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Revised Oct. 2024

## TO ALL PARTICIPANTS AND ELIGIBLE DEPENDENTS:

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

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

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

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

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

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

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

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

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

Sincerely,

## THE BOARD OF TRUSTEES

## Welcome!

Welcome to your Vision 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 vision benefits under the Plan. SPDs for medical, dental, and short-term disability benefits, and life and accidental death and dismemberment insurance are provided separately if you are eligible for such benefits.

Vision benefits are self-funded, which means that health care 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 and taking advantage of preventive care benefits on a routine basis.

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

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

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

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# Schedule of Benefits

The Fund offers two (2) Vision Plans with varying levels of coverage through EyeMed.

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

**PLEASE NOTE:** Possession of this SPD or a Vision Claim Form does not establish their eligibility for benefits under this Plan. If you are a Plan Participant and you wish to verify your eligibility for benefits or check on your level of coverage before obtaining services, you should call EyeMed's Customer Care Center at 1-866-800-5457, or go to www.eyemed.com. You may also contact the Fund Office at 1-800-457-3481.

## Vision Care Benefits – STANDARD PLAN

| Standard Plan[1] | In-Network Participant Cost | Out-of-Network[2] Participant Reimbursement |
|---|---|---|
| **Complete Eye Examination** (with dilation and refraction as necessary) | $10 co-pay | Up to $40 |
| **Retinal Imaging** | Up to $39 | N/A |
| **Frames** | $0 copay, $115 allowance, 80% of balance over $115 | Up to $50 |
| **Standard Plastic Lenses** | | |
| Single Vision | $20 copay | Up to $30 |
| Bifocal | $20 copay | Up to $40 |
| Trifocal or Lenticular | $20 copay | Up to $55 |
| Standard Progressive | $75 copay | Up to $40 |
| Premium Progressive | | |
| Tier 1 | $95 copay | Up to $40 |
| Tier 2 | $105 copay | Up to $40 |
| Tier 3 | $120 copay | Up to $40 |

[1] There is no roll-over of unused benefits. Each benefit and/or allowance can be used only once per calendar year.

[2] You are responsible to pay the out-of-network provider in full at time of service and then submit an out-of-network claim to request reimbursement. Reimbursement is limited to the amount shown in the out-of-network Participant Reimbursement column. If the column says N/A there is no Participant Reimbursement for that service.

| Standard Plan[1] | In-Network Participant Cost | Out-of-Network[2] Participant Reimbursement |
|---|---|---|
| Tier 4 | $75 copay, 80% of charge less $120 allowance | Up to $40 |
| **Lens Options** | | |
| UV treatment | $15 | N/A |
| Tint (solid and gradient) | $15 | N/A |
| Standard scratch coating | $15 | N/A |
| Standard polycarbonate | $40 | N/A |
| Standard anti-reflective coating | $45 | N/A |
| Premium anti-reflective coating | | |
| Tier 1 | $57 | N/A |
| Tier 2 | $68 | N/A |
| Tier 3 | 80% of charge | N/A |
| Photochromatic / Transitions | $75 | N/A |
| Polarized | 80% of retail price | N/A |
| Other add-ons and services | 80% of retail price | N/A |
| **Contact Lenses Fit and Follow-up** (available once a comprehensive eye exam has been completed) | | |
| Standard fit and follow-up | $55 copay | N/A |
| Premium fit and follow-up | 90% of retail price | N/A |
| **Contact Lenses** (allowance includes materials only)[1] | | |
| Conventional | $0 copay, $115 allowance, 85% of balance over $115 | Up to $50 |
| Disposable | $0 copay, $115 allowance, 100% of balance over $115 | Up to $50 |
| Medically necessary | $0 copay | Up to $210 |

[1] If you need prescription contact lenses for only one eye, the benefit will be one-half of the amount provided for contact lenses for both eyes.

| Standard Plan[1] | In-Network<br>Participant Cost | Out-of-Network[2]<br>Participant Reimbursement |
|---|---|---|
| **Frequency** | | |
| Exam | Once per calendar year | Once per calendar year |
| Lenses or Contact Lenses | Once per calendar year | Once per calendar year |
| Frames | Once per calendar year | Once per calendar year |

## Vision Care Benefits – ENHANCED PLAN

| Enhanced Plan[1] | In-Network Participant Cost | Out-of-Network[2] Participant Reimbursement |
|---|---|---|
| **Complete Eye Examination** (with dilation and refraction as necessary) | $0 copay | Up to $40 |
| **Retinal Imaging** | Up to $39 | N/A |
| **Frames** | $0 copay, $145 allowance, 80% of balance over $145 | Up to $70 |
| **Standard Plastic Lenses** | | |
| Single Vision | $10 copay | Up to $30 |
| Bifocal | $10 copay | Up to $40 |
| Trifocal or Lenticular | $10 copay | Up to $55 |
| Standard Progressive | $50 copay | Up to $40 |
| Premium Progressive | | |
| Tier 1 | $70 copay | Up to $40 |
| Tier 2 | $80 copay | Up to $40 |
| Tier 3 | $95 copay | Up to $40 |
| Tier 4 | $50 copay, 80% of charge less $120 allowance | Up to $40 |
| **Lens Options** | | |
| UV treatment | $15 | N/A |
| Tint (solid and gradient) | $15 | N/A |
| Standard scratch coating | $15 | N/A |
| Standard polycarbonate | $10 copay | Up to $5 |

[1] There is no roll-over of unused benefits. Each benefit and/or allowance can be used only once per calendar year.

[2] You are responsible to pay the out-of-network provider in full at time of service and then submit an out-of-network claim to request reimbursement. Reimbursement is limited to the amount shown in the out-of-network Participant Reimbursement column. If the column says N/A there is no Participant Reimbursement for that service.

| Enhanced Plan[1] | In-Network Participant Cost | Out-of-Network[2] Participant Reimbursement |
|---|---|---|
| Standard anti-reflective coating | $45 | N/A |
| Premium anti-reflective coating | | |
| Tier 1 | $57 | N/A |
| Tier 2 | $68 | N/A |
| Tier 3 | 80% of charge | N/A |
| Photochromatic / Transitions | $75 | N/A |
| Polarized | 80% of retail price | N/A |
| Other add-ons and services | 80% of retail price | N/A |
| **Contact Lenses Fit and Follow-up** (available once a comprehensive eye exam has been completed) | | |
| Standard fit and follow-up | $40 copay, paid in full and two follow-up visits | Up to $43 |
| Premium fit and follow-up | $40 copay, 90% of retail, then apply $55 allowance | Up to $43 |
| **Contact Lenses** (allowance includes materials only)[1] | | |
| Conventional | $0 copay, $135 allowance, 85% of balance over $135 | Up to $70 |
| Disposable | $0 copay, $135 allowance, 100% of balance over $135 | Up to $70 |
| Medically necessary | $0 copay | Up to $210 |
| **Frequency** | | |
| Exam | Once per calendar year | Once per calendar year |
| Lenses or Contact Lenses | Once per calendar year | Once per calendar year |
| Frames | Once per calendar year | Once per calendar year |

[1] If you need prescription contact lenses for only one eye, the benefit will be one-half of the amount provided for contact lenses for both eyes.

