan, the plan established by the employer or the other multi-employer plan must make COBRA continuation coverage available to you, your spouse and/or your eligible dependent child, who:

- Was receiving coverage under the Plan (including retiree coverage) immediately before the employer's cessation of participation; and
- Is, or whose qualifying event occurred in connection with, a covered employee or retiree whose last coverage before the qualifying event was through the applicable employer.

Plan Provided Continuation of Coverage Benefit (Self-Pay)

If an active employee loses eligibility because of the termination or reduction in hours of employment, eligibility to participate in health care coverage may be continued by making self-payments, payable to the Fund, for a period of up to six (6) months. This benefit is available to eligible participants in addition to COBRA continuation coverage, **except where such addition would result in more than 36-months of total continuation coverage.**

Note: Upon termination or reduction is hours, the employee will have until the later of: (a) 60 days from the date of notification of the option to elect this benefit, or (b) 60 days from the date eligibility is lost, to notify the Fund Office of his or her election to continue eligibility by making self-payments.

Application of Continuation Coverage to Retirees

Some contributing employers of the National IAM Benefit Trust Fund provide retiree coverage for qualified retirees and their dependents. Refer to the applicable collective bargaining agreement or other participation agreement for information on whether such coverage may be available, and for specific rules about how long such coverage is provided. Other contributing employers have no specific retiree

coverage. If there is a loss of coverage in either case, the Plan offers continuation coverage on a self-pay basis.

If you are a covered employee and you lose coverage due to your termination of employment at retirement, or if you are a covered retiree and you lose retiree coverage for any reason, you may elect continuation coverage by making timely self-payments until the earliest of:

- The date you return to active work;
- The occurrence of other applicable termination events described in the Termination of COBRA Continuation Coverage section.
- If you are a retired employee and should lose retiree coverage due to the bankruptcy of your last contributing employer, you have the right to choose continuation of health coverage for an indefinite period of time, but not beyond the occurrence of other applicable termination events described in the Termination of COBRA Continuation Coverage section.

If you are a self-pay retiree that becomes “orphaned” because your former Employer stops participating in the Fund due to the loss of a service contract, you will not lose your eligibility to continue self-payment for coverage provided:

- The bargaining unit work continues under a successor contractor;
- The successor contractor remains or becomes a contributing Employer to the Fund, and
- The successor contractor continues to make the required contributions to the Fund for coverage of active bargaining unit employees.

Note: Orphaned retirees will lose eligibility for self-pay coverage when there is no successor service contractor or when they experience other termination events.

Continuation Coverage or Extension of Coverage Other Than COBRA

Some contributing employers of the National IAM Benefit Trust Fund provide a temporary extension of healthcare coverage if the employee is terminated or is totally disabled or hospitalized, and/or the employer terminates participation in the Fund. Please contact your Employer for additional information on temporary extension of Dental coverage.

The policy of the Trustees is that any such extension of coverage will be made available to you first, followed by COBRA continuation coverage so that you, your spouse, and/or your eligible dependent children will receive the maximum uninterrupted coverage period that can be provided under the Plan and the terms of your employment.

Comprehensive Dental Coverage

The Plan will pay dental benefits as set forth in this SPD for the types of dental services described in the Schedule of Benefits and the Covered Dental Services List. Charges must be incurred by you, your spouse, or your dependent child while eligible for benefits under the Plan. Services must be provided by a dentist and must be necessary and customary under generally accepted dental practice standards. Delta Dental may use consultants to review treatment plans, diagnostic materials, and/or prescribed treatments to determine generally accepted dental practice.

If a comprehensive dental procedure includes component or interim procedures that are performed at the same time as the comprehensive procedure, the component or interim procedures are considered part of the comprehensive procedure for purposes of determining the dental benefit payable under the Plan. If the dentist bills separately for the comprehensive procedure and each of its component or interim parts, the total dental benefit payable for all related charges will be limited to the maximum dental benefit payable for the comprehensive procedure.

Dental Benefits

A dental benefit (in-network or out-of-network) is the amount the Plan will pay for eligible dental expenses incurred by you, your spouse, or your dependent child. In-network dental benefits are those covered by the Plan and performed by a Delta Dental PPO dentist or a Delta Dental Premier dentist. Out-of-network dental benefits are those covered by the Plan and performed by a non-Delta Dental (out-of-network) dentist.

The amount of a dental benefit is the amount calculated in the steps shown below:

- The charges are tested against the covered dental charges definition and the Covered Charge Limits. Those that meet all the tests are the covered dental charges.
- The covered dental charges are then reviewed to ensure they are eligible dental expenses. Those that meet the definition are reduced by any applicable deductible, then multiplied by any applicable payment percentage.
- If any part of the amount calculated exceeds the Covered Charge Limit or an applicable dental benefit maximum, then that part is subtracted, and the remainder is the amount of the dental benefit.

Necessary and Customary

Necessary and customary with respect to each service or supply means that the service or supply meets all the following tests:

- It is rendered for the prevention, diagnosis, or treatment of dental illness or injury.
- It is appropriate for the symptoms, consistent with the diagnosis, and is otherwise in accordance with generally accepted dental practice and professionally recognized standards.
- It is not mainly for the convenience of the participant or the participant's dentist or other provider.
- It is the most appropriate type and level of service needed to provide safe and adequate dental care.

Covered Dental Charges

A covered dental charge is a charge that: (1) is made for a dental service or supply that is furnished to a participant; and (2) meets all the following tests:

- It is shown in the Covered Dental Services List and/or the Schedule of Benefits;
- It is a necessary and customary dental service;

- It is incurred by a participant while the participant is eligible for dental benefits under the Plan.
- It is furnished by or received from a dentist; and
- It is not listed as a Plan Exclusion.

Covered Charge Limits

The Covered Charge Limits that apply to each single procedure are: (a) the usual charge for the service or supply; (b) the customary charge for the service or supply; (c) any limit specified in the Covered Dental Services List, the Schedule of Benefits, and the Coverage Limitations section; and (d) the PPO dentist fee or maximum plan allowance.

Eligible Dental Expenses

Eligible dental expenses are covered dental charges that are eligible for dental benefits. Any service or expense that is excluded from coverage by the Plan will not be considered an eligible dental expense, including those services that do not meet applicable time limitations of criteria for coverage. If the charge for a covered dental service exceeds the Covered Charge Limits for that service, the excess amount is not considered an eligible dental expense. If a dental care provider discounts, waives, or rebates any portion of a charge, that amount is not considered to be an eligible dental expense and the Plan is not obligated to provide dental benefits that exceed the adjusted charge amount.

Deductible

A deductible is the amount of covered dental charges that a participant must pay to his or her dentist before dental benefits are payable by the Plan.

There is no deductible on services from in-network providers.

The out-of-network deductible shown in the Schedule of Benefits:

- Applies to all eligible dental expenses except diagnostic and preventive services and orthodontics;
- Applies separately to each participant during each calendar year; and
- Must be accumulated during the applicable calendar year.

No charge will be subject to more than one deductible amount. Only those covered dental charges to which a deductible applies will be used to satisfy the applicable deductible.

When a covered individual's cumulative deductible in a calendar year reaches the individual deductible maximum amount as shown in the Schedule of Benefits, the deductible will be considered met in full, and no further deductible amounts will be applied to any charges incurred by the applicable participant in the applicable calendar year.

Family Deductible Maximum

When eligible covered individuals in your family have accumulated their individual deductible amounts in any calendar year that, when combined, reach the family deductible maximum amount as shown in the Schedule of Benefits, the family deductible will be considered met in full, and no further deductible amounts will be applied to any charges incurred in the applicable calendar year by any of the applicable covered individuals in your family.

The result of this rule is that some covered individuals in your family may fully satisfy their individual deductible amount before receiving benefits under the Plan, while other covered individuals may end

up having to satisfy only a portion of their applicable individual deductible amount because collectively between all family members the entire family deductible amount is met in full.

For this purpose, family includes you and all eligible members of your family, including your spouse and dependent children that are covered under the Plan.

Payment Percentage

Each payment percentage and the dental services to which is applies are shown in the Schedule of Benefits. The payment percentage applies to eligible dental expenses after any applicable deductible amount has been met.

Coinsurance

Coinsurance is the share of eligible dental expenses for which you are responsible after the Plan's payment percentage is determined (e.g., if the Plan's payment percentage is 90% for a covered service, your coinsurance is the remaining 10%). Your coinsurance:

- Does not include expenses that are not covered by the Plan; and
- Does not include your deductible.

Out-of-Pocket Expenses

Out-of-pocket expenses are your share of costs for dental treatment that you must pay out of your own pocket. Out-of-pocket expenses include deductible and coinsurance for covered services, plus all costs for services that aren't covered by the Plan, including charges that exceed the maximum plan allowance, balance billing amounts from out-of-network dentists, and the cost of other non-covered services.

Maximums

Dental Calendar Year Maximum

The Plan will not pay more than the dental calendar year maximum shown in the Schedule of Benefits for all covered dental charges incurred by a participant during any one calendar year. The dental calendar year maximum applies separately for you, your spouse, and your children. Both in-network and out-of-network dental benefits accumulate to the dental calendar year maximum, except benefits paid for diagnostic and preventive services as explained below, and orthodontics which has a separate maximum explained below.

Prevention First

The Plan encourages participants to use diagnostic and preventive benefits regularly to maintain good oral health and to help identify potential issues for early intervention. To support this recommendation, the Plan does not add the benefits paid for diagnostic and preventive services (such as exams, x-rays, and cleanings) to the dental calendar year maximum. This eliminates the need to choose between having your teeth cleaned or having other needed dental treatment. You can have routine diagnostic and preventive care without the risk of exhausting benefits needed for other necessary and customary dental treatment.

Orthodontic Treatment Lifetime Maximum

The Plan will not pay more than the orthodontic treatment lifetime maximum shown in the Schedule of Benefits for all covered orthodontic treatment incurred by a participant during their lifetime. The maximum benefit does not renew for multiple stages or courses of treatment. Both in and out-of-network benefits for orthodontics accumulate to the orthodontic treatment lifetime maximum.

Other Limitations and Exclusions

The Plan does not cover all dental services. There are limitations and/or maximums on some covered dental charges that apply on a per service, per year, per multi-year, or lifetime basis. Please refer in this SPD to the sections on Covered Dental Services, Coverage Limitations, and Exclusions for information about other Plan limitations and exclusions.

How to Use the Program

Using the program is simple and has been broken down into typical steps below.

Check Your Benefits

The best way to understand your dental coverage is to review this SPD. You can also register and create a password at www.deltadentalins.com to review your coverage online. When you have secure access, you can check your eligibility and coverage, and review your claim payments. Benefits for dental services will vary depending on your Plan and the dentist who provides treatment. Each Plan covers a certain percentage of the cost for various dental services as shown in the Schedule of Benefits. On most Plans, out-of-network services are paid a lower benefit percentage than in-network services and are subject to a deductible. Since the actual amount you will owe depends on the dentist's fees and the amount the Plan pays on those fees, your cost may be lower if you use an in-network Delta Dental dentist who is not subject to a deductible and has contractually agreed to reduced fees.

Find a Dentist Near You

The Plan will provide coverage as shown in this SPD for eligible dental expenses obtained from either in-network or out-of-network dental care providers. Your coverage does not require referrals.

