NATIONAL IAM BENEFIT TRUST FUND

Better Benefits · Better Life

Vision Plan I-A

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 Fund has provided vision care programs covering all eligible employees and their dependents since March 1, 1977. Vision Plan coverage is self-funded through contributions paid by employers and employees participating in the Plan.

Vision care 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
Alfred C. Nelson	Warren Mart
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Thomas Mitchell	Philip Gruber

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INTRODUCTION

This booklet sets forth the Vision Program for Participants who are covered under **Vision Plan I-A**. It explains all of the Vision Care Benefits provided by the Plan for claims incurred on or after **October 1, 2010**. This booklet also serves as your Summary Plan Description.

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.

THIS PAGE GIVES 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, INCLUDING LIMITATIONS AND EXCLUSIONS THAT MAY AFFECT YOU AND YOUR CLAIMS, WILL BE FOUND IN THE REST OF THIS BOOKLET.

SCHEDULE OF BENEFITS

VISION PLAN I-A

BENEFITS:

This Vision Plan will pay up to 100% of the scheduled Benefit amount for each of the following Routine Vision Care Services once each Calendar Year, but not more than your actual billed charges for any service. See Covered Vision Care Services, Areas of Limited Coverage, and Exclusion sections for other limitations that might apply.

Examinations:

Eye Examination $70.00

Contact Lens Fitting $85.00

Lenses:

Single vision – pair of lenses $60.00

Bifocal – pair of lenses $68.00

Trifocal – pair of lenses $85.00

Frames $75.00

Contact Lenses:

Normal contact lenses $135.00

Contact lenses required after cataract surgery, or when visual acuity cannot be corrected to 20/70 in the better eye with conventional lenses $205.00

DEFINITIONS

Terms when capitalized in this Summary Plan Description have defined meanings that are given in the section below and in other sections throughout this booklet.

"Accident" or **"Accidental"** 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.

"Benefits" means the scheduled amounts that the Vision Plan will pay for Routine Vision Care Services that are provided.

"Calendar Year" means the period of twelve consecutive months that starts on January 1 and ends on December 31.

"Claim Form" means a Vision Claim Form as explained below.

"Covered Person" means a Participant that is eligible for Benefits under this Plan.

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

"Covered Vision Charge" means a charge that: (1) is made for a Routine vision 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 Vision Care Services List.
B. It is incurred by a Covered Person while the Covered Person is eligible for vision 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 furnished by or received from a Covered Vision Provider.
D. It is not listed as a Plan Exclusion.

"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.

"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 participation agreement to make contributions to the National IAM Benefit Trust Fund on behalf of its Employees.

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

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

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

"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.

"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.

"Routine" with respect to vision care means that the services are not related to Illness or Injury, except where allowed by the Plan following cataract surgery.

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

"Vision Claim Form" means the Benefit Trust Fund's standard form used to submit a vision claim for consideration under the Plan.

ELIGIBILITY PROVISIONS

Active Employee Eligibility

You are eligible for coverage if you are a full-time active Employee of an 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.

Retiree Eligibility

Some Employers provide Retiree coverage under this Vision Plan. To qualify for Retiree coverage, you must meet the following Retiree Eligibility requirements:

1. You must retire from active employment with a participating Employer of the National IAM Benefit Trust Fund; and

2. You must retire while you are eligible for Benefits under this Plan; and

3. Your Employer must continue to make the required monthly contributions to the National IAM Benefit Trust Fund on your behalf.

Retiree Eligibility only applies for Employees who are subject to a collective bargaining agreement or other participation agreement that allows for Retiree coverage.

Surviving Spouse Eligibility

If you die while covered as a Retiree, your surviving Dependent spouse may be eligible to continue coverage under this Plan until the earlier of:

1. The date your surviving Dependent spouse dies; or

2. The date your surviving Dependent spouse remarries.

Surviving Spouse Eligibility only applies for covered spouses of Employees who are subject to a collective bargaining agreement or other participation agreement that allows for Surviving Spouse coverage. Your Employer must continue to make the required monthly contributions for your surviving Dependent spouse, providing they were covered by the Plan prior to your death. Coverage is lost permanently upon the remarriage of the surviving Dependent spouse, and will terminate on the last day of the month in which they remarry.

In any case, your surviving Dependent spouse and surviving Dependent children may have rights to Continuation of Health Coverage 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.

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 person who is on active duty in any armed forces.