# Eligibility Provisions

### *Initial Eligibility*

### *Active Employees*

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

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

### *Employees on Leave of Absence*

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

### *Effective Date of Coverage for Active Employees*

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

### *Determination of Eligibility for Coverage*

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

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

### *Eligibility for Retiree Coverage*

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

## Continuation of Eligibility

### *Eligibility During Family Medical Leave (FMLA)*

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

Have worked for a covered employer for at least 12 months;

Have worked at least 1,250 hours over the previous 12 months; and

Work at a location where at least 50 employees are employed by the employer within 75-mile radius.

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

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

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

### *Eligibility for Coverage During Leave Under USERRA (Military Leave)*

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

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

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

**Coverage options for your eligible Dependent(s):** Coverage for your eligible Dependents may be elected under COBRA continuation coverage. You will be required to self-pay for this coverage. In the alternative, coverage may be provided through the military.

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

**Coverage options for yourself:** you may elect coverage under the Plan's continuation of coverage benefit[1] and continue coverage for yourself for up to 24 months. However, the right to elect this continuation coverage is available only to you, not your dependents.

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

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

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

### *Benefits Upon Your Death - Eligibility of Your Surviving Spouse*

Surviving Spouse coverage is available for existing contributing Employers only if the collective bargaining agreement and/or Participation Agreement provide for Surviving Spouse coverage, and the Employee or Retiree meets any required age and/or years of service rules specified in such agreements at the time of death.

To be eligible for Surviving Spouse coverage where provided, the death of an Employee or Retiree must occur while eligible for benefits under the applicable Plan, and the contributing Employer must continue to make the required monthly contributions to the Plan.

There is otherwise no coverage for surviving Spouses under this Plan. However, your covered surviving Spouse and surviving Dependent Children may have rights under this Plan to make payments for continuation of coverage under COBRA as described later in this SPD.

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

[1] This coverage is similar to, but is not COBRA continuation coverage.

## *Eligibility for Your Spouse and Eligible Dependent Children*

Your eligible dependents include:

Your Spouse[1] to whom you are legally married pursuant to federal law and with whom you can file an income tax return, until the last day of month in which a divorce, dissolution of marriage, annulment or legal separation is obtained.

Your biological children, foster children, children placed for adoption, adopted children, stepchildren, and/or children for whom you or your covered Spouse are; (a) legal guardian, or (b) required to provide medical coverage under a Qualified Medical Child Support Order (QMCSO), until the last day of the month in which the child reaches age 26.

Unmarried children of any age provided they are incapable of self-sustaining employment because of a physical or mental disability that occurred when they were covered by this Plan and turned age 26 with such disability present.

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

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

### *Eligibility for Disabled Children*

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

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

### *Important Rules for Dependent's Eligibility*

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

If your eligible dependent child is employed and becomes covered under a group health plan connected to his or her employment, the plan under which he or she is an Employee will be considered the primary plan for coverage. This Plan will be secondary.

[1] The term Dependent does not include a Spouse who is on active duty in any armed forces.

In order for adopted children, children placed with you for adoption, or foster children to be considered eligible dependents, you must provide the Fund Office with appropriate legal documentation, satisfactory to the Plan in its sole discretion, such as adoption papers or a court order appointing you as the legal guardian for the child.

In order for a stepchild to be considered an eligible dependent, the Fund requires that the Employee provide a copy of the child's birth certificate and proof of the Employee's marriage to the child's biological or adoptive parent. The Fund may also require any and all documentation, including paternity papers, court order, state order and/or divorce decree setting forth the relationship with the child.

If a dependent Spouse is eligible for benefits under this Plan as an active participant, benefits will be payable for the Spouse first as a participant, then as a dependent. In no event will benefits exceed 100% of covered Charges incurred.

If a dependent child loses eligibility status, the child may regain eligibility only by satisfying all of the requirements included in the Plan's definition of an eligible dependent and these dependent Eligibility Requirements.

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

A marriage certificate (in the English language);

Birth certificate of biological child showing both parents' names;

Court (legal) documents showing legal guardianship or adoption;

Acknowledgement of paternity;

Receipt of a Qualified Medical Child Support Order pursuant to terms of the Fund; or

Notarized affidavits.

The date a person becomes a dependent means:

With respect to a newborn child, the date of birth;

With respect to a stepchild, the date of your marriage to your stepchild's parent;

With respect to a foster child, the date the child is placed with you for foster care;

With respect to a child named in a QMCSO, the later of the date specified in the court order or the date it is qualified;

With respect to an adopted child, the date of adoption or placement for adoption; or

With respect to a Spouse, the date of the marriage;

With respect to a child for whom you are legal guardian, the date the guardianship papers are signed by the Court.

### *Effective Date of Coverage for Eligible Dependents*

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

If you marry after the date you initially become covered under the Plan, your Spouse becomes covered on the day of marriage provided you give the Fund Office timely notice of the marriage, and complete

the required paperwork within the permissible time period as set forth under the subsection "Special Enrollment During Mid-Coverage Period."

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

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

### *Eligibility Pursuant to a Qualified Medical Child Support Orders*

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

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

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

Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by QMCSO;

Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is determined; and

States the period for which the QMCSO applies.

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

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

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

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

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

### *How to Enroll in Coverage Under the Plan*

You must apply for coverage for yourself and your dependents by completing an enrollment form and providing the completed form to your Employer. Your Employer will process the form and initiate any necessary payroll deduction, indicate the effective date of coverage, and provide the form to the Fund Office. Coverage for you, your Spouse, and/or eligible Dependent Children will not be effective until the Fund Office receives and processes the form. Enrollment forms should be received by the Fund Office prior to your initial effective date for coverage. If submission prior to your effective date is not possible, your form must be received by the Fund Office before the end of the initial coverage month.

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

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

### *Special Enrollment During Mid-Coverage Period*

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

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

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

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

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

# Termination and Continuation of Coverage

### *Termination of Coverage*

### *Termination of Coverage for Employees*

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

The date your Employer ceases to be a contributing Employer;

The date this Plan is discontinued or the National IAM Benefit Trust Fund is terminated;

The last day of the month for which you made a contribution for coverage, if it is required, or for which contributions were made on your behalf by your Employer; or

The last day of the month during which your employment terminates. Your employment will terminate if you are not actively engaged in work in a covered position for your Employer. However, if you are no longer actively engaged in work in a covered position due to any of the following reasons your employment will be deemed to continue provided your Employer does not terminate you, and continues to make the required payments for your coverage:

- Paid vacation;
- Retirement, but only if the Participation Agreement provides for Retiree coverage;
- Disability due to accident or illness; but only if the Participation Agreement provides for such coverage, and limited to no more than 12 months unless otherwise approved by the Board; or
- Layoff; but only if the Participation Agreement provides for such coverage, and limited to no more than 12 months unless otherwise approved by the Board.

### *Termination of Coverage for Dependent Children*

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

The date your coverage terminates;

The last day of the month in which the person no longer qualifies as a Dependent;

The last day of the month for which contributions were made for Dependent coverage; or

The last day of the month during which you die.

### *Termination of Coverage for your Spouse*

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

The date your coverage terminates;

The last day of the month during which you divorce or legally separate from your Spouse; or

The last day of the month during which you die.