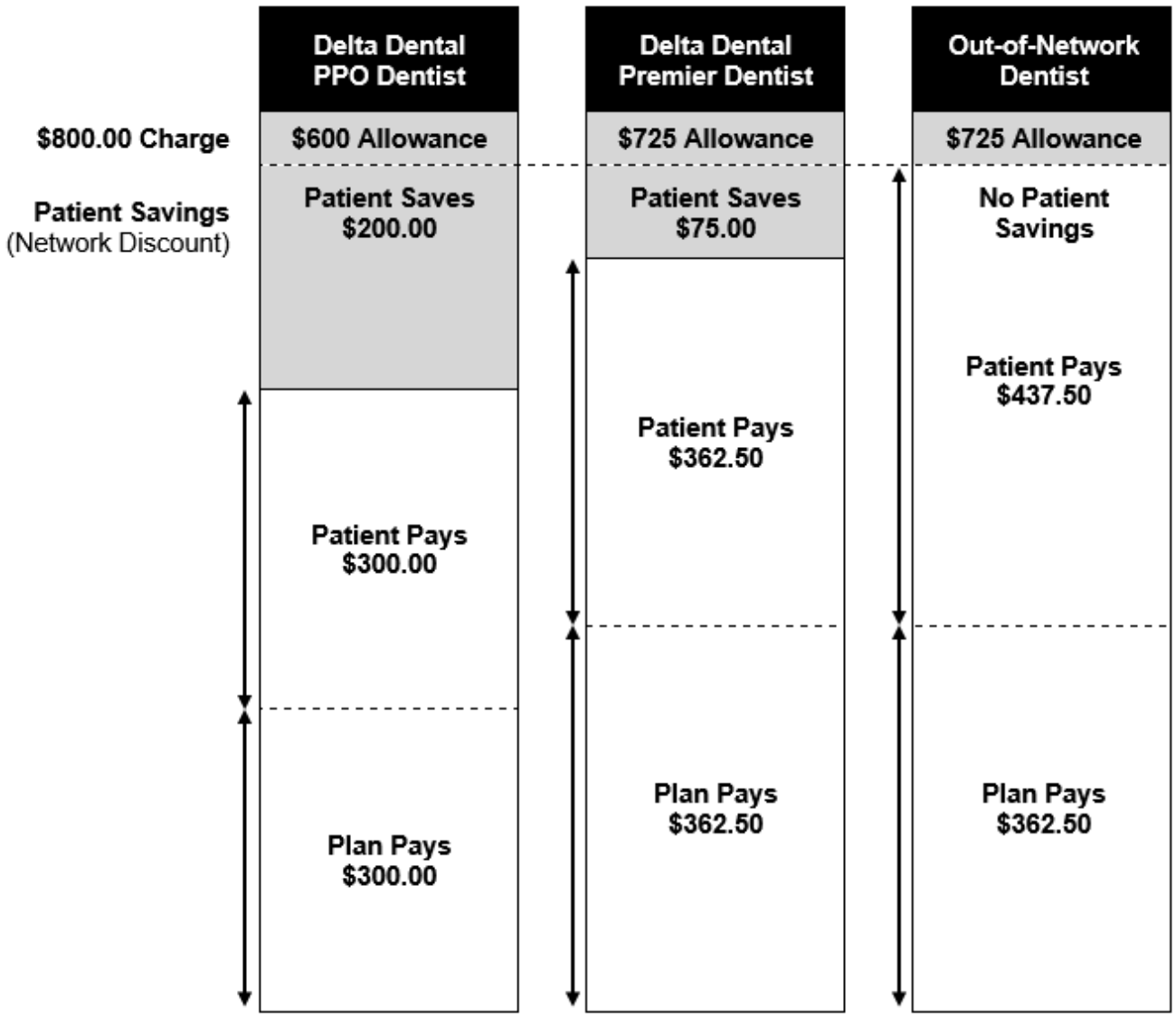
The Plan contracts with Delta Dental Insurance Company for access to a nationwide provider network. The Plan uses Delta Dental's **PPO Plus Premier Network** of contracted providers. Services provided by dentists who participate in the Delta Dental network will result in less cost to both you and the Plan because these dentists have contracted with Delta Dental to charge less than what most dentists in your area charge. PPO and Premier dentists handle claims paperwork for you, and participating dentists cannot "balance bill" patients for any amount above contracted fees.

The combined **PPO Plus Premier Network** allows Plan participants to choose from a panel of **PPO Dentists** and **Premier Dentists** for savings on dental services. You may access Delta Dental's National Dentist Directory on the Internet at www.deltadentalins.com, or you can call Delta Dental Customer Service at 1-800-521-2651 for assistance. Delta Dental does not guarantee that any particular dentist will be available. Dentists are regularly added to the panel. You are responsible for verifying whether the treating dentist is a contracted PPO dentist or a Premier dentist. Additionally, when you make an appointment for services you should always confirm with the dentist's office that a listed dentist is still a contracted PPO dentist or a Premier dentist.

You are not required to use a Delta Dental network dentist. The Plan offers you the choice of selecting a dentist from Delta Dental's panel of PPO and Premier dentists, where PPO dentists provide the greatest savings. Or you may choose to obtain services from an out-of-network dentist.

Although you are not required to use a Delta Dental network dentist, there are advantages to doing so. The following illustration[1] compares how an $800.00 covered dental service might be paid when you use a PPO dentist, a Premier dentist, or an out-of-network dentist. It also shows patient savings due to contractual discounts, and total patient and Plan payment amounts.

[1] Example is for informational purposes only. Sample payment assumes 50% benefit level and a maximum contract allowance of $600 for PPO dentist and $725 for Premier dentist and out-of-network dentist (Note: Premier dentists usually accept lower allowances than out-of-network dentists). Example also assumes any applicable Plan deductible is satisfied and any applicable benefit maximum has not been reached. Actual figures will vary by region, procedure, provider, and Plan design.



Please present your Delta Dental ID card to all service providers. The card identifies you as a Dental Plan participant with access to the Delta Dental PPO Plus Premier Network. Please note that the use of a Delta Dental network dentist is not mandatory. It is your choice. Remember however, that both you and the Plan may experience a savings if you choose a Delta Dental dentist.

Visit the Dentist

If you select a Delta Dental dentist, be sure to reconfirm the dentist's participation in the PPO or Premier Network when you call to make an appointment. When you visit any dentist, you should provide the dentist with a copy of your Delta Dental ID card, which identifies you as a participant of this Plan. If you don't have your ID card, you may print one or have one emailed to you from the Delta Dental website. If you visit an out-of-network dentist, you may also be asked to provide a claim form. You can obtain a claim form from the Fund Office or the Fund's website at www.iambtf.org, or you can download one from Delta Dental's website at https://www.deltadentalins.com/forms/claimform-enterprise.pdf.

If you or your dentist wish to verify eligibility or benefits before you start treatment, you can do so by contacting Delta Dental Customer Service at 1-800-521-2651. Dental offices also have online access

to Delta Dental, which they can utilize to check your eligibility and benefits. You may also contact the Fund Office for eligibility confirmation at 1-800-457-3481.

Dental Treatment

Your dentist will perform an oral examination and develop a course of treatment. It is recommended that you discuss this course of treatment and fees with your dentist. Ask the dentist about the cost of treatment and what the Plan will pay before you have work done. If you are choosing between different treatment options, the amount you will be responsible to pay out-of-pocket may be a relevant factor in making your decision.

If a recommended course of treatment involves services shown in the Predetermination of Benefits Section found later in this SPD, you should ask your dentist to submit a claim form to Delta Dental for predetermination. Predetermination will help to identify your out-of-pocket expenses prior to treatment so you can make an informed decision about whether to proceed with the work, discuss alternative or less costly treatment where possible, and go over payment options with your dentist.

You will be required to pay any applicable deductible and coinsurance for covered services, as well as any amount that is not paid by the Plan. You will also be wholly responsible for all elective care and for any excluded items. In addition, if you use an out-of-network dentist you will be responsible for the balance of charges that exceed Delta Dental's allowance.

Submitting a Claim

When your work is completed, a Delta Dental PPO or Premier dentist will automatically bill Delta Dental for payment under the Plan. An out-of-network dentist may require that you submit your own claim.

In the event that you are required to file your own claim with Delta Dental, you should obtain a claim form as noted in the "Visit the Dentist" paragraph above. Then:

- If you download the claim form from the Fund's website or from Delta Dental's website, choose "Delta Dental Insurance Company" from the interactive "select your plan" drop-down list at the top center of the form;
- Complete the "patient and subscriber" information on the claim form;
- Provide a copy of the dentist's statement of treatment or a detailed receipt that includes:
  - Name, address, and phone number of dentist
  - Patient name and identifying information (date of birth, address, ID number)
  - Employee name and identifying information if patient is a dependent
  - Date each service was performed
  - Description, procedure code, and fee of each service performed
  - List of affected teeth
  - Total cost of services performed
  - Dentist's national provider identifier (NPI)
  - Dentist's federal taxpayer identification number (TIN)
  - State license number
  - Specialty code;

Important note: If the statement of treatment or receipt you receive from your dentist is missing any of the information listed above, please enter it on the claim form. A dental office staff member can provide you with any dentist or treatment information you may need to complete the form.

- Make a copy of the completed claim form and the dentist's statement of treatment or detailed receipt for your records; and
- Mail the original copies of the completed claim form and the dentist's statement of treatment or detailed receipt to the address printed on the claim form or your Delta Dental ID card.
- For questions regarding claims, you can contact Delta Dental of Georgia at 1-800-521-2651

Review Your Explanation of Benefits (EOB)

Delta Dental usually processes claims within two weeks of receipt unless additional information is required from you or your dentist. They will pay your Delta Dental dentist directly. If you use an out-of-network dentist, Delta Dental will follow the payment assignment instructions on the claim form.

Delta Dental will send you an EOB showing the amount paid and the balance due after Plan payment. You should review the EOB to see if the services shown agree with the treatment you received. The dentist will bill you for any remaining balance due after he or she receives the Delta Dental payment.

Questions

If you or your dentist have questions at any time prior to, during, or after your treatment is completed, you can contact Delta Dental Customer Service at 1-800-521-2651. You may also contact the Fund Office at 1-800-457-3481.

Complaints Concerning the Quality of Dental Care

This dental program recognizes the right of each employee or dependent to select a dentist of his or her own choosing. Neither the Plan nor Delta Dental assumes any responsibility for the selection of dentists or for the quality of dental care rendered by such dentists. However, all parties are vitally interested in resolving questions that might arise concerning the availability of or quality of dental care. In fact, Delta Dental is committed to assuring that professional services provided under their programs meet professionally recognized standards of dental care.

Employees who have questions concerning the quality of dental treatment received, either personally or by their dependents, should direct those questions to Delta Dental as noted below. Delta Dental will directly, or in consultation with a review committee of the pertinent local or state dental society, investigate the circumstances and determine an appropriate disposition of the complaint.

When You Have a Complaint About Delta Dental

If you have a complaint of any kind about Delta Dental, you may contact Delta Dental member services. You should contact Delta Dental member services if you have any concerns regarding a Delta Dental employee, the quality of care provided by Delta Dental participating providers, or the processing of a dental claim. As shown on the front of your Delta Dental identification card, the toll-free number for Delta Dental member services is 1-800-521-2651 (TTY/TDD 711). You will also be able to find this number on any EOB or claim form that Delta Dental provides to you. You may also express your concerns to Delta Dental in writing at the address noted above.

Delta Dental will do their best to resolve your concerns on your initial contact. However, if Delta Dental needs more time to address your concerns, they will get back to you as soon as possible, but in any case, within 30 days of your contact.

The National IAM Benefit Trust Fund is also available should you have any complaints about Delta Dental, or about any other aspect of the administration of the Fund or your Plan of benefits. Contact the Fund Office at 202-785-8148 or 1-800-457-3481.

Contacting Delta Dental member services or the office of the National IAM Benefit Trust Fund to make a complaint does not replace the requirement that you file a written appeal if you are not satisfied with the results of a decision by Delta Dental on a claim for benefits. If you do not agree with Delta Dental's decision on any claim that you submit, you may contact Delta Dental member services or the office of the National IAM Benefit Trust Fund about your concerns; however, you must also make a written appeal under the procedures outlined in detail later in this SPD.

Dental Care Outside of the United States

If you are out of the country and an emergency occurs, seek treatment immediately. You can see any licensed dentist anywhere in the world for emergency dental services.

You can get help with a referral to a dentist outside the United States through Delta Dental's partnership with International SOS Assistance, Inc. (I-SOS). I-SOS provides referrals to 3,200 dentists or dental clinics in nearly 200 countries worldwide. English-speaking operators are available around the clock to help you find a dentist when you need one.

Call 1-800-523-6586 toll-free from inside the United States

Call 215-942-8226 **collect** from outside the United States

Note: When you call I-SOS from outside the United States, you must first dial the international dialing code from the country you are in, and then dial the country code for the U.S.

I-SOS dentists are not contracted Delta Dental dentists. When you see a dentist outside of the United States, you are responsible for paying in full at the time of service and submitting a detailed claim to Delta Dental for reimbursement. Be sure to ask for a detailed itemized receipt that includes:

- The dentist's name and address (including country),
- The date of service,
- A specific description of all services performed by the dentist,
- The tooth or teeth that were treated,
- Itemized charges for all services, and
- The total amount paid in the original currency (currency will be converted by Delta Dental when the claim is processed)

If possible, have the receipt translated into English. This will help Delta Dental process your claim in a timely manner. You can access, complete, and print a dental claim form on Delta Dental's website at https://www.deltadentalins.com/forms/claimform-enterprise.pdf or you can get one in on the Benefit Trust Fund website at www.iambtf.org.

Send your completed claim form and the itemized receipt to:

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, Georgia 30023

When Delta Dental processes your claim, you will be reimbursed directly based on the out-of-network benefits provided by the Plan. As with any out-of-network provider claim, this reimbursement may not cover the entire cost of the treatment rendered.

You are always free to choose any dentist you wish, and you will not be penalized if you do not utilize a dentist referred by I-SOS when seeking treatment outside of the United States. You may contact Delta Dental at 1-800-521-2651 if you have any questions.

Get Assistance in a Language Other than English

If you need assistance in a language other than English, Delta Dental can help. Delta Dental's Language Assistance Program (LAP) provides language assistance to Plan participants with limited proficiency in English. LAP services include:

- Delta Dental website in Spanish
- Customer Service phone assistance in more than 170 languages
- Professional interpretive services to help you communicate with your dentist
- Written materials in non-English languages and other accessible formats
- Dentist directories that include the self-reported languages of contracted dentists and staff who speak languages other than English

Interpretation through a trained and certified interpreter is essential if you don't have someone who can provide such services for you; and may be preferable to interpretation through friends or family. Delta Dental can arrange for interpretive services at no cost to you.

