NATIONAL IAM
BENEFIT TRUST FUND

Health and Welfare Plan

Plan H003

Active and Retiree Plan
For Employees and Retirees of
SAMPLE SPD BOOKLET

NATIONAL IAM
BENEFIT TRUST FUND
HEALTH AND WELFARE PLAN

To all Participating Employees:

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

The purpose of the Fund is to provide health and welfare benefits to participants and their families. Medical coverage is self-funded through contributions paid by employers and employees participating in the Plan. Life insurance and Accidental Death and Dismemberment Benefits are insured through a contract with a life insurance company.

Medical benefits are provided only to the extent permitted by the contributions. Should contributions not provide sufficient funding to maintain benefits, the Trustees reserve the right to change the eligibility rules, reduce or change the benefits, or eliminate the Plan, in whole or in part.

Please read this booklet carefully and keep it in a safe place for future reference.

EMPLOYER TRUSTEES	UNION TRUSTEES
Thomas Mitchell	James Conigliaro
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INTRODUCTION

This booklet sets forth the Health and Welfare Plan for active Employees and Retirees of **SAMPLE SPD (Employer name goes here)**. It explains all of the health and welfare benefits provided by the Plan as of its Effective Date. It is subject, however, to the terms of any agreements between the Trustees and third party providers of benefits. This booklet also serves as your Summary Plan Description.

This booklet sets forth benefits in effect for all claims incurred on or after **April 1, 2014 SAMPLE SPD**, unless otherwise stated.

Only the Board of Trustees is authorized to interpret the Plan. The Board 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. The Board also has the discretion to make any factual determinations about any claim. Your Employer or Union Representative does not have the authority to interpret and apply the Plan on behalf of the Board or to act as agent of the Board.

The Board has authorized the Fund Office to respond in writing to any written questions you may have about the Plan. If you have a question about your benefits, please write to the Fund Office for an answer.

As a courtesy to you, the Fund Office may also respond informally to oral questions. However, oral information and answers are not binding on the Board of Trustees and cannot be relied upon in any dispute concerning your benefits.

Plan rules and benefits may change from time to time. If this happens, you will receive written notice of the change. The Trustees reserve the right to set the effective date of any Plan change. Please be sure to read all communications from the Fund and keep them, along with a copy of this booklet, in a safe place.

SCHEDULE OF BENEFITS

THE FOLLOWING PAGES GIVE A BRIEF LISTING OF THE BENEFITS PROVIDED BY THE PLAN FOR YOUR EASY REFERENCE. PLEASE DO NOT RELY ON THIS LISTING ALONE TO DETERMINE YOUR BENEFITS. IMPORTANT COVERAGE DETAILS AND EXCLUSIONS THAT MAY AFFECT YOU AND YOUR CLAIMS WILL BE FOUND IN THE REST OF THIS BOOKLET.

In and Out-of-Network Providers

This Plan provides medical benefits for services, treatments, and supplies provided by "In-Network" providers and "Out-of-Network" providers, unless otherwise noted. You or your Dependents can obtain the names of the "In-Network" providers in your area by consulting the Fund's website at www.iambtf.org, or Cigna's website at www.mycigna.com. You may also get this information by calling the toll-free number shown on the back of your ID card; 1-800-244-6224, or 1-800-Cigna 24. We recommend that you confirm a provider's ***current*** participation in the Open Access Plus network by calling Cigna directly prior to treatment. If you are unable to locate an "In-Network" provider in your area who can provide you with a service or supply that is covered under this Plan, you should call the number on the back of your ID card for assistance. In some circumstances, you may be able to obtain an authorization that the services provided by an "Out-of-Network" provider will be covered at the "In-Network" provider benefit level.

Patient Percentage and Deductible

The patient percentage amounts shown below are expenses to be paid by you or your Dependent to your providers of service for services you receive. The deductible amounts shown below are also expenses to be paid to your providers of service by you or your Dependent. Deductible amounts are separate from patient percentage amounts, and are not included in the covered charges that count toward the calendar year patient percentage limits.

FINANCIAL	IN-NETWORK	OUT-OF-NETWORK
LIFETIME MAXIMUM	Unlimited	Unlimited
DEDUCTIBLE (Per Calendar Year):		
INDIVIDUAL	$400	$400
FAMILY	$1,200	$1,200
PATIENT PERCENTAGE (Per Calendar Year):		
INDIVIDUAL	20% of the first $20,000 in covered charges per individual (equals $4,000 out-of-pocket)	40% of the first $20,000 in covered charges per individual (equals $8,000 out-of-pocket)
FAMILY	20% of the first $40,000 in covered charges per family (equals $8,000 out-of-pocket)	40% of the first $40,000 in covered charges per family (equals $16,000 out-of-pocket)
PREVENTIVE / WELLNESS:	**IN-NETWORK**	**OUT-OF-NETWORK**
ROUTINE EXAMINATIONS Annual physical exam, annual female gyn exam, routine well child visits	100% not subject to deductible	60% not subject to deductible
ROUTINE IMMUNIZATIONS Physician recommended immunizations, annual flu shot (excludes travel vaccines)	100% not subject to deductible	60% not subject to deductible
ROUTINE LAB AND X-RAY Ordered or performed in conjunction with routine exam, includes annual pap & PSA	100% not subject to deductible	60% not subject to deductible
ROUTINE COLONOSCOPY Every 3 yrs beginning at age 50; if high risk of colon cancer, per doctor, benefit provided every 2 yrs regardless of age	100% not subject to deductible	60% not subject to deductible
ROUTINE MAMMOGRAPHY 1 baseline mammogram age 35-39, 1 mammogram per year from age 40	100% not subject to deductible	60% not subject to deductible
ROUTINE NEWBORN CARE	80% after deductible	60% after deductible
FAMILY PLANNING	80% after deductible	60% after deductible
PHYSICIAN SERVICES:	**IN-NETWORK**	**OUT-OF-NETWORK**
OFFICE VISITS	80% after deductible	60% after deductible
URGENT CARE FACILITY VISITS	80% after deductible	60% after deductible
EMERGENCY ROOM VISITS	80% after deductible	80% after deductible (60% after deductible if not a true emergency)

PHYSICIAN SERVICES (continued):	IN-NETWORK	OUT-OF-NETWORK
INPATIENT HOSPITAL VISITS	80% after deductible	60% after deductible
SURGEON	80% after deductible	60% after deductible
ASSISTANT SURGEON	80% after deductible	60% after deductible
ANESTHESIOLOGIST	80% after deductible	60% after deductible
PATHOLOGY & RADIOLOGY INTERPRETATION	80% after deductible	60% after deductible
ACUTE CARE HOSPITAL:	**IN-NETWORK**	**OUT-OF-NETWORK**
INPATIENT	80% after deductible	60% after deductible
OUTPATIENT (Except ER)	80% after deductible	60% after deductible
EMERGENCY ROOM	80% after deductible	80% after deductible (60% after deductible if not a true Emergency)
OTHER SERVICES:	**IN-NETWORK**	**OUT-OF-NETWORK**
ACUPUNCTURE Only by an M.D. for a pain diagnosis	80% after deductible	60% after deductible
ALLERGY TESTING/TREATMENT	80% after deductible	60% after deductible
AMBULANCE TRANSPORT	80% after deductible	60% after deductible
BARIATRIC SURGERY	80% after deductible	Not Covered
CHIROPRACTIC CARE 20 day maximum per calendar year	80% after deductible	60% after deductible
CLINICAL TRIALS Only if sponsored by the Federal Government with other limitations	80% after deductible	60% after deductible
DIAGNOSTIC LAB AND X-RAY	80% after deductible	60% after deductible
DURABLE MEDICAL EQUIPMENT	80% after deductible	60% after deductible
ERECTILE DYSFUNCTION Only if caused by a medical condition	80% after deductible	60% after deductible
GENETIC TESTING	80% after deductible	60% after deductible
HEARING AIDS	Not Covered	Not Covered
HOME HEALTH CARE Only as an alternative to hospitalization	80% after deductible	60% after deductible
HOSPICE CARE	80% after deductible	60% after deductible
MEDICAL SUPPORT CHARGES	80% after deductible	60% after deductible
NUTRITIONAL EVALUATION AND COUNSELING Only for management of organic disease	80% after deductible	60% after deductible

OTHER SERVICES (continued):	IN-NETWORK	OUT-OF-NETWORK
ORGAN TRANSPLANTS	80% after deductible	60% after deductible
PODIATRY CARE 30 day maximum per calendar year; except surgery pays like any illness	80% after deductible	60% after deductible
SECOND SURGICAL OPINION	80% after deductible	60% after deductible
SHORT-TERM REHABILITATIVE THERAPY Physical, occupational, speech, and other therapies; 50 day combined maximum per calendar year for all covered therapies	80% after deductible	60% after deductible
SKILLED NURSING FACILITY 100 day maximum per calendar year, but only following an Inpatient Hospital stay	80% after deductible	60% after deductible
SPECIALIZED FACILITY Ambulatory Surgical Facility, Birth Center	80% after deductible	60% after deductible
TMJ TREATMENT $600 maximum payable per calendar year	80% after deductible	60% after deductible
MENTAL HEALTH SERVICES:	**IN-NETWORK**	**OUT-OF-NETWORK**
INPATIENT	80% after deductible	60% after deductible
OUTPATIENT	80% after deductible	60% after deductible
SUBSTANCE ABUSE TREATMENT:	**IN-NETWORK**	**OUT-OF-NETWORK**
INPATIENT	80% after deductible	60% after deductible
OUTPATIENT	80% after deductible	60% after deductible
OTHER COVERED BENEFITS:	**IN-NETWORK**	**OUT-OF-NETWORK**
ANY COVERED SERVICES THAT ARE NOT LISTED ABOVE	80% after deductible	60% after deductible
PRESCRIPTION DRUGS:	**COVERED THROUGH CVS CAREMARK**	
Up to **34 DAY SUPPLY** of a covered prescription drug at any retail pharmacy	**COPAYMENT:** $20 Generic; $40 Preferred; $50 Non-Preferred	
Up to **90 DAY SUPPLY** of a maintenance drug at a CVS Pharmacy or by mail order	**COPAYMENT:** $40 Generic; $80 Preferred; $100 Non-Preferred	
SPECIALTY MEDICATIONS from CVS Caremark Specialty Pharmacy Services	**COPAYMENT:** $40 Generic; $80 Preferred; $100 Non-Preferred	
FEMALE CONTRACEPTIVES	**NO COPAYMENT** for covered **generics** or **single source brands**	
AGE LIMIT FOR CHILDREN:	Eligible dependent children are covered up to age 26	

COVERED CHARGE LIMITS

The following limitations apply in addition to those listed in the Schedule of Benefits.

Benefit Allowances:	**Limit:**
In-Network	Preferred Provider Organization's contract rates
Out-of-Network	Usual, Customary & Reasonable (UC&R) Charges
Acute Care Hospital:	**Limit:**
Routine Care Daily Limit	Hospital's Average Semi-Private Room Rate
ICU Daily Limit	300% of the Routine Care Daily Limit
Skilled Nursing Facility:	**Limit:**
Daily Limit	50% of the prior Acute Care Hospital's Average Semi-Private Room Rate
Inpatient Maximum	100 days per calendar year
Specialized Care Facility:	**Limit:**
Daily Limit	Facility's Average Semi-Private Room Rate
Hospice Care:	**Limit:**
Inpatient Respite Care	8 day maximum payable per lifetime
Bereavement Counseling	3 sessions
Home Health Care:	**Limit:**
Home Health Aide	40 visits of 4 hours or less per calendar year

MEDICALLY NECESSARY CHARGES

BENEFITS ARE PAYABLE FOR CHARGES INCURRED ONLY TO THE EXTENT THE CHARGES ARE FOR SERVICES, SUPPLIES, AND TREATMENTS THAT ARE MEDICALLY NECESSARY AS DEFINED BY THE PLAN, AND ONLY UP TO THE APPLICABLE MAXIMUM AMOUNT ALLOWED BY THE PLAN.

THIS PLAN'S BENEFITS ARE COORDINATED WITH BENEFITS FROM OTHER PLANS, INCLUDING MEDICARE. SEE THE "COORDINATION OF BENEFITS" SECTION OF THIS BOOKLET FOR AN EXPLANATION OF HOW THIS WORKS. THIS IS ESPECIALLY IMPORTANT IF YOU OR YOUR COVERED DEPENDENTS ARE ELIGIBLE FOR MEDICARE, AS PLAN BENEFITS FOR RETIREES (AND CERTAIN DISABLED PERSONS) WILL BE REDUCED IF YOU NEGLECT TO ENROLL WHEN YOU ARE ENTITLED TO MEDICARE COVERAGE.

PREFERRED PROVIDER ORGANIZATION

(CIGNA OPEN ACCESS PLUS NETWORK)

The National IAM Benefit Trust Fund contracts with Connecticut General Life Insurance Company ("Cigna") for access to a nationwide provider network. Services provided by Physicians or Hospitals in the Cigna **Open Access Plus** network will result in less cost to both you and the National IAM Benefit Trust Fund.

When you select a Cigna participating provider, this Plan pays a greater share of the costs than if you select a non-participating provider. In addition, the Cigna participating provider agrees to accept payments from the Plan at the discounted levels negotiated by Cigna.

Please present your medical ID card to all service providers. The card identifies you as a Cigna **"Open Access Plus"** PPO network participant. Please note that the use of a Cigna Open Access Plus PPO network provider is *not* mandatory. It is your choice. Remember, however, both you and the Plan will experience a savings if you do choose an Open Access Plus "In-Network" provider.

Participating providers include Physicians, Hospitals, other health care professionals, and other health care facilities. Participating providers are committed to providing you and your Dependents appropriate care while lowering medical costs. To search for participating providers in the Cigna **Open Access Plus** network, please access the Fund's website at: www.iambtf.org or Cigna's website at: www.mycigna.com. You may also get this information by calling the toll-free number shown on the back of your ID card, 1-800-244-6224, or 1-800-Cigna 24. We recommend that you confirm a provider's *current* participation in the Open Access Plus network by calling Cigna directly prior to treatment. If you would like a paper directory of providers, please contact Cigna at the number on your medical ID card to request one for your zip code area.

Please contact the Fund Office if you need assistance: 202-785-8148 or 1-800-457-3481.

Applicability of In-Network Benefits

You must utilize a Cigna **Open Access Plus** network provider to obtain "In-Network" benefits.

Exceptions to this rule are:

- **Emergency Medical Care**: Whenever possible, you should request treatment from Open Access Plus providers. However, benefits will be provided at the "In-Network" level for all Medically Necessary Emergency Services associated with true medical Emergencies that are received in the Emergency Rooms of both in and out-of-network Hospitals.

- **Out-of-Network Area**: If there are no Cigna Open Access Plus providers within a 25-mile radius of your home, benefits will be provided at the "In-Network" level for any covered provider, regardless of network participation, that is located in the 25-mile radius.

- **Hospital Assigned Services:** Whenever possible, you should advise your Hospital and your attending Physician of your need to use Open Access Plus providers for all referral services. However, if you receive services from a Cigna Open Access Plus participating Hospital, and a referral is made to a non-participating provider, benefits for covered services will be provided at the "In-Network" level. This would apply when your participating Hospital assigns you a non-participating anesthesiologist or Emergency Room Physician, or refers your lab tests or x-rays to a non-participating pathologist or radiologist for interpretation. This would not apply if your participating surgeon selects a non-participating assistant surgeon, or if your participating attending Physician asks a non-participating Physician or Specialist to see you at the Hospital.

When "Out-of-Network" providers are paid at the "In-Network" level for any of the above situations, the Plan will apply Usual, Customary, and Reasonable (UC&R) allowances, but will pay your claim at the "In-Network" benefit percentage. You will be responsible for any applicable patient percentage, and any amount that exceeds the Plan UC&R allowance.

Please notify Cigna for assistance if you are in any of the above situations. You should also contact Cigna for benefit adjustment if any such claims are paid inadvertently at the "Out-of-Network" level.

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician

It is not required, but if you wish, you may select a Primary Care Physician for yourself and your Dependents from Cigna's Open Access Plus network. If you choose to select a Primary Care Physician from Cigna's list, the Primary Care Physician you choose for yourself may be different from the Primary Care Physician you select for each of your Dependents.

Primary Care Physician's Role/Direct Access to Participating Physicians

Your Primary Care Physician's role is to provide or arrange for medical care for you and your Dependents. However, you and your Dependents are also allowed direct access to Cigna Open Access Plus participating Physicians for all of your covered services. If you select a Primary Care Physician, there is no requirement to obtain an authorization of care from your Primary Care Physician for visits to other Open Access Plus Participating Physicians of your choice, including Participating Specialist Physicians for covered services.

Changing Primary Care Physicians

You may request a transfer from one Primary Care Physician to another by contacting Cigna at the member services number on your ID card. Any such transfer will be effective in Cigna's computer system on the first day of the month following the month in which the processing of the change request is completed. It is not necessary for Cigna's system to be updated for you to see your new Primary Care Physician for covered services.

If at any time a Primary Care Physician ceases to be a participating provider in the Open Access Plus network, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician, if you choose.

Cigna's Toll-Free Care Line

Cigna's toll-free care line allows you to talk to a health professional during normal business hours, Monday through Friday, simply by calling the toll-free number shown on the back of your ID Card; 1-800-244-6224, or 1-800-Cigna 24. Cigna's toll-free care line personnel can always provide you with names of Open Access Plus participating providers. If you or your Dependents need medical care, you may call Cigna's toll free number for assistance.

Access to Cigna Participating Providers While Traveling

If you or your Dependents need medical care while away from home, you have access to a national network of participating providers through Cigna's Away-From-Home Care feature. You can call Cigna's toll free care line, 1-800-Cigna 24, for the names of Open Access Plus participating providers in other network areas. Whether you obtain the name of a participating provider from the website or through the care line, Cigna recommends that you call the provider before you make an appointment to confirm that he or she is a current participant in the Open Access Plus network.

Case Management

Case management is a service that assists individuals with treatment needs extending beyond the acute care setting. The goal of case management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an Outpatient, or as an Inpatient in a Hospital. If there is a need for case management, a case management professional will work closely with the patient, the family, and the attending Physician to determine appropriate treatment options to best meet the patient's needs and keep costs manageable.