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

### *Termination of Coverage for Surviving Spouse*

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

The date your surviving Spouse dies;

The last day of the month in which your surviving Spouse remarries;

The last day of the month in which a monthly contribution is received for coverage; or

The expiration of the applicable continuation of coverage period under the Plan, including COBRA continuation coverage.

## Options Under Which Your Coverage Can Be Extended

### *COBRA Continuation Coverage Benefit*

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

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

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

A reduction in your work hours which causes a loss of eligibility under the Plan; or

Your employment ends for any reason other than your gross misconduct.

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

Your death;

You experience a reduction in work hours, which causes a loss of eligibility under the Plan;

Your employment ends for any reason other than your gross misconduct; or

You become divorced or legally separated from your Spouse.

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

Your death;

You experience a reduction in work hours, which causes a loss of eligibility under this Plan;

Your employment ends for any reason other than your gross misconduct;

You and your Spouse become divorced or legally separated; or

Your dependent child no longer meets the eligibility requirements under the Plan. For example, the dependent child reaches age 26 and no longer meets the eligibility definition as of the end of the month of his or her 26th birthday.

### *Who is a Qualified Beneficiary?*

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

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

### *Who Must Give Notice of the Qualifying Event?*

#### *Employer's Responsibility*

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

You experience a reduction in work hours that causes a loss of eligibility under the Plan;

Your employment ends for any reason other than your gross misconduct; or

You die.

#### *Your Responsibility*

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

You and your Spouse are divorced or are legally separated;

An eligible dependent has ceased to meet the eligibility requirements;

If there is an occurrence of a "second qualifying event" experienced by you or any other qualified beneficiary after you, or the other qualified beneficiary who previously became entitled to COBRA with a maximum duration of 24 (or 35) calendar months. This second qualifying event could include your death, your divorce or legal separation, or your dependent losing eligibility status under the Plan. (More information about second qualifying events is provided later in this section.);

If a qualified beneficiary entitled to receive COBRA continuation coverage with a maximum of 24 calendar months has been determined by the Social Security Administration to be disabled. If this determination is made at any time that an individual is disabled during the first 60 calendar days of COBRA continuation coverage, the qualified beneficiary may be eligible for an 11-calendar month extension of the original 24-calendar month maximum coverage period, for a total of 35 calendar months of COBRA continuation coverage; and

If the Social Security Administration determines that a qualified beneficiary is no longer disabled.

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

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

### *Procedures for Notifying the Plan of a Qualifying Event*

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

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

The date of the disability determination by the Social Security Administration;

The date on which the qualifying event occurs; or

The date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event.

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

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

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

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

### *Determining the Duration of COBRA Continuation Coverage*

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

Generally under COBRA, an Employee may elect to continue coverage by making timely self-payments for up to 18 months for COBRA qualifying events. However, under this Plan, except where otherwise noted below, coverage may be continued by making timely self-payments for up to 24 months if the loss of coverage is for any termination of employment or loss of hours in employment covered by the Plan. Consequently, continuation of coverage with respect to termination of employment or loss of hours in employment will be collectively referred to as continuation of coverage.

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

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

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

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

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

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

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

In no event will any Spouse, or eligible Dependent Child be eligible for more than 36 total months of continuation coverage.

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

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

qualifying event and continuation coverage may not be extended beyond 24 months from the initial, qualifying event.

### *COBRA Continuation Coverage and Disability*

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

The date you cease to be disabled or return to active work;

The occurrence of other applicable termination events described in the Termination of COBRA Continuation Coverage section.

### *Summary of Periods of Continuation Coverage*

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

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

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

[3] Refer to above section concerning Application of Continuation Coverage to retirees.

### *Benefits While on COBRA Continuation Coverage*

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

Following receipt of a notice or after a participant's loss of eligibility due to a termination of employment or reduction in hours of employment, the Plan will notify the Participant, Spouse and their eligible Dependent Child of their rights to purchase COBRA continuation coverage and the cost of such coverage that you will self-pay.

### *Making the Election for COBRA Continuation Coverage*

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

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

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

### *Cost of COBRA Continuation Coverage*

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

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

It is the responsibility of each qualified beneficiary or person acting on behalf of a qualified beneficiary, to ensure that the Fund Office receives the correct payment on a timely basis. Nether the Plan or the Fund Office is responsible if the qualified beneficiary causes himself or herself to lose the continuation coverage through a failure to submit the correct payment in a timely fashion.

### *Termination of COBRA Continuation Coverage*

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

The date of death for the covered individual;

The last day of the applicable maximum continuation period;

The last day of the month for which you made a timely self-payment for COBRA continuation coverage;

The date you (as a Spouse) remarry or marry and obtain coverage under another group health plan;

The date you obtain coverage as an Employee under another Employer-sponsored group health plan;

The date the Social Security Administration or Railroad Retirement Board makes a determination that you are no longer disabled;

The date the Plan terminates; or

The date your Employer ceases to be a contributing Employer, except as noted below.

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

Was receiving coverage under the Plan (including Retiree coverage) immediately before the Employer's cessation of participation; and

Is, or whose qualifying event occurred in connection with, a covered Employee or Retiree whose last coverage before the qualifying event was through the applicable Employer.

### *Plan Provided Continuation of Coverage Benefit (Self-Pay)*

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

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

### *Application of Continuation Coverage to Retirees*

Some contributing Employers of the National IAM Benefit Trust Fund provide Retiree coverage for qualified Retirees and their dependents. Refer to the applicable collective bargaining agreement or other Participation Agreement for information on whether such coverage may be available, and for specific rules about how long such coverage is provided. Other contributing Employers have no specific Retiree coverage. If there is a loss of coverage in either case, the Plan offers continuation coverage on a self-pay basis.

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

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

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

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

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

### *Continuation Coverage or Extension of Coverage Other Than COBRA*

Some contributing Employers of the National IAM Benefit Trust Fund provide a temporary extension of healthcare coverage if the Employee is terminated or is totally disabled or hospitalized, and/or the Employer terminates participation in the Fund. Refer to your applicable Participation Agreement for information on whether such an extension may be available to you.

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

# Vision Care Providers

The Plan will provide coverage as shown in this SPD for Eligible Vision Care Expenses obtained from either in-network or out-of-network Vision Care Providers. Your coverage does not require referrals.

### *EyeMed Insight Network*

The EyeMed Insight Network is a Preferred Provider Organization that consists of private practice optometrists, ophthalmologists, and opticians who deliver high quality patient care. In addition to these eye care professionals, the EyeMed Insight Network also offers services through selected retailers such as LensCrafters, most Sears Optical, Target Optical, and most Pearle Vision locations. These providers have agreed to offer some or all services to EyeMed members at discounted rates.

To locate EyeMed Vision Care Providers near you, visit www.eyemed.com, select "find a provider" and choose the **Insight Network** to get a list of the closest in-network providers. Or, if you register as an EyeMed member, you can select "member login" and then "find a provider", and your covered network will be automatically selected. You or your eligible Dependent may also call EyeMed's Customer Care Center directly at 1-866-800-5457 for assistance. The EyeMed Customer Care Center can be reached Monday through Saturday 7:30 am to 11:00 pm EST and Sunday 11:00 am to 8:00 EST.

### *Provider Choice*

You are not required to use an EyeMed Insight Network provider. It is your choice. However, you will receive the lowest out-of-pocket expense by using an in-network provider.