If you are having trouble communicating with your dentist, call Delta Dental and they will arrange for a qualified interpreter to help you via telephone.

Delta Dental's telephone number for interpretive services is 1-800-765-6003 (TTY 711).

In some cases, and in certain U.S. locations, with at least 72 hours advance notice, Delta Dental may be able to schedule face-to-face interpretive services at your dentist's office. Call the Delta Dental number shown above to explore that option.

Predetermination of Benefits

A predetermination of benefits is a way to find out if recommended dental services are covered by the Plan and get an estimate of how much you will owe if you have those services. Any dentist may submit a claim form to Delta Dental in advance of treatment showing services that are proposed for you, your spouse, or your dependent child. Delta Dental will review the predetermination and advise you and the dentist of what services are covered and the estimated payment under your Plan.

When treatment is complete, and a claim submitted, the actual payment will be based on eligibility, benefits, limitations, and coordination of benefits, if applicable, on the date services were incurred.

Recommended Predeterminations

Your Plan does not *require* predetermination for any procedure. The process is voluntary. However, unless the need is urgent, the Plan recommends that you obtain predetermination for:

- Bridges or bridgework
- Crowns
- Dentures (full or partial)
- Implants
- Gold restorations (inlays or onlays)
- Oral surgery (other than simple extractions)
- Orthodontics
- Periodontics
- Endodontics (root canal therapy)
- Space maintainers
- Extensive or high-cost treatment

Predeterminations generally take three to four weeks and will ensure you are fully informed about what is covered and the cost of treatment before it is performed. This can help you decide whether to proceed with treatment, discuss options with your dentist, arrange for alternative or less expensive procedures where possible, or develop a payment plan that is acceptable to your dentist, if necessary.

Time Limit on Predeterminations

Predeterminations are valid for 60 days, or until an earlier occurrence of any of the following events:

- The date the Plan terminates;
- The date the participant's coverage ends; or
- The date the PPO or Premier dentist's agreement with Delta Dental changes or ends.

Also, be aware that a change in your Dental Plan will likely affect deductible, payment percentage, and treatment maximums that apply on a predetermined claim, but generally does not change services that are covered by the Plan (except orthodontics, which are not covered on Plan D004). If your Dental Plan changes after a predetermination is submitted and before the dental services are performed, you should inform your dentist and ask that the predetermination be resubmitted to Delta Dental for update.

You or your dentist may contact Delta Dental directly at 1-800-521-2651 if you have any questions about the predetermination process or want to check on the status of a pending predetermination.

Please note: A predetermination is not a guarantee of benefits. It is a tool to help you and your dentist confirm covered services and estimate out-of-pocket expenses prior to treatment. The predetermination is based on eligibility and coverage in place on the date the predetermination is processed. When the

dental services are completed, and a claim is submitted for payment, Delta Dental will calculate the payment based on the eligibility and coverage in place on the date services were actually performed.

Covered Dental Services

The Plan covers the following Dental Services, providing that they qualify as eligible dental expenses. Refer to the Schedule of Benefits and Coverage Limitations sections for information on coverage and limitations that might apply to your Dental Services. If you or your dentist have any questions about coverage of a specific service, or about any of the benefits provided by the Plan, contact Delta Dental at 1-800-521-2651 or visit www.deltadentalins.com.

Covered Dental Services List

Diagnostic and Preventive Benefits[1]

- **Diagnostic** - Procedures to assist the dentist in determining required dental treatment, including oral exams and x-rays[2].
- **Preventive** - Routine prophylaxis (cleaning), topical application of fluoride solutions, sealants, and space maintainers. Periodontal prophylaxis in the presence of gingival inflammation is considered a basic benefit for payment purposes.

Basic Benefits[1]

- **Oral Surgery** - Extractions and other surgical procedures, including pre- and post-operative care.
- **General Anesthesia** - When administered by a dentist for covered oral surgery. *General anesthesia is not covered in connection with implants.*
- **Endodontics** - Treatment of tooth pulp, pulp chamber, nerve, and roots of the tooth. Includes root canal therapy and other procedures relating to the interior of the tooth.
- **Periodontics** - Treatment of gums and bones supporting teeth, including periodontal prophylaxis, periodontal scaling and root planing, and crown lengthening.
- **Palliative** - Treatment to relieve pain.
- **Basic Restorative** - Treatment to preserve natural teeth including amalgam, synthetic porcelain, and plastic fillings, and prefabricated stainless-steel restorations for treatment of carious lesions.
- **Denture Repair** - Repair to partial or complete dentures, including rebase procedures and relining.
- **Other Basic Services** - Repair and recementation of crowns, inlays, onlays and cast restorations.

Major Benefits

Treatment of carious lesions where teeth cannot be preserved or restored with basic restorations, and treatment to replace missing or damaged teeth to improve function. Major benefits include:

- **Major Restorative** - Crowns, inlays, onlays, and cast restorations.
- **Prosthodontics** - Artificial appliances to restore and maintain oral function, including fixed and removable bridges and partial or complete standard dentures. Also includes denture adjustment and recementation of fixed prosthodontic appliances.

Implant Benefits

Procedures involving implant surgical placement and removal, implant supported prosthetics, implant connecting bars, and implant repair and recementation. *General anesthesia is not covered in connection with implants*.

[1] See information on Additional Benefits During Pregnancy below.

[2] The term x-ray includes equivalent digital images where appropriate.

Orthodontic Benefits (not covered on Plan D004)

Procedures involving the use of an active orthodontic appliance and post-treatment retentive appliances for treatment of malalignment of teeth and/or jaws which significantly interferes with their function.

Payment for Orthodontic Treatment

The Schedule of Benefits provides the payment percentage for orthodontics and the orthodontic lifetime maximum. However, orthodontic treatment is not paid as a lump sum benefit. Payment for orthodontics is provided monthly. An initial fee is paid for the month treatment begins, then regular ongoing monthly payments are made throughout the treatment plan, or up to a maximum duration determined by Delta Dental, whichever is less.

- If treatment was started prior to a patient's effective date with this Plan, payment will begin with the first monthly payment that is due after the person becomes eligible for benefits under this Plan.
- If a patient that is undergoing orthodontic treatment loses coverage or stops treatment, orthodontic benefits will end with the last payment that was due while the person had eligibility for coverage under this Plan, even though the maximum benefit may not have been paid.

To determine how orthodontic benefits will be paid for you or for your dependent, ask your orthodontist to submit a request for predetermination of benefits (see the Predetermination of Benefits section found later in this SPD). Delta Dental will review the proposed orthodontic treatment plan and provide an estimate of what the Plan will pay and what you will owe.

Additional Benefits During Pregnancy

- When a participant is pregnant, the Plan will pay for additional services to help improve the oral health of the participant during the pregnancy. The additional services that can be allowed each calendar year while covered by the Plan include:
  - One (1) additional routine oral evaluation, and **either**:
    - One (1) additional routine cleaning, including periodontal cleaning, **or**
    - One (1) additional periodontal scaling and root planing per quadrant.

Written confirmation of the pregnancy must be provided by the participant or her dentist when the claim is submitted to Delta Dental.

Completion of Dental Care

The Plan will not pay dental benefits for any services incurred after your coverage ends. However, the Plan will pay for completion of a single procedure started within 31 days prior to the date your coverage ended, provided such procedure is completed within 31 days after the date your coverage ended.

Service Not Listed?

No list can show every individual dental treatment that is covered by the Plan – only representative categories and services. Your dentist can tell you if a proposed service is covered by the Plan by reviewing your benefits on Delta Dental's website, www.deltadentalins.com, by contacting Delta Dental at 1-800-521-2651, or by requesting a predetermination of benefits as explained later in this SPD.

Coverage Limitations

Dental plans typically do not cover every dental procedure. There are always some conditions or certain circumstances that include limits or exclusions from coverage, including limitations related to time or frequency. Plan limitations include, but are not limited to:

Limitations on Diagnostic and Preventive Benefits

- Routine oral evaluations are limited to two (2) of any type of evaluation procedure per calendar year[1]. In addition, within the two (2) per calendar year limit:
  - Comprehensive oral evaluations are limited to once per provider. A comprehensive evaluation may be allowed again if an established patient has had a significant change in health conditions or other unusual circumstances (by report), or if an established patient has been absent from active treatment for three or more years.
  - Visits for pre-diagnostic screening of patient and pre-diagnostic assessment of patient are each limited to once per participant's lifetime.
- Limited oral evaluations related to a specific oral health complaint are limited to two (2) problem focused evaluations per calendar year.
- Routine prophylaxis (cleaning) is limited to two (2) of any prophylaxis procedure per calendar year[1] (including periodontal prophylaxis which is covered as a basic benefit).
- Topical application of fluoride solution is limited to two (2) fluoride procedures per calendar year for children under age 19.
- Sealants and sealant repairs are limited to once per tooth within a 24-month period on permanent molars without caries for children under age 15.
- Space maintainers are limited to the initial appliance only for children under age 14 (except distal shoe space maintainers are limited to children under age 9).
- Bitewing x-rays are limited to two (2) of any bitewing x-ray procedure per calendar year.
- Full-mouth x-rays are limited to one complete series of intraoral films within a three (3) year period.
- Panoramic (or panographic) x-ray is limited to once within a five (5) year period. When taken in conjunction with a full-mouth series, the panoramic x-ray is considered to be included in the fee for the complete series, and a separate fee may not be charged to the patient.

Limitations on Basic Benefits

- Periodontal scaling and root planing are limited to once per quadrant within a 24-month period[1] (radiographic images and a copy of the treatment record are required if more than two quadrants of scaling and root planing are performed on the same date of service).
- Fillings are limited to once per surface per tooth within a 24-month period.
- Prefabricated stainless-steel restorations are limited to once per tooth within a 24-month period.

Limitations on Major Benefits

- The benefit for dentures is limited to a standard partial or denture.
- Denture adjustments are limited to once per arch within a six (6) month period.
- Crowns, jackets, inlays, onlays and cast restorations are limited to once per tooth within a five (5) year period. Inlays and onlays are also limited to participants age 12 and over.

[1] Except as provided under Additional Benefits During Pregnancy as shown in the Covered Dental Services List.

- Prosthodontic appliances are limited to once within a five (5) year period, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory.

Limitations on Implant Benefits

- Implants are limited to once per tooth within a five (5) year period.
- The Plan will not pay to replace any implant that was placed within the previous five (5) years under this Plan or any other Delta Dental program.
- The Plan will not pay for implants on teeth that are part of a crown, bridge, partial or denture that was placed within the previous five (5) years under this Plan or any other Delta Dental program.
- The Plan will not pay to replace any implant supported prosthesis that was not originally provided by this Plan except after five (5) years if Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the prosthesis cannot be made satisfactory.
- The Plan will pay for the removal of an implant only once per tooth during a participant's lifetime.
- The Plan will not pay for general anesthesia in connection with implants.

Limitations on Orthodontic Benefits

- Orthodontic benefits are not provided on Plan D004.
- X-rays, extractions, and surgical procedures are not covered under the orthodontic benefit and do not add to the orthodontic lifetime maximum. Such services, even if performed solely due to orthodontic treatment, are covered at the benefit level that applies to the service provided.
- Orthodontic diagnostic procedures including cephalometric x-rays, diagnostic casts, and oral/facial photographic images are paid under the diagnostic benefit and are limited to once per lifetime.
- The Plan will not pay to repair or replace any orthodontic appliance furnished in whole or in part under this program.
- Benefits are not provided for orthodontic retreatment procedures.

Limitations on All Benefits

- **Optional Services** are services that are more expensive than the method of treatment customarily provided under accepted dental practice standards. This includes specialized techniques instead of standard procedures. It could also include procedures that are not covered under the terms of the Plan, where an alternative treatment might be covered. Some examples include, but are not limited to, selection of:
  - A crown where a filling would restore the tooth - The Plan will allow the filling.
  - An inlay or onlay where an amalgam restoration would restore the tooth - The Plan will allow the amalgam restoration.
  - A precision denture or partial where a standard denture or partial could be used - The Plan will allow the standard denture or partial.

  When an optional service is performed, Delta Dental will review the claim to determine what amount, if any, will be paid for the service. If more expensive optional services are performed, benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the optional services. You will be responsible for the difference between the higher cost of the optional services and the lower cost of the customary service or standard procedure.

