



NATIONAL IAM
BENEFIT TRUST FUND

Health and Welfare Plan
Short-Term Disability Income Coverage

Summary Plan Description
Effective May 1, 2021



For More Information, Visit www.iambfo.org

Board of Trustees

Union Trustees

Dora H. Cervantes - Co-Chair
General Secretary Treasurer, IAMAW
c/o National IAM Benefit Trust Fund
99 M Street, SE, Suite 600
Washington, DC 20003

Steve Galloway
General Vice President, IAMAW
c/o National IAM Benefit Trust Fund
99 M Street, SE, Suite 600
Washington, DC 20003

Rickey Wallace
General Vice President, IAMAW
c/o National IAM Benefit Trust Fund
99 M Street, SE, Suite 600
Washington, DC 20003

Employer Trustees

Thomas Mitchell - Co-Chair
President, Allen-Mitchell & Co.
c/o National IAM Benefit Trust Fund
99 M Street, SE, Suite 600
Washington, DC 20003

Marie Underwood
Managing Director Finance & Controller,
McGee Air Services
c/o National IAM Benefit Trust Fund
99 M Street, SE, Suite 600
Washington, DC 20003

Amy Kehoe
Manager, Benefit Systems, PAE
c/o National IAM Benefit Trust Fund
99 M Street, SE, Suite 600
Washington, DC 20003

Executive Director

Ryk Tierney

Directors

Karen Brown
Diana Lott

Plan Administrator

Board of Trustees

Consultants and Actuaries

The Segal Group

Fund Counsel

Raymond Goad

Fund Auditors

Novak Francella, LLC

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 the short-term disability income coverage available to eligible active employees 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. We also suggest that you keep this SPD with your important papers so that 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 plan of benefits provisions (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 short-term disability 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 Short-Term Disability 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 short-term disability benefits under the Plan. SPDs for medical, dental, and vision benefits, and life and accidental death and dismemberment insurance are provided separately if you are eligible for such benefits.

Short-term disability income coverage benefits are self-funded, which means that claims are paid directly from Fund resources 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, choosing generic medication instead of brand name, and taking advantage of preventive care benefits on a routine basis.

This SPD explains the general provisions of the Plan with regard to employee short-term disability income coverage. It includes legally required notices, an overview of your coverage, information about your eligibility requirements, 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, 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.

Table of Contents

Schedule of Benefits	1
Eligibility Provisions	2
Employee Short-Term Disability Income Coverage	4
Exclusions	9
Third-Party Liability and Right of Recovery	11
Claims Filing and Appeal Procedures	15
Miscellaneous Provisions.....	24
General Information	32
Glossary	36
Statement of ERISA Rights.....	39

Schedule of Benefits

The Fund offers eight (8) Short-Term Disability Plans with varying levels of coverage. When you receive this SPD, you may want to mark the Plan that is provided by your employer.

Please do not rely on this table alone to determine your disability benefits. Important coverage details, limitations, exclusions, and definitions that may affect your disability claims are found throughout this SPD.

Short-Term Disability Income Coverage

The plan covers 70% of gross weekly wages up to the weekly benefit amount shown below. The actual disability benefit payment is subject to Plan provisions found later in this SPD.

CURRENT PLANS	WEEKLY BENEFIT
S200	\$200 per week
S300	\$300 per week
S400	\$400 per week
S500	\$500 per week
S600	\$600 per week
S800	\$800 per week
S01K	\$1,000 per week
0014 ¹	\$2,200 per week

Please Note: A person's possession of this Summary Plan Description or a short-term disability claim form does not establish their eligibility for benefits under this Plan. If you are a Plan participant and you want to verify your eligibility for disability benefits or confirm which of the above Plans apply to you, please contact the Fund Office at 800-457-3481.

¹ Plan 0014 is an old legacy plan that is not available to new groups.

Eligibility Provisions

Eligibility for Active Employees

This section describes the rules regarding an individual's eligibility to be a participant of the Plan. Short-term disability benefits are available to active employees only. Coverage is not available to dependents or retirees.

You will become a participant on the first day of the month in which you become 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 (Covered Employment), you enroll for benefits under the Plan (see above), and your employer is required to make monthly contributions to the Plan on your behalf.

Your continued eligibility for coverage under this Plan is determined each month, based on the contributions received from your employer. Your eligibility and coverage will terminate on the last day of any month in which you are no longer an active employee of an employer participating in the Plan who is working in Covered Employment, and your employer does not remit the required contribution for your coverage.