You also have the option of using more than one Vision Care Provider to meet your needs. If you choose to maintain a relationship with an existing or long term out-of-network provider for your routine eye exam, you could choose to use an in-network provider for your materials (frames, lenses, or contact lenses). Please note, out-of-network provider expenses do not apply toward in-network provider expenses and in-network provider expenses do not apply toward out-of-network provider expenses.

### *Provider Nomination*

If your preferred doctor is not currently in the EyeMed Insight Network, you can ask him/her to consider participation. The provider must complete EyeMed's online form at www.eyemedinfocus.com/join. All doctors must accept EyeMed terms and conditions, complete the credentialing process, and be accepted before providing in-network services to EyeMed members. If you ask your provider to join, be sure to tell him/her that you participate in the EyeMed Insight Network.

### *In-Network Providers*

When you receive services from an EyeMed Insight Network provider, the provider will file your claim.

When making an appointment with the EyeMed Insight Network provider of your choice, identify yourself as an EyeMed member and provide your name and the group name, National IAM Benefit Trust Fund, or the group number located on the front of your EyeMed ID card. Confirm that the provider is an in-network provider for the **EyeMed Insight Network**. The in-network provider will then contact EyeMed to confirm your enrollment and obtain authorization for your services. While your ID card is not necessary to receive those services, it is helpful to present your EyeMed Vision Care ID card to the provider at the time of your visit to identify you as a Plan Participant and EyeMed member, and to provide the necessary information to identify and reconfirm your coverage if needed.

#### *Using Your In-Network Benefits Online*

As a Participant with coverage through EyeMed, you have the convenience of using your in-network benefits online to order contact lenses or eyeglasses from certain providers. Call the EyeMed Customer

Care Center at 1-866-800-5457 for more information, or visit www.eyemed.com and click “using your benefit online” to see which in-network providers offer this option.

### *Out-of-Network Providers*

When you receive services from an out-of-network provider, you must file your own claim.

You are responsible to pay the out-of-network provider in full at the time services are rendered, and will be reimbursed for Eligible Vision Care Expenses up to the out-of-network reimbursement amount, if any, shown in the Schedule of Benefits. To receive reimbursement, call the EyeMed Customer Care Center at 1-866-800-5457 to verify eligibility and request an out-of-network claim form. For your convenience, an out-of-network claim form is also available at www.eyemed.com. Fully complete and sign the claim form, attach a copy of your itemized receipts, and send the claim to First American Administrators Inc. (FAA), a wholly owned subsidiary of EyeMed Vision Care, at the following address:

FAA/EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

Claims are processed in the order received. Once your claim is received by EyeMed, please allow at least 14 calendar days for processing. A check and/or explanation of benefits will be mailed within seven calendar days of the date your claim is processed. Inquiries regarding your submitted claim should be made to the Customer Care Center number shown above.

### *If You are Not Able to Access an EyeMed Insight Network Provider*

Based from your home or office location, you have the right to obtain the in-network level of benefits with an out out-of-network provider when you cannot schedule an appointment with an EyeMed Insight Network provider within two-weeks because there is no in-network provider available without excessive travel or delay.

Excessive travel or delay means (a) that in-network providers you contacted were unable to see you within two-weeks, (b) you were unable to locate an in-network provider within a 10-mile radius of your home or office in an urban-suburban area, or (c) you were unable to locate an in-network provider within a 20-mile radius of your home or office in a rural area.

Excessive travel or delay does not include choosing to use an out-of-network provider (a) due to your preference, (b) because your personal schedule does not permit you to schedule an appointment with an available in-network provider within two-weeks, or (c) you are outside of your home or office location.

Benefit enhancement is not automatic. You will be responsible to submit an out-of-network claim form and itemized paid receipts to EyeMed for reimbursement. You will be required to complete a section called “network access exceptions” to provide details about your attempts to locate an in-network provider, what participating providers were contacted, your zip code, and other information. EyeMed will review your information and contact providers for confirmation. Any person who, with intent to defraud or knowing that he or she is facilitating a fraud, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Before you elect to use an out-of-network provider, you should contact the EyeMed Customer Care Center at 1-866-800-5457 to ask them for assistance in locating an Insight Network provider near you.

### *When You Have a Complaint About EyeMed*

If you are dissatisfied with an EyeMed Provider's quality of care, services, materials or facility, or with EyeMed's benefit administration, you should first call the EyeMed Customer Care Center at 1-866-800-5457 to explain the problem and request resolution. The EyeMed Customer Care Center will make every effort to resolve your matter informally.

If you are not satisfied with the resolution from the Customer Care Center service representative, you can file a formal complaint with EyeMed's Quality Assurance Department. Your written comments and supporting documentation should be sent to the following mailing address or fax number:

FAA/EyeMed Vision Care, LLC
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040
Fax: 1-513-492-3259

The EyeMed Quality Assurance Department will resolve your complaint within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after EyeMed's receipt of your complaint. Upon final resolution, EyeMed will notify you in writing of its decision.

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

Contacting EyeMed's Customer Care Center or the Fund Office to make a complaint does not replace the requirement that you file a written appeal if you are not satisfied with the results of a decision by EyeMed on a claim for benefits. If you do not agree with EyeMed's decision on any claim that you submit, you may contact EyeMed's Customer Care Center or the Fund Office about your concerns; however, you must also make a written appeal under the procedures outlined in detail later in this SPD.

# Vision Plan Coverage

The Plan will pay vision benefits as set forth in this SPD for Covered Vision Charges incurred by you, your Spouse, and your Dependent Children while eligible for vision benefits under the Plan.

### *Vision Benefit*

A **vision benefit** is the amount, if any, the Plan will pay for Covered Vision Charges incurred by you, your Spouse, or your Dependent Child, providing they are Eligible Vision Care Expenses.

### *Medically Necessary*

The Plan provides a vision benefit for **medically necessary** contact lenses as shown in the Covered Vision Care Services list. Otherwise, vision benefits are provided for Routine vision care services only. Charges for medical treatment of the eyes is not covered.

### *Copayment*

A **copayment** is the amount a Participant must pay to an **in-network** Vision Care Provider to obtain covered services. Copayments shown in the Schedule of Benefits:

Apply to services received from EyeMed Insight Network providers;

Apply separately to each covered service that is described in the Schedule of Benefits; and

Apply separately to each Participant during the calendar year.

### *Participant Reimbursement*

The **participant reimbursement** amount shown in the Schedule of Benefits is the maximum amount that the Plan will reimburse you directly when you submit a claim for Covered Vision Charges from an **out-of-network** Vision Care Provider. There is no other Plan benefit for out-of-network services.

**Note:** Not all Covered Vision Charges have an out-of-network Participant reimbursement. If a service listed in the Schedule of Benefits does not show an out-of-network Participant reimbursement amount, there will be no payment made to you by the Plan for out-of-network charges incurred for that service.

### *Participant Responsibility*

**In-Network** – When you use in-network Vision Care Providers you are responsible for copayments on Eligible Vision Care Expenses and payment of amounts that exceed Plan allowances, less any discount given by the provider. You are also responsible to pay 100% of charges incurred for services that are not covered by the Plan. The in-network provider will supply you with these costs and expect payment on the date you receive services. Any vision benefit due from the Plan beyond your liability will be paid directly to the EyeMed Insight Network provider.