Exclusions

The Plan does **not** cover charges for all services and supplies, even when ordered or recommended by a dentist or other provider. Exclusions include, but are not limited to, the following:

1. Charges or services for which benefits are payable under any Workers' Compensation law or any other law of similar purpose, regardless of whether benefits are paid in full or in part.
2. Charges or services that result from, or arise out of, any past or present employment or occupation for compensation or profit.
3. Charge for any service or supply that is required by an employer as a condition of employment, or which an employer is required to provide due to a labor agreement, or which is required by a government body.
4. Charges or services that result from an act of declared or undeclared war, the participant's commission of a crime, or non-therapeutic release of nuclear energy.
5. Charges for services, supplies, or treatments that are furnished, paid for, or otherwise provided by reason of past or present service in the armed forces of a government, except as otherwise provided by law.
6. Charges for services, supplies, or treatments that are furnished, paid for, or otherwise provided by any local, state, or federal government agency, program, or institutions, unless otherwise provided by law.
7. A charge or part of a charge that the participant is not obligated to pay, or for which the participant would not have been billed except for the fact that the participant was covered under the Plan.
8. Services or supplies that are provided by (a) a person who ordinarily lives in the participant's home, or (b) a spouse, child, parent, or sibling of the participant or of the participant's spouse.
9. Treatment performed by someone other than a dentist or a person who by law may work under a dentist's direct supervision.
10. Services rendered by an unlicensed provider, or any provider who is operating outside the scope of his or her license.
11. Charges for any services, supplies, or treatments that are unreasonably priced or that exceed the maximum plan allowance (MPA).
12. Services, supplies or treatments that are not necessary and customary.
13. Experimental, investigational, or unproven services, treatments, or devices.
14. Cosmetic services, surgery, or dentistry for purely cosmetic reasons.
15. Treatment of congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for cleft lip or cleft palate.
16. Treatment to restore tooth structure lost from wear, erosion or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize the teeth. Examples include but are not limited to equilibration, periodontal splinting or occlusal adjustment.
17. Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

18. Charges for anesthesia, other than by a licensed dentist for administering general anesthesia in connection with covered oral surgery services. General anesthesia is not covered in connection with implants.
19. Services incurred in connection with TMJ (temporomandibular joint) disorders.
20. Fees charged by any hospital or other surgical or treatment facility and any additional fees charged by a dentist for treatment in any such facility.
21. Charges incurred for treatment of complications from excluded procedures.
22. Charges incurred for oral hygiene instruction, a plaque control program, dietary instruction, x-ray duplications, cancer screening or broken appointments.
23. Prescribed drugs, medication, or painkillers.
24. Charges incurred on a date when no eligibility exists, except as provided under the Completion of Dental Care section where the Plan will pay for completion of a single procedure started within 31 days prior to the date coverage ended and completed within 31 days after the date coverage ended.
25. Any dental services, including single procedures, that were started prior to the date the participant became eligible for dental benefits under this Plan.
26. Coverage for the children of your children, unless such children are otherwise determined to be your qualified eligible dependents within the meaning of Section 152 of the Internal Revenue Code and legal documentation is provided to the Fund as required during the enrollment process.
27. Services that exceed the maximum frequency allowed by the Plan.
28. Charges for services or supplies that are included as covered expenses under any other benefit provided by the Plan, except that this Dental Plan will pay benefits for surgical extraction of wisdom teeth that is also a covered benefit under some Medical Plans. When such services are covered by both Plans, this Dental Plan is the primary payer and the Medical Plan is the secondary payer.
29. Dental treatment where payment has been denied by the primary plan because the treatment was received from a non-participating dentist, or because of failure to follow the primary plan's rules for coverage, unless the primary plan explanation of benefits (EOB) statement shows that the patient is liable for payment.
30. Telephone, e-mail, and internet consultations, and telemedicine.
31. Claims that are received more than one year after the date of service, unless shorter filing limits are required under an in-network provider's contract with the Delta Dental.
32. Charges orthodontic treatment incurred by participants while covered under Plan D004.
33. Any service, supply, or treatment that is not identified as a covered benefit under the terms of the Plan and as set forth in this SPD.

Coordination of Benefits

The benefits provided by this Plan are coordinated with any benefits payable to you, your spouse, or your eligible dependent child for the same expenses paid from other group health plans or insurance plans. Coordination means that benefits from the Plan described in this SPD and from other benefit plans and insurance plans cannot exceed 100% of the allowable expense for each covered individual in each calendar year. Coordination is intended to permit up to the full payment of actual allowable expenses without duplication of benefits.

There are several circumstances that may result if you, your spouse, and/or your eligible dependent child are reimbursed for your dental expenses from this Plan and from another source. If any of the possible sources of payment for health benefits, as listed below, apply in the case of you, your spouse, or eligible dependent child, you must let this Plan know about *all* such plans under which you have coverage.

The application of the COB provisions can occur if you, your spouse, and/or an eligible dependent child also is covered by:

- Another group dental plan;
- Motor vehicle no-fault coverage;
- Workers' Compensation; or
- Government programs;

Effect of Coordination of Benefits

When a covered individual is entitled to dental benefits or services under more than one plan, the rules shown in the order as set forth below will be used to decide which plan is the primary plan. If the Plan described herein:

1. Is the primary plan among all plans that cover the participant, then its benefits will be determined without taking into account the benefits or services of any other plan.
2. Is not the principal plan, then its benefits may be reduced. The benefits will be reduced so that the benefits provided by all plans will not be more than 100% of the allowable expenses incurred by the applicable participant. The benefits provided under a plan include the benefits that would have been provided if a claim had been duly made.

The benefits from this Plan will never be greater than those that would be paid in the absence of other coverage.

How Much the Plan Pays When it is Secondary

When the Plan described in this SPD pays second, it will pay the same benefits that it would have paid had it paid first, **less** whatever payments were made by the plan (or plans) that was required to pay first. In addition, when this Plan pays second, it will never pay more in benefits than it would have paid had it paid the claim as the primary plan. Deductibles, coinsurance, and exclusions of this Plan still apply. As a result, when this Plan pays second, you may not receive 100% of the total cost of the covered dental services.

Plan. The term plan for Coordination of Benefits purposes means a plan that provides benefits or services for dental care by or through any:

- Group dental plan, including group insurance and a self-insured group dental plan;
- Group practice or prepayment coverage;
- Group service plan;

- Method of coverage for persons in a group other than those shown above; or
- Coverage that is required or provided by law.

The term plan shall also include no-fault motor vehicle insurance.

Understanding Coordination of Benefits

Primary Plan. If a plan is considered primary, that plan is responsible for paying first, in accordance with its benefits schedule, all claims for a covered person.

Secondary Plan. If a plan is considered secondary, that plan is responsible for paying benefits, if any remain, after the primary plan has paid its share.

Pre-Paid Plans. Pre-paid plans (HMOs, EPOs, etc.) that require use of specific providers and pay benefits to only those providers will always be primary for dependents whose coverage by the pre-paid plan is because they are, or were, an employee. In such cases, this Plan will reimburse only copayments or expenses that remain on covered charges after the pre-paid plan has paid benefits.

Allowable Expense. Allowable expense means any necessary, reasonable, and customary item or expense, at least a part of which is a covered expense under any of the plans that cover the person for whom the claim is made. When the benefits from a plan are in the form of services, not payments, the service is considered to be both an allowable expense and a benefit paid.

Claim Determination Period. Claim determination period means a calendar year.

Coordination of Benefits with Government Programs

Medicaid

If a covered individual, active or retired, is covered by both the Plan described in the SPD and Medicaid, this Plan pays first (primary) and Medicaid pays second (secondary).

Military Insurance Coverage

The Plan does not cover dependent spouses who are on active duty in any armed forces. However, if any covered individual is covered by both this Plan and military coverage only, this Plan pays first (primary) and the military coverage pays second (secondary).

Veterans Affairs Facility Services

If a covered individual receives services in a U.S. Department of Veterans Affairs hospital or facility on account of a military service-related illness, injury, or condition, benefits related to the illness, injury, or condition are not payable by the Plan.

If a covered individual receives services in a U.S. Department of Veterans Affairs hospital or facility on account of any other condition that is not a military service-related illness, injury, or condition, benefits are payable by the Plan to the extent those services are determined to be covered by the Plan.

Motor Vehicle No-Fault Coverage Required by Law

If you, your spouse, or your eligible dependent child are involved in a motor vehicle accident and you have, or are required by state law to have, basic reparation coverage, your insurance carrier will be primarily liable for lost wages, medical, dental, surgical, hospital, and related charges.

Regardless of whether the Plan described in this SPD is primary or secondary, you, your spouse, or your eligible dependent child (if an adult) may be required to sign a Reimbursement Agreement and Consent to Lien before any claims relating to the accident will be paid by the Plan. The Reimbursement Agreement permits the Fund to receive reimbursement for expenses paid by the Fund that you recover through litigation or settlement with another party or insurance company.

Rules to Determine Payment

Group plans determine which plan pays first by applying Uniform Order of Benefit Determination rules in a specific sequence. This Plan uses the Order of Benefit Determination rules established by the National Association of Insurance Commissioners (NAIC), and which are commonly used by insured and self-insured plans. Any group plan that does not use these rules will be deemed by this Fund to be the primary plan.

Under the rules set forth below, if the first rule does not establish a sequence or order of benefits, the next rule is applied and so on, until an order of benefits is established. The rules are:

Rule 1: No Coordination of Benefit Provision

If your other plan does not have a Coordination of Benefits provision which coordinates benefits, the Plan will always be the primary Plan.

Rule 2: Coverage as a Subscriber and as a Dependent

If you are covered under one plan as a subscriber and under the other plan as a dependent, the plan which covers you as a subscriber will be primary.

Rule 3: Dependent Child Covered Under More Than One Plan

If you are covered as a dependent under two plans, then the rules are as follows:

- The coverage of the parents whose birthday is first in the year will be primary and the parent whose birthday is later in the year will be secondary. The word **birthday** refers only to the month and day in a calendar year; not the year in which the person was born.
- If both parents have the same birthday, the benefits of the plan in effect longer will be primary;
- If the other plan does not have this rule, but instead has a rule based upon the parents' gender; and if as a result, the plans do not agree on the order of benefits, then the rule in the other plan will determine the order of payment for the claimed benefits.

Rule 4: For a Child of Separated or Divorced Parents

- If the terms of a court decree specify which parent is responsible for the health care coverage and expenses of the child, and that parent's plan has actual knowledge of the Court Order, then that parent's plan shall be primary.
- If no such court decree exists, or if the plan of the parent designated under such a court decree as responsible for the child's health care coverage and expenses does not have actual knowledge of the court decree, benefits for the child are determined in the following order:
  - First, the plan of the parent with custody of the child;
  - Then, the plan of the spouse of the parent with custody of the child;
  - Finally, the plan of the parent not having custody of the child.

Rule 5: Coverage of Active Employee and/or Employee's Dependent

A plan which covers you as an active employee, or that employee's dependent, is primary. A plan which covers you as a laid-off or retiree employee, or that employee's dependent, is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on which plan is primary, this Rule 5 is ignored.

Rule 6: Longer/Shorter Length of Coverage

If none of the above rules determines the order of benefits, the plan that covered you longer is primary.

The length of time a person is covered under a plan is measured from the date the person was first covered under that plan, and does **not** start over as the result of a change:

- In the amount or scope of a plan's benefits;
- In the entity that pays, provides or administers the plan; or
- From one type of plan to another (such as from a single employer plan to a multiemployer plan).

Administering Coordination of Benefits

To administer COB, the Plan reserves the right to:

- Exchange information with other plans involved in paying claims;
- Require that you or your health care provider furnish any necessary information;
- Reimburse any plan that made payments this Plan should have made; or
- Recover any overpayment from your hospital, physician, dentist, other health care provider, other insurance company, you, your spouse, or your adult dependent child.

If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount that the Fund Office, or its designee, determines to be proper under this provision. Any amounts so paid will be considered to be covered benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

To obtain all the benefits available to the covered individual, a claim should be filed under each plan that covers the person for the dental expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information this Plan will need to apply COB requirements.

Third-Party Liability and Right of Recovery

Payment Prior to Determination of Responsibility of a Third Party

The Plan does not cover, nor is it liable for, any charges or expenses incurred by a participant, his or her parent(s) and eligible dependent(s) or a representative, guardian or trustee of the participant, parent(s) or eligible dependent(s) (hereinafter, collectively "claimant") as a result of an accident or injury for which one or more third parties (any person or entity) are, or may be, liable. However, subject to the terms and conditions of this Section, the Board of Trustees or their designee, at their discretion, may advance payment for some or all of a claimant's dental expenses after receipt of a properly executed Reimbursement Agreement and Consent to Lien. In addition, acknowledgement of the Agreement must be provided to the Fund Office Claims Administrator, or designee by the claimant's attorney. The Reimbursement Agreement and Consent to Lien, and Acknowledgement must be executed without alteration or any other condition.

Where the Plan has made payments for an injury, irrespective of any signed written agreement, the Plan will have the right to recover from the participant the full amount of benefits paid without deductions or adjustments of any kind if the claimant obtains any settlement, judgment, arbitration or recovery from a third party or from any insurance provider or other source. In such event, the Plan will have a first lien on any such recovery and must be promptly reimbursed in full within 30 calendar days, or the claimant will have additional liability for interest and all costs of collection, including reasonable attorney's fees. The claimant will first reimburse the Fund out of any recovery before the claimant is entitled to any portion of the recovery and without regard to the extent of the recovery that has been, or may be, provided to the claimant.