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.

Limitations on Eligibility

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, provided that the language has been accepted by the Fund.

How to Enroll in Coverage Under the Plan

You must apply for coverage 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 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.

Special Enrollment During Mid-Coverage Period

If you are declining this coverage because of other disability coverage, in the future you may be able to enroll provided you request enrollment within 30 calendar days after coverage under the other plan ends. The loss of coverage must be due to exhaustion of 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 of coverage due to failure to make payments on a timely basis under the applicable terms of the other plan, or termination of coverage for cause.

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

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 required to be made on your behalf by your employer; or

The last day of the month during which your employment terminates. Your employment will be considered as terminated if you continue to work for your employer, but you are not actively working in Covered Employment.

Employee Short-Term Disability Income Coverage

The Plan will pay a disability income benefit for actively working employees who become Totally Disabled by a Covered Disability while they are eligible for benefits under the employee short-term disability income coverage. This benefit is not available to dependents or retirees. Please refer to this section for the definition of all capitalized terms.

Disability Income Benefit

A disability income benefit is 70% of gross weekly wages **up to** the weekly benefit amount shown in the Schedule of Disability Benefits. The weekly benefit amount is the maximum amount allowed by the Plan for each seven (7) day week of Covered Disability following the applicable Disability Waiting Period.

For each disability claim, the employee's actual gross weekly wages reported by the employer are used to determine the individual weekly benefit that applies for that employee, which could be equal to or less than the weekly benefit amount.

For example. If you are covered under **Plan S600** which has a maximum weekly benefit of \$600, and your gross weekly wages are:

\$1,000 → 70% of gross wages is \$700, so your weekly benefit would be \$600 (\$600 maximum)

\$900 → 70% of gross wages is \$630, so your weekly benefit would be \$600 (\$600 maximum)

\$800 → 70% of gross wages is \$560, so your weekly benefit would be \$560

\$700 → 70% of gross wages is \$490, so your weekly benefit would be \$490

The weekly benefit is subject to FICA withholding and other reductions described below, as well as all other provisions of the Plan.

Note: Once a disability claim commences, the Plan will not change the benefit calculation if you receive a pay increase or decrease or if your employer's disability Plan is changed to a greater or lesser weekly benefit before you return to work following your disability. Benefits for the entire disability payment period are based of eligibility and coverage on the date a disability claim commences.

You must be actively working in covered employment when your disability commences. You will not be eligible for short-term disability benefits if you are on a leave of absence or if you are no longer working in covered employment. The date you become eligible for short-term disability income benefits is based on the initial date of a Covered Disability. If you are determined to be eligible for disability benefits, your benefits will start after the Disability Waiting Period and continue until the earliest of the following:

The date the employee's Covered Disability ends;

The last date the disability is certified by a physician;

The date the employee returns to active employment; or

The date you reach the end of the Maximum Payment Period and the disability benefits provided by the Plan are exhausted.

Your benefits will continue even if your employer ceases to make monthly contributions to the Fund after you start receiving disability benefits.

Disability income benefits are not covered for any day that you receive paid wages from your employer. This includes full or partial day payment of any type of accrued leave, unless your collective bargaining

agreement specifically allows for payment of leave to supplement the disability benefit or the disability waiting period. Disability income benefits are also subject to FICA withholding (Medicare and Social Security) and other reductions described below, as applicable.

Covered Disability

A **Covered Disability** is a Total Disability that:

Starts while you are actively working and covered under this disability benefit;

Is the result of a covered illness (including pregnancy), accident, or injury;

Lasts longer than the applicable disability waiting period; and

Is continuously certified by a physician or allied health provider; and

As used here, **Total Disability** and **Totally Disabled** mean that:

You are unable, due to illness, accident, or injury, to perform the substantial and material duties of the occupation in which you were engaged when you became so disabled; and

You are not engaged in any employment.

Any **two Covered Disabilities** shall be deemed to be a single disability unless:

Your physician released you from the earlier disability and you returned to work on a full-time basis for at least two consecutive weeks between the two covered disabilities; or

The later Covered Disability:

- Is due to an illness, accident, or injury that is entirely unrelated to the causes of the earlier disability; and
- Your physician released you from the earlier disability and you returned to work on a full-time basis for at least one full day between the two Covered Disabilities.