**Out-of-Network** – When you use out-of-network Vision Care Providers you are responsible for 100% of your incurred charges, less any discount or rebate given by the provider. The Plan will reimburse you directly for any vision benefit due on your claim for Eligible Vision Care Expenses, up to the maximum Participant reimbursement amounts shown in the Schedule of Benefits.

### *Limitations and Maximums*

Please refer to the Schedule of Benefits, Covered Vision Services, and Coverage Limitations sections for information about Plan limitations and maximums.

# Covered Vision Services

The Plan covers the following Routine Vision Care Services, providing that they qualify as Eligible Vision Care Expenses. Refer to the Schedule of Benefits and Coverage Limitations sections for information on coverage and limitations that might apply to your Vision Care Services. If you or your Vision Care Provider have any questions about coverage of a specific service, or about any of the Benefits provided by the Plan, contact EyeMed at 1-866-800-5457 or visit www.eyemed.com.

### *Covered Vision Care Services List*

#### *Eye Examination*

A comprehensive eye examination is covered by the Plan once per calendar year, including dilation, refraction, and prescription for eyeglass lenses, as necessary. Getting an eye exam is part of a healthy person's regular routine, whether your vision is 20/20 or requires correction. In addition to detecting glaucoma or cataracts, an eye exam may detect other health issues such as high blood pressure, diabetes, and high cholesterol, to name a few, which could alert you to the need for further medical treatment. If the Vision Care Provider detects a condition that requires further examination, the provider will recommend that you see your primary care physician.

#### *Contact Lens Fit and Follow-up*

If you wear or would like to wear contact lenses, your Vision Care Provider will recommend additional services including contact lens fitting and follow-up care. Contact lens fit and follow-up services are covered by the Plan once a comprehensive eye exam has been completed. This service can be performed at the time of your eye exam, or it can be performed later as a stand-alone service where appropriate, even by another Vision Care Provider, but no more than once per calendar year.

**Standard contact lens fitting** applies to standard contact lenses; spherical clear contact lenses in conventional wear and planned replacement (e.g., disposables, frequent replacement).

**Premium contact lens fitting** applies to more complex applications, materials, and specialty fittings other than standard contact lenses (e.g., toric, mutifocal, etc.).

Coverage of contact lens fitting includes some follow-up services. Ask your Vision Care Provider what follow-up services are included when you have your fitting.

#### *Retinal Imaging*

Retinal imaging is a diagnostic tool that provides a high-resolution, permanent digital record of your inner eye which can be compared year over year and may help to detect developing conditions. Retinal imaging is covered once per calendar year when performed by an in-network provider. The Plan provides no out-of-network reimbursement for retinal imaging. Please consult with your Vision Care Provider to determine if you are a candidate for retinal imaging.

#### *Frames*

Eyeglass frames are covered once per calendar year. If you use an in-network provider, the Plan will provide an allowance as shown in the Schedule of Benefits. If you choose a frame that retails for more than the Plan allowance, the in-network provider will discount the balance that exceeds the allowance, and you are responsible for the difference. If you use an out-of-network provider, you must pay in full for your charges, and you will be reimbursed up to the out-of-network Participant reimbursement amount shown in the Schedule of Benefits.

### *Eyeglass Lenses*

Prescription eyeglass lenses are covered by the Plan. The benefit includes standard uncoated plastic lenses (single vision, bifocal, trifocal, or lenticular), as well as standard and premium progressive lenses, regardless of size or power. This benefit can be used toward the purchase of prescription sunglasses. Non-prescription sunglasses are excluded. Eyeglass lenses are covered once per calendar year in lieu of coverage for contact lenses.

### *Lens Options*

The Plan provides in-network coverage for certain lens options when eyeglass lenses are covered. These include UV treatment, tints, coatings, and other upgrades at additional cost or discounted rate. Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. See the Schedule of Benefits or speak to your Vision Care Provider for lens options that are available.

**Note:** There is very little or no out-of-network reimbursement for lens options.

### *Contact Lenses*

Prescription contact lenses are covered once per calendar year in lieu of coverage for eyeglass lenses, as provided in the Schedule of Benefits. Be sure to use the entire available allowance or benefit when you obtain contact lenses, since there is no rollover of unused benefits. Contact lenses can be obtained from any Covered Vision Provider. There are three levels of coverage:

**Conventional Contact Lenses** - Contact lenses designed for long-term use (up to one year); can be either daily or extended wear.

**Disposable Contact Lenses** - Contact lenses designed to be thrown away daily, weekly, bi-weekly, monthly or quarterly.

**Medically Necessary Contact Lenses** - Contact lenses to correct extreme vision problems that cannot be corrected by spectacle lenses. Medically necessary with respect to contact lenses means one of the following conditions exists:

- **Anisometropia** of 3D in meridian powers;
- **High Ametropia** exceeding –10D or +10D in meridian powers;
- **Keratoconus** where the Participant's vision is not correctable to 20/30 in either or both eyes using standard spectacle lenses; or
- **Vision Improvement** for Participant's whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses

This benefit may not be expanded for other eye conditions even if you or your providers deem contact lenses necessary for other eye conditions or visual improvement.

Vision Care Providers should contact EyeMed at 1-866-521-3605 before purchase of medically necessary contact lenses to confirm the Participant is eligible for benefits and that the above coverage requirements are met.

### *Additional Services*

EyeMed members may be eligible for some in-network discounts and special offers on additional vision care materials after calendar year benefits have been used, and laser vision correction services. These services are not covered by the Plan, but may be available from EyeMed. Ask your in-network provider for information about any discounts for EyeMed members, or contact EyeMed at 1-866-800-5457.

# Coverage Limitations

### *Eye Examination*

Coverage is limited to one comprehensive eye examination per calendar year.

Except as provided for retinal imaging, there is no additional benefit for routine testing performed during a comprehensive eye examination. Ask your Vision Care Provider if any recommended testing will require you to pay an additional fee.

### *Contact Lens Fit and Follow-up*

Contact lens fitting is covered by the Plan once a comprehensive eye exam has been completed. The benefit is limited to once per calendar year. Participant should ask about covered follow-up services at the time of contact lens fitting.

### *Retinal Imaging*

Retinal imaging is limited to once per calendar year.

### *Eyeglass Lenses*

One pair of conventional prescription eyeglass lenses (two lenses) is covered per calendar year, in lieu of the benefit for contact lenses. There is no coverage for both eyeglass lenses and contact lenses within the same calendar year.

There is no benefit for Plano (non-prescription) lenses or for cosmetic lenses.

### *Frames*

Eyeglass frames can be purchased independently of eyeglass lenses.

### *Contact Lenses*

Contact lenses are covered once per calendar year, in lieu of the benefit for eyeglass lenses. There is no coverage for both contact lenses and eyeglass lenses within the same calendar year.

If prescription contact lenses are required for only one eye, the benefit is one-half of the amount that applies to contact lenses for both eyes.

There is no benefit for Plano (non-prescription) contact lenses or for cosmetic contact lenses.

Providers should contact EyeMed before purchase of medically necessary contact lenses to confirm the Participant is eligible and that coverage requirements are met.