As noted above, the Plan has the right to recover the full amount of benefits paid by the Plan, without deductions or adjustments of any kind. For example, there is no deduction or adjustment for attorney's fees incurred by the claimant in obtaining the settlement, judgment, arbitration or recovery. The Plan's lien is **not** reduced by any such attorney's fees. Regardless of the sufficiency of any recovery, the Plan is **not** subject to any state law doctrines, including but not limited to, the common fund doctrine, which would purport to require the Plan to reduce its recovery by any portion of a claimant's attorney's fees and costs. The Plan is also **not** subject to the make whole doctrine or other similar doctrines which purport to subject the Plan's recovery to the claimant's full compensation for all of his Injuries.

In the event the claimant fails to reimburse the Fund from proceeds received from a third party, the Fund will also have the right to withhold future benefits equal to the amount otherwise due the Fund, plus interest and the costs of collection including attorneys' fees incurred by the Fund.

Reimbursement and Consent to Lien

Every claimant, on whose behalf an advance may be payable, must execute and deliver to the Fund a Reimbursement Agreement and Consent to Lien in the form provided without alteration. Claimants must do whatever is necessary to protect the Fund in obtaining reimbursement and/or its subrogation rights. Each such claimant must promptly notify the Fund Office if he or she makes a claim or brings an action against a third party or if he or she obtains any settlement, judgment, or other recovery from any source.

If a claimant does not execute a Reimbursement Agreement or Consent to Lien for any reason, it will **not** waive, compromise, diminish, release or otherwise prejudice any of the Fund's reimbursement rights if the Fund, at its discretion, makes an advance and inadvertently pays benefits in the absence of a Reimbursement Agreement.

The Fund's standard administrative procedure will be used to determine whether a third party might potentially be held liable in connection with an accident or injury. Claims will **not** be paid until this

determination is made. If it is determined that the claim may be the result of a third party's negligence or other misconduct, the Fund will not process any claims without a properly signed Reimbursement Agreement and Consent to Lien along with acknowledgement by the claimant's attorney, both executed without alteration or other conditions.

Sources of Payment

The Plan's sources of payment through subrogation or reimbursement are as follows:

- Money from a responsible party or third party that you, your family members, your guardian, or other representatives or beneficiaries receive or are entitled to receive;
- Any constructive trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your family members, your guardian, or other representatives or beneficiaries receive;
- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable.

Cooperation with the Plan by All Covered Persons

By accepting an advance for related claim payment, every claimant agrees to do nothing that will waive, compromise, diminish, release or otherwise prejudice the Fund's reimbursement rights.

By accepting an advance payment for related claims to an injury, every claimant agrees to notify and consult with the Board of Trustees, its Fund Office or designee before:

- Starting any legal action or administrative proceeding against a third party based on any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the claimant's injury that resulted in the Fund's advance payment of claims; or
- Entering into any settlement agreement with that third party or that third party's insurer that may be related to any actions by that third party that may have caused or contributed to the claimant's injury that resulted in the Fund's advance for claims related to such injury.

By accepting an advance in claim payments, every claimant agrees to keep the Board of Trustees, its Fund Office, or designee informed of all material developments with respect to all such claims, actions, or proceedings.

Your Responsibilities

You have the duty to cooperate fully with the Plan and any party designated by the Plan Administrator if the Plan's rights of subrogation or reimbursement are asserted, including executing and delivering any documents the Plan may require or appearing in court for a deposition or testimony, if necessary. You must do nothing to prejudice the Plan's rights of subrogation and reimbursement.

When making or filing a claim, you or your legal representative must give the Plan written notice about whether or not you were injured by a third party. You also must provide the following information in a timely manner:

- The name, address and telephone number of:
  - The third party who in any way caused the injury;
  - The attorney representing the third party;
  - The third party's insurer; and
  - The attorney who represents you with respect to the third party's act or omission.

- Before any meeting, the date, time and location of the meeting between the third party or his or her attorney and yourself or your attorney;
- All terms of any settlement offer made by the third party or his or her insurer;
- All information you or your attorney discovered concerning the third party's insurance coverage;
- The amount and location of any funds you recover from the third party or his or her insurer, and the dates on which such funds were received;
- All information related to any oral or written settlement agreement between you and the third party or his or her insurer;
- All information regarding any legal action that has been brought on your behalf against the third party or his or her insurer;
- All other information the Plan may request.

All Recovered Proceeds Are to Be Applied to Reimbursement of the Fund

By accepting an advance payment of claims for an injury, every claimant agrees to reimburse the Fund for all such advances by applying any and all amounts paid or payable to them by any third party or that third party's insurer by way of settlement, judgment, arbitration or recovery, or in satisfaction of any judgment or agreement, regardless of whether those proceeds are characterized as being paid on account of the medical expenses for which any advance has been made by the Fund. The Fund will have the right to recover from the claimant the full amount of benefits paid without deductions or adjustments of any kind including attorney's fees. In such event, the Fund must be fully reimbursed within 30 calendar days of the date proceeds are received by the claimant or his attorney, or the claimant will have additional liability for interest and all costs of collection, including reasonable attorney's fees. The Fund may offset future claims/benefits in order to receive the full amount of benefits paid if full reimbursement is not made.

Furthermore, once the claim is settled and further liability is closed, the Fund is not liable for, and will not pay, future benefits for claims related to that injury or accident.

Note: This Fund is a self-insured employee welfare benefit plan and, therefore, ERISA preempts any state law purporting to restrict the Fund's right under this provision. Furthermore, any state law directed at insurance companies will not apply to the Fund since it is self-insured.

No-Fault Insurance Coverage

Where the participant or eligible dependent is involved in a motor vehicle accident covered by a no-fault insurance policy, whether or not required by state insurance law, the automobile no-fault insurance carrier will initially be liable for lost wages, medical, surgical, hospital and related charges and expenses up to the greater of:

- The maximum amount of basic reparation benefit required by applicable law; or
- The maximum amount of the applicable no-fault insurance coverage in effect.

The Plan will thereafter consider any excess charges and expenses under the applicable provisions of the respective Plan in which you are provided dental coverage. Before related claims will be paid through the Fund, the participant or his/her eligible dependent will be required to sign a Reimbursement Agreement and Consent to Lien.

If the participant or his/her eligible dependent fails to secure no-fault insurance as required by state law, the participant or eligible dependent is considered as being self-insured and must pay the amount of

the basic medical reparation expenses for himself and/or his eligible dependents arising out of the accident.

Refund of Overpayment of Benefits — Right of Recovery

If the Fund pays benefits for expenses incurred on account of you or your eligible dependent, you or any other person or organization that was paid must make a refund to the Fund if:

- All or some of the expenses were not paid or did not legally have to be paid by you or your eligible dependents;
- All or some of the payment made by the Fund exceeds the benefits under the Plan; or
- All or some of the expenses were recovered from or paid by a source other than this Plan including another plan to which this Plan has secondary liability under the Coordination of Benefit provisions. This may include payments made as a result of claims against a third party for negligence, wrongful acts or omissions.

The refund will equal the amount the Fund paid in excess of the amount it should have paid under the Plan. In the case of recovery from or payment by a source other than this Plan, the refund equals the amount of the recovery or payment up to the amount the Fund paid.

If you or any person or organization that was paid does not promptly refund the full amount, the Fund may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required repayment, plus interest. The Fund may have other rights in addition to the right to reduce future benefits.

Claims Filing and Appeal Procedures

This Section of the SPD describes the procedures for filing claims for benefits as provided under the terms of the National IAM Benefit Trust Fund. It also describes the procedures for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

The Plan's internal claims and appeal procedures are designed to provide you with full, fair, and fast claim review and so that Plan provisions are applied consistently with respect to you and other similarly situated participants. In addition, the Plan may consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a judgment that a dental service is not necessary and customary.

The internal claims process pertains to determinations made by the appropriate Claims Administrator about whether a request for benefits (known as a "claim") is payable. If the appropriate Claims Administrator denies your claim for benefits (known as an "adverse benefit determination"), you have the right to appeal the denied claim under the Plan's internal appeals process.

Appropriate Claims Administrator	Types of Claims Processed
Delta Dental Insurance Company P.O. Box 1809 Alpharetta, Georgia 30023 www.deltadentalins.com	Dental Claims First Level Appeals
Board of Trustees National IAM Benefit Trust Fund 99 M Street, SE, Suite 600 Washington, DC 20003 www.iambtf.org	Eligibility Determinations Second Level Appeals

Right to an Authorized Representative

In making a claim or appeal, you may be represented by any authorized representative. An "authorized representative" means a person you authorize, in writing, to act on your behalf, such as your spouse, attorney, parent, court appointed guardian, or a health care professional with knowledge of your condition. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. You must designate the representative by a signed written statement. A form can be obtained from the Fund Office to designate an authorized representative.

The Plan will honor the designated authorized representative until the designation is revoked, or as mandated by a court order. You may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to the appropriate Claims Administrator or the Fund Office.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

Adverse Benefit Determination

An adverse benefit determination, for purposes of the internal claims and appeal process, means:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit; or
- A reduction of a benefit resulting from the application of any exclusion or other limitation, or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not medically necessary.

Health Care Professional

A health care professional, for the purposes of the claims and appeals provisions, means a physician, dentist, or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

Definition of a Claim

A claim is a request for a Plan benefit made by you, your spouse, or your covered dependent child (also referred to as "claimant") or your authorized representative in accordance with the Plan's reasonable claims procedures. Generally, claims under the Plan will be requests for payment of services *after* you receive the service.

Casual inquiries about benefits or the circumstances under which benefits might be paid according to the terms of the Plan are **not** considered claims.

The Plan does not require that you seek prior approval of any dental services before receiving them. However, if you request a predetermination of benefits for a specific benefit and you are determined not to be eligible for benefits, that coverage determination is considered a claim that you can appeal.

Claim Elements

A claim must include the following elements to trigger the Plan's internal claims process:

- Be written or electronically submitted;
- Be received by the Claims Administrator;
- Name a specific individual participant and his/her Social Security Number or other assigned unique identification number;
- Name a specific claimant and his/her date of birth;
- Provide a description and date of a specific treatment, service or product for which payment is requested (must include an itemized detail of charges and applicable service codes);
- Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
- When another plan is primary payer, include a copy of the other Plan's explanation of benefits (EOB) statement along with the submitted claim.

A request is *not* a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures described in this section;
- Made by someone other than you, your covered dependent, or your (or your covered dependent's) authorized representative;
- Made by a person who will not identify himself or herself (anonymous);

- A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- A request for prior approval where prior approval is not required by the Plan;
- An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;

If you submit a claim that is not complete or lacks required supporting documents, the Claims Administrator will notify you about what information is necessary to complete the claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim or which relate to proposed or anticipated treatment or services that do not require prior approval.

How to File a Claim

Please make sure that you present your benefit identification card to each provider before you are given any services so that the provider will know that you participate in the Delta Dental PPO Plus Premier Network. Out-of-network dentists may require that you pay them first and that you seek reimbursement by filing your own claim with Delta Dental.

In-Network Benefits

If you use Delta Dental PPO Plus Premier Network providers, your claim for benefits will go directly from the in-network dental care provider through an automated electronic system, or through the mail, to the Claims Administrator for processing. Generally, you are **not** required to file a claim form for in-network benefits.

Out-of-Network Benefits

If you use out-of-network providers not affiliated with the Delta Dental PPO Plus Premier Network, you are required to submit your own completed claim form and follow the claims procedures outlined in this Section, as applicable.

You may obtain a claim form by calling Delta Dental Customer Service at 1-800-521-2651, or download one from Delta Dental's website at https://www.deltadentalins.com/forms/claimform-enterprise.pdf. To expedite the processing of your claim, please be sure to complete the form thoroughly. Your written claim must be mailed to Delta Dental as soon as reasonably possible after the expense is incurred, but in no event more than one year after the expense is incurred.

Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit may be guilty of a crime and may be subject to fines and confinement in prison.

Filing a Claim

You may file claims for out-of-network dental benefits and appeal adverse claim decisions yourself or have an authorized representative do it for you. The in-network provider will make the claim on your behalf directly to Delta Dental. If your claim is denied, in whole or in part, you will receive a written notice of the denial from Delta Dental. The notice will explain the reason for the denial and the review procedures, including any applicable statute of limitation within which the claimant may file a claim in a court of law.

Submit Directly to Delta Dental

Fully completed and signed claim forms, with a copy of your itemized receipts, should be sent to Delta Dental at the following address:

Delta Dental Insurance Company

P.O. Box 1809
Alpharetta, Georgia 30023

You will be notified of the decision not later than 30 calendar days after receipt of the claim. This time period may be extended up to an additional 15 calendar days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 30 calendar day period.

The time period may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 calendar days after receiving the notice to furnish that information. You will be notified of the Plan's claim decision no later than 15 calendar days after the end of that additional period (or after receipt of the information, if earlier).