Case managers help coordinate the treatment program and arrange for necessary resources. Case managers also answer questions and provide ongoing support for the family in times of medical crisis. While case managers, who are trained Registered Nurses and other credentialed health care professionals, may recommend alternate treatment programs and coordinate resources, your attending Physician remains in charge of and responsible for the actual medical care.

Participation in case management is recommended for patients who need post hospitalization services or have difficult to manage or costly Illnesses. Cigna may on occasion contact you or your attending Physician if they feel case management might be helpful. However, participation in case management is always strictly voluntary. Patients should discuss the option with their attending Physician and contact Cigna for more information. In addition, you, your Dependent, or your attending Physician may request case management services by calling Cigna at the toll free number on your ID card, 1-800-244-6224 or 1-800-Cigna 24.

When You Have a Complaint About Cigna

If you have a complaint of any kind about Cigna, you may contact Cigna's member services. You should contact Cigna's member services if you have any concerns regarding a Cigna employee, the quality of care provided by Cigna participating providers, or claims processing. The toll-free number for Cigna member services is 1-800-Cigna 24, or 1-800-244-6224 as shown on the back of your Cigna identification card. You will also be able to find this number on any

explanation of benefits or claim form that Cigna provides to you. You may also express your concerns to Cigna in writing.

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

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

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

DISEASE MANAGEMENT PROGRAM

(CIGNA "YOUR HEALTH FIRST")

The Plan provides a Disease Management Program through Cigna HealthCare called "Your Health First". The Your Health First program offers extra support and resources for participants with the following conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Asthma
- COPD
- Type I or Type II Diabetes
- Metabolic Syndrome
- Peripheral Artery Disease
- Low Back Pain
- Osteoarthritis
- Depression
- Anxiety
- Bipolar Disorder

If you or any of your Dependents have one or more of the above conditions, a member of Cigna's team – trained as a nurse, coach, nutritionist or clinician – may be calling to get things started; or you can call 1-855-246-1873 and enroll yourself. If you choose to participate in the Your Health First Program, a team member who has expertise with your particular condition will talk to you, answer your questions, provide insight, and make recommendations for treatment, medications, and Physician visits, where applicable.

You will be connected with one dedicated contact that will help you **Manage** a chronic condition, **Create** a personal care plan, **Understand** medications or your doctor's orders, **Identify** triggers that affect your condition, **Make** educated decisions about your treatment options, **Know** what to expect if you need to spend time in the hospital, and **Improve** your lifestyle by coping with stress, becoming tobacco-free, maintaining good eating habits, and managing or losing weight.

Your team member will work with you and your Physician to monitor your progress throughout your participation in the program. When you are doing well on your own, they can still assist you though a variety of on-line self-service resources to help you better understand your condition and overcome barriers to better health.

Participation in Your Health First is no cost to you, totally voluntary, and completely private. Your personal information will be kept confidential, and will not be shared with your Employer. The Your Health First program meets all Federal and State regulations, including those that are part of the HIPAA Privacy Act (see Confidentiality and Protection of Your Health Information found later in this booklet).

Please note that information and recommendations received in connection with Your Health First do not imply coverage under this Plan. Participants should contact Cigna or the Fund Office directly to confirm coverage for recommended services, or to get answers to any questions about what the Plan provides.

You can contact Your Health First directly by calling 1-855-246-1873. Please also feel free to contact the Fund Office if you have any questions.

DEFINITIONS

"**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.

"Acute Care Hospital" or **"Hospital"** means only an institution that meets all of the following tests:

A. It mainly provides medical treatment to Inpatients.
B. It maintains facilities for diagnosis.
C. It provides treatment only by or under a staff of Physicians.
D. It provides care by Registered Nurses 24 hours per day.
E. It maintains permanent facilities for surgery.
F. It maintains a daily medical record for each patient.
G. It complies with all licensing and other legal requirements.
H. It is not a Skilled Nursing Facility or a Specialized Facility.
I. It is not, other than incidentally, (1) a place for Custodial Care; (2) a place for the aged; (3) a place for the care of a person addicted to or dependent on a drug or chemical including alcohol; (4) a place for the care of persons with mental, nervous, or emotional disorders or conditions; (5) a place of rest; or (6) a nursing home, hotel, or a similar institution.

"Allied Health Professional" means only a provider listed below who is licensed and practicing within the scope of his or her license:

A. A chiropractor
B. A clinical social worker
C. A dentist
D. A dietician
E. A midwife
F. A Nurse practitioner
G. An occupational therapist
H. An optician
I. An optometrist
J. A physical therapist
K. A Physician's assistant
L. A podiatrist
M. A psychologist
N. A speech therapist

"Ambulatory Surgical Facility" means a facility that meets Professionally Recognized Standards and all of the following tests:

A. It provides a setting for Outpatient surgeries.
B. It does not provide services or accommodations for overnight stays.

C. It has at least; two operating rooms and one recovery room; all the medical equipment needed to support the surgery performed; x-ray and laboratory diagnostic facilities; and Emergency equipment, trays, and supplies for use in life threatening events.
D. It has a medical staff that is supervised full time by a Physician and that includes a registered Nurse at all times when patients are in the facility.
E. It maintains a medical record for each patient.
F. It has a written agreement with a local Acute Care Hospital and a local ambulance company for the immediate transfer of patients who require greater care than can be furnished at the facility.
G. It complies with all licensing and other legal requirements.
H. It is not the office or clinic of one or more Physicians.

For purposes of determining a medical benefit, a surgical procedure performed in an Ambulatory Surgical Facility that, as determined by the Claims Administrator, is commonly performed in a Physician's office shall be deemed to have been performed in a Physician's office.

"Average Semi-Private Room Rate" means the rate a Hospital normally charges for semi-private room accommodations for the condition being treated, as identified by the Hospital.

"Birth Center" means a facility that meets Professionally Recognized Standards and all of the following tests:

A. It mainly provides an Outpatient setting for childbirth following a normal, uncomplicated Pregnancy.
B. It has: (1) at least two birthing rooms; (2) all the medical equipment needed to support the services furnished by the facility; (3) laboratory diagnostic facilities, and (4) Emergency equipment, trays, and supplies for use in life threatening events.
C. It has a medical staff that: (1) is supervised full time by a Physician, and (2) includes a registered Nurse at all times when patients are in the facility.
D. It has written agreements with a local Acute Care Hospital and a local ambulance company for the immediate transfer of patients who require greater care than can be furnished at the facility.
E. It admits only patients who: (1) have undergone an educational program to prepare them for the birth, and (2) have records of adequate prenatal care.
F. It schedules stays of not more than 24 hours for a birth.
G. It maintains a medical record for each patient.
H. It complies with all licensing and other legal requirements that apply.
I. It is not: (1) the office or clinic of one or more Physicians; (2) an Acute Care Hospital; (3) a Specialized Facility other than a Birth Center.

"Chiropractic Care" means the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function.

"Complication of Pregnancy" means: (1) an unscheduled cesarean section; (2) spontaneous termination of Pregnancy that occurs during a period of gestation in which a viable birth is not possible; (3) a condition, that requires Hospital confinement (when the Pregnancy is not terminated), whose diagnosis is distinct from Pregnancy but is caused or adversely affected by Pregnancy, such as: acute nephritis, nephrosis; cardiac decompensation; missed abortion; and similar medical and surgical conditions of comparable severity.

The term **does not** include: false labor; occasional spotting; Physician prescribed rest during a Pregnancy; morning sickness; pre-eclampsia; or similar conditions that are associated with a difficult Pregnancy but do not constitute classifiably distinct Complications of Pregnancy. Pregnancy Benefits are payable on the same basis as benefits for treatment of an Illness.

"Covered Medical Charge" means a charge that: (1) is made for a Medically Necessary service or supply that is furnished to a covered person; and (2) meets all of the following tests:

A. It is shown in the Covered Medical Charges List or is otherwise listed as a Covered Medical Charge in this booklet.
B. It is incurred by a covered person while the covered person is eligible for medical benefits. 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.
C. It is not listed as a Plan Exclusion.
D. It does not exceed the smallest of the Covered Charge Limits that apply to the service or supply for which the charge is made. The part of a charge that does not exceed the smallest of the Covered Charge Limits shall be considered a Covered Medical Charge if it meets the above tests.

"Custodial Care" means care that consists of services and supplies that are given mainly to help a person to meet the activities of daily living, whether or not the person is Disabled, and that are not rendered mainly for their therapeutic value in the treatment of an Injury or disease. Custodial Care includes, but is not limited to, care such as:

A. Care mainly to provide room and board;
B. Preparation of special diets;
C. Supervision of the administration of medications that can normally be self-administered; and
D. Personal care such as helping the person to walk, get in or out of bed, bathe, dress, eat, or use the toilet.

"Disability" or **"Disabled"** means the inability to perform substantially all the duties of the person's occupation because of a physical or mental Illness or Injury.

"Durable Medical Equipment" means equipment that is: (1) designed for repeated use; (2) mainly and customarily used for medical purposes; (3) not generally of use to a person in the absence of a disease or Injury; and (4) not disposable. Durable Medical Equipment includes, but is not limited to, such items as: crutches; Hospital beds; wheelchairs; oxygen concentrators; CPAP machines; and TENS units.

The following items are examples of some, but not all, types of equipment that are not considered to be Durable Medical Equipment: air conditioners; air purifiers; bed and bath items; fixtures to real property; heat lamps; heating pads; bed boards; orthopedic shoes; corrective devices for use in shoes; gravity traction devices; exercise bicycles; weight lifting equipment; and specially equipped vans.

"Emergency" means an unexpected onset of bodily Injury or serious sickness that could be expected by a reasonably prudent layperson with an average knowledge of medical science to result in a loss of life, serious medical complications, or a permanent impairment of bodily functions in the absence of immediate medical attention. Some examples of emergencies could include:

A. Seizure or loss of consciousness
B. Uncontrolled Bleeding
C. Shortness of Breath
D. Poisoning or suspected overdose of medication
E. Chest pain or squeezing sensation in the chest
F. Sudden paralysis or slurred speech
G. Broken bones
H. Severe pain
I. Severe burns

"Emergency Services" are medical, psychiatric, surgical, Hospital and related heath care services and testing, including ambulance service, which are required to treat an Emergency.

"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 National IAM Benefit Trust Fund. An unincorporated sole proprietor or partner in a partnership cannot be treated as an Employee under any Plan of the National IAM Benefit Trust Fund.

"Employer" means any Employer obligated under a Collective Bargaining Agreement or other signed agreement to make contributions to the National IAM Benefit Trust Fund on behalf of its Employees. The cover of this booklet and the Introduction page show the Employer to which this Plan applies.

"Extended Care Facility" means an institution that is approved as such under Medicare.

"Home Health Care" is medical care that is furnished by or through a Home Health Agency to a covered person in the covered person's home.

"Home Health Agency" means an agency that provides Home Health Care services that (1) meets any legal licensing required by the state or other locality in which it is located; or (2) qualifies as a participating Home Health Agency under Medicare.

"Hospice Care" is care that:

A. Is furnished or arranged by a Hospice Care Program;
B. Is provided as part of a coordinated plan of home and Inpatient care designed to meet the special needs of the terminally ill patient and the family unit due to the terminal Illness;
C. May include medical care, palliative care, respite care, and medical social services for the terminally ill patient; and
D. May include medical social services and bereavement counseling for the family unit.

"Hospice Care Program" means an agency, facility, or organization that provides care for terminally ill patients and meets established standards, including certification by the National Hospice Organization, Federal Medicare, and any legal licensing required by the state or other locality in which it is located.

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

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

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

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

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

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

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

"Intensive Care Unit" means only a separate, clearly designated service section that is part of an Acute Care Hospital and that meets all of the following tests:

A. It is solely for treatment of patients who are in a critical condition.
B. It provides constant special nursing care and observation not available in the other sections of the Hospital.
C. It contains special life-saving equipment that is ready for immediate use.
D. It contains at least two beds for critically ill patients.
E. It has, at all times, at least one registered Nurse who is in constant attendance.
F. It meets the standards set for an Intensive Care Unit by the Joint Commission on Accreditation of Healthcare Organizations.

The term "Intensive Care Unit" shall include a burn unit or a cardiac care unit that meets all of the above tests. The term shall not include a unit for intensive alcoholism, drug or chemical dependence, or psychiatric treatment.

"Intensive Outpatient Therapy" means distinct levels or phases of treatment that are provided by a certified/licensed Mental Health or Substance Abuse Treatment program. Intensive Outpatient Therapy programs typically provide a combination of individual, family, and/or group therapy in a day, totaling 9 or more hours in a week.

"Medically Necessary" with respect to each service or supply means that the service or supply meets all of the following tests:

A. It is rendered for the treatment or diagnosis of an Injury or Illness, including premature birth, congenital defects, and birth defects.
B. It is appropriate for the symptoms, consistent with the diagnosis, and is otherwise in accordance with generally accepted medical practice and Professionally Recognized Standards.
C. It is not mainly for the convenience of the covered person or the covered person's Physician or other provider.
D. It is the most appropriate supply or level of service needed to provide safe and adequate care. When applied to confinement in a Hospital or other facility, this test means that the covered person needs to be confined as an Inpatient due to the nature of the services rendered or due to the covered person's condition and that the covered person cannot receive safe and adequate care through Outpatient treatment.

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

"Mental Health Services" are the services that are required to treat a disorder that impairs behavior, emotional reaction, or thought processes, but not including substance abuse, and not including learning, behavioral, and developmental disorders. In determining benefits payable, charges made for the treatment of any physiological conditions related to mental health will not be considered to be charges made for the treatment of mental health.

"Mental Health Residential Treatment Center" means a facility that meets all of the tests of the Acute Care Hospital definition with the following exceptions:

A. It is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center for Mental Health Services, or

B. Meets all of the tests of the Acute Care Hospital definition with the exceptions that follow:

    1. In place of test A, it mainly provides psychiatric treatment.
    2. In place of test E, it maintains psychology and social work departments.
    3. It shall not be subject to test H or item 4 of test I.

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

"Partial Hospitalization Care" means only continuous treatment of substance abuse or of a mental, nervous or emotional disorder or condition for at least 4 hours, but not more than 12 hours, in any 24-hour period.

"Participant" means a person who is eligible for benefits 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.

"Preferred Provider Organization" means an organization that negotiates discounted rates with medical providers in an effort to provide benefits to participants and beneficiaries.

"Pregnancy" means any Pregnancy, a complication thereof, or the termination of a Pregnancy. Pregnancy benefits are payable on the same basis as benefits for treatment of an Illness.

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

"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 National IAM Benefit Trust Fund, but only if the particular Plan allows for Retiree coverage. The cover of this booklet and/or the Introduction page should indicate whether this Plan provides Retiree coverage.

"Skilled Nursing Facility" and **"Rehabilitation Hospital"** each mean only an institution that meets all of the following tests:

A. It mainly provides skilled nursing care or rehabilitation care to registered Inpatients.
B. It provides care that is supervised, 24 hours per day, by a Physician or registered Nurse.
C. It has available at all times a Physician who is a staff member of an Acute Care Hospital.
D. It has a registered Nurse, licensed vocational Nurse, or licensed practical Nurse on duty 24 hours per day and has a registered Nurse on duty at least eight hours per day.
E. It maintains a daily medical record for each patient.
F. It complies with all licensing and other legal requirements.
G. It is not a Specialized Facility.
H. It is not, other than incidentally: (1) a place for Custodial Care; (2) a place for the aged; (3) a place for the care of persons addicted to or dependent on a drug or chemical, including alcohol; (4) a place for the care of persons with mental, nervous, or emotional disorders or conditions; (5) a place of rest; or (6) a nursing home, a hotel, or a similar institution.

"Specialist" means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

"Specialized Facility" means only an Ambulatory Surgical Facility, a Birth Center, a Mental Health Residential Treatment Center, and a Substance Abuse Residential Treatment Center; whether physically or legally a part of another facility.

"Substance Abuse Residential Treatment Center" means a facility that:

A. Is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center for alcoholism, drug or chemical dependence; or

B. Meets all of the tests of the Acute Care Hospital definition with the exceptions that follow:

    1. In place of test A, it mainly provides treatment of alcoholism, drug or chemical dependence.
    2. It shall not be subject to test E, test H, or item 3 of test I.

"Substance Abuse Treatment Services" are services that are required to treat psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges for treatment of substance abuse.

"Total Disability" or **"Totally Disabled"** means that you are prevented by Illness or Injury from engaging in any duty of your occupation for wages or profit. For your Dependents, it means they are prevented by Illness or Injury from engaging in their normal daily activities.

"Usual, Customary and Reasonable Charges" or **"UC&R Charges"** (sometimes referred to as "Maximum Reimbursable Charge" or "MRC") means charges for Medically Necessary services or supplies that are determined to be the lowest of:

A. The usual charge by the health care provider for the same or similar service or supply; or
B. The prevailing charge of most other health care providers in the same or similar geographic area for the same or similar health care service or supply; or
C. With respect to a PPO health care provider, the charge set forth in the agreement between the PPO health care provider and the PPO, or the Plan; or
D. The health care provider's actual charge.

ELIGIBILITY PROVISIONS

Active Employee Eligibility

You are eligible for coverage if you are a full-time active Employee of the above mentioned Employer that is participating in the National IAM Benefit Trust Fund, and you are working in a position for which coverage is provided under the terms of the applicable collective bargaining agreement (or other participation agreement), and your Employer is making the required monthly contributions to the National IAM Benefit Trust Fund on your behalf.

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 (or other 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 Fund, and the Employer continues to make the required monthly contributions to the National IAM Benefit Trust Fund on the Employee's behalf.

Retiree Eligibility

To be eligible for Retiree coverage where provided, you must retire from active employment with this participating Employer while you are eligible for benefits under this Plan, and your Employer must continue to make the required monthly contributions to the National IAM Benefit Trust Fund on your behalf, but only if the Plan allows for Retiree coverage.