### *General Limitations*

There is no roll-over of unused benefits. Each benefit and/or allowance can be used only once per calendar year.

There is no additional benefit for component services billed by multiple Vision Care Providers. However, different providers may be used for different service types if desired (e.g., complete eye exam from one provider, eyeglasses or contact lenses from another). Each provider, in-network or out-of-network, would be subject to the applicable coverage shown in the schedule of benefits.

All Vision Care Providers may not carry all brands at all levels of coverage. Speak to your provider and/or EyeMed if you have questions about what products are available from a provider, or about what services are provided by your Plan.

# Exclusions

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

1. Charges or services for which benefits are payable under any Workers' Compensation law or any other law of similar purpose, regardless of whether benefits are paid in full or in part.
2. Charges or services that result from, or arise out of, any past or present employment or occupation for compensation or profit.
3. Charge for any service or supply that is required by an Employer as a condition of employment, or which an Employer is required to provide due to a labor agreement, or which is required by a government body.
4. Charges or services that result from an act of declared or undeclared war, the Participant's commission of a crime, or non-therapeutic release of nuclear energy.
5. Charges for services, supplies, or treatments that are furnished, paid for, or otherwise provided by reason of past or present service in the armed forces of a government, except as otherwise provided by law.
6. Charges for services, supplies, or treatments that are furnished, paid for, or otherwise provided by any local, state, or federal government agency, program, or institutions, unless otherwise provided by law.
7. A charge or part of a charge that the Participant is not obligated to pay, or for which the Participant would not have been billed except for the fact that the Participant was covered under the Plan.
8. Services or supplies that are provided by (a) a person who ordinarily lives in the Participant's home, or (b) a spouse, child, parent, or sibling of the Participant or of the Participant's Spouse.
9. Charges for services or supplies that are included as covered expenses under any other benefit provided by the Plan.
10. Services or materials provided by any other group benefit plan providing vision care.
11. Benefits may not be combined with any discount, promotional offering, or other group benefit plan.
12. Experimental, investigational, or unproven services, treatments, or devices.
13. Charges incurred on a date when no eligibility exists.
14. Services rendered after the date a person ceases to be covered under the Plan, except when vision materials ordered before coverage ended are delivered, and the services rendered to the Participant are within 31 days from the date of such order.
15. Coverage for the children of your children, unless such children are otherwise determined to be your qualified eligible Dependents within the meaning of Section 152 of the Internal Revenue Code and legal documentation is provided to the Fund as required during the enrollment process.
16. Services rendered by an unlicensed provider, or any provider who is operating outside the scope of his or her license.
17. Medical, pathological, or surgical treatment of the eye, eyes, or supporting structures, including treatment of any eye disease or eye injury.

18. More than one Routine eye examination, one pair of conventional lenses or contact lenses, and one eyeglass frame during each calendar year.
19. Eyeglass lenses and contact lenses during the same calendar year.
20. There is no roll-over of unused benefits. Benefit allowances provide no remaining balance for future use within the same calendar year. Each benefit and/or allowance can be used only once per calendar year.
21. Aniseikonic lenses.
22. Plano (non-prescription) lenses.
23. Non-prescription sunglasses.
24. Two pair of glasses in lieu of bifocals.
25. Duplicate or spare eyeglasses, lenses, or frames, except in the next calendar year when vision materials would next become available.
26. Replacement of lost, stolen, or broken lenses, frames, or contact lenses, except in the next calendar year when vision materials would next become available.
27. Repair of broken lenses, frames, glasses, or contact lenses, except in the next calendar year when vision materials would next become available.
28. Charges for any services or materials connected with charges for special procedures, treatments, or supplies, including surgical vision correction, orthoptic or vision training, subnormal vision aids and any associated supplemental testing.
29. Cosmetic services or cosmetic extras (except lens options as provided), eyeglass cases, eyeglass repair kits, lens care kits, cleaning solutions, insurance coverage, or warranty.
30. Any sales tax charged by a provider as part of the transaction for covered services are not covered by the Plan.
31. Telephone, e-mail, and internet consultations, and telemedicine.
32. Claims that are received more than one year after the date of service, unless shorter filing limits are required under an in-network provider's contract with the EyeMed.
33. Any service, supply, or treatment that is not identified as a covered benefit under the terms of the Plan and as set forth in this SPD.

# Coordination of Benefits

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

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

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

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

### *Effect of Coordination of Benefits*

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

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

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

### *How Much the Plan Pays When it is Secondary*

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

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

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

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

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

### *Understanding Coordination of Benefits*

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

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

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

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

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

### *Coordination of Benefits with Government Programs*

#### *Medicaid*

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

#### *Military Insurance Coverage*

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

#### *Veterans Affairs Facility Services*

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

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

### *Motor Vehicle No-Fault Coverage Required by Law*

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

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

### *Rules to Determine Payment*

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

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

**Rule 1: No Coordination of Benefit Provision**

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

**Rule 2: Coverage as a Subscriber and as a Dependent**

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

**Rule 3: Dependent Child Covered Under More Than One Plan**

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

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

**Rule 4: For a Child of Separated or Divorced Parents**

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

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

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

**Rule 6: Longer/Shorter Length of Coverage**

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

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

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

### *Administering Coordination of Benefits*

To administer COB, the Plan reserves the right to:

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

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

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

# Third-Party Liability and Right of Recovery

### *Payment Prior to Determination of Responsibility of a Third Party*

The Plan does not cover, nor is it liable for, any charges or expenses incurred by a participant, his or her parent(s) and eligible dependent(s) or a representative, guardian or trustee of the participant, parent(s) or eligible dependent(s) (hereinafter, collectively "claimant") as a result of an accident or injury for which one or more third parties (any person or entity) are, or may be, liable. However, subject to the terms and conditions of this Section, the Board of Trustees or their designee, at their discretion, may advance payment for some or all of a claimant's vision care 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;

All other information the Plan may request.

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

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

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

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

### *No-Fault Insurance Coverage*

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

The maximum amount of basic reparation benefit required by applicable law; or

The maximum amount of the applicable no-fault insurance coverage in effect.

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

If the participant or his/her eligible dependent fails to secure no-fault insurance as required by state law, the participant or eligible dependent is considered as being self-insured and must pay the amount of the basic medical reparation expenses for himself and/or his eligible dependents arising out of the accident.

### *Refund of Overpayment of Benefits — Right of Recovery*

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

All or some of the expenses were not paid or did not legally have to be paid by you or your eligible Dependents;

All or some of the payment made by the Fund exceeds the benefits under the Plan; or

All or some of the expenses were recovered from or paid by a source other than this Plan including another plan to which this Plan has secondary liability under the Coordination of Benefits provisions. This may include payments made as a result of claims against a third party for negligence, wrongful acts or omissions.

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

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

# Claims Filing and Appeal Procedures

This Section of the SPD describes the procedures for filing claims 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 is denied in whole or in part and you wish to appeal the decision.