Note: Any claims Delta Dental receives more than one year after the expense is incurred will be denied as untimely. Delta Dental may also have shorter filing limits for their network providers. You will not be responsible for payment of charges Delta Dental denies for untimely filing if a Delta Dental contracted provider fails to file your claim in accordance with Delta Dental's contractual requirements.

Notice of Decision

If your claim is denied, in whole or in part, you will receive a written notice of the denial from Delta Dental. The notice will state:

- The claim involved.
- The specific reason(s) for the determination.
- The Plan standard that was used, if any.
- The specific Plan provision(s) on which the determination is based.
- A description of any additional material or information necessary to perfect or decide the claim, and an explanation of why the material or information is necessary.
- A description of the appeal procedures and applicable time limits for pursuing the appeal or filing a legal claim.
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule, or a statement that such a rule was relied upon in deciding the claim and that a copy will be provided to you upon request at no charge.
- If the determination was based on a service not being necessary and customary, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

Internal Appeals of Dental Claims

1. First Level Appeal

- **Dental Benefits Appeal**

  If you disagree with Delta Dental's decision on any of your claims for dental benefits, you may submit an appeal to Delta Dental. Your request for appeal review must be made in writing within 180 days of receipt of your denial notice, and should be mailed to Delta Dental Insurance Company, Attn: Appeals Dept., P.O. Box 1809, Alpharetta, GA 30023. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. Your appeal

will be reviewed by someone at Delta Dental not involved in the initial decision. **Note: *You must first file your internal appeal with Delta Dental as you initiate the appeals process.*** First level appeals received more than 180 days after receipt of the notice of the claim denial or adverse determination will be denied as untimely.

Delta Dental will respond in writing to your appeal no later than 30 calendar days after the appeal is received. In ruling on such first level appeals, Delta Dental serves in the capacity of a named fiduciary under ERISA.

- **Eligibility Appeal**

If you are appealing an adverse determination relating to eligibility, your appeal must be made to the Board of Trustees in writing within 180 days after receipt of the determination notice. Appeals received more than 180 days after receipt of the notice will be denied as untimely.

If you file an appeal with the Board of Trustees, you will be deemed to authorize the Fund to obtain information relevant to your claim. Mail your written appeal directly to the Board of Trustees, National IAM Benefit Trust Fund, 99 M Street, SE, Suite 600, Washington, DC 20003.

The Board of Trustees will make a determination at the next scheduled meeting of the Board of Trustees following the Plan's receipt of a request for review, unless the request for review is filed within 30 calendar days preceding the date of such meeting. In such case, a benefit determination may be made no later than the date of the second meeting following the Plan's receipt of a request for review.

If special circumstances require a further extension of time, a determination will be rendered not later than the third meeting of the Board of Trustees following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Board of Trustees will notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. Notice of the benefit determination and review by the Board of Trustees will be made as soon as possible, but not later than five calendar days after the benefit determination is made.

You may submit written comments, documents, records and other information relating to your claim. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

2. Second Level Appeal

- **Right to Second Level Appeal**

If you are dissatisfied with the appeal decision made by Delta Dental on your appeal for dental benefits, you may request a second level review of your appeal by the Board of Trustees. Your request for second level appeal review must be made in writing and be submitted to the office of the National IAM Benefit Trust Fund within 90 days of your receipt of Delta Dental's denial notice on the first level appeal review. Your second level appeal should include a copy of the first level appeal denial, and any information supporting your appeal. Second level appeals received more than 90 days after receipt of the denial of the first level appeal will be denied as untimely.

- **Filing a Second Level Appeal**

On second level, the Board of Trustees will review your claim and make a decision on the date of the first meeting of the Board that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such

case, a benefit determination may be made on the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a determination will be made no later than the third meeting following the initial receipt of the appeal. If an extension is required, you will be notified of the extension and the reasons for it prior to the commencement of the extension.

If you submit an appeal to the Board of Trustee, any applicable statute of limitations will be delayed while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. No fees or costs are imposed upon you as part of the appeal to the Board of Trustees. The decision to submit a denial made by Delta Dental to the Board of Trustees will have no effect upon your rights to any other benefits under the Plan.

If you choose to appeal to the Board of Trustees following an adverse determination at the first level of appeal by Delta Dental, you must do so in writing, and you should send the following information:

- The specific reason(s) for the appeal;
- Copies of all past correspondence with the Fund, including any explanation of benefits (EOBs);
- Copies of the adverse appeal determination made by Delta Dental; and
- Any applicable information that you have not yet sent to the Fund Office.

If you file an appeal with the Board of Trustees, you will be deemed to authorize the Fund to obtain information relevant to your claim. Mail your written appeal directly to:

Board of Trustees
National IAM Benefit Trust Fund
99 M Street, SE, Suite 600
Washington, DC 20003

The Board of Trustees will review your appeal. They will evaluate your claim within the timeframes described above. You will be notified of the Board of Trustees decision on your appeal within five calendar days after the date your appeal is reviewed.

Elimination of Conflict of Interest

To ensure that the persons involved with adjudicating claims and appeals (such as claim processors and medical experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

Facility of Payment

If the Board of Trustees or its designee determines that you cannot submit a claim or prove that you or your covered dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent or incapacitated, the Plan may, at its discretion, pay Plan benefits directly to the health care professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Board of Trustees, appropriate Claims Administrator nor any other designee of the Plan will be required to see to the application of the money so paid.

Board of Trustee Decisions Are Final and Binding

The decision of the Board of Trustees are final and binding on all parties, including anyone claiming a benefit on your behalf.

The Board of Trustees of the National IAM Benefit Trust Fund has full discretion and authority to determine all matters relating to the benefits provided under this Plan including, but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits, as well as full discretion and authority over the standard of proof required for any claim and over the application and interpretation of the Plan. The Fund Office maintains records of determinations on appeals and Plan interpretations so that those determinations and interpretations may be referred to in future cases with similar circumstances to maintain consistency.

Right to Judicial Review

ERISA, Section 502(a) establishes your right to seek judicial review of your adverse determination of your benefit claim after you have exhausted your internal review and appeal procedures except where the plan (or plan sponsor) has violated a specific ERISA standard of conduct.

If the Board of Trustees or the IRO deny your appeal in whole or in part and you decide to seek judicial review, the decisions made by the Trustees or the IRO are subject to limited judicial review to determine only whether the decision was arbitrary and capricious. No evidence may be used in court unless it was first submitted to the Board of Trustees or to the IRO.

Miscellaneous

Misrepresentation and Fraud

In the event you, your spouse, or your eligible dependent children receive benefits as a result of misleading representation or any type of false information or other fraudulent representations to the Fund, you, your spouse, or your eligible dependent child will be liable to repay all amounts paid by the Fund.

Fraud includes a person's failure to disclose any other group health coverage in which such person is entitled to receive reimbursement of a claim submitted to the Fund for payment or reimbursement from a third party (See the Section on Third-Party Liability for more information). You, your spouse, or your adult dependent children will be prosecuted for fraud and held liable for all costs of collection, including interest, court, and attorney's fees. In addition, you may be subject to criminal penalties.

Overpayments and Erroneous Payments

If a claim payment is made to a participant or assigned to a provider and it is later determined that the payment is an overpayment or an erroneous payment, the Board of Trustees may offset future claim payments or take any other action it deems appropriate in order to recover the overpayment or erroneous payment.

Notices Sent to Addresses of Participants

The Board of Trustees and/or the Fund Office will give notice by mail to participants of actions taken with respect to eligibility, claims, and other important matters.

All such notices will be sent to your address, as it appears in the Fund's records. To protect yourself and your rights, you must be sure the Fund Office always has your current address. If you fail to notify the Fund Office of your current address, you may miss receiving an important notice and might lose valuable rights or benefits. You may even lose coverage.

Any notice sent to you at the address in the Fund's records will be deemed to have been received by you. The time in which you must reply to such a notice will **not** be extended, because you did not give the Fund Office your current address.

Cost Savings

Provider Fees and Treatment Plans

Whenever possible, you should use an in-network provider. If you use an out-of-network provider, you should ask about the provider's services and fees, as it is important to know whether the Fund will recognize them as covered charges, or necessary and customary where applicable.

Remember that coverage under the Plan for out-of-network services is subject to a deductible and reduced coinsurance in some cases. You are liable for charges billed by a provider that exceed the allowable covered charges or maximum payment under the Plan, and for non-covered services. You do not have this risk of being billed above the allowance recognized by the Fund if you utilize a provider from the Delta Dental PPO Plus Premier Network.

Bills and Unnecessary Services

Review out-of-network bills and any explanation of benefit statements (EOBs) thoroughly to assure correct charges and payments. When deciding on dental care, request predetermination of benefits when possible, and avoid requesting unnecessary services. By adhering to these suggestions, you may utilize your benefit to its fullest, while simultaneously cutting dental care costs.

Reliance on Coverage Statements

If you contact Delta Dental or the Fund Office to determine if a particular service is a covered expense, including eligibility and other benefits, unless you receive written confirmation, the Plan is not necessarily responsible for these representations. If there is any question about eligibility for coverage of a specific service or procedure, you should not rely on any verbal representation from Delta Dental or the Fund Office, but request a predetermination of benefits to assure that there will be no misunderstandings.

Use and Disclosure of Protected Health Information

The Plan maintains a "Privacy Notice" describing how your medical information may be used or disclosed, as well as how you may gain access to your medical information and your other rights regarding that information. The Plan's Privacy Notice is reproduced here for your careful review:

Privacy Notice

Section 1: Purpose of This Notice and Effective Date

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date. The effective date of this Notice is April 14, 2003.

This Notice is required by law. The National IAM Benefit Trust Fund (the "Fund") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Fund's uses and disclosures of Protected Health Information (PHI),
- Your rights to privacy with respect to your PHI,
- The Fund's duties with respect to your PHI,
- Your right to file a complaint with the Fund and with the Secretary of the United States Department of Health and Human Services (HHS), and
- The person or office you should contact for further information about the Fund's privacy practices.

Section 2: Your Protected Health Information

Protected Health Information (PHI) Defined

The term "Protected Health Information" (PHI) includes all individually identifiable health information relating to your past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Fund in oral, written, or electronic form.

When the Fund May Disclose your PHI

Under the law, the Fund may disclose your PHI without your consent or authorization, and without providing you an opportunity to agree or object, in the following cases:

At your request. If you request it, the Fund is required to give you access to certain PHI in order to allow you to inspect and/or copy it. You have additional rights explained in Section 3.

As required by HHS. The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Fund's compliance with the privacy regulations.

For treatment, payment or health care operations. The Fund and its business associates will use PHI in order to carry out:

- Treatment,
- Payment, or
- Health care operations.

Treatment is the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Fund may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist.

Payment includes, but is not limited to, actions to make coverage determinations and payment (including billing, claims management, subrogation, Fund reimbursement, reviews for medical necessity and appropriateness of care, utilization review and preauthorization).

For example, the Fund may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. If we contract with third parties to help us with payment operations, such as a physician that reviews medical claims, we will also disclose information to them. These third parties are known as "business associates."

Health care operations includes, but is not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the Fund may use information about your claims to refer you into a disease management program, a well-pregnancy program, project future benefit costs or audit the accuracy of its claims processing functions.

Disclosure to the Fund's Trustees. The Fund will also disclose PHI to the Plan Sponsor, the Board of Trustees of the National IAM Benefit Trust Fund, for purposes related to treatment, payment, and health care operations, and has amended the Trust Agreement to permit this use and disclosure as required by federal law. For example, we may disclose information to the Board of Trustees to allow them to decide an appeal or review a subrogation claim.

When the Disclosure of your PHI Requires your Written Authorization

Although the Fund does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Fund will use or disclose psychotherapy notes about you. However, the Fund may use and disclose such notes when needed by the Fund to defend itself against litigation filed by you.

Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

Disclosure to Other Benefit Plans. On certain occasions, it may be necessary to receive information from the Health Fund in order to process life insurance benefits, Weekly Disability Income Benefits or benefits from the Pension Fund. In those cases, we will request an authorization from you to release such information in order to continue processing your benefits.

Use or Disclosure of Your PHI that Requires You be Given an Opportunity to Agree or Disagree Before the Use or Release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed under federal law if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected. You should note that under certain circumstances described below, federal law allows the use and disclosure of your PHI without your consent, authorization or opportunity to object to such use or disclosure.

Use or Disclosure of Your PHI for Which Consent, Authorization, or Opportunity to Object Is Not Required

The Fund is allowed under federal law to use and disclose your PHI without your consent or authorization under the following circumstances:

- When required by applicable law.
- **Public health purposes.** To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- **Domestic violence or abuse situations.** When authorized by law to report information about abuse, neglect or domestic violence to public authorities, if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.
- **Health oversight activities.** To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).
- **Legal proceedings.** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.
- **Law enforcement health purposes.** When required for law enforcement purposes (for example, to report certain types of wounds).
- **Law enforcement emergency purposes.** For certain law enforcement purposes, including:
  - Identifying or locating a suspect, fugitive, material witness or missing person, and
  - Disclosing information about an individual who is or is suspected to be a victim of a crime.
- **Determining cause of death and organ donation.** We may give PHI to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation purposes.