Please be sure that you and your Medicare eligible Dependents are enrolled for Medicare before your retirement, or as soon as you become entitled to Medicare after retirement. This Plan has a Medicare enrollment provision for Retirees (and certain disabled persons) which requires that you enroll for Medicare when you become entitled. If a participant could enroll for Medicare but neglects to do so, the Plan will reduce medical benefit payments by the amount Medicare would have paid if the person had enrolled (See Coordination of Benefits).

Please Note – The cover of this booklet and/or the Introduction page should indicate whether this Plan provides Retiree coverage. Retiree coverage is only provided when the Employer's contract with the Benefit Trust Fund includes coverage for eligible Retirees. If there is no Retiree coverage you may have rights to make payments for continuation of coverage under COBRA when you retire, as described later in this booklet. If you are unsure whether your Plan provides Retiree coverage, please ask your Employer or contact the Fund Office.

Surviving Spouse Eligibility

There is no special coverage for surviving spouses under this Plan, however, your surviving Dependent spouse and surviving Dependent children may have rights to make payments for continuation of coverage under COBRA as described later in this booklet.

Dependent Eligibility

To become covered under the Plan as a Dependent, a person must qualify as a Dependent and must be enrolled, and your Employer must make the appropriate monthly contribution to the National IAM Benefit Trust Fund for Dependent coverage where required.

Effective September 1, 2010 the term "Dependent" means only:

1. Your lawful spouse; and

2. Your child under age 26.

"Child" means your biological child, legally adopted child, and child placed with you for adoption. "Child" also means the following children who are under age 26:

1. Your legal step-children; and

2. Any other children under your legal guardianship.

The term Dependent does not include a spouse who is on active duty in any armed forces.

A marriage certificate is required to enroll a spouse. Employees must submit a completed eligible dependent certification (EDC) form for any child whose last name differs from the Employee's last name, for step-children, 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 step-children 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. The Fund Office may also ask you for other related information it needs to evaluate the terms of your relationship with the child.

Disabled Dependents

A covered Dependent 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, will not have his or her medical coverage terminated when he or she reaches age 26. The eligibility for such a child will continue as long as the child was covered by the Plan when he or she turned age 26, continues to be incapable of earning a living due to the physical or mental Disability, and continues to chiefly depend on you for financial support and maintenance. Proof of the Disability must be submitted prior to age 26 and may be required periodically thereafter.

Qualified Medical Child Support Orders

The Plan will honor any medical child support order, which it finds to be a Qualified Medical Child Support Order ("QMCSO") under ERISA. QMCSO's are defined by Federal law and include judgments, decrees, or orders issued by courts of competent jurisdiction or by state administrative bodies that have the force of court judgments, decrees, or orders. To be a

QMCSO, a judgment, decree, or order must require a child to be enrolled in the Plan under state domestic relations law, or enforce a state law relating to medical child support, and must meet a series of Federal legal requirements. You may obtain a copy of the Plan's procedures governing QMCSO's without charge from the Fund Office.

Enrollment

You must apply for the coverage for yourself and your Dependents by completing the enrollment form provided by your Employer who will forward the form to the Trust Fund Office.

You must enroll all of your Dependents in order to cover them. If you acquire a new Dependent, you should notify your Employer and sign a new enrollment form within 30 days so that your Dependent may be covered.

Special Enrollment

If you are declining enrollment, where applicable, for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, 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. 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 for more information about special enrollment for yourself or your Dependents.

Effective Date

Except as otherwise stated herein, your coverage will become effective on the first day of the month following the month during which you become an eligible Employee, provided contributions are paid to the Fund by the Employer.

Provided they meet all of the requirements outlined above, your Dependents will become covered on the later of the date your coverage becomes effective or the date they qualify as eligible Dependents.

The date they qualify as eligible Dependents means:

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

2. With respect to a step-child, the date of your marriage to your step-child's parent; or

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

4. With respect to a child named in a Qualified Medical Child Support Order (QMCSO), the date specified in the court order; or

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

Limitations

Eligibility under the Plan is also 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.

TERMINATION AND CONTINUATION OF COVERAGE

Termination of Coverage for Employees

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

1. The date your Employer ceases to be a contributing Employer; or

2. The date this Plan is discontinued or the Benefit Trust Fund is terminated; or

3. The end of the period for which you last made a contribution, if it is required, or for which contributions were made on your behalf by your Employer; or

4. The last day of the month during which your employment terminates. Your employment will terminate if you cease to be actively engaged in work on a full-time basis for your Employer. However, if you cease to be actively engaged in work on a full-time basis 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:

   A. Paid vacation, or

   B. Retirement (but only if the Plan allows for Retiree coverage), or

   C. Disability due to Accident or Illness (applies to medical benefits only), or

   D. Layoff (applies to medical benefits only).

   Any continuation by the Employer after a layoff shall not extend beyond the end of the six-month period commencing on the first day of the month next following the month in which the layoff occurs.

Termination of Coverage for Dependents

The coverage for each of your Dependents will terminate on the earlier of the following dates:

1. The date your coverage terminates; or

2. The last day of the month in which that person no longer qualifies as an eligible Dependent; or

3. The last day of the month during which you die.

Spouse's Termination of Coverage

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

1. The date your coverage terminates; or

2. The date of your divorce or legal separation from your spouse; or

3. The last day of the month during which you die.

Family and Medical Leaves of Absence

In determining your continued eligibility for benefits, the Plan will comply in all respects with the Family and Medical Leave Act ("FMLA") of 1993 (as amended), which entitles eligible employees to continued medical coverage during certain defined periods of leave from their employment. The FMLA allows an Employee to take up to 12 weeks of unpaid leave during any 12-month period due to:

1. The birth of a child of the Employee, or placement of a child with the Employee for adoption or foster care;

2. To provide care for a spouse, child, or parent who is seriously ill;

3. The Employee's own serious illness; or

4. A "qualifying exigency" that arises in connection with the covered active duty of a child, spouse, or parent of the Employee in the Armed Forces (including the National Guard or Reserves).

Additionally, an eligible Employee who is a qualifying family member or next of kin of a covered military service member of the Armed Forces (including the National Guard or Reserves) is able to take up to 26 workweeks of leave in a single 12 month period to care for the covered service member if he or she is on the temporary disability retired list or undergoing medical treatment, recuperation or therapy as a result of a serious injury or illness sustained in or aggravated by service in the line of covered active duty. Covered service members include veterans who were members of the Armed Forces (including the National Guard or Reserves) at any time during the 5 years preceding the date on which the medical treatment, recuperation or therapy began.

During his or her leave, the Employee may continue all of his medical coverage and other benefits offered through the Fund. The Employee is generally eligible for leave under the FMLA if the Employee:

1. Has worked for a covered Employer for at least 12 months;

2. Has worked at least 1,250 hours over the previous 12 months; and

3. Has worked at a location where at least 50 employees are employed by the Employer within 75 miles.

The Fund will maintain the Employee's eligibility status until the end of the leave, provided the contributing Employer properly grants the leave under the FMLA and the contributing Employer makes the required notification and payment to the Fund. If you need to take leave for an FMLA-qualifying event you should immediately notify your Employer. You should also contact

the Fund Office so that the Fund is aware of your Employer's responsibility to report the period of your absence.

Coverage During Military Service

If you enter the Uniformed Services as defined in the Uniformed Services Employment and Reemployment Rights Act (USERRA) for active military duty or training, inactive duty or training, full-time National Guard or Public Health Service Duty, or fitness-for-duty examination, for services that will last more than 30 days, coverage for you and your eligible dependents will terminate immediately. You have the right to continue coverage at your own expense for up to 24 months. This continuation right operates in the same way as COBRA continuation coverage. See Continuation of Health Coverage (COBRA) section of this Summary Plan Description. Coverage may also be provided through the military.

If you have sufficient hours in previous work periods to continue eligibility for one or more months following the month you enter the Uniform 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 Uniform Services or as of the date you enter the Uniform Services if you enter on the first of the month. If you freeze your eligibility you may reclaim this eligibility when you return to work for a Participating Employer under the criteria set forth in USERRA. You must notify the Fund Office of which option you select. If you do not notify the office your eligibility will be automatically extended until it is exhausted.

If you are honorably discharged from the Uniformed Services, Plan coverage for you and your eligible dependents will be reinstated on the day that you begin work with an employer participating in the Fund, 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 Department of Labor website at: http://www.dol.gov/vets/programs/userra/userra_fs.htm.

Extension of Benefits for Total Disability

If your medical coverage under this Plan terminates while you are Totally Disabled, coverage will be extended, for treatment for that Total Disability only, for three months while you remain Totally Disabled. In addition, medical coverage for Hospital confinement for the disabling condition will be extended until the end of a confinement that begins within three months after your coverage terminated. This extension also applies to your Dependent who is Totally Disabled on the date his coverage terminates.

Extension of benefits for Total Disability will end on the earlier of the following dates:

1. The date the Total Disability ends; or

2. The date the person becomes covered under Medicare or any group plan that provides medical benefits; or

3. Three months from the date the person's medical coverage terminated.

Medically Necessary Student Leaves of Absence

Effective January 1, 2010 a Dependent child age 19 or over, who is covered because he or she is enrolled as a full-time student at an accredited college, university, high school, or vocational, technical, or trade school, may be able to continue coverage if he or she takes a Medically Necessary Leave of Absence from the educational institution.

A "**Medically Necessary Leave of Absence**" means any leave of absence or other change in enrollment from the educational institution, such as a change to part-time student status, that begins while the Dependent child is suffering from a serious Illness or Injury, and that causes the child to lose full-time student status for purposes of continued eligibility under this Plan.

If your Dependent child qualifies for a continuation of eligibility under this provision, the Trust Fund will provide coverage identical to that described elsewhere in this Plan booklet. Eligibility that is extended under this provision will continue, while the Dependent remains disabled, until the earlier of:

1. One year after the first day of the Medically Necessary leave of absence; or

2. The date coverage would otherwise terminate under the terms of this Plan.

Continuation of coverage under this provision is not automatic. This type of Dependent eligibility is available only if the Fund Office receives written certification from the treating Physician which states that the Dependent child is suffering from a serious Illness or Injury, and that the leave of absence or change in enrollment status is Medically Necessary. The Dependent child must be a covered full-time student prior to and up until the first day of the leave, and the Physician certification must be received by the Fund Office in a timely manner.

Contact the Fund Office if you have any questions about Medically Necessary Student Leaves of Absence or continuation of Dependent coverage under this provision.

Reinstatement of Coverage

If your coverage terminates because of involuntary termination of employment for any reason except being discharged, and you return to active work as an eligible Employee with your Employer within 12 months after the date your coverage under the group Plan terminates, you will again become covered under the Plan on the date you return to active work with your Employer as an eligible Employee and contributions are made.

Continuation of Health Coverage (COBRA)

Federal law requires that group health plans offer Employees and their Dependents the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") in certain circumstances (called "qualifying events") when coverage under the Plan would otherwise end. To receive this continuation coverage, the Employee, spouse, or Dependent child must make timely monthly payments directly to the Fund. An eligible Employee or eligible Dependent (either spouse or child, including a child born or placed for adoption after your continuation coverage begins) who becomes eligible for continuation coverage is called a qualified beneficiary.

Continuation Coverage Rules for Employees

Under COBRA an Employee has the right to choose continuation of health coverage, by making timely self payments, if there is a loss of coverage due to one of the following COBRA qualifying events:

1. Voluntary or involuntary termination of employment for any reason other than your gross misconduct; or

2. Your hours of employment covered by this Plan are reduced.

In addition, this Plan allows you to choose continuation of health coverage, by making timely self payments, if your loss of coverage is because of any other termination of employment for any reason.

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.

Continuation Coverage Rules for Dependents

If the Employee chooses not to purchase continuation coverage, the Dependent spouse and/or Dependent children can separately purchase continuation coverage for themselves by making the election and the required monthly payments. Generally under COBRA, Dependents can elect continuation coverage by making timely self payments for up to 18 months if coverage would otherwise end because of the termination of the Employee's employment for reasons other than the Employee's gross misconduct or a reduction in the Employee's hours.

However, under this Plan Dependents can elect such coverage by making timely self payments for up to 24 months if the loss of coverage is for any termination of the Employee's employment or any reduction in the Employee's hours. In addition, coverage may be continued by making timely self payments for up to 36 months for the Employee's spouse and Dependent children if their coverage would otherwise end because of:

1. The death of the Employee; or

2. The divorce or legal separation of the Employee and spouse; or

3. A child's loss of status as a "Dependent" under this Plan.

Generally, the maximum period of continuation coverage for Dependents is 36 months from the date the spouse or Dependent child would otherwise lose eligibility under the Plan due to one of the events listed above, even if two or more of these events occur.

In addition, if the covered Employee becomes eligible for Medicare (either Part A or Part B or both) before experiencing a qualifying event that is a reduction in hours or termination of

employment, the period of coverage for the Employee's spouse and Dependent children ends with the *later* of the 36-month period that begins on the date the covered Employee became entitled to Medicare, or the 24-month period (or 35-month period if any of the members of the family is disabled as described below) that begins on the date of the covered Employee's termination of employment or reduction in hours. For example, if Joe becomes eligible for Medicare coverage six months prior to terminating employment on September 30, 2010, his spouse and Dependent children will be entitled to 30 months of continuation coverage beginning October 1, 2010. Consequently, if Joe becomes eligible for Medicare 30 months prior to terminating employment on September 30, 2010, his spouse and Dependent children will be entitled to 24 months of continuation coverage beginning October 1, 2010 (or 35 months if a disability extension applies as described below).

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

Disability and Continuation Coverage

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 continue your coverage by making timely self payments until the earliest of:

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

2. The date you attain age 65; or

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

If you are no longer entitled to continuation coverage because you have attained age 65, you may extend your continuation coverage for up to 24 additional months by making timely self payments.

In addition, an eleven month extension of continuation coverage is available to any qualified beneficiary who has received 24 months of continuation coverage, and who makes timely self payments; provided the qualified beneficiary is determined by the Social Security Administration or the Railroad Retirement Board to be disabled. If you or anyone in your family is receiving continuation coverage and any covered member of your family is determined to be disabled by the Social Security Administration or the Railroad Retirement Board, you must notify the Fund Office of that fact in order to receive the 11 month extension of continuation coverage. If the determination of disability was issued prior to the commencement of continuation coverage, such notice must be provided to the Fund Office within 60 days of the commencement of continuation coverage. If the determination of disability is issued after the start of continuation coverage, such notice must be provided to the Fund Office within 60 days of the date of the disability determination and prior to the expiration of the initial 24-month continuation coverage period. This notice must include a copy of the Social Security or Railroad Retirement disability determination letter.

If the qualified beneficiary is determined by the Social Security Administration or the Railroad Retirement Board to be no longer disabled, you must notify the Fund Office of that fact within 30 days of the Social Security Administration's or Railroad Retirement Board's determination.

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 Plan. If there is a loss of coverage in either case, the Benefit Trust Fund offers continuation coverage.

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:

1. The date you return to active work;

2. The date you attain age 65; or

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

If you are no longer entitled to continuation coverage because you have attained age 65, you may extend your continuation coverage for up to 24 additional months by making timely self-payments.

However, 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 Continuation Coverage section below.

Your covered spouse or Dependent child has the same continuation of coverage options based on the applicable qualifying events as described in the Continuation Coverage Rules for Dependents section above.

Multiple Qualifying Events While on Continuation Coverage

If, during a 24-month period of continuation coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced or legally separated, or if a Dependent child ceases to be a Dependent child under the Plan, the maximum continuation coverage period for the affected spouse and/or child is extended to 36 months from the date of your termination of employment or reduction in hours. In no event will any spouse or 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(ren) born to, adopted by, or placed for adoption with you (the active Employee) during the 24-month period of continuation coverage.

In cases where the spouse and Dependent children are eligible for additional months of continuation coverage because the covered Employee became eligible for Medicare prior to his

reduction in hours or termination from employment (as explained above), such additional months of coverage will be credited to the spouse and Dependent children in determining their maximum continuation coverage period. For example, if Joe becomes eligible for Medicare six months before terminating employment June 30, 2010, his spouse and Dependent children will be entitled to receive 30 months of continuation coverage beginning July 1, 2010. If Joe then dies six months after he and his family begin to receive continuation coverage, his spouse and children will be eligible for an additional 24 months of continuation coverage, up to the maximum of 36 months measured from the date of his initial Medicare eligibility.

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.

Summary of Periods of Continuation Coverage

Qualifying Event Resulting in Loss of Coverage	Qualified Beneficiary	Maximum Continuation Coverage Period
1. Reduction in covered Employee's work hours	Employee, spouse, and Dependent children	24 months after the date of the qualifying event [1]
2. Covered Employee's termination of employment [2]	Employee, spouse, and Dependent children	24 months after the date of the qualifying event [1]
3. Death of covered Employee	Spouse and Dependent children	36 months after the date of the qualifying event
4. Divorce or legal separation of covered Employee	Spouse	36 months after the date of the qualifying event
5. Loss of Dependent child status under the Plan	Affected Dependent child	36 months after the date of the qualifying event
6. Covered Employee's termination of employment due to Disability	Employee, spouse, and Dependent children	24 months after the date of the qualifying event [1] or longer in certain circumstances [3]
7. Covered Employee's termination of employment due to retirement	Employee, spouse, and Dependent children	24 months after the date of the qualifying event [1] or longer in certain circumstances [4]

1 This maximum period includes the 18 month statutory COBRA period plus an additional 6 months self pay. There are additional rules concerning length of coverage for dependents based on Employee's entitlement to Medicare found in the Continuation Coverage Rules for Dependents section above.

2 Statutory COBRA qualifying event is a termination of employment for reasons other than gross misconduct. This Plan treats any termination of employment as a qualifying event.

3 Refer to above section concerning Disability and Continuation Coverage.

4 Refer to above section concerning Application of Continuation Coverage to Retirees.

Loss of Other Group Health Plan Coverage or Other Health Insurance Coverage

If, while you are enrolled in continuation coverage, your Dependent spouse or Dependent child loses coverage under another group health plan, you may enroll the Dependent for coverage for the balance of the period of continuation coverage. The Dependent must have been eligible but not enrolled for coverage under the terms of the Plan and, when enrollment previously was offered under the Plan and declined, the Dependent must have been covered under another group health plan or had other health insurance coverage.

