NATIONAL IAM BENEFIT TRUST FUND

Better Benefits · Better Life

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Dental Program

PPO Plus Premier Plan G

SAMPLE SPD BOOKLET

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PLAN G

This Dental Program was established by the Board of Trustees of the National I.A.M. Benefit Trust Fund.

This Dental Program is Delta Dental Insurance Company Group Number #5104 (Plan G).

SPECIAL NOTE TO TREATING DENTISTS

A patient's possession of this booklet **does not** establish that patient's eligibility for Benefits. If you wish to verify eligibility before undertaking treatment, you can do so by contacting Delta Dental at 1-800-521-2651. You may also contact the Fund Office for eligibility confirmation at 1-800-457-3481.

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NATIONAL I.A.M.
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 I.A.M. Benefit Trust Fund.

The purpose of the Fund is to provide health and welfare benefits to participants and their families. Dental coverage is self-funded through contributions paid by employers and employees participating in the Plan.

Dental 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.

Sincerely,

Board of Trustees

EMPLOYER TRUSTEES	UNION TRUSTEES
Alfred Nelson	Warren Mart
D. L. “Pete” Peterson	Lynn Tucker
Thomas Mitchell	Philip Gruber

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INTRODUCTION

This booklet sets forth the Dental Program for Participants who are covered under this Plan. It explains all of the Dental Benefits provided by the Plan for claims incurred on or after **June 1, 2008**. It is subject, however, to the terms of any agreements between the Trustees and third party providers of benefits. This booklet also serves as your Summary Plan Description.

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.

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

SCHEDULE OF BENEFITS
DENTAL PLAN G

CALENDAR YEAR:

You have a calendar year Plan. Unless otherwise noted, Benefit maximums will be based upon the calendar year, which is January 1 through December 31.

BENEFITS:	***In-Network***	***Out-of-Network***
Diagnostic and Preventive Benefits	90%	90%
Basic Benefits	80%	80%
Major Benefits	80%	80%
Orthodontic Benefits	Not Covered	Not Covered

DEDUCTIBLE:

Individual: N/A

Family N/A

This Dental Plan **does not** have a Deductible.

MAXIMUM:

Dental Benefit: $1,000 payable per Participant per calendar year

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DEFINITIONS

Terms when capitalized in your Summary Plan Description booklet have defined meanings, given in the section below or throughout the booklet sections.

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

"Approved Amount" means the maximum amount a Dentist may charge for a Single Procedure.

"Benefits" (In-Network or Out-of-Network) means the amounts that Delta Dental will pay for dental services under the Contract. In-Network Benefits are those covered by the Contract and performed by a Delta Dental PPO Dentist or a Delta Dental Premier Dentist. Out-of-Network Benefits are those covered by the Contract but performed by a Non-Delta Dental Dentist.

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

"Carious Lesions" means visible destruction of hard tooth structure resulting from the process of decay.

"Claim Form" means the standard form used to submit a dental claim for consideration under the Plan or to request Predetermination for dental treatment.

"Contract" means the written agreement under which Benefits are provided.

"Contract Allowance" means the maximum amount Delta Dental will use for calculating the Benefits for a Single Procedure. The Contract Allowance for services provided:

1. **By Delta Dental PPO Dentists** is the lesser of the Dentist's submitted fee, the Delta Dental PPO Dentist's Fee or the Dentist's filed fee with Delta Dental in the Participating Dentist Agreement;

2. **By Delta Dental Premier Dentists** (who are not Delta Dental PPO Dentists) is the lesser of the Dentist's submitted fee, the Dentist's filed fee with Delta Dental in the Participating Dentist Agreement or the Maximum Plan Allowance; or

3. **By Non-Delta Dental Dentists** is the lesser of the Dentist's submitted fee or the Maximum Plan Allowance.