Disability Waiting Period

There is a seven (7) day waiting period prior to payment. The waiting period is the number of unpaid days that must elapse before any disability income benefits are payable for a Covered Disability. All available employer sick pay must be exhausted before the seven-day waiting period begins or any disability income benefits are paid, unless your collective bargaining agreement provides otherwise. Benefit payment will generally begin on the eighth unpaid day, except where a waiver of the disability waiting period applies (see Waiver of the Disability Waiting Period Section below).

For example. You are disabled due to illness on March 1, and you have four days of accrued sick leave on the books. You must use the accrued leave to receive sick pay from your employer for March 1 through March 4¹. Your waiting period would then begin on March 5 and run for seven consecutive days through March 11. Benefits would begin on March 12, which would have otherwise been the eighth unpaid day of your disability period (presuming you do not return to work before that).

Waiver of the Disability Waiting Period

There are two instances where the Disability Waiting Period will be fully or partially waived. They are:

1. **Disability due to accident or injury.** The Disability Waiting Period will be fully waived if your disability is the result of a covered accident or injury, providing your disability payment period begins

¹ Examples presume all days are work days, although employer pay is actually based on your normally scheduled work days. The Plan waiting period and disability benefits that apply after employer pay ends are based on seven (7) day weeks.

within 90 days of the accident or injury. This waiver is provided only one time per accident or injury. If more than one disability claim occurs due to the same accident or injury, the waiting period will apply.

For example. You have a covered accident and are immediately disabled. The Disability Waiting Period will be fully waived, and benefits will begin on your first unpaid day. You then return to work full-time for two or more weeks, but later your doctor puts you off work again for a surgical repair that could not be performed until you had time to recover. Because the waiting period was already waived for the first disability claim, a seven-day waiting period will apply on the claim for your second accident-related disability. **However,** if you do not return to work on a full-time basis for two consecutive weeks after the first period of disability, the two periods would be considered a single disability, and payment would resume under the original claim if benefits remain available.

2. **Disability that requires inpatient hospital admission.** The Disability Waiting Period will be waived if you are admitted to the hospital on an inpatient basis before you complete the seven-day waiting period. If you require immediate hospital admission, the disability waiting period will be fully waived. If you are disabled, and then admitted to the hospital before seven days have passed, the Disability Waiting Period will be partially waived from the date of inpatient admission (does not apply to outpatient services).

For example. You are pregnant. On March 1 your physician puts you on disability and bed rest until delivery. On March 4 you are admitted to the hospital for delivery. The waiting period would apply for three days, March 1 through March 3 (providing they are unpaid days), and then be waived on March 4 due to inpatient hospital admission. **However,** paid wages can delay application of the partial waiting period. In the same scenario, if you have four days of accrued sick leave available, you must use the leave to receive sick pay from your employer for March 1 through March 4. Although admitted to the hospital on March 4, the sick pay cannot supplement the waiting period (unless provided by your collective bargaining agreement), so the abbreviated three-day waiting period would start on your first unpaid day and apply from March 5 through March 7.

Disability Waiting Period is reviewed independently and applied separately to each Covered Disability. If you have any question of whether or how a Disability Waiting Period will apply for your situation, you may contact the Fund Office at 800-457-3481 or 202-785-8148.

FICA Taxes

Disability income benefits are subject to FICA taxes (Medicare and Social Security) when an employer's monthly contributions for the short-term disability income coverage are made on a pre-tax basis.

The Plan is responsible for payment of the employee portion of FICA taxes due on your disability claim. Medicare and Social Security FICA taxes will be deducted from your weekly benefit and paid to the federal government as required by law. Each week that a payment is issued for any employee the Fund Office will send the applicable employer a letter that shows disability benefit amounts paid and FICA tax deductions for their covered employees. In addition, a summary letter will be sent to all employers at year-end listing all disability benefits and FICA payments issued in that calendar year for their covered employees. Although you and your payments are identified in your employer's letters because of tax liability, there is no information provided about the reason for or nature of your disability.

Your employer is responsible for payment of the employer portion of FICA taxes due on your disability income benefits, and other taxes if applicable. Your employer is also responsible for reporting your disability income as third-party sick pay on your W2 form at year end, and on any other report or form required by the IRS during the payment year or at year end. This office does not issue W2 forms to participants. We send only the employer notification letters noted above that describe payments so that the employer can report them.

Note: If an employer's monthly contributions for the short-term disability income coverage are made on a post-tax basis, they are not subject to FICA tax. If you think that might be the case for you, please contact your employer and ask them to notify the Plan so that employee FICA taxes can be waived.