You must enroll the Dependent within 31 days after the termination of the other coverage. Adding a Dependent child may cause an increase in the amount you must pay for continuation coverage.

The loss of coverage must be due to exhaustion of continuation coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of Employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to make payments on a timely basis or termination of coverage for cause.

Benefits While on Continuation Coverage

If you choose to elect continuation coverage, the Trust Fund will provide you with extended health coverage identical to that described elsewhere in this Health and Welfare Plan booklet. However, life insurance, AD&D and short term disability benefits will not be provided.

Notification Requirements for Continuation Coverage

The Fund Office (in cooperation with the Employers) will track Employee terminations, reductions in hours, and Employee deaths.

You or your eligible Dependents must notify the Fund Office of a divorce or a child's loss of Dependent status under the Plan. Notification must be made in writing within 60 days after the event occurs. Your family must also notify the Plan within 60 days of the date of your death. In addition to including the names, addresses, telephone and social security numbers of all persons whose coverage will be affected by such event, the notice must also include an explanation of the nature of the qualifying event, the date on which it occurred and any supporting documents. Some examples of acceptable supporting documents include divorce decrees, separation agreements, and death certificates.

Disabled Employees or family members must also notify the Fund Office of the Social Security Administration or Railroad Retirement Board determination within the time periods listed in the Disability extension of continuation coverage provision above.

All notices required under this section should be sent to the Fund Office at the following address:

National IAM Benefit Trust Fund
1300 Connecticut Avenue, NW, Suite 300
Washington, DC 20036

Your Employer must notify the Plan of all other qualifying events.

Following receipt of a notice or after an Employee's loss of eligibility due to a termination of employment or reduction in hours of employment, the Plan will notify Employees and their Dependents of their rights to purchase continuation coverage and the cost of the coverage.

Election of Continuation Coverage

When information is received by the Fund Office concerning the loss of health coverage due to a qualifying event, the participating Employee or family member will be sent a notice explaining the right to continuation coverage. This notice will provide information on the coverage options available and the cost, and will include an election form. To elect continuation coverage, the eligible beneficiary must complete the election form and submit it to the Plan within 60 days after the later of the date coverage would otherwise end or 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. If, for any reason, the completed election form is not received by the Fund Office within the sixty (60) day period, with respect to any particular qualified beneficiary, that qualified beneficiary's eligibility for continuation coverage will expire and his/her health benefits will terminate as of the date on which he/she first became a qualified beneficiary. The Plan is not responsible if a parent or guardian, acting on behalf of a minor qualified beneficiary, does not inform the minor qualified beneficiary of his/her rights to continuation coverage within the sixty (60) day period.

Cost of Continuation Coverage

The continuation coverage rates are set annually by the Board of Trustees in accordance with COBRA, and reflect the cost of the Health and Welfare Plan benefits plus a 2% administration fee, as allowable under the law. There may be a surcharge if your coverage is based on a Social Security Administration or Railroad Retirement Board disability award. The self payment rate may change due to the changes in the benefits offered by the Plan and, in certain circumstances, to reflect changes in the cost of the Plan's benefits.

Under the law, you are required to pay the full cost for this coverage. The details will be explained in the individual notice that you will receive. The initial payment must be received by the Plan within forty-five (45) days after the date you elect continuation coverage. This payment must 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 payments are due on the first (1st) day of each calendar month.

It is the responsibility of each qualified beneficiary or person acting on behalf of a qualified beneficiary, to ensure that correct payment is received by the Fund Office on a timely basis. The Plan is not 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 Continuation Coverage

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

1. The date of your death;

2. The last day of the applicable maximum continuation period;

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

4. The date you (as a spouse) remarry and obtain coverage under another group health plan, unless the other plan excludes or limits your benefits because of a pre-existing condition;

5. The date you obtain coverage as an employee under another employer-sponsored group health plan, unless the other plan excludes or limits your benefits because of a pre-existing condition and the pre-existing condition limitation actually applies to you after your coverage under this Plan is taken into account;

6. The date you become eligible for coverage under Medicare, unless other rules apply as noted above;

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

8. The date the plan terminates; or

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

If your Employer stops participating in the Benefit Trust Fund, the Fund will continue to carry the continuation coverage obligations for you and your qualified Dependents 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 coverage available to you and/or your eligible Dependent who:

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

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

Continuation Coverage and Other Extensions of Coverage

Some contributing Employers of the National IAM Benefit Trust Fund provide for a temporary extension of coverage at no charge if an Employee is terminated, if the Employer ceases to participate, or if an Employee is Totally Disabled or hospitalized. Refer to the applicable collective bargaining agreement or other participation agreement for information on whether such an extension may be available.

The policy of the Trustees is that any such extensions will be made available to you first, followed by the continuation coverage provisions outlined above. In this manner, you and your Dependents will receive the maximum coverage period that can be provided.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

If you lose coverage under the Plan, the Fund will issue you a Certificate of Creditable Coverage showing how long you were covered under the Plan. You will receive the certificate automatically when you lose coverage or become entitled to continuation coverage, and when your continuation coverage ceases. Also, you may request the Fund to provide you with a certificate at any time while you are covered by the Plan and within 24 months after losing coverage under the Plan.

This certificate may be necessary if you and/or your Dependents become eligible for coverage under another group health plan, or if you buy for yourself and/or your Dependents an individual health insurance policy within 63 days after your coverage under this Plan ends. The certificate is necessary because it may reduce any exclusion period for pre-existing conditions that may apply to you and/or your Dependents under your new group health plan or health insurance policy.

The certificate will be provided to you shortly after the Plan knows, or has reason to know, that coverage (including continuation coverage) for you and/or your Dependents has ended. A duplicate certificate will be provided upon request, provided that the Fund Office receives the request within two years after the later of the date your coverage under this Plan has ended or the date your continuation coverage ended.

Please address all requests for certificates of creditable coverage to the Fund Office at the following address:

National IAM Benefit Trust Fund
1300 Connecticut Avenue, NW, Suite 300
Washington, DC 20036

COMPREHENSIVE MEDICAL COVERAGE

The Trust Fund will pay a medical benefit as determined below for the Covered Medical Charges a participant incurs while eligible for medical benefits under this Plan.

MEDICAL BENEFITS AND COVERED CHARGES

Medical Benefit

A "**Medical Benefit**" is the amount, if any, that will be paid for Covered Medical Charges incurred by you or your Dependent. The amount of a medical benefit is the amount the Claims Administrator calculates in the steps shown below:

1. The charges for which a claim is submitted to the Claims Administrator are tested against the Covered Medical Charge definition. Those that meet all of the tests are the Covered Medical Charges.

2. Any deductible amount that applies to the charges and that has not yet been met is subtracted from the amount of Covered Medical Charges.

3. The amount of Covered Medical Charges that remains is then multiplied by any applicable percentage payable.

4. If any part of the amount calculated exceeds an applicable benefit maximum, then that part is subtracted and the remainder is the amount of the medical benefit.

Covered Medical Charge

A "**Covered Medical Charge**" is a charge that: (a) is made for a Medically Necessary service or supply that is furnished to a covered person; and (b) meets all of the tests listed below:

1. It is shown in the Covered Medical Charges List.

2. It is incurred by a covered person while the covered person is eligible for medical benefits. 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.

3. It is not listed as a Plan Exclusion.

4. It does not exceed the smallest of the covered charge limits that apply to the service or supply for which the charge is made. The part of a charge that does not exceed the smallest of the covered charge limits shall be considered a Covered Medical Charge if it meets the tests in items 1, 2, and 3 above.

Covered Charge Limits

The "**Covered Charge Limits**" that apply to each service or supply are: (a) the usual charge for the service or supply; (b) the customary charge for the service or supply; (c) any limit specified in the Covered Charges List, the Schedule of Benefits, or the Areas of Limited Coverage section.

Deductible

A "**Deductible**" is the amount of Covered Medical Charges a participant must pay to his or her provider of service before benefits are payable by the Plan. The deductible shown in the Schedule of Benefits:

1. Applies to all Covered Medical Charges unless the Schedule of Benefits states otherwise; and

2. Applies separately to each covered person during each calendar year; and

3. Must be accumulated during that calendar year.

No charge will be subject to more than one deductible. Only those charges to which a deductible applies can be used to satisfy that deductible.

Family Deductible Maximum

If covered persons in your family satisfy the family deductible maximum shown in the Schedule of Benefits in any one calendar year, then the deductible will not be applied to any other charges incurred in that calendar year by covered persons in your family. As used here, "family" means you and all of your Dependents that are covered under this Plan.

Deductible Carry-Over

If a covered person incurs charges during the last three months of a calendar year that are applied toward satisfaction of the deductible, those charges will also be applied toward the covered person's deductible for the next calendar year.

Common Accident

If you and your Dependents incur Covered Medical Charges as a result of injuries suffered in a common Accident, just one deductible will be applied during each calendar year to those charges. If greater medical benefits would be paid in the absence of this provision, then it will not apply.

Percentage Payable

Each percentage payable and the Covered Medical Charges to which it applies are shown in the Schedule of Benefits.

A percentage payable:

1. Is applied after any deductible amount has been met; and

2. Applies separately to each covered person.

Unless the Schedule of Benefits says otherwise the percentages payable on covered charges are as follows:

1. In-Network: 80% of Preferred Provider contract rates

2. Out-of-Network: 60% of Usual, Customary & Reasonable Charges

Percentage Payable Increase

Individual - After a covered person has incurred $20,000 of Covered Medical Charges during the calendar year for which benefits are paid at less than 100%, the percentage payable will be increased to 100% for Covered Medical Charges incurred by that covered person during the remainder of the calendar year.

Family - After covered persons in your family have incurred $40,000 in Covered Medical Charges for which benefits are paid at less than 100%, the percentage payable will be increased to 100% for Covered Medical Charges incurred by covered persons in your family during the remainder of that calendar year.

Out-of-Pocket Maximum

The out-of-pocket maximum is the maximum patient copayment responsibility during a calendar year, in addition to the deductible, as shown in the Schedule of Benefits. The Plan's out-of-pocket maximums are listed below.

Individual: In-Network: $4,000 (20% of $20,000 in covered charges)

Out-of-Network: $8,000 (40% of $20,000 in covered charges)

Family: In-Network: $8,000 (20% of $40,000 in covered charges)

Out-of-Network: $16,000 (40% of $40,000 in covered charges)

The above provisions do not apply to charges in excess of Usual, Customary & Reasonable Charges.

Accumulation of Deductibles and Out-of-Pocket

Expenses incurred for either participating provider or non-participating provider charges will be used to satisfy both the participating provider deductibles and out-of-pocket maximums simultaneously, until the participating provider and non-participating provider deductibles and the participating provider out-of-pocket maximums have been satisfied. However, only expenses incurred for non-participating provider charges will be used to satisfy the remainder of the non-participating provider out-of-pocket maximums.

Notwithstanding the foregoing, once an individual has incurred a total of $20,000 of Covered Medical Charges during a calendar year that are paid at less than 100% ($40,000 per family), whether in-network or out-of-network, the Percentage Payable Increase explained above will apply and all further Covered Medical Charges for that calendar year, both in-network and out-of-network, will be paid at 100%. This does not apply to charges in excess of Usual, Customary & Reasonable Charges.

Lifetime Maximum

Effective October 1, 2010 there is no longer any overall lifetime dollar maximum under this Plan. However, there are some visit, day, and/or dollar limits on certain benefits. Please refer to the Schedule of Benefits, the Covered Charge Limits, and the Areas of Limited Coverage sections for further information concerning any such benefit specific limitations.

Individuals whose coverage previously ended because they reached the former lifetime dollar limit under the Plan may again enroll in the Plan, providing they qualify for coverage under current Eligibility Provisions.

COVERED MEDICAL CHARGES LIST

Subject to the Schedule of Benefits, the Covered Charge Limits, the Areas of Limited Coverage provisions, and any applicable Exclusions and limitations, the following is a list of Covered Medical Charges under this Plan. Covered charges are the expenses covered by the Plan which you or your covered Dependents incur once you become eligible under the Plan. Covered charges are only covered to the extent that the services or supplies provided are recommended by a Physician and are Medically Necessary.

Facility Charges. The charges listed below are "Facility Charges." They are subject to any applicable limit shown in the Areas of Limited Coverage section.

1. The room and board charge of an Acute Care Hospital for each day a covered person is an Inpatient.

2. The Covered Medical Charge for room and board for each day of confinement in an Acute Care Hospital shall not be more than:

   A. The Routine Care Daily Limit for each day the covered person is an Inpatient in a routine care unit.

   B. The Intensive Care Daily Limit for each day the covered person is an Inpatient in an Intensive Care Unit.

   C. The Routine Care Daily Limit for each day the covered person is an Inpatient in a special care unit other than an Intensive Care Unit.

   The Routine Care and Intensive Care Daily Limits are shown in the Covered Charge Limits.

3. The charges of an Acute Care Hospital, other than room and board charges, for medical services and supplies furnished to a covered person who is an Inpatient.

4. The charges of a Hospital Emergency Room for Emergency Services.

5. The charges of an Acute Care Hospital for medical services and supplies furnished on an Outpatient basis.

6. The charges of an Ambulatory Surgical Facility for an Outpatient surgery done in that facility.

7. The charges of a Skilled Nursing Facility for the confinement of a covered person as an Inpatient, but only if the confinement: (a) follows a stay of at least five days as an Inpatient in an Acute Care Hospital; and (b) starts within seven days after the covered person is discharged from that Hospital stay. The Covered Medical Charge for all charges for each day of confinement shall not be more than the Skilled Nursing Facility Daily Limit shown in

the Schedule of Benefits. Benefits will not be paid for more than 100 days of confinement in a Skilled Nursing Facility during any one calendar year.

8. The charges for medical services and supplies furnished by a Specialized Facility that is recognized in the Specialized Facility definition. If the Specialized Facility provides Inpatient care, the Covered Medical Charge for room and board for each day a covered person is an Inpatient shall not be more than the Specialized Facility Daily Limit shown in the Schedule of Benefits.

Practitioner Charges. The charges listed below are "Practitioner Charges." They are subject to any applicable limit shown in the Areas of Limited Coverage section.

1. The charge of a Physician for the following professional services:

   A. Office visits, visits in an Acute Care Hospital, at the patient's home, or at any other place, but not for more than one visit per day per doctor.

   B. Surgery, subject to the Surgery Guidelines shown below.

   C. Radiation, chemotherapy, and dialysis treatment.

   D. Anesthesiology, subject to the Surgery Guidelines shown below.

   Surgery Guidelines: (a) If two or more surgical procedures are performed at the same time, the Covered Medical Charges will be limited to those incurred for the major procedure plus 50% of those incurred for each lesser procedure that adds significant time or complexity; (b) the benefit for performing surgery includes normal follow-up care and the administration of any local, digital block, or topical anesthesia; and (c) reduced benefits may be paid for the administration of other anesthetics if done by the operating or assisting surgeon.

2. The charges of a Physician or laboratory for a diagnostic laboratory test or x-ray examination. Laboratory charges are only covered for laboratory tests ordered by a Physician.

3. The charge of a Physician for casts, splints, surgical dressings, and other medical supplies.

4. The charge for the professional services of a Nurse for private duty nursing, but only during a period for which the Claims Administrator validates a Physician's certification.

   A. That those private duty nursing services are Medically Necessary; and

   B. For Outpatient private duty nursing, that the covered person would otherwise need to be an Inpatient at an Acute Care Hospital.

5. The charges for medical services and supplies furnished by an Allied Health Professional are Covered Medical Charges, but only if and to the extent that the charges would be Covered Medical Charges if they had been made by a Physician. Medical benefits for Covered

Medical Charges from an Allied Health Professional will be determined on the same basis as medical benefits are determined for the charges of a Physician.

6. The charges for other services by an Allied Health Professional to the extent they are otherwise covered under other provisions of this Plan.

Medical Support Charges. The charges listed below are "Medical Support Charges." They are subject to any applicable limit shown in the Areas of Limited Coverage section.

1. Charges of a professional ambulance service for transportation to or from a local Acute Care Hospital or Skilled Nursing Facility where treatment is rendered.

2. Charges for non-experimental and Medically Necessary internal prosthetics and/or medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts. Medically Necessary repair, maintenance or replacement of a covered internal appliance is also covered.

3. Charges for the initial purchase and fitting of non-experimental, Medically Necessary external prosthetic and orthotic appliances or devices, but only if ordered or prescribed by a Physician and necessary for the alleviation or correction of an Illness, Injury, or congenital defect, including prostheses/prosthetic appliances and devices, orthoses/orthotic devices, braces and splints. The appliance or device must be available only if ordered or prescribed by a Physician. Prostheses/prosthetic devices are defined as fabricated replacements for missing body parts. Includes but is not limited to basic limb prostheses, terminal devices such as a hand or hook, and speech protheses. Orthoses/orthotic devices are defined as orthopedic appliances and apparatus used to support, align, prevent or correct deformities. After a reasonable period of time, payment for replacement or repair of the prosthetic device may be authorized if determined to be Medically Necessary. Repair and replacement that result from a person's misuse are not covered. See the Podiatry Care benefit below for information about coverage for foot related orthotics ordered by a podiatrist.

4. The charges made for the purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician up to the purchase cost of standard equipment (Durable Medical Equipment may be purchased if less expensive than rental, if accompanied by documentation from the Physician regarding the estimated duration of usage). Coverage is limited to the lowest cost reasonable alternative. You are encouraged, but not required to use vendors approved by Cigna. After a reasonable period of time, payment for replacement or repair of Durable Medical Equipment may be authorized if determined to be Medically Necessary. Repair and replacement that result from a person's misuse are not covered.

5. The charge for oxygen, blood, blood products, anesthetics, or other medical supplies that can be lawfully obtained only with the prescription of a Physician.

6. The charge for glucose testing devices when ordered by a Physician. The Plan will also cover charges for insulin needles and syringes, and lancets and test strips for use with glucose testing devices, but only when purchased from a medical supply company (when purchased at a pharmacy such items are covered by the Prescription Drug Coverage).

7. The charge for a drug or medicine that can be lawfully obtained only with the written prescription of a Physician or dentist, if it cannot be obtained under the terms of the Prescription Drug Coverage and it has not been excluded from coverage by the terms of that coverage or any exclusion or limitation of this Plan.