Employees are required to submit a completed eligible dependent certification (EDC) form for any child whose last name differs from the employee's last name, for 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 vision 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 vision 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 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, or

   D. Layoff.

   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 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 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 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 of 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.

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 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; or

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

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

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 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 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. 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	Indefinite [3]
7. Covered Employee's termination of employment due to retirement	Employee, spouse, and Dependent children	Indefinite [3]

1 This maximum period includes the 18 month statutory COBRA period plus an additional 6 months self pay.

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 The maximum coverage period for spouse and Dependent children will change as applicable under 3, 4 and 5 if any such event occurs after Employee elects continuation coverage following termination of employment due to Disability or retirement.

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 coverage identical to that described elsewhere in this Vision Plan booklet.

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, N.W., 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 the Social Security Administration or Railroad Retirement Board makes a determination that you are no longer disabled;

7. The date the plan terminates; or

8. 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.

VISION CARE COVERAGE

This Plan will pay a Vision Care Benefit for Eligible Vision Care Expenses incurred by you and your eligible Dependents. You may obtain services from any Covered Vision Provider you choose, and you will be directly reimbursed by the Fund.

Vision Care Benefits

A "**Vision Care Benefit**" is 100% of Eligible Vision Care Expenses incurred per Participant, not to exceed the maximum shown in the Schedule of Benefits. If any part of a charge exceeds the applicable maximum that is shown in the Schedule of Benefits, that part is denied and the remainder is the amount of the Vision Care Benefit.

Eligible Vision Care Expenses

"**Eligible Vision Care Expenses**" are the Covered Vision Charges for the Routine vision services or supplies listed in the Schedule of Benefits and the Covered Vision Care Services List. If any of the listed expenses are excluded from coverage because of a reason described in the Exclusions provision, those expenses will not be considered Eligible Vision Care Expenses. If a Vision Care Provider discounts, waives, or rebates any portion of a charge, that amount is not considered to be an Eligible Vision Care Expense and the Vision Plan is not obligated to provide Benefits that exceed the adjusted charge amount.

Deductible

A "**Deductible**" is the amount a Participant normally has to pay before Benefits are payable by a Plan. This Vision Plan **does not have** a Deductible, and Vision Care Benefits are payable immediately for Eligible Vision Care Expenses.

Percentage Payable

This Vision Plan pays 100% up to the maximum allowance shown in the Schedule of Benefits.

Participant Responsibility

The Participant is responsible for paying 100% of expenses incurred, less any discount, waiver, or rebate given by the Vision Care Provider. The Plan will reimburse the Employee directly for Eligible Vision Care Expenses in accordance with the Plan provisions.

Maximum Amounts

The Plan will not pay more than the Calendar Year maximums shown in the Schedule of Benefits for all Eligible Vision Care Expenses incurred by a Participant during any one Calendar Year. Please refer to the Schedule of Benefits and the Areas of Limited Coverage section for important information about benefit limitations and maximums.

COVERED VISION CARE SERVICES

The Vision Plan will pay a Vision Care Benefit up to the allowance shown in the Schedule of Benefits for the following Routine vision services, providing that they qualify as Eligible Vision Care Expenses. Please refer to the Areas of Limited Coverage section for specific limitations that might apply for each of the following services.

If you or your Vision Care Provider have any question about coverage of a specific service or about any of the Benefits provided by the Plan, you should contact the Fund Office.

Covered Vision Care Services List

Eye Examination: Routine eye examination, including refraction, is covered by the Plan. This benefit includes a medical history and all related Routine testing that is performed during the examination. Examples of related Routine testing include, but are not limited to, visual acuity exam, visual fields exam, perimetry test, extraocular movement test, pupillary test, cover test, retinal exam, retinoscopy, tonometry, dilated fundus exam, color vision test, slit lamp exam, glaucoma test, and retinal photos.

Contact Lens Fitting: Fitting of contact lenses is covered by the plan. Benefit is payable when service is necessary in addition to routine eye examination or as a stand alone service where appropriate.

Lenses: Single vision, bifocal, and trifocal prescription lenses are covered by the Plan. Progressive lenses are paid under the trifocal lens benefit.

Frames: Eyeglass frames are covered for use in connection with covered lenses.