Reductions

State Disability and Federal Social Security Disability Income Benefits are any disability income benefits to which you are entitled for a Covered Disability (or could have been entitled if you had properly applied for them) under either the Federal Social Security Act or a State Disability Income Plan. It is your responsibility to notify this Plan of any State Disability and/or Federal Social Security Disability Income Benefits to which you are entitled, and to provide confirmation of payments where applicable.

Disability income benefits provided by this Plan will be reduced by the daily amount of any State Disability and Federal Social Security Disability Income Benefits, so that the benefits of all plans do not exceed 100% of your gross weekly wages.

In addition, it is your responsibility to notify this Plan if you have another group short-term disability coverage, so that the benefits of both plans do not exceed 100% of your gross weekly wages (this does not apply to individual plans).

Payment of Benefits

Employee Short-Term Disability Income Benefits are paid weekly by the Fund office for the previous seven-day period, Monday through Sunday, or portion thereof as applicable based on disability start date and physician certification date. Payment is issued under the contributing employer's taxpayer identification number, and benefit checks are sent to employees via U.S. mail.

Disability Extension

The Fund office will not issue benefits past the disability date certified by your physician or allied health professional, or your estimated return to work date, whichever is earlier. If you reach the end of a medical certification period or an estimated return to work date and you remain Totally Disabled, it is your responsibility to obtain a written extension of disability from your health care provider and forward it to the Fund Office for processing by the Plan (you should also notify your employer).

When a new disability certification is required, no additional benefits will be paid past the previously certified disability date or estimated return to work date until the provider's written extension is received and can be evaluated to determine whether benefits can be continued. Unless the Plan is notified that you have returned to work, the Fund office will send you a blank extension form when you reach a certification date, or when you request one.

Release from Disability

It is your responsibility to notify the Plan when you are released from your Total Disability, especially if you are released earlier than expected or prior to the date certified by your physician or allied health professional, **even if you do not return to work.**

You will be responsible to reimburse the Plan for any overpayment of benefits due to your failure to notify the Plan of your release from disability, whether or not you return to work, even if the physician made an error in certification of your Total Disability period. This is especially important because disability benefits are issued in arrears (i.e., for the previous seven-day period, Monday through Sunday, or portion thereof as applicable). If you receive a disability benefit check after you are released from disability, be sure to look at the disability dates shown on the explanation of benefits to ensure that all paid days are before the date you were released.

Maximum Payment Period

The Maximum Payment Period under the disability Plan is 26 weeks, or 182 days of disability. This is the maximum period, following any applicable waiting period, that disability income benefits are payable under the Plan for any Covered Disability.

The Maximum Payment Period applies separately to each Covered Disability. There is no separate payment period if two disability periods are determined to be a single Covered Disability as explained in the Covered Disability Section above.

Note: Please contact the Fund Office at 800-457-3481 or 202-785-8148 if you have any questions about the information provided in the above sections.

Exclusions

The Plan does **not** provide disability benefits for all conditions or situations. No disability benefits will be paid for:

1. Your dependents (disability income benefits are provided for active employees only).
2. Retirees (disability income benefits are provided for active employees only).
3. Any disability that begins while you are not eligible for benefits under this Plan.
4. Any days for which you receive paid wages from your employer. This includes payment for time worked, sick pay, vacation pay, paid time off (PTO), holiday pay, etc., except where your collective bargaining agreement or other participation agreement allows the use of accrued leave to supplement this disability coverage.
5. Any days that could be paid from available accrued sick leave. All sick leave must be exhausted before the disability waiting period starts or disability benefits are paid, except where all leave is bucketed under PTO and there is no separately identifiable sick leave, or where your collective bargaining agreement or other participation agreement allows the use of sick leave to supplement this disability coverage.
6. Any days that you are working in employment for your current contributing employer or for an alternative employer.
7. Any days that you are not under the care of a physician or allied health professional.
8. Any days prior to your first office visit with the physician or allied health professional who certifies your disabling condition, except where you are treated first in the emergency room or other hospital setting and are referred to the physician or allied health professional for continuing care.

Note: You must arrange to see the physician or allied health professional as soon as possible to certify your disability following discharge from the emergency room or other hospital setting.