AREAS OF LIMITED COVERAGE

Acupuncture

The charges for acupuncture treatments are Covered Medical Charges, but only when performed by a Physician for a pain diagnosis. The Plan does not cover acupuncture treatments performed by any other provider of service.

Allergy Testing and Treatment

The charges for allergy testing and treatment are Covered Medical Charges, but limited to the charges of a Physician for diagnostic allergy testing and allergy serums dispensed by the Physician in the office (including injections at the office of the Physician).

Bariatric Surgery

Effective January 1, 2011 the Plan provides in-network coverage for Medically Necessary bariatric surgery that meets with Cigna HealthCare's clinical criteria for medical necessity and recommended procedural guidelines.

Guidelines for Coverage

The guidelines below provide an overview of medical necessity requirements for coverage of bariatric surgery. These guidelines are subject to periodic change without notice, and should be reviewed with Cigna well in advance when bariatric surgery is being considered.

1. The individual should be at least 18 years of age or should have reached full expected skeletal growth;

2. Body Mass Index (BMI) of 40 or greater; or

3. BMI of at least 35 with at least one clinically significant comorbidity, including but not limited to, cardiovascular disease, Type 2 diabetes, hypertension, coronary artery disease, or pulmonary hypertension;

4. Failure of medical management, including evidence of active participation within the last two years in a weight-management program that is supervised either by a Physician or a registered dietician for a minimum of six months without significant gaps. The program must include monthly documentation of ALL of the following components:

   A. Weight;

   B. Current dietary program; and

   C. Physical activity (e.g., exercise program).

Programs such as Weight Watchers®, Jenny Craig®, and Optifast® are acceptable alternatives if done in conjunction with the supervision of a Physician or a registered dietician and detailed documentation of participation is available for review. For individuals with long-standing morbid obesity, participation in a program within the last five years is sufficient if reasonable attendance in the weight-management program over an extended period of time of at least six months can be demonstrated. However, Physician-supervised programs consisting exclusively of pharmacological management are not sufficient to meet this requirement.

5. A thorough multidisciplinary evaluation within the previous 12-months which includes:

   A. An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure(s) and all associated current CPT codes;

   B. A separate medical evaluation, from a Physician other than the surgeon recommending surgery, that includes a medical clearance for bariatric surgery;

   C. Unequivocal clearance for bariatric surgery by a mental health provider;

   D. A nutritional evaluation by a Physician or registered dietician.

Coverage Information

Charges for bariatric surgery are payable in accordance with the Schedule of Benefits, and are subject to all limitations shown in the Schedule of Benefits and the Covered Charge Limits.

1. Coverage is **limited to in-network benefits** for contracted Hospitals and facilities designated as Centers of Excellence for Bariatric Surgery, and their affiliated contracted providers. **There is no out-of-network coverage for bariatric surgery**.

2. Coverage is available only for certain bariatric surgery procedures that are determined to be medically appropriate by Cigna HealthCare. Coverage is excluded for bariatric surgery procedures that are considered experimental, investigational, or unproven. Please contact a Cigna Center of Excellence for Bariatric Surgery in order to determine whether a proposed bariatric surgery procedure is covered by the Plan.

3. Services required to establish medical necessity of bariatric surgery are not automatically included in this benefit. The Plan provides coverage for some required services (e.g., evaluation by a bariatric surgeon), but does not necessarily provide coverage for all required services (e.g., weight management programs). Each service must be considered independently for coverage based on the type of service being provided. Please examine this Summary Plan Description and/or speak to Cigna HealthCare to determine which pre-surgical services are covered by the Plan and which are not.

Please Note – Covered and excluded bariatric surgery procedures and clinical guidelines are subject to change without notice as appropriate in accordance with advances in treatment and changes in industry standards as determined by Cigna HealthCare. **PLEASE ASK YOUR PHYSICIAN TO CONTACT CIGNA HEALTHCARE WELL IN ADVANCE OF ANY PROPOSED BARIATRIC SURGERY.**

Chiropractic Care

The charges of a chiropractor that meet all the tests of the Covered Medical Charge definition are Covered Medical Charges providing that (a) the chiropractor is acting within the scope of his or her license, (b) the services are Medically Necessary treatment of musculoskeletal disease or Injury, (c) the services are restorative in nature, designed to restore levels of function that had previously existed but that have been lost due to Injury or Illness. Restorative therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the Injury or Illness.

The Trust Fund will not pay for any type of (a) maintenance or preventative treatment, (b) services that are considered custodial, training, developmental or educational in nature, (c) vitamin therapy, (d) massage therapy, or (e) for medical equipment and supplies provided by a chiropractor.

Chiropractic Care benefits are paid in accordance with the Schedule of Benefits. The Trust Fund will not pay more than the calendar year maximum shown in the Schedule of Benefits. There is no other benefit under the Plan for services provided by a chiropractor.

Clinical Trials

Charges made for routine patient services associated with clinical trials approved and sponsored by the Federal Government are Covered Medical Charges under this Plan as long as all of the following requirements are met:

1. The clinical trial is listed on the NIH website www.clinicaltrials.gov as being sponsored by the Federal Government;

2. The trial investigates a treatment where: (a) the person has failed standard therapies for the disease; (b) cannot tolerate standard therapies for the disease; or (c) no effective non-experimental treatment for the disease exists.

3. The person meets all inclusion criteria for the clinical trial and is not treated "off-protocol;" and;

4. The trial is approved by the Institutional Review Board of the institution administering the treatment; and

Routine patient services do not include, and reimbursement will not be provided for:

1. The investigational service or supply itself;

2. Services or supplies listed herein as Exclusions;

3. Services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);

4. Services or supplies, which in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

Erectile Dysfunction

Charges for the treatment of erectile dysfunction are Covered Medical Charges. Benefits are limited to Physician charges for diagnostic services to determine the cause of the erectile dysfunction, and charges for internal penile implants or external devices for an erectile dysfunction that is clearly caused by an established medical condition, such as postoperative prostatectomy and diabetes. Penile implants and external devices are not covered to treat psychogenic erectile dysfunction.

Effective January 1, 2014, the Prescription Drug Coverage requires prior authorization for coverage of male androgens (testosterone and erectile dysfunction medications). Your doctor can call CVS Caremark directly at 1-855-240-0536 to request prior authorization approval. The doctor will be required to provide supporting clinical information, which CVS Caremark will review to determine whether medical necessity has been established.

If medical necessity is confirmed, coverage will be provided subject to a 10 pill per month limit for on-demand products, or a 30 pill per month limit for daily use Cialis 2.5mg or 5mg. However, if the review is not favorable, and CVS Caremark determines that the use of a male androgen is not medically necessary, coverage will be denied.

Genetic Testing

The charges for genetic testing that uses a proven testing method for the identification of genetically linked inheritable Illness are Covered Medical Charges only if one of the following requirements is met:

1. A covered person has symptoms or signs of a genetically linked inheritable Illness; or

2. It has been determined that a covered person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically linked inheritable Illness when the results will impact clinical outcome; or

3. The therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Home Health Care

The charges for Home Health Care that are listed below and that meet all the tests of the Covered Medical Charges definition are Covered Medical Charges. The Trust Fund will not pay for Home Health Care unless:

1. A plan of Home Health Care is drawn up, or approved, by the covered person's Physician; and

2. The Physician certifies that:

   A. The Home Health Care is Medically Necessary; and

B. In the absence of the Home Health Care, the covered person would be an Inpatient at an Acute Care Hospital; or

3. The Home Health Care services are recommended by a Cigna case manager as being the most appropriate treatment in the most effective setting possible for the patient for his or her medical condition.

Home Health Care charges include:

1. The charge for the services of a home health aide on a part-time or intermittent basis. The Trust Fund will not pay for more than 40 such visits during one calendar year. One home health aide visit is a visit of 4 hours or less.

2. The charge for nutrition counseling.

3. The charge for psychiatric treatment by a licensed social worker who is practicing within the scope of the license.

4. Practitioner charges and medical support charges.

Home Health Care benefits are paid in accordance with the Schedule of Benefits.

Hospice Care

The charges for Hospice Care by a Hospice Care Program that are listed below and that meet all the tests of the Covered Medical Charges definition are Covered Medical Charges. Benefits will be paid for charges that are incurred only: (a) during a period (no longer than 6 months) for which the Claims Administrator validates a Physician's certification that the covered person is a terminally ill patient, and (b) during the bereavement period.

Covered Hospice Care charges include the following if provided by a Hospice Care Program:

1. Confinement of the terminally ill patient as an Inpatient in a Hospice Care facility.

2. Home Health Care furnished to the terminally ill patient in the patient's home. Such Home Health Care may include as part of Hospice Care:

   A. The services of a home health aide.

   B. The professional services of a Nurse.

   C. Physical therapy or other therapy furnished by an Allied Health Professional practicing within the scope of his or her license.

   D. The charge for nutrition counseling and special meals.

   E. Medical Support Charges.

3. The charge for medical social services furnished to the terminally ill patient or to the family unit.

4. The charge for bereavement counseling furnished to the family unit during the bereavement period up to 3 individual or family sessions for all covered persons in the terminally ill patient's family unit.

Hospice Care charges are paid in accordance with the Schedule of Benefits and the Covered Charge Limits.

For Hospice Care only, the terms of the medical coverage are changed as follows so that Hospice Care charges meet the tests of the Covered Medical Charges definition:

1. The exclusion for Custodial Care does not apply.

2. The definition of "Medically Necessary":

   A. Is deemed to include medical social services and bereavement counseling; and

   B. Is changed as follows: (i) test A is changed to include palliative care as well as treatment or diagnosis; and (ii) test D is changed to allow Inpatient respite care.

The following additional special definitions apply to Hospice Care:

"**Bereavement Counseling**" is counseling by a licensed or certified social worker or licensed pastoral counselor to assist the family unit in coping with the death of the terminally ill patient.

The "**Bereavement Period**" is the 12-month period that begins on the date of the death of the terminally ill patient.

The "**Family Unit**" is each member of the terminally ill patient's family who is a covered person.

"**Medical Social Services**" include counseling furnished to the terminally ill patient or to the family unit to assist each in coping with the dying process of the terminally ill patient. The counseling may be furnished by a social worker or a pastoral counselor but only if such person is licensed and practicing within the scope of the license.

"**Palliative Care**" is care that is rendered to relieve the symptoms or effects of an Illness without curing the Illness.

"**Respite Care**" is care that is furnished a terminally ill patient so that the family unit may have relief from the stress of caring for the terminally ill patient.

A "**Terminally Ill Patient**" is a covered person whose Physician has certified that the covered person is: (a) terminally ill; and (b) expected to live 6 months or less.

Mental Health Services

The Facility, Practitioner, and Medical Support Charges that are incurred for the treatment of mental health conditions are Covered Medical Charges, providing they meet all the tests of the Covered Medical Charge definition and the Mental Health Services definition. No other charges for treatment of mental health conditions are Covered Medical Charges under this Plan.

Benefits for Mental Health Services will be payable only if your treatment is provided by a Hospital or a Mental Health Residential Treatment Center, or by a Physician or a psychologist holding a Master or Doctorate in Psychology or another similarly degreed practitioner legally licensed to provide Mental Health Services or practice psychotherapy by the state in which he or she practices.

Coverage is provided for both Inpatient and Outpatient Mental Health Services, including, but not limited to, treatment of conditions such as anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention) and Outpatient testing and assessment. Covered services may also include Inpatient care at a Mental Health Residential Treatment Center, Partial Hospitalization and Intensive Outpatient Therapy programs.

The Plan does not cover diagnoses such as: learning, behavioral and developmental disorders under this benefit. Nor does the Plan cover therapies such as: art, music, drama, physical, speech, recreational, occupation and adjunctive under this benefit.

Mental Health Services are payable in accordance with the Schedule of Benefits.

Nutritional Evaluation

Charges for nutritional evaluation and counseling are Covered Medical Charges when ordered by a Physician, but only when diet is part of the medical management of a diagnosed and documented organic Illness.

Organ Transplants

Charges in connection with Medically Necessary, non-experimental, human organ and tissue transplant, including services that include solid organ and bone marrow/stem cell procedures are Covered Medical Charges as provided below.

Transplant services include the covered recipient's medical, surgical and Hospital services; Inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants; allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestinal which includes small bowel, liver or multivisceral.

All covered transplant services received from non-participating providers are payable at the out-of-network level.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal and organ transportation. Charges for transportation and hospitalization of a live donor are covered only if both the donor and the recipient are covered participants under this Plan. Donor compatibility testing undertaken prior to procurement, and costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered, if both the potential donor and the recipient are covered participants under this Plan.

Organ Transplant charges are paid in accordance with the Schedule of Benefits.

Podiatry Care

The charges for podiatry care that are Covered Medical Charges are only the Medically Necessary services of a podiatrist acting within the scope of his or her license that meet all the tests of the Covered Medical Charge definition. For example, podiatry care includes charges such as those made for the diagnosis and treatment of chronic foot pain; instability or imbalance of the feet; foot deformities; and toenail infections (as long as Medically Necessary). Podiatry care also includes the charge for custom molded orthotics, but does not include the charge for shoes or pre-fabricated shoe inserts. The podiatry care benefit does not cover routine foot care such as paring and removal of corns and calluses or trimming of toenails. However, services associated with foot care for diabetes and peripheral vascular disease are Covered Medical Charges when Medically Necessary.

Podiatry care benefits are paid in accordance with the Schedule of Benefits. The Trust Fund will not pay more than the calendar year maximum shown in the Schedule of Benefits. There is no other benefit under the Plan for services provided by a podiatrist, except that benefits for Medically Necessary surgery performed by a podiatrist are not subject to the podiatry limitations, but are payable on the same basis as benefits for any other covered surgery.

Preventative / Wellness Services

The following preventative / wellness services are provided by the Plan for all Participants in keeping with prevailing medical standards, including frequency and age recommendations as appropriate for the type of service noted. The requirement that benefits are paid only for charges that are Medically Necessary does not apply to these routine services.

Please Note - Services performed as the result of medical symptoms, or due to a known or suspected medical condition, are not covered under this benefit. Such services would be considered under the related medical benefit where appropriate, subject to the deductible and applicable payment percentage for the service provided.

Routine Examinations

The following routine charges are Covered Medical Charges.

1. The charges of a Physician for annual complete physical exam.

2. The charges of a Physician for annual gynecological exam for female participants.

3. The charges of a Physician for routine well child visits for Dependent children, including developmental assessment and anticipatory guidance.

Routine examination charges are not subject to the deductible and are paid in accordance with the Schedule of Benefits.

Routine Immunizations

The following routine charges are Covered Medical Charges.

1. The charge for an annual flu shot.

2. The charge for other medically appropriate routine childhood and adult immunizations when recommended or provided by a Physician, excluding immunizations solely for travel.

Routine immunization charges are not subject to the deductible and are paid in accordance with the Schedule of Benefits.

Routine Lab and X-ray Screening

The following routine charges are Covered Medical Charges.

1. The charges for routine laboratory, electrocardiogram, and x-ray screening services ordered or performed by a Physician in connection with a covered routine examination.

2. The charge for an annual Papanicolaou (PAP) screening for female participants.

3. The charge for an annual prostate specific antigen (PSA) screening for male participants.

Routine lab and x-ray screening charges are not subject to the deductible and are paid in accordance with the Schedule of Benefits.

Routine Colonoscopy Screening

This benefit applies to all Plan Participants once every 3 years **beginning at age 50** or, if there is a high risk of colon cancer indicated by a Physician, once every 2 years regardless of age.

The following charges for routine colonoscopy screening are Covered Medical Charges.

1. The charge of a surgeon and an anesthesiologist who perform the procedure.

2. The charge for Outpatient facility use at a Hospital or other approved surgical facility.

3. The charge for related professional interpretation services required as a result of surgery.

Routine colonoscopy charges are not subject to the deductible and are paid in accordance with the Schedule of Benefits.

Routine Mammography Screening

The charges for routine screening for breast cancer by low-dose mammography that are listed below are Covered Medical Charges if ordered by a Physician.

Mammography screening charges include only:

1. The charges for a baseline mammogram for a covered person age 35 but less than age 40.

2. The charges for a mammogram performed once every year for a covered person age 40 and over.

The term "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, films and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

Mammography screening charges are not subject to the deductible and are paid in accordance with the Schedule of Benefits.

Family Planning

Physician charges for family planning related services and charges for implanted or injected contraceptives are Covered Medical Charges (oral contraceptives are covered under the Prescription Drug Coverage). In addition, vasectomy and tubal ligation are covered surgeries.

Family planning services are paid in accordance with the Schedule of Benefits and the Covered Charge Limits.

Routine Newborn Care

The charges that are listed below for routine care of a newborn at the time of delivery are Covered Medical Charges payable on the same basis as an Illness in accordance with the Schedule of Benefits and the Covered Charge Limits.

1. The charge of an Acute Care Hospital for routine nursery care furnished to a newborn well baby at the time of birth.

2. The charge of a Physician for one routine examination of a newborn well baby performed each day before the child is released from nursery care.

Women's Preventive Care

Routine annual gynecological exam, annual Papanicolaou (PAP) screening, and routine mammography screening are provided by the Plan as specified above. Effective October 1, 2012 the Plan also provides coverage for female participants as follows:

1. **Gestational Diabetes Screening** – Covered for women who are 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes.

2. **HPV DNA Testing** – Covered every three (3) years for women age 30 and over, regardless of Pap smear results.

3. **STI Counseling** – Covered annually for sexually active women. An "**STI**" is a sexually transmitted infection.

4. **HIV Screening and Counseling** – Covered annually for sexually active women.

5. **Contraception and Contraceptive Counseling** – All FDA approved contraceptive methods, sterilization procedures, patient education and counseling. Note – Oral contraceptives are covered under the Prescription Drug Coverage

6. **Breastfeeding Support, Supplies, and Counseling** – Pregnant and postpartum women are covered for lactation support and counseling, and breastfeeding equipment.

7. **Interpersonal and Domestic Violence Screening and Counseling** – Adolescent and adult women are covered for screening and counseling for interpersonal and domestic violence.