Contact Lenses: Prescription contact lenses are allowed in lieu of the Benefit for eyeglass lenses and frames. The Schedule of Benefits provides an increased allowance for contact lenses required following cataract surgery, or when visual acuity cannot be corrected to 20/70 in the better eye using conventional lenses. This Benefit is payable for all necessary covered lenses, up to the Calendar Year maximum shown in the Schedule of Benefits.

AREAS OF LIMITED COVERAGE

Limitations on Routine Eye Examination

- Benefit is limited to one Routine eye examination, including refraction, per Calendar Year. If eye examination is determined to be medical in nature and not covered by this Vision Plan, the eye examination benefit can be paid for Routine refraction service.

- All Routine testing performed during an eye examination is included in the Benefit for the eye examination, and there is no separate Benefit for such services. There is no additional Benefit for component services billed by multiple Vision Care Providers, even if the full scheduled Benefit amount was not paid on the first eye examination claim that was processed for the Calendar Year.

Limitations on Contact Lens Fitting

- Benefit is limited to one contact lens fitting per Calendar Year.

Limitations on Conventional Lenses

- Benefit is limited to one pair of conventional lenses (two lenses) per Calendar Year.

Limitations on Frames

- Eyeglass frames can be purchased independently of eyeglass lenses; however, there is no Benefit for frames used with non-covered eyeglass lenses.

Limitations on Contact Lenses

- Benefit for contact lenses is provided in lieu of the Benefits for conventional lenses and frames. There is no coverage for both eyeglasses and contact lenses within the same Calendar Year.

- For consideration of increased Benefit for contact lenses required following cataract surgery or when visual acuity cannot be corrected to 20/70 in the better eye using conventional lenses, Participant should submit Vision Care Provider certification that confirms cataract surgery or visual acuity, whichever is applicable.

- There is no benefit for cosmetic lenses.

HOW TO USE THE PROGRAM

As explained earlier in this booklet, you and your Dependents have free choice to obtain Routine Vision Care Services from any covered Vision Care Provider you choose. You should pay your bill at the time of service and then submit a claim for reimbursement to the Fund Office.

To make a claim for Benefits, you will need to obtain a Vision Claim Form from your Employer, the Fund Office, or the Fund Website, www.iambtf.org. You should complete the Employee section of the form in full, then present the Claim Form to your provider of service and ask them to fill out the doctor section of the form on your behalf. The provider should return the form to you when completed. We recommend that you also attach any receipt you are given in case the Plan has question about your charges, and send both to the Fund Office.

In lieu of completing Part 2 of the Vision Claim Form, your provider may choose to give you a receipt for your services. Please be sure the receipt includes a complete itemization and description of all charges, as well as details of any discount, waiver, or rebate that was given. You should complete Part 1 of the Vision Claim Form, attach the itemized receipt, and send both to the Fund Office.

In some cases your provider may be willing to submit a vision claim on your behalf using an HCFA uniform claim form. If your provider offers to do this, please ask them to use the mailing address indicated below, and be sure they understand that they will not receive any direct reimbursement from this Plan.

All vision claims should be sent to the Fund Office for processing at the following address:

National IAM Benefit Trust Fund
1300 Connecticut Avenue, N.W., Suite 300
Washington, DC 20036

When a vision claim is received, the Fund Office will pay a Vision Benefit directly to you for any Eligible Vision Care Expenses. This Vision Plan does not make direct payment to any Vision Care Provider. If Benefits are not payable when your claim is received, you will be notified of any information that might be needed to process your claim, or the reason for denial.

PLEASE NOTE - Possession of this Summary Plan Description and/or a Benefit Trust Fund Vision Claim Form does not establish a patient's eligibility for Benefits under the Plan. If you wish to verify eligibility before obtaining services, you can contact the Fund Office for eligibility confirmation at 1-800-457-3481.

EXCLUSIONS

The Plan does not cover all charges that are incurred, treatments that are provided, or supplies that are received, even when ordered or recommended by a Physician or Vision Care Provider. Exclusions include but are not limited to:

1. Charges or services for which benefits are payable under any Workers' Compensation law or any other law of similar purpose, regardless of whether benefits are paid in full or in part.

2. Charges or services that result from or arise out of any past or present employment or occupation for compensation or profit.

3. Charge for any service or supply that is required by an Employer as a condition of employment, or which an Employer is required to provide by virtue of a labor agreement, or which is required by a government body.

4. Charges or services that result from an act of declared or undeclared war, the Covered Person's commission of a crime, or non-therapeutic release of nuclear energy.