9. Any disability certified by a professional who is not practicing within the scope of his or her license.
10. Any disability that is the result of a work-related condition.
11. Any disability related to treatment of an illness or injury for which benefits are payable under any Workers' Compensation law.
12. Any disability related to treatment of an illness or injury that results from, arises out of, or occurs in the course of, any past or present employment or occupation for compensation or profit.
13. Any disability that results from an act of declared or undeclared war, the participant's commission of a crime, or non-therapeutic release of nuclear energy.
14. Any disability that is the result of services or treatments furnished, paid for, or otherwise provided as the result of past or present service in the armed forces of a government, except as otherwise provided by law.
15. Any disability due to services or treatments furnished, paid for, or otherwise provided by any local, state, or federal government agency, program, or institutions, unless otherwise provided by law.
16. Any disability related to treatment that is excluded under the Benefit Trust Fund medical plan coverage, regardless of whether you are covered by the medical plan. These exclusions include, but are not limited to, any periods of disability related to the following:

- Experimental, investigational, or unproven services or treatments, unless provided during an approved clinical trial;
- Services, supplies, or treatments that are not medically necessary;
- Cosmetic surgery and therapies, with limited exceptions;
- Reversal of sterilization;
- Treatment of infertility;
- Transsexual surgery;
- Treatment of complications from excluded procedures; and
- Court ordered treatment or hospitalization, unless treatment is prescribed by a physician or an allied health professional and is listed as a covered benefit under the term of the medical plan.

Note: A disability related to treatment that is excluded under the medical plan solely because of provider selection (i.e., the Plan requires use of a network provider) is not necessarily excluded under this disability benefit, providing the service is otherwise covered under the plan.

17. If you have State Disability or Federal Social Security Disability Income Benefits, or another group short-term disability coverage, this Plan excludes payment of any disability benefit that would cause the total of benefits between all plans to exceed 100% of your gross weekly wages.
18. Any claim for short-term disability benefits that is received more than one year after the date the disability commenced.

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 medical 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, as well as 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; and

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 or other claims 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 coverage. Before related claims will be paid through the Fund, the participant 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 his 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 would have secondary liability. 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 and 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 for short-term disability benefits 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 must 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 medical judgment (such as a determination that a service is not medically necessary or appropriate or is experimental or investigational).

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
National IAM Benefit Trust Fund 99 M Street, SE, Suite 600 Washington, DC 20003 Phone: 800-457-3481 or 202-785-8148 Fax: 202-728-0585 www.iambtf.org	<ul style="list-style-type: none">• Short-Term Disability Income Claims
Board of Trustees National IAM Benefit Trust Fund 99 M Street, SE, Suite 600 Washington, DC 20003 www.iambtf.org	<ul style="list-style-type: none">• Eligibility Determinations• Short-Term Disability Income Claim Appeals

Right to an Authorized Representative

In making a claim or appeal, you may be represented by any authorized representative. If your representative is not an attorney, parent, or court appointed guardian, you must designate the representative by a signed written statement. For this purpose, an authorized representative also includes a health care professional. An "authorized representative" means a person you authorize, in writing, to act on your behalf, such as your Spouse. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative. A form can be obtained from the Fund Office to designate an authorized representative.

The Plan requires you to provide a written statement declaring your designation of an authorized representative along with the representative's name, address, phone number, and email address. To designate an authorized representative, you must submit a completed authorized representative form (available from the Fund Office). 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 the purpose 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 utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not medically necessary or appropriate, or experimental or investigational.

Health Care Professional

A health care professional, for the purposes of the claims and appeals provisions, means a physician 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.

Casual inquiries about benefits or the circumstances under which benefits might be paid according to the terms of the Plan are **not** considered claims. A determination of whether an individual is eligible for benefits under the Plan is considered to be a claim that you can appeal if you are determined to be ineligible for benefits.

Claim Elements

A claim for short-term disability income benefits must include the following elements to trigger the Plan's internal claims process:

Be written using the appropriate form;

Be received by the Claims Administrator;

Name a specific claimant and his/her Social Security Number and date of birth;

Provide the date last worked and the date for which last pay was received;

Provide a date of disability and a return to work date (or an estimated return to work date);

Name a specific disabling medical condition or symptom; and

Identify the certifying provider's name, address, phone number, and professional degree or license.

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 condition is a covered benefit or the estimated disability benefit allowance;

A request for prior approval where prior approval is not required by the Plan; or

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.