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

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 |
|---|---|
| FAA/EyeMed Vision Care, LLC<br>Attn: Quality Assurance Dept.<br>4000 Luxottica Place<br>Mason, OH 45040<br>Fax: 1-513-492-3259<br>www.eyemed.com | Vision Claims<br>First Level Appeals |
| Board of Trustees<br>National IAM Benefit Trust Fund<br>99 M Street, SE, Suite 600<br>Washington, DC 20003<br>www.iambtf.org | Eligibility Determinations<br>Second-Level Appeals |

### *Right to an Authorized Representative*

In making a claim or appeal, you may be represented by any authorized representative. An "authorized representative" means a person you authorize, in writing, to act on your behalf, such as your Spouse, attorney, parent, court appointed guardian, or a health care professional with knowledge of your condition. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. You must designate the representative by a signed written statement. A form can be obtained from the Fund Office to designate an authorized representative. A consent form that you may use for this purpose can also be provided by EyeMed upon request. If you do so, you must notify the Fund Office and EyeMed Vision Care in writing of your choice of an authorized representative.

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

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

### *Adverse Benefit Determination*

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

A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit; or

A reduction of a benefit resulting from the application of any exclusion or other limitation, or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not medically necessary.

### *Health Care Professional*

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

### *Definition of a Claim*

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

Casual inquiries about benefits or the circumstances under which benefits might be paid according to the terms of the Plan are **not** considered claims. 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 must include the following elements to trigger the Plan's internal claims process:

Be written or electronically submitted;

Be received by the Claims Administrator;

Name a specific individual participant and his/her Social Security Number or other assigned unique identification number;

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

Provide a description and date of a specific treatment, service or product for which payment is requested (must include an itemized detail of charges and applicable service codes);

Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and

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

Not made in accordance with the Plan's benefit claims filing procedures described in this section;

Made by someone other than you, your covered dependent, or your (or your covered dependent's) authorized representative;

Made by a person who will not identify himself or herself (anonymous);

A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;

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

An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;

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

### *How to File a Claim*

Please make sure that you present your benefit identification card to each provider before you are given any services so that the provider will know that you participate in the EyeMed Insight Network Preferred Provider Organization. Non-Preferred Providers will require that you pay them first and that you seek reimbursement by filing your own claim with EyeMed.

#### *In-Network Benefits*

If you use EyeMed Insight Network providers, your claim for benefits will go directly from the in-network Vision Care Provider through an automated electronic system, or through the mail, to the Claims Administrator for processing. Generally, you are **not** required to file a claim form for in-network benefits.

#### *Out-of-Network Benefits*

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

You may obtain a claim form by calling the EyeMed Customer Care Center at 1-866-800-5457 or by going online at www.eyemed.com. To expedite the processing of your claim, please be sure to complete the form thoroughly. Your written claim must be mailed to EyeMed as soon as reasonably possible after the expense is incurred, but in no event more than one year after the expense is incurred.

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

### *Filing a Claim*

You may file claims for out-of-network vision benefits and appeal adverse claim decisions yourself or have an authorized representative do it for you. The in-network provider will make the claim on your behalf directly to EyeMed. If your claim is denied, in whole or in part, you will receive a written notice of the denial from EyeMed. 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.

#### *Post-Service Claims—Submit Directly to EyeMed*

Fully completed and signed out-of-network claim forms, with a copy of your itemized receipts, should be sent to First American Administrators Inc. (FAA), a wholly owned subsidiary of EyeMed Vision Care, at the following address:

FAA/EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

For post-service claims, you will be notified of the decision not later than 30 calendar days after receipt of the claim. These time periods may be extended up to an additional 15 calendar days due to

circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30 calendar day period.

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

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

### *Notice of Decision*

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

The claim involved.

The specific reason(s) for the determination.

The Plan standard that was used, if any.

The specific Plan provision(s) on which the determination is based.

A description of any additional material or information necessary to perfect or decide the claim, and an explanation of why the material or information is necessary.

A description of the appeal procedures and applicable time limits for pursuing the appeal or filing a legal claim.

A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule, or a statement that such a rule was relied upon in deciding the claim and that a copy will be provided to you upon request at no charge.

If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

### *Internal Appeals of Vision Claims*

*1. First Level Appeal*

**Vision Benefits Appeal**

If you disagree with EyeMed's decision on any of your claims for vision benefits, you may submit an appeal to EyeMed. Your request for appeal review must be made in writing within 180 days of receipt of your denial notice, and should be mailed to FAA/EyeMed Vision Care, LLC, Attn: Quality Assurance Dept., 4000 Luxottica Place, Mason, OH 45040. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal including:

- The applicable claim number or a copy of the written denial or a copy of the EOB, if applicable.
- The item of vision coverage that the Participant feels was misinterpreted or inaccurately applied.

- Additional information from the Vison Care Provider that will assist FAA in completing its review of the first level appeal, such as documents, records, questions or comments.

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

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

**Eligibility Appeal**

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

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

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

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

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

*2. Second Level Appeal*

**Right to Second Level Appeal**

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

**Filing a Second Level Appeal**

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

for review. If special circumstances require a further extension of time for processing, a determination will be made no later than the third meeting following the initial receipt of the appeal. If an extension is required, you will be notified of the extension and the reasons for it prior to the commencement of the extension.

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

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

- The specific reason(s) for the appeal;
- Copies of all past correspondence with the Fund, including any Explanation of Benefits (EOB's);
- Copies of the adverse appeal determination made by EyeMed; and
- Any applicable information that you have not yet sent to the Fund Office.

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

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

The Board of Trustees will review your appeal. They will evaluate your claim within the timeframes described above. You will be notified of the Board of Trustees decision on your appeal within 5 calendar days calendar days after the date your appeal is reviewed.

### *Elimination of Conflict of Interest*

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

### *Facility of Payment*

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

### *Board of Trustee Decisions Are Final and Binding*

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

# Miscellaneous

### *Misrepresentation and Fraud*

In the event you, your Spouse, or your Eligible Dependent Children receives benefits as a result of misleading representation or any type of false information or other fraudulent representations to the Fund, you, your Spouse, or your Eligible Dependent Child will be liable to repay all amounts paid by the Fund.

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

### *Overpayments and Erroneous Payments*

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

### *Notices Sent to Addresses of Participants*

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

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

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

### *Cost Savings*

#### *Provider Fees and Treatment Plans*

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

Remember that coverage under the Plan for out-of-network services is limited and, in some cases, may not be covered. You are liable for charges billed by a provider that exceed the allowable covered charges or maximum payment under the Plan, and for non-covered services.

#### *Bills and Unnecessary Services*

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

### *Reliance on Coverage Statements*

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

## *Use and Disclosure of Protected Health Information*

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

## *Privacy Notice*

## *Section 1: Purpose of This Notice and Effective Date*

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

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

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

The Fund's uses and disclosures of Protected Health Information (PHI),

Your rights to privacy with respect to your PHI,

The Fund's duties with respect to your PHI,

Your right to file a complaint with the Fund and with the Secretary of the United States Department of Health and Human Services (HHS), and

The person or office you should contact for further information about the Fund's privacy practices.

## *Section 2: Your Protected Health Information*

### *Protected Health Information (PHI) Defined*

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

### *When the Fund May Disclose your PHI*

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

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

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

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

Treatment,

Payment, or

Health care operations.