5. Charges for services, supplies, or treatments that are furnished, paid for, or otherwise provided by reason of past or present service in the armed forces of a government, except as otherwise provided by law.

6. Charges for services, supplies, or treatments that are furnished, paid for, or otherwise provided by any local, state, or Federal Government agency, program, or institutions, unless otherwise provided by law.

7. 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.

8. Charges for services or supplies 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.

9. Charges for services or supplies that are included as covered expenses under any other benefit provided by the Plan.

10. Charges for services or supplies that are covered under any other medical or vision care plan provided by a participating Employer; however, this Plan will coordinate benefits where appropriate when another plan is determined to be the primary plan (there is no Coordination of Benefits between this Vision Plan and any Medical Plan Benefits provided by this Fund).

11. Charges where payment has been denied by a 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.

12. Experimental, investigational, or unproven services, treatments, or devices.

13. Charges incurred on a date when no eligibility exists.

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

15. Medical or surgical treatment of the eyes.

16. Charge for more than one Routine eye examination, one pair of conventional lenses, and one eyeglass frame during each Calendar Year.

17. Charges for both eyeglasses and contact lenses purchased during the same Calendar Year.

18. Charges for more than one contact lens fitting per Calendar Year.

19. Charges for any lens coatings or tints, including photosensitive (transitions), antireflective, and polarized lenses, or for prescription and non-prescription sunglasses, even if ordered or recommended by your Physician or Vision Care Provider.

20. Charges for non-prescription eyeglasses of any kind.

21. Charges for protective eyewear including occupational safety glasses, safety goggles, side shields, or any other item or device that is made especially to protect your eyes.

22. Charges for frames used with non-covered eyeglass lenses.

23. Charges for duplicate or spare eyeglasses, lenses, or frames.

24. Charges for replacement of lost, stolen, or broken lenses, frames, or contact lenses.

25. Charges for repair of broken lenses, frames, or contact lenses.

26. Charges for any special procedures, treatments, or supplies, including surgical vision correction, orthoptics (visual training), and any type of subnormal vision aids.

27. Charges for cosmetic services or cosmetic extras, eyeglass cases, eyeglass repair kits, lens care kits, cleaning solutions, insurance coverage, or warranty.

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

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

30. Any services, supplies, or treatments that are not shown as covered, and any benefits not otherwise provided herein.

GENERAL BENEFIT PROVISIONS

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 vision plans, 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 a patient's actual liability on the billed charges 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 vision care under the Plan. You should file all claims with each plan under which you are eligible for coverage.

Please Note: There is no Coordination of Benefits between this Vision Plan and any Medical Plan Benefits provided by this Fund.

Effect on Benefits

When a Covered Person is entitled to 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 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 co-payments 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. Plans without an Anti-duplication Provision generally pay benefits without regard to other plans. This Plan includes an Anti-duplication Provision, and does consider benefits of other plans prior to payment of claims.

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. Part B also covers prosthetic lenses, including cataract glasses, intraocular lenses, and conventional glasses and contact lenses after surgery with an intraocular lens. 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 the Fund Office.

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 more than that amount and the provider cannot legally bill you more than that amount.

Plans <u>Without</u> 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 <u>With</u> 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 Participant 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 Participant 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 Participant's benefit, the Fund may request that the Participant, and the Participant'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 Participant 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 Participant 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 Participant 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 or Illness if you later receive payment from the third party for that Injury or Illness. 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.

CLAIMS AND APPEALS

In order to receive Vision Care Benefits from the Fund, you must file a written claim with the Fund Office. You may obtain Vision Claim Forms from your Employer, the Fund Office, or by going on line at www.iambtf.org. To expedite the processing of your vision claim, please be sure to complete the Claim Form thoroughly, including information about Workers' Compensation or any other plan where benefits may be payable on your behalf. You must submit vision claims directly. They cannot be submitted through a provider of service.

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.

In order to be considered, your written claim must be mailed to the National IAM Benefit Trust Fund as soon as reasonably possible after the expense is incurred, but in no event more than one year after the expense is incurred. Properly completed Claim Forms must be accompanied by billings from the provider, and such other proof as may be required. Any claims received by the Fund more than one year after the expense is incurred will be denied as untimely.

All benefits are payable to you, but only upon receipt of due written proof of claim.