How to File a Claim

Claims for benefits under the short-term disability income coverage are filed directly with the Fund Office in writing on special disability claim forms that are available from the Fund Office. You are required to submit your own completed claim form and follow the claims procedures outlined in this section, as applicable. Your claim will be considered filed as soon as the Fund Office receives a written claim form by mail, fax, or personal delivery. Telephone calls and e-mails are not acceptable.

You may obtain a disability claim form from the Fund Office or by going online at www.iambtf.org. To ensure prompt processing of your claim, please be sure that the form is completed thoroughly.

The following information must be provided on the claim form for your request for disability benefits to be considered a claim:

Employer Statement. An authorized employer representative must complete the employer portion of the claim form, providing the following about you (the employee) and your employment:

Your name and Social Security Number;

The date you last physically worked at your job;

The date you returned to work, or are expected to return to work;

The last date for which you received, or will receive, employer pay.

Note: The last paid date does not mean your last payday or day your paycheck was received. It means the last date you had any hours that resulted in paid wages, whether for worked time or for paid leave time after you stopped working;

Whether or not you have been terminated (including lay-off);

Your regularly scheduled gross weekly wages, and the number of hours of work per week on which the regularly scheduled gross weekly wages are based;

Your regular work day schedule from Monday through Sunday;

Whether or not light duty is available to you if ordered by your physician; and

The employer name, address, phone number, taxpayer identification number, and signature and title of the authorized representative who completes the employer statement of the claim form.

Employee Statement. You (the employee) or your authorized representative must complete the employee portion of the claim form to apply for disability benefits, providing the following:

Your name, date of birth, Social Security Number, address, and phone number;

The last date you worked before your disability and the date you returned to work after the disability. If you have not yet returned to work when the form is completed, the date you expect that you will be able to return to work;

The date you were first disabled and the medical cause of your disability;

Whether your disability was caused (or aggravated) by your occupation. If so, whether you have already filed a Workers' Compensation claim;

Whether your disability was caused by illness, pregnancy, accident or injury, or something else;

- If the disability was caused by an accident or an injury, the specific details of the accident or injury including how, when, and where it occurred; or
- If the disability was caused by something else, an explanation of the cause of disability.

Information about any disability related hospitalization including name and phone number of the hospital and the dates and times of hospital admission and discharge;

If you are eligible for or receiving any state or other disability income (this includes State Disability and Federal Social Security Disability Income Benefits, as well as disability coverage through any other group or individual plan);

Whether you have group health coverage; and

Your signature and the date signed. Your signature is to certify that the information is true and correct, and that you authorize all providers of medical care and your employer to furnish any information necessary to process your claim for disability benefits.

Attending Physician's Statement. Your physician or allied health professional must complete the physician's portion of the claim form to certify your disability, providing the following:

Your name and date of birth;

Your diagnosis and concurrent conditions;

Information about the cause of the condition, like is it work related and has a claim been filed, is it related to pregnancy and when the pregnancy commenced, is it due to accident or injury and when the accident or injury occurred;

The date your symptoms first occurred and the date the certifying provider was first consulted about the condition;

The date of your most recent visit with the certifying provider, the date of your next scheduled visit, and any additional dates of service related to the disabling condition;

Information about whether you were referred to this provider by someone else, ever had the same or similar condition, had testing to confirm the condition, are still under the certifying doctor's care, or were referred to another physician;

Whether you had any period of continuous Total Disability, and if so, the specific dates of disability;

Whether you were hospitalized because of the current disability, whether inpatient or outpatient, and specific hospitalization dates;

Whether you have been released to return to work;

- If released, the date you were released from disability; or
- If not released, an estimate of the date you might be released (the estimate can be updated later if you are not able to be released by the estimated date).

Note: If benefits are determined to be payable, they will not be paid past the date the certifying provider signs the claim form if he or she does not provide a potential return to work date).

Whether you have other health coverage;

The certifying provider's name, degree, specialty, address, and phone and fax numbers;

The providers signature and the date signed. The provider's signature certifies that the information provided on the claim form is true and correct, including any certification of Total Disability; and

Any additional remarks that the provider might wish to include.

Note: Your claim for short-term disability benefits cannot be processed unless all the claim form statements are fully completed, and all above information is provided.

Filing a Claim

You may file claims for disability benefits and appeal adverse claim decisions yourself or have an authorized representative do it for you. If your claim is denied, in whole or in part, you will receive a written notice of the denial from the Fund Office. 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.