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

For example, the Fund may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your vision 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:

Yolanda Montgomery, Privacy Official
National IAM Benefit Trust Fund
99 M Street, SE, Suite 600
Washington, DC 20003

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

### *You May Request Restrictions on PHI Uses and Disclosures*

You may request the Fund to:

Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or

Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

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

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

### *You May Request Confidential Communications*

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

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

### *You May Inspect and Copy PHI*

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

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

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

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

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

### *You Have the Right to Amend your PHI*

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

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

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

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

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

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

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

*Your Personal Representative*

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

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

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

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

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

## *Section 4: The Fund's Duties*

*Maintaining your Privacy*

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

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

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

The uses or disclosures of PHI,

Your individual rights,

The duties of the Plan, or

Other privacy practices stated in this notice.

*Disclosing Only the Minimum Necessary Protected Health Information*

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

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

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

Uses or disclosures made to you,

Uses or disclosures made pursuant to your authorization,

Disclosures made to the Secretary of the United States Department of Health and Human Services pursuant to its enforcement activities under HIPAA,

Uses or disclosures required by law, and

Uses or disclosures required for the Fund's compliance with the HIPAA privacy regulations.

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

Does not identify you, and

With respect to which there is no reasonable basis to believe that the information can be used to identify you.

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

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

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

Yolanda Montgomery, 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 above. The Board of Trustees has designated an Executive Director to supervise the daily functions of the Plan. As the legal Plan Administrator, the Trustees have the authority to allocate or delegate their responsibilities for the administration of the Plan to others and employ others to carry out or provide guidelines with respect to their responsibilities under the Plan.

### *Agent for Service*

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

### *Fund Office Administration*

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

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

Phone: 202-785-8148
Fax: 202-728-0585
www.iambtf.org

The Fund Office performs the following:

Receives Employer contributions

Keeps eligibility records

Provides information about the Plan

### *Claims Administrator*

Claims for vision benefits are processed by the Claims Administrator, which is EyeMed Vision Care. EyeMed has delegated the responsibility of its claims determinations to First American Administrators, Inc. (FAA), a wholly-owned subsidiary of EyeMed. FAA has the discretionary authority to decide claims and first level appeals, including the authority to interpret EyeMed provisions and the authority to grant and/or deny any and all claims for vision benefits.

Claims for out-of-network benefits should be sent to FAA, at the following address:

FAA/EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

Inquiries should be made to the EyeMed Customer Care Center at 1-866-800-5457.

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

### *Selection of Preferred Providers*

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

The Board of Trustees currently has a contract with the following organization for a Preferred Provider network:

EyeMed Vision Care
P.O. Box 8504
Mason, OH 45040-7111
Phone: 1-866-800-5457

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

### *Trust Fund*

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

### *Identity of Source of Benefits*

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

### *Plan Year*

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

### *Collective Bargaining Agreements*

This Plan is maintained pursuant to one or more collective bargaining agreements, or other type of agreement. A copy of any such agreement may be obtained upon written request to the Fund Office and is available for examination at the Fund Office. Upon written request, the Fund Office will tell you if an Employer is contributing to the National IAM Benefit Trust Fund on behalf of its Employees or will supply you with a list of such Employers.

### *Workers' Compensation*

The Plan is not in place of and does not affect any requirement for coverage by workers' compensation insurance. Benefits are not paid under this Plan for diseases for which benefits are payable under any workers' compensation law or for accidental bodily injuries which arise out of or 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 physician or other provider of health care, whether designated by the Plan or otherwise, is your voluntary act. Nothing in this SPD is meant to be a recommendation or instruction to use any provider. You should select a provider or course of treatment based on all appropriate factors, only one of which is coverage by the Plan. Providers are independent contractors, not Employees of the Fund. The Trustees make no representation regarding the quality of service or treatment of any provider and are not responsible for any acts of commission or omission of any provider in connection with Plan coverage. The provider is solely responsible for the services and treatments rendered.

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

### *Right to Amend*

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

### *Erroneous Benefit Payments*

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

### *No Assignment of Benefits*

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

### *Plan Termination*

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

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

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

### *Savings Clause*

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

### *Source of Plan Funding*

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

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

The amount of contributions and the Employees on whose behalf contributions are made are determined by the provisions of the collective bargaining agreements or other agreements, as approved by the Trustees. The Employer must make the required payments for a month for coverage to be provided for the period. The Trustees reserve the right to terminate the participation of any Employer at any time for any reason.

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

### *Erroneous Contributions*

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

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

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

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

# Glossary

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

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

**Claims Administrator** means the entity that processes vision claims.

**Covered Vision Charge** means a charge that: (1) is made for a Routine vision service or supply that is furnished to a Participant; and (2) meets all the following tests:

It is shown in the Covered Vision Care Services List and/or the Schedule of Benefits;

It is incurred by a Participant while the Participant is eligible for vision benefits under this Plan. A charge is deemed to be incurred at the time the service is rendered or the supply is furnished for which the charge is made;

It is furnished by or received from a Covered Vision Provider; and

It is not listed as a Plan Exclusion.

**Covered Vision Provider** means a person or place that is licensed to provide Routine vision care or optometric services to covered Participants, including a legally qualified ophthalmologist, optometrist, optician or optical supply company.

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

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

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

**Eligible Vision Care Expenses** are the Covered Vision Charges for the Routine vision services or supplies listed in the Schedule of Benefits and the Covered Vision Care Services List. Any service or expense that is excluded from coverage by the Plan will not be considered an Eligible Vision Care Expense. If the charge for a Covered Vision Service exceeds the Plan's allowance for that service, the excess amount is not considered an Eligible Vision Care Expense. If a Vision Care Provider discounts, waives, or rebates any portion of a charge, that amount is not considered to be an Eligible Vision Care Expense and the Plan is not obligated to provide benefits that exceed the adjusted charge amount.

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

**Employer** means any Employer obligated under a collective bargaining agreement 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.

**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.

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

**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.

**Preferred Provider Organization** means an organization that negotiates discounted rates with health care providers in an effort to provide benefits to Participants.

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

**Retinal Imaging** is a diagnostic tool that provides high-resolution permanent records of the inside of the eye including the retina, optic nerve, macula, and blood vessels. The image is used to screen for eye diseases and can be compared to images taken in future examinations.

**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.

**Routine** with respect to vision care means that the services are not related to Illness or Injury, except where allowed by the Plan under the benefit for Medically Necessary contact lenses.

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

**Vision Care Provider** means a Covered Vision Provider who is acting within the scope of his license to provide Vision Care Services to Plan Participants.

**Vision Claim Form** means the FAA/EyeMed out-of-network claim form provided by EyeMed.

**You and your** means the Employee/participant who is eligible for coverage under the terms of the plan and who can enroll his or her Spouse and/or eligible Dependent Children.

# Statement of ERISA Rights

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

As a participant in the National IAM Benefit Trust Fund Health and Welfare Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights:

### *Receive Information about your Plan and Benefits*

You have the right to:

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator's office, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator's office may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### *Continue Group Health Plan Coverage*

You have the right to continue group health coverage for yourself, Spouse or eligible Dependent Child if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

### *Prudent Actions by Plan Fiduciaries*

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### *Enforce your Rights*

If your claim for a benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen

that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

However, in all cases including those described in the above paragraph, you must first exhaust your administrative remedies under the Plan (by following the claims and appeals procedures described in the SPD) before you may file suit in any court.

### *Assistance with Questions*

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

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

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

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