Filing Claims for Vision Care Benefits

All claims for Vision Care Benefits under this Plan are considered post service claims. Post service claims involve the payment or reimbursement of costs of vision care after that care has already been provided. There are no benefits under this Plan for which a Participant must obtain pre-authorization as a condition for the receipt of benefits.

Your vision claim will be considered filed as soon as the Benefit Trust Fund receives your written Claim Form 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 the Benefit Trust Fund's receipt of the claim.

The Fund Office will notify you of its determination on your vision claim 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 the Fund Office require that additional time is needed to process your claim. If an extension is needed, the Fund Office will notify you prior to the expiration of the initial 15-day period of the circumstances requiring an extension and date by which the Fund Office expects to reach a decision. If the Fund Office 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 45 calendar days after receiving this notice to provide the specified information. The Fund Office'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 social security number when you submit your Vision Claim Form, or when you contact the Fund Office about your claim.

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 is guilty of a crime and may be subject to fines and confinement in prison.

Notice of Denial of Claim

If your claim for Vision Care Benefits is denied, in whole or in part, the Fund Office 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 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 necessity determination, or 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 circumstances or a statement that such explanation will be provided free of charge upon request.

Appeals of Denied Vision Claims

If you disagree with any determination on your claim for Vision Care Benefits, you may request that the Appeals Committee of the Board of Trustees review your benefit denial. 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. Failure to file a timely written appeal will result in a complete waiver of your right to appeal, and the initial claim decision made by the Fund Office will be final and binding.

Your appeal will be decided by the Appeals 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. 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 Appeals 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 to or considered in the initial determination. The reviewers will not afford deference to the initial determination on your claim, and the review will not be conducted by an individual who was involved in 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 vision care judgment (including determinations about whether a particular service is experimental, investigational, or not necessary or appropriate), the reviewer will consult with a Vision Care Provider who has appropriate training and expertise in the particular field of care, and who was not consulted in connection with its determination. On request, you will also be provided with the identity of any expert 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 of the Appeals Committee on your appeal. If your appeal is denied, in whole or in part, the written notice will set forth: (1) the specific reason(s) 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; and (4) a statement of your right to bring a civil action under 502(a) of ERISA.

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 necessity determination or 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 circumstances or a statement that such explanation will be provided free of charge upon request.

Appeals Committee Decisions are Final and Binding

The decision of the Appeals Committee on review is final and binding on all parties, including anyone claiming a benefit on your behalf. As a committee of the Trustees, the Appeals 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 a committee of the Trustees, the Appeals Committee also has 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 appeal and Plan interpretations so that those determinations and interpretations may be referred to in future cases with similar circumstances.

If the Appeals Committee denies your appeal, and you decide to seek judicial review, the Appeals Committees' decision will be 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 Appeals Committee prior to the decision on appeal.

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 Vision Care Benefits are also processed by the Fund Office. Vision claims and inquiries about benefits, claims, eligibility, and the Plan in general, should be directed to:

National IAM Benefit Trust Fund
1300 Connecticut Avenue, N.W., Suite 300
Washington, DC 20036
Phone: 202-785-8148
Fax: 202-728-0585

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 Fund Director is Stephen R. Sleigh, 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

Warren Mart, GST
International Association of Machinists
9000 Machinists Place
Upper Marlboro, MD 20772-2687

Lynn Tucker, GVP
International Association of Machinists
Executive Plaza III
135 Merchant Street, Suite 265
Cincinnati, OH 45246

Philip Gruber, GVP
International Association of Machinists
1733 Park Street, Suite 100
Naperville, IL 60563

EMPLOYER TRUSTEES

Alfred C. Nelson
Government Contracting Resources, Inc.
P.O. Box 21211
Kennedy Space Center, FL 32815

D.L. "Pete" Peterson
Minnesota Rubber Co./Quadion Corp.
1100 Xenium Lane North
Minneapolis, MN 55441-7000

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

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 this Vision Plan are self-insured. There is no liability on the Board of Trustees to pay any benefits 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.

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.

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 any services, or for treatment of any illnesses or injuries, 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.

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 pre-existing 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 $110.00 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, N.W., 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.

Fund Director
STEPHEN R. SLEIGH
1300 Connecticut Avenue, N.W., Suite 300
Washington, DC 20036
202-785-8148

Fund Consultant
THE SEGAL COMPANY

Fund Counsel
O'DONOGHUE & O'DONOGHUE, L.L.P.

Fund Auditor
SALTER AND COMPANY, L.L.C.
Certified Public Accountants

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