- **Funeral purposes.** We may give PHI to funeral directors to carry out their duties with respect to the decedent.
- **Research.** For research, subject to certain conditions.
- **Health or safety threats.** When, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- **Workers' compensation programs.** When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization.

Other Uses or Disclosures

The Fund may disclose protected health information to the plan sponsor of the Fund for reviewing your appeal of a benefit claim or for other reasons regarding the administration of this Plan. The "plan sponsor" of this Fund is the Board of Trustees of the National IAM Benefit Trust Fund.

Section 3: Your Individual Privacy Rights

Following is a description of your individual privacy rights. It is important to note that while all requests should be directed to the Health Fund, the Fund contracts with numerous vendors, also called "business associates," who provide services to the Fund and services and benefits to you on the Fund's behalf. Once the Fund is notified that you choose to invoke any of the individual rights listed below, it will notify the appropriate vendor on your behalf. Because some of your PHI is maintained and used by these business associates to provide or process your benefits, the Fund requires that they administer certain aspects of the individual privacy rights. You may contact the Privacy Official at the address and phone number listed below:

Ryk Tierney, Privacy Official
National IAM Benefit Trust Fund
99 M Street, SE, Suite 600
Washington, DC 20003
Phone: 202-785-8148
Fax: 202-728-0585

You May Request Restrictions on PHI Uses and Disclosures

You may request the Fund to:

- Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or
- Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Fund, however, is not required to agree to your request.

You must contact the Fund to receive an application to make a request to restrict the use or disclosure of PHI. You may contact the Privacy Official at the address and phone number listed above.

You May Request Confidential Communications

The Fund will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request alternative means and/or locations for communication of PHI. You may contact the Privacy Official at the address and phone number listed above.

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," as long as the Fund maintains the PHI. However, you do not have a right to inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to law(s) that otherwise prohibits access to PHI.

The Fund must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Fund is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. A reasonable fee may be charged. You may contact the Privacy Official at the address and phone number listed above.

Under limited circumstances, access may be denied. If access is denied, you will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Fund and HHS.

Designated Record Set: Includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a Health Fund or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

You Have the Right to Amend your PHI

You have the right to request that the Fund amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set, subject to certain exceptions. See the Fund's Right to Amend Policy for a list of exceptions.

The Fund has 60 days after receiving your request to act on it. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60-day deadline. If the Fund denies your request in whole or part, the Fund must provide you with a written denial that explains the basis for the decision. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

You may contact the Privacy Official at the address and phone number listed above. You or your personal representative will be required to complete a form to request amendment of the PHI.

You Have the Right to Receive an Accounting of the Fund's PHI Disclosures

At your request, the Fund will also provide you with an accounting of certain disclosures by the Fund of your PHI. We do not have to provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing. See the Fund's Accounting for Disclosure Policy for the complete list of disclosures for which an accounting is not required.

The Fund has 60 days to provide the accounting. The Fund is allowed a single 30-day extension if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Fund may charge a reasonable, cost-based fee for each subsequent accounting.

Your Personal Representative

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by calling the Fund Office.

The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Fund will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, absent notice of restrictions under the Fund's Right to Request Restrictions on the Use and Disclosure Policy and Procedures, the Fund will automatically consider a spouse to be the personal representative of an individual covered by the plan.

In addition, the Fund will consider a parent, guardian *or other person acting* in loco parentis as the personal representative of an unemancipated minor unless applicable law requires otherwise. A spouse or a parent may act on an individual's behalf, including requesting access to their PHI. Spouses and unemancipated minors may, however, request that the Fund restrict access of PHI to family members as described above at the beginning of Section 3 of this Notice.

You should also review the Fund's Policy and Procedure for the Recognition of Personal Representatives for a more complete description of the circumstances where the Fund will automatically consider an individual to be a personal representative.

Section 4: The Fund's Duties

Maintaining your Privacy

The Fund is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices.

This notice is effective beginning on April 14, 2003 and the Fund is required to comply with the terms of this notice. However, the Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Fund still maintains PHI. A Privacy Notice will be sent by U.S. Mail.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Plan, or
- Other privacy practices stated in this notice.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,

- Uses or disclosures made to you,
- Uses or disclosures made pursuant to your authorization,
- Disclosures made to the Secretary of the United States Department of Health and Human Services pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Fund's compliance with the HIPAA privacy regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Fund may use or disclose "summary health information" for purposes of obtaining premium bids or modifying, amending or terminating the group health plan. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Fund has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Section 5: Your Right to File a Complaint with the Fund or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Fund in care of the following official:

Ryk Tierney, Privacy Official
National IAM Benefit Trust Fund
99 M Street, SE, Suite 600
Washington, DC 20003
Phone: 202-785-8148
Fax: 202-728-0585

You may also file a complaint with:

Secretary of the U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

The Fund will not retaliate against you for filing a complaint.

Section 6: All Other Uses & Disclosures of your PHI

All other uses or disclosures of your PHI will only be made with your authorization or the authorization of a duly appointed personal representative pursuant to the Fund's Recognition of Personal Representative Policy and Procedures.

Section 7: If You Need More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Privacy Official at the address and phone number listed above.

Section 8: Conclusion

PHI use and disclosure by the Fund is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts

160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

General Information

Plan Name

This Plan is known as the National IAM Benefit Trust Fund Health and Welfare Plan.

Type of Plan

This Plan is a multi-employer health and welfare plan. It also is a group health plan.

Plan Identification Numbers

The employer identification number (EIN) is: 36-6562520

The Plan number is: 501

Plan Sponsor and Administration

The Board of Trustees is both the legal Plan Sponsor and the legal Plan Administrator under the Employee Retirement Income Security Act. The Board of Trustees consists of employer and union representatives, selected in accordance with the Trust Agreement. If you wish to contact the Board of Trustees, you may do so at the Fund Office address below. The Board of Trustees has designated an Executive Director to supervise the daily functions of the Plan. As the legal Plan Administrator, the Trustees have the authority to allocate or delegate their responsibilities for the administration of the Plan to others and employ others to carry out or provide guidelines with respect to their responsibilities under the Plan.

Agent for Service

The Board of Trustees has designated the Executive Director as Agent for Service of legal process. The address at which the process may be served is the Fund Office, as indicated below. Service of legal process also may be made upon any individual Trustee.

Fund Office Administration

The day-to-day administration of the Plan is handled by the Fund Office. Claims for dental benefits are not handled by the Fund Office. Inquiries about eligibility and the Plan in general should be directed to:

National IAM Benefit Trust Fund
99 M Street, SE, Suite 600
Washington, DC 20003
Phone: 202-785-8148
Fax: 202-728-0585
www.iambtf.org

The Fund Office performs the following:

- Receives employer contributions
- Keeps eligibility records
- Provides information about the Plan

Claims Administrator

Claims for dental benefits are processed by the Claims Administrator, which is Delta Dental Insurance Company (Delta Dental of Georgia). Delta Dental Network Providers will submit claims directly.

Claims for services from out-of-network providers should be sent to the following address:

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, Georgia 30023

Inquiries regarding claims should be made to Delta Dental of Georgia at 1-800-521-2651.

The rules and regulations described in this SPD apply to claims incurred on or after May 1, 2021. Your claims prior to this date will be processed and reimbursed based on the rules and regulations of the benefits under the Plan in force when the claim was incurred.

Selection of Preferred Providers

The Board of Trustees may from time to time, in its sole discretion, enter into written agreements with preferred provider organizations. The use of such preferred provider organizations is solely at your option. The existence of any preferred provider agreement does not, in any manner, imply an endorsement of any specific provider, nor does it constitute any guarantee of the services rendered.

The Board of Trustees currently has a contract with the following organization for a preferred provider network:

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, Georgia 30023
1-800-521-2651
www.deltadentalins.com

The use of preferred providers is solely at your option. However, you should note that use of the preferred provider network will result in the lowest out-of-pocket expense for you. The existence of a preferred provider network does not, in any manner, imply an endorsement of any specific provider, nor does it constitute any guarantee of payment for the services rendered.

Trust Fund

The assets of the National IAM Benefit Trust Fund are held in trust by the Board of Trustees.

Identity of Source of Benefits

All of the types of benefits provided by the Plan are set forth in this SPD. The Trust Fund is the source of the benefits of this Plan.

Plan Year

The Plan year begins on January 1 and ends on December 31.

Collective Bargaining Agreements

This Plan is maintained pursuant to one or more collective bargaining agreements, or other type of agreement. A copy of any such agreement may be obtained upon written request to the Fund Office

and is available for examination at the Fund Office. Upon written request, the Fund Office will tell you if an employer is contributing to the National IAM Benefit Trust Fund on behalf of its employees or will supply you with a list of such employers.

Workers' Compensation

The Plan is not in place of and does not affect any requirement for coverage by workers' compensation insurance. Benefits are not paid under this Plan for diseases for which benefits are payable under any workers' compensation law or for accidental bodily injuries which arise out of or during employment.

Action of the Trustees

The Trustees have full discretion and authority over the standard of proof required for any inquiry, claim, or appeal and over the application and interpretation of the Plan. No legal proceeding may be filed in any court or before any administrative agency against the Trustees, the Fund, or the Plan unless all review procedures have been exhausted. No legal action may be commenced or maintained more than three years after all remedies have been exhausted. Any action concerning a claim for benefits must be brought in the federal district court for the District of Columbia.

Exclusive Rights

No individual shall have any right to any benefits except as specified in this SPD. The National IAM Benefit Trust Fund will not be bound by any oral representations that are inconsistent with the contents of this SPD, and you should not rely on any oral representations that are inconsistent with the terms of this Plan. None of the benefits provided under this Plan are vested.

No Fund Liability

The use of services of any physician or other provider of health care, whether designated by the Plan or otherwise, is your voluntary act. Nothing in this SPD is meant to be a recommendation or instruction to use any provider. You should select a provider or course of treatment based on all appropriate factors, only one of which is coverage by the Plan. Providers are independent contractors, not employees of the Fund. The Trustees make no representation regarding the quality of service or treatment of any provider and are not responsible for any acts of commission or omission of any provider in connection with Plan coverage. The provider is solely responsible for the services and treatments rendered.

The Fund, the Board of Trustees, or any of their designees are not engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or over any health care services provided or delivered to anyone by any health care provider. Neither the Fund, the Board of Trustees, nor any of their designees, have any liability whatsoever for any loss or injury caused to anyone by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Right to Amend

The Board of Trustees has complete discretion to amend or modify this Plan or the Trust Agreement or any of the provisions of this Plan or the Trust Agreement in whole or in part at any time. This means that the Trustees can reduce, eliminate, or modify benefits, as well as improve benefits. The Trustees may also modify the length of or eliminate coverage for employees, dependents, and/or retirees, and the Trustees may also modify any eligibility requirements for coverage. The benefits under the Plan are not guaranteed and are provided only from assets of the Benefit Trust Fund collected and available for such purposes.

Erroneous Benefit Payments

Every effort will be made to ensure accuracy in the payment of your benefits. If an error is discovered, however, and it is determined that the Fund has paid any benefits that you are not entitled to, the Trustees have the right to seek repayment from you, including the right to reduce future benefit payments by the amount of the erroneous payment.

No Assignment of Benefits

You may not assign your benefits under this Plan except that you may direct that benefits payable to you be paid directly to an institution or provider of dental care. However, the Fund is not legally obligated to accept such a direction from you, and no payment by the Fund to a provider can be considered a recognition by the Fund that it has a legal duty to pay the provider, except to the extent that it chooses to do so. Direct payment to an institution or provider of dental care does not waive the anti-assignment clause under the Plan.

Plan Termination

The Trustees may terminate the Fund through a written document. The Fund may be terminated if, in the opinion of the Trustees, the Trust Fund is not adequate to meet the payments due or which may become due. The Fund may also be terminated if there are no longer any collective bargaining agreements requiring contributions to the Fund. The Trustees have complete discretion to determine when and if the Fund should be terminated.

If the Fund is terminated, the Trustees will: (a) pay the expenses of the Fund incurred up to the date of termination and the expenses in connection with the termination; (b) arrange for a final audit of the Fund; (c) give any notice and prepare and file any reports which may be required by law; and (d) apply the assets of the Fund in accordance with the Plan including amendments adopted as part of the termination until the assets of the Fund are distributed.

No part of the assets or income of the Fund will be used for purposes other than for the exclusive benefit of the employees and dependents or the Fund's administrative expenses. Under no circumstances will any portion of the Fund revert or inure to the benefit of any contributing employer or the union, either directly or indirectly.

Savings Clause

If any provision of this Plan is held to be unlawful, or unlawful as to a particular person or circumstance, such finding shall not adversely affect the application of the other provisions of the Plan as they are described in this SPD, unless the illegality makes the continued operation of the Plan impossible.