The above services will be covered by the Plan in accordance with PPACA guidelines. Covered services received from an in-network provider are not subject to the deductible and will be paid at 100%. Covered services received from an out-of-network provider are not subject to the deductible, but the out-of-network payment percentage will apply.

Please contact Cigna Healthcare at 1-800-Cigna 24 (1-800-244-6224) if you have any questions about what preventive services are covered, or if you need help finding an in-network provider.

Second Surgical Opinion

The charges for a second surgical opinion are paid in accordance with the Schedule of Benefits and the Covered Charges List on the same basis as charges for an Illness. The charges for a third surgical opinion will also be covered if the first and second opinions do not confirm that the surgery is Medically Necessary.

Short-Term Rehabilitative Therapy

Short-term rehabilitative therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting is covered subject to the following limitations.

1. To be covered all therapy services must be restorative in nature. Restorative therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of Injury or Illness. Restorative therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the Injury or Illness.

2. Services are not covered if they are custodial, training, educational or developmental in nature.

3. Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or an Injury or sickness.

Short-term rehabilitative therapy services that are not covered include, but are not limited to:

1. Sensory integration therapy, group therapy; treatment of dyslexia, behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntary acted conditions without evidence of an underlying medical condition or neurological disorder;

2. Treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury; and

3. Maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status.

If multiple Outpatient services are provided on the same day they constitute one visit.

Services that are provided by a chiropractor are not covered under this benefit.

The Plan does not cover physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation, or pulmonary rehabilitation therapy except for the short-term treatment of an acute condition. There are no such benefits for chronic conditions or for developmental problems, or for health club memberships, recreational or exercise programs, even if recommended by a Physician.

Benefits for short-term rehabilitative therapy are payable in accordance with the Schedule of Benefits. The Trust Fund will not pay more than the maximum shown in the Schedule of Benefits for all such services in any one calendar year.

Substance Abuse Treatment

The Facility, Practitioner, and Medical Support Charges that are incurred for the treatment of alcoholism, drug or chemical dependence are Covered Medical Charges, providing they meet all the tests of the Covered Medical Charge definition and the Substance Abuse Treatment Services definition. No other charges for treatment of alcoholism, drug, or chemical dependence are Covered Medical Charges under this Plan.

Benefits for Substance Abuse Treatment Services will be payable only if your treatment is provided by a Hospital or a Substance Abuse Residential Treatment Center, or by a Physician or a psychologist holding a Master or Doctorate in Psychology or another similarly degreed practitioner legally licensed to provide Substance Abuse Treatment by the state in which he or she practices.

Coverage is provided for both Inpatient and Outpatient Substance Abuse Treatment Services, including both detoxification and rehabilitation. Covered services may also include Inpatient care at a Substance Abuse Residential Treatment Center, Partial Hospitalization and Intensive Outpatient Therapy programs.

The Plan does not cover diagnoses such as: learning, behavioral and developmental disorders under this benefit. Nor does the Plan cover therapies such as: art, music, drama, physical, speech, recreational, occupational and adjunctive under this benefit.

Substance Abuse Treatment Services are payable in accordance with the Schedule of Benefits.

TMJ Treatment

"TMJ" stands for temporomandibular joint. The term "TMJ disorder" means a disorder, disease, or dysfunction of the TMJ, regardless of the diagnosis. Charges for Medically Necessary surgical and non-surgical treatment of a TMJ disorder that are not covered by a dental plan are payable on the same basis as charges for an Illness, except that benefits are limited to the amount shown in the Schedule of Benefits.

EXCLUSIONS

The Plan does not cover charges or treatments of all Injuries or Illnesses, or pay expenses for all medications. These exclusions include, but are not limited to, the following:

1. Treatment of an Illness for which benefits are payable under any Workers' Compensation law or treatment of an Injury which arises out of or in the course of employment.

2. Treatment of an Illness or Injury that results from or arises out of any past or present employment or occupation for compensation or profit.

3. Injury or Illness that results from an act of declared or undeclared war, the covered person's commission of a crime, or non-therapeutic release of nuclear energy.

4. Charge, or part of a charge, that the covered person is not obligated to pay, or for which the covered person would not have been billed except for the fact that the covered person was covered under the Plan.

5. Services, supplies, or treatments that are rendered by a (a) person who ordinarily lives in the covered person's home or (b) by a spouse, child, parent, or sibling of the covered person or of the covered person's spouse.

6. Experimental, investigational, or unproven services, treatments, or devices, unless provided during an approved clinical trial as explained above. Experimental, investigational, and unproven services, treatments, or devices are health care technologies, supplies, treatments, procedures, drug therapies, or devices that are not demonstrated through existing peer-reviewed, evidence based, scientific literature to be safe and effective for treating and diagnosing the condition or sickness for which its use is proposed, or is not approved by the FDA or other appropriate regulatory agency to be lawfully marketed for the proposed use.

7. 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.

8. 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.

9. Services, supplies, or treatments that are not Medically Necessary.

10. Services, supplies, or treatments that are not ordered by a Physician or by an Allied Health Professional who is practicing within the scope of his or her license.

11. Charges that are not necessary for the treatment of an Illness or Injury except as otherwise provided herein.

12. Custodial Care.

13. Services primarily for rest, domiciliary care, or convalescent care.

14. Charges that exceed the Usual, Customary, and Reasonable charge.

15. Expenses for any services, supplies, or treatments that are unreasonably priced, or are not reasonably necessary in light of the Illness or Injury being treated.

16. Charges incurred for reversal of sterilization (however, benefits are payable for sterilization).

17. Charges incurred for treatment of infertility, including infertility drugs, surgical or medical treatment programs, impregnation techniques, such as artificial insemination, in vitro fertilization and development of an embryo, implantation of an embryo developed in vitro, and variations of these procedures. Cryopreservation of donor sperm and eggs are also excluded from coverage.

18. Services, supplies or procedures related to treatment of obesity or weight reduction, except as specifically provided by the Plan earlier in this booklet under the "Areas of Limited Coverage" section concerning "Bariatric Surgery."

19. Charges incurred for treatment of complications from excluded procedures.

20. Charges incurred on a date when no eligibility exists, except where provided herein under the extension of benefits for Total Disability.

21. Drugs labeled: "Caution - limited by Federal law to investigational use," or experimental drugs, unless provided in connection with an approved clinical trial as explained above.

22. Over the counter medicines and supplies.

23. Routine eye examinations, refractions, orthoptics, glasses, contact lenses, or the fitting of glasses or contact lenses; except for the first pair of glasses or the first pair of lenses for use after cataract surgery.

24. Dental work or dental treatment; unless it is rendered for: (a) surgical removal of impacted teeth; (b) treatment of tumors; (c) treatment of ectodermal dysplasias (except orthodontia); or (d) repair of damage to sound natural teeth if damage is sustained in an Accident and the charges are incurred within one year from the date of the Accident. The term "sound natural tooth" means a tooth that: (a) is organic and formed by the natural development of the body (not manufactured); (b) has not been extensively restored; and (c) has not become extensively decayed or involved in periodontal disease.

25. Cosmetic surgery and therapies, unless resulting from an Injury occurring while covered under this Plan, and charges are incurred within one year from the date of the Injury. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance. The Plan does cover charges

made for reconstructive surgery or therapy to repair or correct severe physical deformity or disfigurement which is accompanied by functional deficit (other than abnormalities of the jaw or conditions related to TMJ disorder which is covered under another provision of this Plan) provided that: (a) the surgery or therapy restores or improves function; or (b) reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or (c) the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

26. Anti-wrinkle agents.

27. Hair growth stimulants.

28. Exercise equipment, tanning booths, whirlpools, swimming pools, saunas, spas, or health club and gym memberships.

29. Charges for prescription drug plan copayments.

30. Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.

31. Coverage for the children of your Dependents, unless such children are otherwise determined to be your qualified eligible Dependents as set forth above.

32. Vitamins or nutritional supplements (except for infant formula needed for the treatment of inborn errors of metabolism).

33. Massage therapy.

34. Fees associated with the donation of blood.

35. Cosmetics, dietary supplements, and health and beauty aids.

36. Court ordered treatment or hospitalization, unless such treatment is prescribed by a Physician, and is listed as a covered benefit under this Plan.

37. Treatment of erectile dysfunction, except for penile implants and external devices for a medical condition as set forth above.

38. Non-medical counseling or ancillary services, including but not limited to, custodial services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, driving safety and training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism, or mental retardation.

39. Therapy or treatment intended primarily to improve general physical condition or for the purpose of enhancing job, school, athletic, or recreational performance, including, but not limited to, routine, long term or maintenance care which is provided after the resolution of an acute medical problem and when significant therapeutic improvement is not expected.

40. Personal items or comfort items such as personal care kits provided on admission to the Hospital, television, telephone, complimentary meals, newborn infant photographs, birth announcements, or other items which are not for specific treatment of an Injury or Illness.

41. Artificial aids including, but not limited to, corrective orthopedic shoes, pre-fabricated arch supports, elastic stockings, garter belts, corsets, dentures, and wigs.

42. Hearing aids or the fitting of hearing aids; including but not limited to removable hearing devices, semi-implantable hearing devices, audiant bone conductors, Bone Anchored Hearing Aids (BAHAs), and related batteries.

43. Aids or devices that assist with nonverbal communications, including, but not limited to, communication boards, prerecorded speech devices, laptop computers, desktop computers, personal digital assistants, Braille typewriters, visual alert systems for the deaf, and memory books.

44. Medical treatment where payment has been denied by the primary plan because the treatment was received from a non-participating provider, or because of failure to follow the primary plan's rules for coverage, unless the primary plan explanation of benefits statement shows that the patient is liable for payment.

45. Telephone, e-mail, and internet consultations, and telemedicine.

46. Claims that are received more than one year after the services are incurred.

47. Any services, supplies, or treatments not shown as covered; any benefits not otherwise provided herein.

PRESCRIPTION DRUG COVERAGE

The Plan will pay for certain drugs that are prescribed by your Physician, after a copayment by you. If you or your Dependent gets a prescription filled or refilled at a participating pharmacy that has an agreement with the pharmacy benefit manager (CVS Caremark), the Plan pays the total cost of the prescription minus your copayment. You will be supplied with a CVS Caremark Prescription Drug Card, which you must present at the participating pharmacy when you get the prescription filled.

The prescription copayment shown in the Schedule of Benefits is your out-of-pocket expense for each covered prescription that is filled. The Plan has different copayment levels for generic drugs, preferred brand name drugs, and non-preferred brand name drugs. The Plan also includes generic substitution, which means that you will be dispensed a generic drug when available and appropriate, unless you or your doctor request that a brand name drug be dispensed instead.

Use of generic drugs, whenever possible, will result in the lowest out-of-pocket expense for you and the lowest cost to the Plan. To determine the copayment amount for any particular drug, you can go to the CVS Caremark website at www.caremark.com, and register to obtain specific benefit information. Or you can call the CVS Caremark Customer Care line at 1-800-282-8503.

Please Note: There is no Coordination of Benefits under the Prescription Drug Coverage, and prescription drug copayments are not reimbursable under the medical Plan benefits.

The Plan limits the amount of a drug you can get at any one time under the prescription drug benefit. Effective January 1, 2013, you have the following options:

1. **Mail Order** will provide up to a 90-day supply of covered maintenance medication.
2. **CVS Retail Pharmacies** will provide up to a 90-day supply of covered maintenance medication.
3. **Other Retail Pharmacies** will provide up to a 34-day supply of any covered medication.
4. **CVS Caremark Specialty Pharmacy Services** will provide up to a 30-day supply of specialty medication, or as appropriate based on dosing, therapy, and handling limitations.

Covered Charges (Formulary)

Covered charges include only the reasonable and customary charges for drugs and medications which, in accordance with federal or state laws, may not be dispensed without the written prescription of a Physician. The CVS Caremark covered drug list (formulary) includes coverage for most prescription drugs; however, some products are excluded from the formulary in favor of therapeutic equivalents. A therapeutic equivalent is a drug that has essentially the same effect in the treatment of a disease or condition as one or more other drugs; or more simply, a drug that controls a symptom or condition in the exact same way as another.

CVS Caremark may make changes to the formulary from time to time. To determine whether a particular drug is covered, you can go to the CVS Caremark website at www.caremark.com, and register to obtain specific benefit information. Or you can call the CVS Caremark Customer Care line at 1-800-282-8503. In addition, if your physician feels there is a clinical reason why

you or your dependent cannot or should not use any of the available therapeutic equivalent alternatives in place of an excluded product, CVS Caremark provides a review option. Your doctor can call CVS Caremark toll-free at 1-855-240-0536 to initiate such a review.

Contraception

Effective October 1, 2012, the Plan covers certain prescribed contraceptives and contraceptive devices for eligible female participants with no copayment. In all cases the drug or other contraceptive item must be prescribed by the physician. Prescribed **generics and single source brands will be covered with no copayment.** Standard time limits for dispensing of such items apply. Please contact CVS Caremark directly at 1-866-282-8503 if you have questions about what prescribed items are covered.

Male Androgens (testosterone and erectile dysfunction medications)

Effective January 1, 2014 prior authorization is required for coverage of male androgens. Your doctor can call CVS Caremark at 1-855-240-0536 to request prior authorization approval. The doctor will be required to provide supporting clinical information, which CVS Caremark will review to determine whether medical necessity has been established.

If medical necessity is confirmed, coverage will be provided subject to a 10 pill per month limit for on-demand products, or a 30 pill per month limit for daily use Cialis 2.5mg or 5mg. However, if the review is not favorable, and CVS Caremark determines that the use of a male androgen is not medically necessary, coverage will be denied.

Obtaining Your Prescription

CVS Caremark has a large nationwide network of participating pharmacies. To locate a participating pharmacy you can check the website noted above, or you can contact the Fund Office for assistance. When you fill your prescription, you should present your CVS Caremark Prescription Drug Card to the pharmacist and pay the applicable copayment. The pharmacy will submit a claim to CVS Caremark for direct reimbursement of the amount that exceeds your copayment. You are not responsible for any paperwork after you pay your copayment.

While using a CVS Caremark pharmacy is the easiest way to fill your prescriptions, there are a few pharmacies that do not belong to the CVS Caremark network. If you go to a pharmacy that does not accept your CVS Caremark Prescription Drug Card, you must pay the pharmacist for the prescription and then seek reimbursement from CVS Caremark by filing a paper claim. CVS Caremark will reimburse you for the cost of the prescription, minus the applicable copayment. Paper claim forms are available from the Fund Office.

If you have any questions or problems in connection with your prescription drug purchase, please contact the Fund Office at 202-785-8148 or 1-800-457-3481 for assistance.

Specialty Medications

CVS Caremark Specialty Pharmacy Services is the exclusive provider for specialty drugs under the Prescription Drug Coverage. Specialty Medications include select injectable and oral

medications that target and treat specific chronic and/or genetic conditions. They are bioengineered proteins, blood derived products, and complex molecules that generally require special handling and dispensing. Prescriptions for these medications are not filled at a retail pharmacy using your CVS Caremark Prescription Drug Card. Instead, you must obtain Specialty Medications through the Specialty Pharmacy Program.

The Plan also participates in the CVS Caremark Specialty Guideline Management Program, which is designed to promote the appropriate use of Specialty Medications. The Program starts with a **review and approval process** overseen by clinical specialists at CVS Caremark. When Specialty Medications are prescribed, CVS Caremark will contact your doctor directly to obtain clinical information necessary to make approval decisions based on drug-specific guidelines. CVS Caremark must approve the use of all Specialty Medications, and will discuss alternatives with your doctor if any proposed medication does not meet with the applicable guidelines. Following approval, Specialty Medications may be obtained only through CVS Caremark Specialty Pharmacy Services.

A list of covered Specialty Medications can be obtained by calling CaremarkConnect® toll-free at 1-800-237-2767. If you are prescribed a drug that is on the list, or if your pharmacist tells you that an item you are requesting is a Specialty Medication, you should call CVS Caremark at the toll free number shown above and identify yourself as a participant of the National IAM Benefit Trust Fund. CVS Caremark will contact your doctor directly and take care of all paperwork and provide confidential and convenient delivery of your medication to the location of your choice (i.e., home, doctor's office, vacation spot, etc.)

In addition, CVS Caremark's pharmacist-led CareTeam will provide condition-specific education, drug administration instruction, and expert advice to help you manage your therapy. The program includes access to pharmacists and other health experts who can provide condition-specific materials. The CareTeam will also perform follow-up calls to remind you when it's time to refill your prescription, check on your therapy progress, and answer any questions you may have.

If you have any questions please call the toll-free CaremarkConnect® number, 1-800-237-2767. If you have a hearing impairment and need telecommunications device (TDD) assistance, please call CaremarkConnect® toll-free at 1-800-231-4403. In addition, you can always contact the Benefit Trust Fund at 202-785-8148 or 1-800-457-3481.

Mail Order Program

The Prescription Drug Coverage also includes a convenient mail order option that is an excellent alternative for prescription drugs that are used on an on-going basis. Under this program the CVS Caremark Mail Service Pharmacy will send your prescription drugs directly to the location of your choice, and standard shipping is free. You also have the ability to speak to a registered pharmacist 24 hours a day, seven days a week, and can order refills from CVS Caremark by telephone or through the internet at www.caremark.com.

Contact CVS Caremark's mail order department at 1-866-282-8503 to obtain information about this program, or go to the CVS Caremark website at www.caremark.com, and register to obtain

more information or to complete mail order forms. You can also contact the Fund Office for further information about the Mail Order Program by calling 202-785-8148 or 1-800-457-3481.

Prescription Exclusions

No Prescription Drug Benefit will be paid for any charge that is listed as a Medical Plan Exclusion, or for any items in the list that follows.

1. Administration or injection of any drug or medicine.

2. Biological serums, blood products, vaccines/toxoids and immunization agents other than allergy serums.

3. Cosmetic products: including, but not limited to; anti-wrinkle agents; Botox Cosmetic, hair growth stimulants and hair removal agents; and similar items. However, retinoid medications are covered for treatment of acne for participants through age 25.