The Fund Office must receive your claim for short-term disability benefits within one year of the start of the disability. Any short-term disability claim received more than one year after the start of your disability will be denied as untimely.

Note: Do not make any claims to Cigna for short-term disability benefits. Cigna has no role in the administration of these benefits.

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.

Notice of Decision

You will be notified of the decision on your claim for benefits under the short-term disability income coverage within a reasonable period, but no later than 45 calendar days after receipt of your claim. The initial 45-day period may be extended for up to two additional 30-day periods for special circumstances beyond the control of the Fund Office that require additional time to process your claim, provided the Fund Office notifies you of the extensions prior to the expirations of the initial 45 day and the first 30-day extension period respectively. Any notice of extension will indicate the circumstances requiring an extension, the date by which a decision is expected to be reached, the standards upon which entitlement to a benefit is based, the unresolved issues that require an extension, and additional information needed to resolve those issues.

If the extension is made because additional information must be furnished, you will have 45 calendar days within which to provide the requested information. The time for the Plan's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Fund Office receives your response or upon the date the requested information is required to be furnished expires, whichever is sooner.

During the review period, the Plan may require that you undergo a medical examination, at the Plan's expense, or additional information regarding the claim. If a medical examination is required, the Fund Office will notify you of the date and time of the examination and the physician's name and location. If additional information is required, the Fund Office will notify you, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Plan will pay the appropriate benefit. If the claim is denied, in whole or in part, you will be provided with written notice of denial of the claim. This notice will be mailed to you by the Fund Office, and will include the following information:

The claim involved;

The specific reason(s) for the decision;

Specific reference to the Plan provision(s) on which the decision was based;

A description of any additional material or information required to perfect the claim, and the reason this information is necessary;

A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal;

A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) if presented by the claimant, the views of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit decision, without regard to whether the advice was relied upon in making the benefit decision; and (3) if presented by the claimant, a disability decision regarding the claimant made by the Social Security Administration;

Either the specific internal rules, guidelines, protocols, standards, or other similar Plan criteria that was relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;

If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and

A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Appeal of Denied Short-Term Disability Claims

Whenever a claim decision is fully or partially adverse, unless ERISA provides otherwise, you may appeal, once, to the Board of Trustees of the Plan. As part of your appeal, you may receive, upon request, free of charge, copies of all documents, records, and other information relevant to your claim for benefits, and you may submit to the Board of Trustees written comments, documents, records, and other information relating to the claim. The Board of Trustees will take into account all comments, documents, records and other information you submit related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by the Board of Trustees, a full and fair review of the claim appeal will take place.

A written request for appeal must be received by the Board of Trustees within 180 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived.

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.

The review will give no deference to the original claim decision. The review will not be made by the person who made the initial claim decision, or a subordinate of that person. When deciding an appeal based in whole or in part upon medical judgment, the Board of Trustees will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational experts consulted by the Board of Trustees for the review will be identified and will not be the expert who was consulted during the initial claim decision, if any, or a subordinate of that expert.

During the appeal process, the Board of Trustees may require that you undergo a medical examination, at the Plan's expense, or additional information regarding the claim. If a medical examination is required, the Board of Trustees will notify you of the date and time of the examination and the physician's name and location.

Before the Board of Trustees issues an adverse benefit decision on appeal, if the Board of Trustees considered, relied upon, or generated any new or additional evidence in connection with the claim, and/or if the Board of Trustees intends to rely on any new or additional rationale in connection with that review, then such evidence and/or rationale will be provided to you, free of charge, as soon as possible and sufficiently in advance of the date that the decision on appeal is required to be made, giving you a reasonable opportunity to respond.

If the appeal is approved, the Trustees will instruct the Plan to pay the appropriate benefit. If the appeal is denied, in whole or in part, you will be provided with written notice of denial. This notice will be mailed to you by the Fund Office, and will include the following information:

The specific reason(s) for the decision;

Specific reference to the Plan provision(s) on which the decision was based;

A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;

A statement describing any voluntary appeal procedures offered, and your right to obtain the information about those procedures;

A statement of your right to bring a civil action under section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to your right to bring such an action, and the calendar date on which the contractual limitations period expires for the claim;

A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) if presented by the claimant, the views of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit decision, without regard to whether the advice was relied upon in making the benefit decision; and (3) if presented by the claimant, a disability decision regarding the claimant made by the Social Security Administration;

Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria the Board of Trustees relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;

If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Where to Send Your Appeal

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 5 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 because you are incompetent or incapacitated, the Plan may, at its discretion, pay Plan benefits directly to another 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, 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 is 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 denies your appeal in whole or in part and you decide to seek judicial review, the decision made by the Trustees is 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.