Source of Plan Funding

The benefits under the Plan are funded by monthly contribution payments by the employers. There also are circumstances in which employees self-pay to the Fund.

Benefits are provided only to the extent permitted by the contributions. If contributions are not sufficient to maintain benefits, the Board of Trustees (Board) reserves the right to change the eligibility rules, reduce or change the benefits, or eliminate the Plan, in whole or in part.

The amount of contributions and the employees on whose behalf contributions are made are determined by the provisions of the collective bargaining agreements or other agreements, as approved by the Trustees. The employer must make the required payments for a month for coverage to be

provided for the period. The Trustees reserve the right to terminate the participation of any employer at any time for any reason.

All contributions and income from earnings are used exclusively for providing benefits to eligible employees and their dependents, and for paying expenses incurred with respect to the operation of the Fund.

Erroneous Contributions

Once contributions are made to the Fund, they may be returned to an employer, at the Trustees' discretion, only upon the employer's written request and only if the employer conclusively demonstrates that the contributions were made in error and the result would not be an impermissible rescission. Employers may not unilaterally take a credit against a future payment. In determining whether the contributions were made in error and whether a refund will be made, the Trustees will consider all circumstances, including the period of time that has elapsed since the contributions were made.

Federal law provides that coverage by group health plans may not be rescinded (cancelled) retroactively (except to the extent attributable to a failure to pay timely monthly contributions towards coverage), unless there is fraud, or an individual makes an intentional misrepresentation of material fact. In determining whether a refund of contributions will be made, the Trustees will consider whether the requested refund will result in an impermissible rescission of coverage under federal law or applicable regulations. If so, the contributions will not be refunded.

Any costs the Fund incurred in correcting the employer's error, including administrative and computer costs and benefits paid in reliance on the employer's erroneous contributions, including amounts paid after discovery of the error during a review period (including external review), may be deducted from any amounts refunded. Interest will not be paid to the employer on the erroneous contributions.

It is very important that employers carefully review contributions and reports to the Fund to avoid erroneous payments. The Fund relies on the accuracy of employer reports to credit employees for eligibility. Any errors must be reported to the Fund promptly.

Glossary

Accident means an unexpected and unintentional event occurring through external means, not necessarily involving another person. Injuries caused by normal activities of daily living (such as walking, bending, stretching, etc.) are not considered to be accidents.

Bridge or **Bridgework** means to replace missing natural teeth with artificial teeth using a fixed or removable appliance.

Caries or **Carious Lesions** means visible destruction of hard tooth structure resulting from the process of decay; cavities.

Child means your biological child, legally adopted child, legal stepchild, child placed with you for adoption and any other child under your legal guardianship, all of who are below age 26.

Claim Form means the standard form used to file a dental claim or request a predetermination estimate for proposed dental treatment.

Claims Administrator means the entity that processes dental claims.

Contract Allowance means the maximum amount Delta Dental will use for calculating the benefits for a single procedure. The contract allowance for services provided by a:

- **Delta Dental PPO Dentist** is the lesser of the dentist's submitted fee, the Delta Dental PPO dentist's fee or the dentist's filed fee with Delta Dental in their Participating Dentist Agreement;
- **Delta Dental Premier Dentist** (who is not also a Delta Dental PPO dentist) is the lesser of the dentist's submitted fee, the dentist's filed fee with Delta Dental in their Participating Dentist Agreement; or the maximum plan allowance; or
- **Non-Delta Dental Dentist** or **Out-of-Network Dentist** is the lesser of the dentist's submitted fee or the maximum plan allowance.

Covered Dental Charge means a charge that: (1) is made for a dental service or supply that is furnished to a participant; and (2) meets all the following tests:

- It is shown in the Covered Dental Services List and/or the Schedule of Benefits;
- It is a necessary and customary dental service;
- It is incurred by a participant while the participant is eligible for dental benefits under this Plan.
- It is furnished by or received from a dentist; and
- It is not listed as a Plan Exclusion.

Crown means a prosthesis that is used to restore a tooth to proper occlusion, contact, and contour. It may be placed as a restoration or as an abutment to a fixed bridge.

Delta Dental PPO Dentist or **PPO Dentist** means a participating Delta Dental dentist who agrees to accept Delta Dental's PPO dentist's fees as payment in full and comply with Delta Dental's administrative guidelines. All PPO dentists are also Delta Dental Premier dentists. All PPO dentists must be contracted in the Delta Dental Premier network.

Delta Dental PPO Dentist's Fee or **PPO Dentist's Fee** means the fee outlined in the PPO Dentist Agreement. PPO dentists agree to charge no more than this fee for treating PPO participants.

Delta Dental Premier Dentist or **Premier Dentist** means a dentist who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and who agrees to abide by certain administrative guidelines. Not all Premier dentists are PPO dentists; however, all Premier dentists agree to accept Delta Dental's maximum plan allowance for each single procedure as payment in full.

Dental Benefits (in-network or out-of-network) means the amount that Delta Dental will pay for eligible dental expenses under the Plan. In-network dental benefits are those covered by the Plan and performed by a Delta Dental PPO dentist or a Delta Dental Premier dentist. Out-of-network dental benefits are those covered by the Plan but performed by a non-Delta Dental (out-of-network) dentist.

Dental Care Provider means a dentist who is acting within the scope of his license to provide dental services to Plan participants.

Dentist means a person licensed to practice dentistry when and where services are performed, including specialists (endodontists, periodontists, and oral surgeons).

Dependent means your spouse, child under age 26, and your disabled dependent. The term dependent does not include a spouse who is on active duty in any armed forces.

Disabled or **Disability** means the inability to perform substantially all the duties of the person's occupation because of a physical or mental illness or injury. For your children, it means they are prevented by illness or injury from engaging in their normal daily activities.

Disabled Dependent means a child, who is incapable of self-sustaining employment because of a physical or mental disability that occurred before the dependent child turned age 26, and who is chiefly dependent on you for financial support. Proof of the disability must be submitted before age 26 and may be required periodically thereafter.

Eligible Dental Expenses are covered dental charges that are eligible for dental benefits. Any service or expense that is excluded from coverage by the Plan will not be considered an eligible dental expense, including those services that do not meet applicable time limitations for coverage. If the charge for a covered dental service exceeds the maximum plan allowance for that service, the excess amount is not considered an eligible dental expense. If a dental care provider discounts, waives, or rebates any portion of a charge, that amount is not considered to be an eligible dental expense and the Plan is not obligated to provide dental benefits that exceed the adjusted charge amount.

Employee means a person who is actively working for an employer in a covered position and on whose behalf the employer makes the required contributions to the Plan. An unincorporated sole proprietor or partner in a partnership cannot be treated as an employee under the Plan.

Employer means any employer obligated under a collective bargaining agreement, participation agreement, or other signed agreement to make contributions to the Plan on its employees' behalf.

Endodontics means the diagnosis, prevention, and treatment of pathological conditions within the pulp chamber or apical area of the tooth root, including root canal treatment.

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

Illness means a disease or disorder resulting in an unsound condition of the mind or body.

Implants means prosthetic appliances placed into or on the bone of the maxilla or mandible (upper or lower jaw) to retain or support dental prosthesis, including endosseous, transosseus, subperiosteal and endodontic implants, implant connecting bars, and implant repairs.

Incurred generally means the time a service is performed, or a supply furnished. There are a few variations for dental services. Dental services are incurred as follows:

- For an appliance (or change to an appliance), at the time the impression is made;
- For a crown, bridge, or cast restoration, at the time the tooth or teeth are prepared;
- For a root canal, at the time the pulp chamber is opened; and
- For all other dental services, at the time the service is performed, or the supply furnished,

Injury means a wound or damage to the body sustained by accident or through external force.

Maximum Plan Allowance or **MPA** means the maximum amount Delta Dental will reimburse for a covered procedure. Delta Dental establishes the MPA for each procedure through a review of proprietary filed fee data and actual submitted claims. MPAs are set annually to reflect charges based on actual submitted claims from providers in the same geographical area with similar professional standing. The MPA may vary by the type of network dentist.

Medicare means the health insurance benefits provided under Title XVIII of the Social Security Act, as amended in 1965.

Necessary and Customary with respect to each service or supply means that the service or supply meets all the following tests:

- It is rendered for the prevention, diagnosis, or treatment of dental illness or injury.
- It is appropriate for the symptoms, consistent with the diagnosis, and is otherwise in accordance with generally accepted dental practice and professionally recognized standards.
- It is not mainly for the convenience of the participant or the participant's dentist or other provider.
- It is the most appropriate type and level of service needed to provide safe and adequate dental care.

Network means a panel of dentists that contractually agree to provide treatment according to the administrative guidelines for a particular preferred provider program, including limits to the fees they will accept as payment in full.

Non-Delta Dental Dentist means a dentist who is neither a Premier dentist nor a PPO dentist, and who is not contractually bound to abide by Delta Dental's administrative guidelines. A non-Delta Dental dentist is an out-of-network dentist.

Orthodontics is a dental specialty dedicated to diagnosing, preventing, and treating malocclusion (improper alignment of biting or chewing surfaces of upper and lower teeth) through braces, corrective procedures and other appliances to straighten teeth and correct jaw alignment.

Out-of-Network Dentist means a non-Delta Dental dentist as defined above.

Participant means a person who is eligible for dental benefits under the Plan.

Participating Dentist Agreement means an agreement between a member of the Delta Dental Plans Association and a dentist that establishes the terms and conditions under which services are provided.

Participation Agreement means the agreement providing for coverage under the Plan.

Periodontics means the area of dentistry dealing with examination, diagnosis, and treatment of diseases of the supporting tissues of the teeth (i.e. treatment of gum disease).

Physician means a doctor of medicine or a doctor of osteopathy who is licensed by his jurisdiction and acting within the scope of his license to practice medicine or to perform surgery.

Plan means the National IAM Benefit Trust Fund.

PPO Dentist Agreement means an agreement between a member of the Delta Dental Plans Association and a dentist which establishes the terms and conditions under which covered services are provided under a PPO program.

Predetermination means Delta Dental's written estimate of dental benefits available under the Plan as of a specific date for services proposed to a covered participant.

Preferred Provider Organization or **PPO** means an organization that negotiates discounted rates with providers in an effort to provide benefits to participants.

Preferred Provider means a provider that enters into an agreement with the preferred provider organization to provide services at negotiated discount rates.

Procedure Code means the Current Dental Terminology number (CDT code) assigned to a single procedure by the American Dental Association.

Professionally Recognized Standards means professionally recognized standards of quality, as determined by the Fund Office. To determine such standards, the Fund Office may use such groups as The American Medical Association, The American Dental Association, their affiliates and successors, peer review groups, professional review groups, and similar groups.

Prophylaxis means prevention of disease by removing calculus, stains, and other extraneous materials from the teeth (i.e. cleaning and scaling of teeth by a dentist or dental hygienist).

Prosthodontics means the area of dentistry concerned with restoration and maintenance of function by providing artificial replacement for missing natural teeth.

Restoration means the replacement of missing or damaged tooth structure with artificial materials.

Retiree means a person who formerly qualified as an employee, who has retired from active employment while covered by this Plan, and on whose behalf the employer continues to make the required contributions to the Plan, but only if the particular collective bargaining agreement or participation agreement allow for retiree coverage.

Single Procedure means a dental procedure that is assigned a separate procedure code.

Spouse means the person to whom an employee is legally married, as determined by both state law and with whom the employee can file a joint income tax return pursuant to the U.S. Tax Code.

Standard Denture means a basic conventional removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.

TMJ means the temporomandibular joint. The term **TMJ disorder** means a disorder, disease, or dysfunction of the TMJ, regardless of the diagnosis.

You and **your** means the employee/participant who is eligible for coverage under the terms of the plan and who can enroll his or her spouse and/or eligible dependent children.

Statement of ERISA Rights

This statement of your rights under ERISA is required by federal law and regulation.

As a participant in the National IAM Benefit Trust Fund Health and Welfare 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 Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including 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 Plan Administrator's office, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator's office may make a reasonable charge for the copies.
- 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 annual report.

Continue Group Health Plan Coverage

You have the right to continue group health coverage for yourself, spouse or eligible dependent child if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents 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.

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 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 benefit is denied 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 materials 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 Plan 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 Plan 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, you must first exhaust your administrative remedies under the Plan (by following the claims and appeals procedures described in the SPD) before you may file suit in any court.

Assistance with Questions

If you have any questions about your Plan (for example, any questions about the processing of your claims, or allowances considered by the Plan, covered expenses, or questions regarding your eligibility), you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or write to the EBSA's Office of Assistance:

Office of Participant Assistance
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW, Suite N-5625
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling EBSA's Toll-Free Employee & Employer Hotline at (866) 444-EBSA (3272) or visit the EBSA website at www.dol.gov/dol/ebsa.

National IAM Benefit Trust Fund

99 M Street, SE, Suite 600
Washington, DC 20003
202-785-8148
1-800-457-3481 (Toll-Free)

For More Information, Visit
www.iambfo.org