4. Devices and supplies of any type; including, but not limited to: elastic bandages and supports; ostomy and irrigation supplies; glucose testing devices; hypodermic needles and syringes; nebulizers; and similar items. However, the Plan does cover insulin needles and syringes; and lancets and test strips for use with glucose testing devices.

5. Drugs or medicines that are to be taken by or administered to a covered person in whole or in part while the covered person is a patient in: a Hospital; a sanitarium; a rest home; a Skilled Nursing Facility; an Extended Care Facility; a nursing home; or a similar institution.

6. Male androgens (testosterone and erectile dysfunction medications) that are not approved for medical necessity by CVS Caremark; and drugs for the treatment of erectile dysfunction in excess of 10 pills per month, except for CIALIS® (tadalafil) 2.5 or 5.0 mg tablets that are covered for daily use.

7. Drugs for treatment of infertility.

8. Experimental drugs or drugs that are labeled: "Caution – limited by Federal law to investigational use".

9. Medications lawfully obtainable over the counter, medications not requiring a prescription from a Physician, and any medication that is equivalent to an over the counter medication.

10. Non-legend drugs other than insulin.

11. Refills that are in excess of the number prescribed by the Physician, or that are dispensed more than one year after the order of a Physician.

12. Specialty Medications that are not approved for coverage under the CVS Caremark Specialty Guideline Management program.

13. Prescription drugs that are not included for coverage on the CVS Caremark formulary on the date a prescription is filled, or that are excluded from the formulary in favor of therapeutic equivalents (unless approved under the CVS Caremark review option).

Benefits After Termination of Coverage

After the date a covered person's Prescription Drug Coverage ends, the only Prescription Benefits that will be paid on behalf of the covered person shall be for covered prescription charges that were incurred while the covered person was eligible for the Prescription Drug Coverage. Drugs received after a covered participant's termination date must be reimbursed in full to the Fund.

Medicare Part D

The Medicare, Prescription Drug Improvement and Modernization Act of 2003 ("MMA") added a new prescription benefit for those eligible for Medicare called Medicare Part D. The Trustees have determined, with the assistance of an actuary, that the Plan's prescription drug coverage for covered persons who are eligible for Medicare is "actuarially equivalent" to Medicare Part D. This means, on average, the Fund's benefits are equal to or better than the standard Medicare Part D drug plan.

As required by MMA, each covered person who is Medicare eligible will periodically receive a notice, called a Notice of Creditable Coverage, advising whether the Plan's prescription drug benefit continues to be actuarially equivalent to Medicare Part D. Such covered persons are also entitled to receive such notices upon request to the Fund Office.

Covered persons who are Medicare eligible are not required to sign up for Medicare Part D, and may still obtain their prescription benefits through the Benefit Trust Fund. Moreover, if a covered person who is Medicare eligible wishes to enroll in Medicare Part D, he or she may do so without penalty from the Plan. Please be advised that, if you do enroll in Medicare Part D, the Benefit Trust Fund will not coordinate benefits with Medicare Part D, and there will be no adjustment to any applicable contribution you pay for your coverage through the Benefit Trust Fund. If you are a Medicare eligible actively working covered Employee, the Fund will be the primary payor. If you are a Medicare eligible covered Retiree, Medicare will be the primary payor.

GENERAL BENEFIT PROVISIONS

Newborns and Mothers Health Protection Act

The Plan will pay benefits for Pregnancy on the same basis as an Illness or Injury. Under Federal law, group health plans may not restrict benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending provider (e.g., Physician, Nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification.

Women's Health and Cancer Act

In the case of any participant or beneficiary receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided under the Plan for:

1. Reconstruction of the breast on which the mastectomy was performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

As with other benefits under the Plan, applicable deductibles and patient percentage amounts apply to the above coverage.

Confidentiality and Protection of Your Health Information

The Fund will comply with the Standards for Privacy of Individually Identifiable Health Information promulgated by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("Privacy Rules"). Under these standards, the Fund will protect the privacy of individually identifiable health information and will block or limit the disclosure of this information to the Trustees, Employers, the Union, your family members, service providers and other third parties. Protected health information will be disclosed only (1) to the extent authorized by the patient; (2) as necessary for the administration of the Plan, including the review and payment of claims and the determination of appeals; or (3) as otherwise authorized or required by law. The Fund has adopted certain written rules and

policies to ensure that with regards to its use, disclosure and maintenance of protected health information, it complies with applicable law.

You may authorize the disclosure of your protected health information to the third parties by signing a written authorization and submitting it to the Fund Office. You may also cancel any previous written authorization you have provided the Fund by submitting a written cancellation of authorization with the Fund Office. You may request these forms from the Fund Office.

The Fund has provided participants with a Notice of Privacy Practices for Protected Health Information. If you need a copy of the Notice or would like additional information about the Fund's use and disclosure of protected health information or your rights with regards to this information, you may request a copy of the Notice from the Fund Office.

COORDINATION OF BENEFITS

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

The following Coordination of Benefits provisions apply to each covered person and to any coverage for medical, dental, or vision care under the Plan. There is no Coordination of Benefits under the Prescription Drug Coverage. You should file all claims with each plan under which you are eligible for coverage.

Effect on Benefits

When a covered person is entitled to medical, dental, or vision care benefits or services under more than one plan, the rules shown in the order of benefit determination section below will be used to decide which plan is the principal plan. If this Plan:

1. Is the principal Plan among all of the plans that cover the covered person, 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. They will be reduced so that all of the benefits and services provided by all of the Plans during each claim determination period will not be more than 100% of the allowable expenses incurred by the covered person. The benefits provided by a Plan include those that would have been provided if a claim had been duly made.

The benefits from this Plan will never be greater than the sum of the benefits that would have been paid if there were no other plan covering the covered person.

Plan. The term "plan" means a plan that provides benefits or services for medical, dental, or vision care by or through any:

1. Group health plan, including group insurance and a self-insured group health plan;

2. Group practice or prepayment coverage;

3. Group service plan;

4. Method of coverage for persons in a group other than as shown in items 1, 2, and 3; or

5. Coverage that is required or provided by law.

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

Principal Plan. With respect to any two plans that cover a covered person on whose expenses a claim is based, the "Principal Plan" is the plan under which benefits will be determined first.

Pre-Paid Plans. Pre-paid plans (HMO's, EPO's, 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 remaining after the Pre-paid plan has paid benefits.

Allowable Expense. The term "Allowable Expense" means any necessary, reasonable, and customary item of expense that is, at least in part, a covered expense under one or more of the plans that cover the covered person. When a plan provides a service, the service will be deemed to be both an Allowable Expense and a benefit paid.

Claim Determination Period. The term "Claim Determination Period" means a calendar year.

Anti-duplication Provision. An "Anti-duplication Provision" is a provision that reserves to a Plan the right to consider the benefits or services of other Plans in determining its benefits.

Order of Benefit Determination

Medicare. If a covered person is eligible for Medicare, Medicare will be the Principal Plan except when the law requires this Plan to be the Principal Plan. The Plan requires that you enroll in Medicare when you become eligible.

Medicare has two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Part A covers Inpatient Hospital care and generally is available to all individuals over age 65 at no cost. Part B covers doctor's services, Outpatient Hospital services and other medical supplies and is optional. You must pay a monthly premium for Medicare Part B.

When Medicare is the Principal Plan, its benefits will be taken into account in determining any benefits to be paid under this Plan as follows:

The benefits of Medicare Parts A and B will be taken into account whether or not the covered person has enrolled.

This means that the benefits of Medicare Parts A and B will be estimated and benefits under this Plan will be reduced to the extent that benefits would have been paid had you enrolled for Medicare.

In addition, if you are enrolled in Medicare and elect to use a provider who does not participate in Medicare, the benefits of Medicare Parts A and B will be estimated and the benefits under this Plan will be reduced to the extent that benefits would have been paid had your provider been a Medicare participating provider.

Your claims and your spouse's claims (if your spouse is also eligible for Medicare) should be submitted to Medicare first. After Medicare pays the claim, submit a copy of the bill along with the Medicare explanation of benefits to Cigna.

The Plan's benefit payment will coordinate with Medicare's payment. For covered expenses, the Plan will figure its benefit based on the total expense and then subtract the Medicare benefit and consider the balance under the provisions of this Plan. For these expenses the Plan "carves out" Medicare's payment. However, Federal law limits the amount a provider (Hospital, Physician, etc.) can charge above the Medicare payment. The Fund cannot pay the provider more than that amount and the provider cannot legally bill you more than that amount.

Plans Without Anti-Duplication Provisions. When one of any two Plans does not include an Anti-Duplication provision, then that Plan will be the principal Plan. If any part of a Plan is not subject to an Anti-Duplication provision, then that part will be deemed to be a separate Plan and will be the principal Plan.

Plans With Anti-Duplication Provisions. These rules will be used to decide which of any two Plans is the principal Plan when both contain an Anti-Duplication provision. The first rule listed that describes one, but not both, of the Plans will identify the Principal Plan.

1. The Plan that covers the covered person through present employment instead of a Plan that covers the covered person through prior employment. Through prior employment means as a laid off or retired employee. This rule will not be used when: (a) the other Plan does not include a similar rule; and (b) the result of using this rule is that the Plans do not agree on which Plan is the Principal Plan.

2. The Plan that covers the covered person other than as a Dependent.

3. The Plan that covers the covered person as a Dependent of the parent whose birthday occurs earlier in a calendar year. If both parents have the same birthday, the Plan that has covered the parent for the longer period of time. The rule of the other Plan will be used in place of this rule when: (a) the rule of the other Plan is **not** based on the birthday of the parent; and (b) the result of using this rule is that the Plans do not agree on which Plan is the Principal Plan.

4. The Plan that has covered the covered person for the longer period of time.

5. The Pre-paid Plan is primary for Dependents whose coverage by the Pre-Paid Plan is because they are or were an employee.

Exception to Rule 3. If the covered person is a Dependent child of parents who are divorced or separated, then the following rules will be used in place of Rule 3:

1. The Plan of the parent who has been assigned the financial duty for the child's health care by a court decree.

2. The Plan of the parent who has custody of the child.

3. The Plan of the stepparent who is married to the parent with custody of the child.

4. The Plan of the parent who does not have custody of the child.

Any other Plan that is required or provided by law, including a "no-fault" Plan, will be the Principal Plan unless the law forbids such Plan to be the Principal Plan.

Right to Information, Payment, and Recovery of Payment

To meet the intent of the Coordination of Benefits provisions or an Anti-Duplication provision of any other plan, the Fund Office may, in any way allowed by law, give or get any information that is needed to decide the benefits that are payable. A covered person must declare coverage under any other plans and give to the Fund Office the information it needs to meet the intent of this provision. The Fund Office shall have the right to pay to any organization the amount that organization has paid that should have been paid by the Plan. An amount so paid will be deemed to be a benefit paid under the Plan. To the extent of the payment, the Plan will have no more liability.

If the Plan has paid more than it should have paid to meet the intent of this provision, it may recover the excess amount from one or more of the following, as the Trust Fund may decide:

1. Any person to, or for, or with respect to whom the payment was made (including reimbursement from amounts that would other wise be paid on a future claim);

2. Any insurance company; or

3. Any other organization.

THIRD PARTY RESPONSIBILITY

If a covered person is injured or becomes ill through the act or omission of another person, and if benefits are paid under the group Plan due to the Injury or Illness, then to the extent the covered person recovers any payment for the same Injury or Illness from a third party or its insurer, the Fund shall be entitled to a refund of such benefits.

Accordingly, prior to a payment of a covered person's benefit, the Fund may request that the covered person, and the covered person's attorney, execute a written agreement acknowledging the Fund's subrogation of all rights, claims, interest, and causes of action that the claimant has against a third party in connection with the claim.

The Fund has a right to first reimbursement out of any recovery. A covered person who recovers payment from a third party shall reimburse the Fund in full and without reduction for attorneys' fees or costs, from any of the proceeds received by the covered person or his agent or attorney from the third party, regardless of how the payment, settlement, or judgment is characterized. The Fund has an equitable interest in any amounts that you recover, or will recover, for the entire amount paid by the Fund for the claim. This includes any amounts that you may receive from a personal homeowner's insurance policy, an automobile insurance policy or a group insurance arrangement of any kind. Any amounts recovered by a claimant will be applied first to reimburse the Fund even if the participant is not made whole. Any amounts recovered are assets of the Fund by virtue of the Fund's reimbursement interest, and must be separately segregated until the Fund's interests are resolved in accordance with the Plan.

The Fund's right to reimbursement applies even if the covered person fails to inform the Fund of his claim against the third party, or fails or refuses to execute the written subrogation agreement, or does not separately segregate any monies he recovers from a third party.

If the Fund pays benefits to, or on behalf of, you or your Dependents, and you do not reimburse the Fund after you receive a recovery from any third party, the Fund can withhold any other benefits that may be payable to you or your Dependents, or may take legal action against you, in order to recover the amounts paid, plus the costs of such legal proceedings, including attorney's fees.

As noted above, before the Fund pays any benefits to you or your Dependents, you and your attorney may be required to sign a written agreement stating that the Fund will be reimbursed for any amounts that it pays in connection with the Injury if you later receive payment from the third party for that Injury. Any settlement that you make against the third party must be approved by the Trustees. You must agree to help the Fund in pursuing your claims against the third party, or to allow the Fund to pursue the claims on your behalf before any benefits are paid from the Fund.

The Fund's right to reimbursement also includes the right to reimbursement made to you from any source to which you assign your claim against, or otherwise agree to reimburse any recovery from, the person who caused your Injury.

The Trustees have absolute discretion to settle subrogation claims on any basis they deem warranted and appropriate under the circumstances.

EMPLOYEE SHORT TERM DISABILITY INCOME COVERAGE

This Plan does not provide Employee Short Term Disability Income Coverage.

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

This Plan does not provide Life and Accidental Death and Dismemberment Benefits.

CLAIMS AND APPEALS

In order to receive medical benefits from the Fund, you must file a written claim form with Cigna. You may obtain claim forms from your Employer, the Fund Office, Cigna, or by going on line at www.iambtf.org. To expedite the processing of your medical claim, please be sure to complete the form thoroughly, including information about Medicare eligibility and any other group benefits that may be payable on your behalf. You may make medical claims directly or through a provider subject to the limitations on assignments.

Requests for determination of whether a person is eligible for benefits will not be considered claims under these provisions. Casual inquiries about benefits or the circumstances under which benefits might be paid will also not be considered claims hereunder. However a rescission of coverage may be the source of a claim hereunder.

In order to be considered, your written claims must be mailed to Cigna as soon as reasonably possible after the expense is incurred, but in no event more than one year after the expense is incurred. Any claims received by Cigna more than one year after the expense is incurred will be denied as untimely. Properly completed claims must be accompanied by billings from the provider and such other proof as may be required by Cigna. If you have any additional bills after your first treatment, file them periodically. Cigna will pay the benefits to you only upon receipt of due written proof.

All benefits are payable to you. However, claims by Cigna Preferred Providers are usually filed directly with Cigna by the Preferred Provider, and Cigna pays the Preferred Provider directly. 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 a Cigna Open Access Plus Preferred Provider Organization. Non-Preferred Providers may require that you pay them first and that you seek reimbursement by filing your own claim with Cigna.

Filing Claims for Medical Benefits

All claims for medical benefits under this Plan are considered Post-Service Claims. Post-Service Claims involve the payment or reimbursement of costs of medical care after that care has already been provided.

You are not required to obtain pre-authorization for any claim filed with or through Cigna. However, some of Cigna's Preferred Providers must obtain pre-authorization from Cigna in order to provide you services. This is the sole obligation of the Provider, and will not affect your coverage. If one of Cigna's Providers fails to obtain any necessary pre-authorization from Cigna, you cannot be billed extra by that provider.

Your medical claims will be considered filed as soon as a written claim form is received by Cigna from the provider or from you by mail, personal delivery, or fax. Telephone calls and e-mails are not acceptable. If additional documentation is required, you will be notified as soon as reasonably possible, but no later than 30 calendar days after Cigna's receipt of the claim from you or your provider.

Cigna will notify you of its determination on your medical claims within a reasonable period of time, but no later than 30 calendar days after its receipt of your claim. This period may be extended by one 15-day period, if special circumstances beyond the control of Cigna require that additional time is needed to process your medical claim. If an extension is needed, Cigna will notify you prior to the expiration of the initial 15-day period of the circumstances requiring an extension and date by which Cigna expects to reach a decision. If Cigna needs an extension because you have not submitted information necessary to decide the claim, the notice will also describe the information needed to make a decision. You will have at least 45 calendar days after receiving this notice to provide the specified information. Cigna's time for making the decision will be tolled until the earlier of the date you provide the information, or 45 days after you receive the request for information.

Claim Reminders

1. Be sure to use your member ID and account number when you file Cigna's claim forms, or when you call your Cigna claim office. Your member ID is the ID shown on your benefit identification card. Your account number is the 7-digit policy number that is also shown on your benefit identification card. For all National IAM Benefit Trust Fund Medical Plans the Cigna account number is 3316316.

2. Prompt filing of any required claim forms results in faster payment of your claims.

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.

Prescription Drug Benefit Claims

There are separate procedures for making claims for the Prescription Drug Benefit, including a special procedure to fill prescriptions for Specialty Medications. For all prescriptions, you do not have to complete a written claim form as long as you have a CVS Caremark prescription card and use a participating pharmacy. If any claim for a prescription drug benefit is denied, you have the right to appeal by following the procedures explained below.

You may get your general prescriptions filled at any participating pharmacy by presenting your CVS Caremark prescription card to the pharmacist. However, if a pharmacy does not accept your CVS Caremark card, you must first pay the pharmacist and then seek reimbursement by filing a written claim with CVS Caremark. CVS Caremark will then respond like any other Post-Service Claim explained under the medical benefits claims provisions above. Any prescription drug claim received by CVS Caremark more than one year after the date of purchase will be denied as untimely.

Specialty Medications

Specialty Medications can be filled only by using CVS Caremark Specialty Pharmacy Services. Specialty Medications are considered Pre-Service Claims, and you must get pre-authorization as a condition of coverage. If you are prescribed a Specialty Medication, or if your pharmacist tells you that an item you are requesting is a Specialty Medication, you must call CaremarkConnect® toll-free at 1-800-237-2767. When notified, CVS Caremark will contact your doctor directly to

obtain clinical information needed to perform a pre-authorization review, and you will not have to complete a written claim form.