Miscellaneous Provisions

Misrepresentation and Fraud

In the event you receive benefits as a result of misleading representation or any type of false information or other fraudulent representations to the Fund, you 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 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 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.

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" to the Fund Sponsor 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 a Fund Sponsor 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's 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 give advice 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. 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 short-term disability income benefits are processed by the Fund Office. Short-term disability claims should be sent to the following address:

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

Phone: 202-785-8148
Fax: 202-728-0585

Disability claim inquiries should be made to the phone number noted above.

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.

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 in the course of 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 hospital, physician, or other provider of health care 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. 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, and 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 short-term disability income coverage benefits under this 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 (where applicable), 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. 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.

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) as required by federal law, 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.

Allied Health Professional means a health care provider who is licensed and practicing within the scope of his or her license.

Cosmetic Surgery or **Cosmetic Therapy** is defined as surgery or therapy performed to improve or alter appearance or self-esteem, or to treat psychological symptomatology or psychosocial complaints related to one's appearance. The medical plan covers charges made for reconstructive surgery or therapy to repair or correct severe physical deformity or disfigurement which is accompanied by functional deficit (other than abnormalities of the jaw or conditions related to TMJ disorder which is covered under another benefit under the terms of the Plan) provided that: (a) the surgery or therapy restores or improves function; (b) reconstruction is required as a result of medically necessary, non-cosmetic surgery; or (c) the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review process. Cosmetic Surgery required by federal law will be covered by the medical plan.

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. This short-term disability income coverage is not available to dependents.

Emergency Room means the department of a hospital that provides immediate treatment for acute illnesses and trauma.

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 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 or other signed agreement to make contributions to the Plan on its employees' behalf.

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

Hospital means only an institution that meets all of the following tests:

It mainly provides medical treatment to inpatients.

It maintains facilities for diagnosis.

It provides treatment only by or under a staff of physicians.

It provides care by Registered Nurses 24 hours per day.

It maintains permanent facilities for surgery.

It maintains a daily medical record for each patient.

It complies with all licensing and other legal requirements.

It is not a skilled nursing facility or a specialized facility.

It is not, other than incidentally, (1) a place for Custodial Care; (2) a place for the aged; (3) a place for the care of a person addicted to or dependent on a drug or chemical including alcohol; (4) a place for the care of persons with mental, nervous, or emotional disorders or conditions; (5) a place of rest; or (6) a nursing home, hotel, or a similar institution.

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

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

Inpatient and **Outpatient** refer either to the setting in which medical care is given or to a person who is receiving care in that setting.

When these terms describe the setting in which medical care is given:

- Inpatient means that the care is furnished to a person while the person is confined in a facility as a registered bed patient and is being charged a fee for inpatient room and board; and
- Outpatient means that the care is furnished to a person while the person is not so confined.

When these terms refer to a person who is receiving medical care:

- Inpatient means a person who is confined in a facility as a registered bed patient and is being charged a fee for inpatient room and board; and
- Outpatient means a person who is not so confined.

Medically necessary with respect to a medical service or supply means that the service or supply meets all of the following tests:

It is rendered for the treatment or diagnosis of an injury or illness, including premature birth, congenital defects, and birth defects;

It is appropriate for the symptoms, consistent with the diagnosis, and is otherwise in accordance with generally accepted medical practice and professionally recognized standards;

It is not mainly for the convenience of the participant or the participant's physician or other provider;

It is the most appropriate supply or level of service needed to provide safe and adequate care. When applied to confinement in a hospital or other facility, this test means that the participant needs to be confined as an inpatient due to the nature of the services rendered or due to the participant's condition and that the participant cannot receive safe and adequate care through outpatient treatment.

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

Nurse means only a person who is a registered Nurse (R.N.), a licensed vocational Nurse (L.V.N.), or a licensed practical Nurse (L.P.N.).

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

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

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.

Pregnancy means any Pregnancy, a complication thereof, or the termination of a Pregnancy. Pregnancy is covered on the same basis as any other illness.

Professionally Recognized Standards means professionally recognized standards of quality, as determined by the Trustees, or their delegates. 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.

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.

You and your means the employee who is eligible for coverage under the terms of the Plan.

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.

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