CVS Caremark will notify you in writing of its determination on your claim for coverage of a Specialty Medication within a reasonable period of time, but no later than 15 calendar days after it receives notification of the claim. This period may be extended by one 15-day period, if special circumstances beyond the control of CVS Caremark require that additional time is needed to process your claim. If an extension is needed CVS Caremark will notify you in writing prior to the expiration of the initial 15-day period of the circumstances requiring an extension and the date by which it expects to reach a decision. If the extension is required because additional information is needed from you in order to decide the claim, the notice of extension will specifically describe the information that is needed from you, and you will be given at least 45 days from your receipt of the notice within which to provide the information.

If your claim for a Specialty Medication is an Urgent Claim, you will be notified of CVS Caremark's determination more quickly. An Urgent Claim is one for which waiting the longer time frames in the preceding paragraph could seriously jeopardize your life or health or your ability to regain maximum function. Urgent Claims also include those for which waiting the longer time frames, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be managed without the medications.

For Urgent Claims for Specialty Medications, CVS Caremark will notify you of its determination as soon as possible, taking into account the medical exigencies, but no later than 72 hours after you first call CVS Caremark about the prescription for the Specialty Medication, unless you or your doctor fail to provide sufficient information to make the determination, in which case you will be notified within 24 hours of the information that is needed. The determination will then be made no more than 24 hours after CVS Caremark receives the information.

Short Term Disability Claims

If your Plan provides Employee Short Term Disability Income Coverage, claims for such benefits are filed directly with the Fund Office in writing on special forms that are available from the Fund Office. Your claim will be considered filed as soon as the Fund Office receives a written claim form by mail, fax, or personal delivery. Telephone calls and e-mails are not acceptable. The Fund Office must receive your claim for Short Term Disability benefits within one year of the start of the Disability. Any claim received more than one year after the start of the Disability will be denied as untimely. Do not make any claims for Short Term Disability benefits with Cigna. Cigna has no role in the administration of these benefits.

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

If your claim for Short Term Disability Income Coverage benefits is denied in whole or in part, you have the right to appeal that decision under the applicable procedures as described below.

Life, Accidental Death, and Dismemberment Claims

If your Plan provides Life and Accidental Death and Dismemberment coverage, claims for such benefits are filed directly with the Fund Office in writing on forms available from the Fund Office. Your claim will be considered filed as soon as the Fund Office receives a written claim form by mail or personal delivery. Faxes, telephone calls, and e-mails are not acceptable. The Fund Office will forward your claim to Cigna Group Insurance (Life Insurance Company of North America) for processing. Claims for Life, Accidental Death, and Dismemberment Benefits must be received by the Fund Office within one year of the death or dismemberment. Any claims received more than one year after the death or dismemberment occurred will be denied as untimely. Do not make any claims for Life, Accidental Death, and Dismemberment Benefits with Cigna. All such claims should be submitted to the Fund Office.

You will be notified of the decision on your claim for Dismemberment Benefits within a reasonable time but not later than 45 days from the date of the receipt of the claim. The initial 45-day period may be extended for up to two additional 30-day periods for circumstances beyond the control of the Fund Office, if the Fund Office notifies you of the extensions prior to the expirations of the initial 45-day and first 30-day extension period, respectively. Any notice of extension will indicate the circumstances requiring an extension, the date by which a decision is expected to be reached, the standards upon which entitlement to a benefit is based, the unresolved issues that require an extension, and additional information needed to resolve those issues. You have at least 45 days after receiving the extension notice to provide the additional information.

You will be notified of the decision on your claim for Life and Accidental Death Benefits within 90 days from the date of the receipt of the claim. This period may be extended for up to 90 additional days for special circumstances, if you are notified of the extension and the circumstances prior to the expiration of the 90-day period.

If your claim for Life, Accidental Death, or Dismemberment Benefits is denied in whole or in part, you have the right to appeal that decision under the applicable procedures as described below.

Notice of Denial of Medical Claims or Prescription Drug Claims

If your claim for medical benefits is denied, in whole or in part, Cigna will provide you with a written notice that states the specific reasons for the denial, refers to the specific Plan provisions on which the denial is based, describes any additional material or information that might help your claim, explains why that information is necessary, and describes the Fund's review procedures and applicable time limits, including your right to bring a civil action under Section 502(a) of ERISA. If your claim for prescription drug benefits is denied, in whole or in part, CVS Caremark will provide the notice to you.

If an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, either you will be provided with the specific rule, guideline, protocol or similar criterion, or you will receive a statement that such a rule, guideline, protocol or similar criterion

was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you upon request.

If the adverse determination is based on a medical necessity determination or an experimental treatment or similar exclusion or limitation, you will be provided either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Appeals of Medical Claims Denied by Cigna

If you disagree with Cigna's decision on any of your claims for medical benefits, you may submit an appeal to Cigna. Your request for appeal review must be made in writing within 180 days of receipt of your denial notice, and should be mailed to the Cigna Appeals Unit, P.O. Box 188011, Chattanooga, TN 37422-8011. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. Your appeal will be reviewed by someone at Cigna not involved in the initial decision. Cigna will respond in writing to your appeal within 30 calendar days of receipt of your appeal. In ruling on such first level appeals, Cigna serves in the capacity of a named fiduciary under ERISA.

If Cigna denies your appeal, in whole or in part, you may request a second level review of your appeal. Your request for second level appeal review must be made in writing to the Board of Trustees, and be submitted to the office of the National IAM Benefit Trust Fund within 180 days of your receipt of Cigna's denial notice on the first level appeal review. Appeals involving medical necessity will be reviewed by a health care professional that was not involved in any prior adverse decision made by Cigna. On second level, your appeal will be reviewed further by the Administrative Committee of the Board of Trustees, which will make a decision and respond to you in writing no more than 30 days after its receipt of your appeal.

Appeals of Prescription Drug Claims Denied by CVS Caremark

If you disagree with a determination made by CVS Caremark on any prescription drug claim, you must submit a request for appeal in writing to the office of the National IAM Benefit Trust Fund within 180 days of receipt of your denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. Such appeals must be made directly with the Fund Office and should not be sent to CVS Caremark. The Administrative Committee of the Board of Trustees will review appeals of all denied prescription drug claims.

For appeals of denied claims that do not involve Specialty Drugs, your appeal will be decided by the Administrative Committee of the Board of Trustees at its next quarterly meeting following the receipt of the appeal by the Fund Office. If your appeal is received within 30 days of the quarterly meeting, your appeal will not be decided until the meeting after that one. 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.

The Fund Office will refer appeals involving Specialty Medications to CVS Caremark for a first level appeal review. For appeals not involving Urgent Claims, CVS Caremark will notify you of its decision within a reasonable period of time appropriate to the medical circumstances, but in no event will CVS Caremark take more than 15 days to notify you of its decision. If CVS Caremark denies your appeal, the matter will then be automatically reviewed further by the Administrative Committee of the Board of Trustees of the National IAM Benefit Trust Fund, which will notify you of its decision within 30 days after the first receipt of your initial appeal by the Fund Office. If the Specialty Medication appeal is from a denied Urgent Claim, the final decision on the appeal will be made as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the appeal by the Fund Office.

Appeals of Determinations on Other Claims

If you disagree with any determination on a Short Term Disability claim, a Life and Accidental Death and Dismemberment claim, or a rescission of coverage, you must submit a request for appeal in writing to the office of the National IAM Benefit Trust Fund within 180 days of receipt of your denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal.

Your appeal will be decided by the Administrative Committee of the Board of Trustees at its next quarterly meeting following the receipt of the appeal by the Fund Office. If your appeal is received within 30 days of the quarterly meeting, your appeal will not be decided until the meeting after that one. 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.

Appeals Generally

Appeals received more than 180 days after your receipt of a claim denial will be denied as untimely. In presenting any appeal, you have the opportunity to submit written comments, documents, records, and other information relating to your claim for benefits. You are also entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits, including any new or additional evidence considered, relied upon, or generated by the Fund in connection with your claim. If applicable, the Fund will also provide you with new or additional rationale on which the adverse benefit determination was based. Personal appearances on appeals are not permitted.

Your written appeal should state the specific reasons why you believe the denial of your claim was in error. You should also submit any documents or records that support your claim. This does not mean that you are required to cite all of the Plan provisions that apply or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefits you are claiming. The Administrative Committee can best consider your position if it clearly understands your claims, reasons, or objections.

The review of your appeal will take into account all comments, documents, records, and other information that you submit, without regard to whether such information was submitted or considered in the initial determination. The review will also not afford deference to the initial

determination and will not be conducted by an individual who made the initial adverse benefit determination, nor the subordinate of such an individual.

In deciding an appeal of a benefit determination that was based, in whole or in part, on a medical judgment (including determinations about whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate), the reviewer will consult with a health care professional who has appropriate training and expertise in the particular field of medicine, and who was not consulted in connection with the original determination. You will also be provided, upon request, with the identity of any medical or vocational experts whose advice was obtained at any level of the claims and appeals process, without regard to whether that advice was relied on.

Notice of Decisions on Appeals

You will be mailed a written notice of the decision on any appeal. If your appeal is denied, in whole or in part, the written notice will set forth: (1) the specific reasons for the denial; (2) the specific Plan provisions on which the denial is based; (3) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding a claim; (4) a statement of your right to bring a civil action under 502(a) of ERISA; and, for medical and prescription drug appeals, (5) your right to request an external review of your claim.

If an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, either you will be provided with the specific rule, guideline, protocol or similar criterion, or you will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you upon request.

If the decision is based on a medical necessity determination or an experimental treatment or similar exclusion or limitation, you will be provided either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request.

External Review of an Adverse Benefit Determination after Appeal

If you receive an adverse benefit determination on your appeal of a prescription drug benefit denial, or if an adverse benefit determination is made by the Administrative Committee on your appeal of a medical benefit denial, you have the right to request an external review. Your request for external review should be sent to the office of the National IAM Benefit Trust Fund, and must be made no later than four months after the date you received the adverse decision on your appeal. Requests for external review received more than four months after an appeal denial will be denied as untimely.

Within five business days following receipt of your request, the Fund Office will make a preliminary review to determine if your case is eligible for external review. If your case is not eligible for external review, a notification will be issued to you explaining why or what additional information is required. If your case is eligible for external review, it will be forwarded to an Independent Review Organization (IRO), and the IRO will contact you. Once you are contacted by the IRO, you will have ten business days to submit additional information

directly to the IRO if you choose to do so. The Fund Office will provide to the IRO the documents and information considered on your appeal. Within 45 days after the IRO receives your request for external review from the Fund Office, the IRO will issue to you a written notice of its decision.

If the adverse benefit determination on appeal involves a medical condition for which the timeframe to complete a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the appeal concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency care services, but has not been discharged from a facility, you have the right to request an expedited external review. If your request for an expedited external review is granted, the IRO will provide notice of the final external review decision as expeditiously as possible, but in no event more than 72 hours after the IRO receives the request.

Administrative Committee Decisions are Final and Binding

The decision of the Administrative Committee and the IRO are final and binding on all parties, including anyone claiming a benefit on your behalf. As a committee of the Trustees, and only as limited by the IRO, the Administrative Committee 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.

If you are unsatisfied with the outcome of your appeal after exhausting all available internal and external administrative review processes, you may seek judicial review. If the Administrative Committee 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 lawsuit may be brought without first exhausting the above claims and appeals procedure. Nor may any evidence be used in court unless it was first submitted to the Administrative Committee or to the IRO.

Right to Authorized Representative

In making a claim or appeal, you may be represented by any authorized representative. If your representative is not an attorney, parent, or court appointed guardian, you must designate the representative by a signed written statement.

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 is also a group health Plan.

Plan Identification Numbers

The employer identification number ("EIN") is: 36-6562520
The Plan number is: PN 501

Fund Office Administration

The day-to-day administration of the Plan is handled by the Fund Office. Claims for medical 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
1300 Connecticut Avenue, NW, Suite 300
Washington, DC 20036
Phone: 202-785-8148
Fax: 202-728-0585

Claims Administrator

Claims for medical benefits are processed by the Claims Administrator, which is Cigna Healthcare. Medical Claims should be sent to the address on the back of your benefits identification card and inquiries should be made to the phone number on the back of your benefits identification card.

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 a Fund Director to supervise the daily functions of the Benefit Trust Fund. The Executive Director is Ryk Tierney, and he may be contacted at the Fund Office address above. As the legal Plan Administrator, the Trustees have the authority to allocate or delegate their responsibilities for the administration of the Plan to others and employ others to carry out or give advice with respect to their responsibilities under the Plan.

Trustees of the Plan

UNION TRUSTEES

James Conigliaro, GVP
International Association of Machinists
9000 Machinists Place
Upper Marlboro, MD 20772-2687

Dora H. Cervantes, GST
International Association of Machinists
9000 Machinists Place
Upper Marlboro, MD 20772-2687

Philip J. Gruber, GVP
International Association of Machinists
113 Republic Avenue, Suite 100
Joliet, IL 60435

EMPLOYER TRUSTEES

Thomas Mitchell
Allen-Mitchell & Co.
515 V Street, NE
Washington, DC 20002

David R. Dietly
PAE
1320 N. Courthouse Road, Suite 800
Arlington, VA 22201

Marie Underwood
McGee Air Service
901 Powell Avenue, SW, Suite 100
Renton, WA 98057

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 shall not, in any manner, imply an endorsement of any specific provider, nor shall 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:

Cigna Healthcare
10490 Little Patuxent Pkwy, Suite 400
Columbia, MD 21044
Phone: 410-884-2500

Prescription Drug Benefits Administration

The Board of Trustees has contracted with CVS Caremark for the prescription drug benefit, as part of the Fund's participation in the Health Care Cost Containment Corporation (HCCCC):

CVS Caremark, Inc.
9501 East Shea Blvd.
Scottsdale, AZ 85260-6719
Phone: 888-727-5575

Funding of Benefits

The benefits under the Plan are funded and provided by the National IAM Benefit Trust Fund, which, in turn, is funded by monthly payments by the Employers. There also are circumstances in which Employees self-pay to the Fund.

All benefits under the Plan are self-insured, except Life and Accidental Death and Dismemberment. The Trustees have a group life insurance policy through Cigna Group Insurance, under a contract with:

Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, PA 19192-2235
Phone: 1-800-238-2125

In addition, the Trustees have purchased stop loss insurance from Unimerica Insurance Company to cover losses to the fund in the event of large claims:

Unimerica Insurance Company
6300 Olson Memorial Highway
Golden Valley, MN 55427
Phone: 800-454-0233

The continuation of these insurance arrangements is at the discretion of the Trustees.

There is no liability on the Board of Trustees to pay any benefits or premiums above and beyond the amounts in the Fund collected and available for such purpose. Should contributions not provide sufficient funding to maintain benefits, the Trustees reserve the right to change the eligibility rules, reduce or change the benefits, or eliminate the Plan, in whole or in part.

Except as stated above, the benefits described in this booklet are self-insured by the National IAM Benefit Trust Fund. Cigna provides only claims administration, and it does not insure any of the benefits described in this booklet.

Agent for Service

The person designated as Agent for Service of legal process is the Fund Director. The address at which the process may be served on that person is the address of the Fund Office indicated above. Service of legal process may also be made upon any of the individual Trustees.

Source of Plan Contributions

The contributions necessary to finance the Plan are made by the Employers and, in some instances, Employees. 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 in order for coverage to be provided to you. 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.

Some health plans of the National IAM Benefit Trust Fund provide benefits for Retirees and/or their Dependents. If Retiree coverage is provided under this Plan, such coverage is funded from current monthly contributions and is not guaranteed. If the monthly contributions cease, the Retiree coverage ends. The Trustees reserve the right to change the rate of contributions for any Retirees at any time.

Erroneous Contributions

Once contributions are made to the Fund, they may be returned to an Employer, in 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.

The Patient Protection and Affordable Care Act of 2010 (PPACA) 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 PPACA or applicable regulations. If so, the contributions will not be refunded.

Any costs incurred by the Fund in correcting the Employer's error, including administrative and computer costs and benefits paid in reliance on the Employer's erroneous contributions, including amounts paid after discovery of the error during a review period (including external review) as required by the PPACA, will 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.

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 booklet. The Trust Fund is the source of the benefits of this Plan.

Plan Year

The Plan year begins on October 1 and ends on September 30.

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 group Plan is not in lieu 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 two years after a claim has been denied.

Exclusive Rights

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

No Fund Liability

The use of services of any Hospital, Physician or other provider of health care, whether designated by the Benefit Trust Fund or otherwise, is your voluntary act. Nothing in this Plan booklet 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 Benefit Trust 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 Benefit Trust 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 Benefit Trust 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 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.

Misrepresentation or Fraud

If you receive benefits as a result of false information or a misleading or fraudulent representation, you will be required to repay all amounts and you will be liable for all costs of collection including attorneys' fees. The Trustees reserve the right to reduce future benefit payments by the amount of the payment made because of fraud or misrepresentation.

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 medical 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.

Plan Termination

The Fund may be terminated by a document in writing adopted by the Trustees. 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 as well as 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 of Benefits 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 the Beneficiaries or the administrative expenses of the Fund. 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 booklet, unless the illegality makes the continued operation of the Plan impossible.

STATEMENT OF ERISA RIGHTS

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 shall be entitled to:

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 Pension and Welfare Benefits 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 also have the right to:

Continue group health coverage for yourself, spouse or Dependents 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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage free of charge, from your group health plan or health insurance issuer, when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in coverage in another plan.

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 Employee Benefit 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 welfare 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 Fund 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 domestic relations order or 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.

Assistance with Questions

If you have any questions about your Plan, 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration. For single copies of publications, contact the Employee Benefits Security Administration Brochure Request Line at 1-800-998-7542 or contact the EBSA field office nearest you. You may also find answers to your Plan questions at the website of the EBSA at http://www.dol.gov/dol/ebsa.

NATIONAL IAM
BENEFIT TRUST FUND

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Executive Director

RYK TIERNEY, CEBS