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

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"Delta Dental PPO Dentist" (or PPO Dentist) means a participating Delta Dental Dentist who agrees to accept Delta Dental's PPO Dentist's Fees as payment in full and comply with Delta Dental's administrative guidelines. All PPO Dentists are also Delta Dental Premier Dentists. All PPO Dentists must be contracted in the Delta Dental Premier network.

"Delta Dental PPO Dentist's Fee" (or PPO Dentist's Fee) means the fee outlined in the PPO Dentist Agreement. PPO Dentists agree to charge no more than this fee for treating PPO Enrollees.

"Delta Dental Premier Dentist" (or Premier Dentist) means a Dentist who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and who agrees to abide by certain administrative guidelines. Not all Premier Dentists are PPO Dentists; however, all Premier Dentists agree to accept Delta Dental's Maximum Plan Allowance for each Single Procedure as payment in full.

"Dentist" means a person licensed to practice dentistry when and where services are performed.

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

"Employer" means any Employer obligated under a Collective Bargaining Agreement or other participation agreement to make contributions to the National I.A.M. Benefit Trust Fund on behalf of its Employees.

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

"Enrollee" means a Participant who is enrolled to receive Benefits under the Plan.

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

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

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

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

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

1. It is rendered for the treatment or diagnosis of a dental Injury or Illness.

2. It is appropriate for the symptoms, consistent with the diagnosis, and is otherwise in accordance with generally accepted dental practice and Professionally Recognized Standards.

3. It is not mainly for the convenience of the Participant or the Participant's Dentist or other provider.

4. It is the most appropriate type and level of service needed to provide safe and adequate dental care.

"Non-Delta Dental Dentist" means a Dentist who is neither a Premier Dentist nor a PPO Dentist, who is not contractually bound to abide by Delta Dental's administrative guidelines.

"Orthodontics" means the area of dentistry concerned with detection, prevention, and correction of abnormalities in the positioning of teeth in their relationship to the jaw. It includes treatment of malocclusion of the teeth.

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

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

"Participating PPO Dentist Agreement" (or PPO Dentist Agreement) means an agreement between a member of the Delta Dental Plans Association and a Dentist that establishes the terms and conditions under which covered services are provided under a PPO program.

"Predetermination" means an estimation of the allowable Benefits under the Contract for the services proposed, assuming the person is an eligible Enrollee.

"Procedure Code" means the Current Dental Terminology (CDT) number assigned to a Single Procedure by the American Dental Association.

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

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

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

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

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

"Retiree" means a person who formerly qualified as an Employee, who has retired from active employment while covered by this Plan, and on whose behalf the Employer continues to make the required contributions to the National I.A.M. Benefit Trust Fund, but only if the particular Plan allows for Retiree coverage.

"Single Procedure" means a dental procedure that is assigned a separate CDT number.

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

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NATIONWIDE PROVIDER NETWORK

(DELTA DENTAL PPO PLUS PREMIER PLAN)

The National I.A.M. Benefit Trust Fund contracts with Delta Dental Insurance Company for access to a Nationwide Provider Network. Services provided by Dentists who participate in the Delta Dental contracted provider network will result in less cost to both you and the National I.A.M. Benefit Trust Fund. This is due to the fact that when you select a Delta Dental Dentist, the Dentists have contracted with Delta Dental to charge less than what most Dentists in your area charge.

Please present your Delta Dental ID card to all service providers. The card identifies you as a Delta Dental network Participant. Please note that the use of a Delta Dental network provider is *not* mandatory. It is your choice. Remember, however, both you and the Plan will experience a savings if you do choose a Delta Dental Dentist.

Choice of Dentist

The Plan offers you a choice of selecting a Dentist from Delta Dental's panel of PPO Dentists and Premier Dentists, or you may choose to obtain services from a Non-Delta Dental Dentist. A list of Delta Dental Dentists can be obtained by accessing the Delta Dental National Dentist Directory at www.deltadentalins.com. Dentists are regularly added to the panel. You are responsible for verifying whether the Dentist you select is a PPO Dentist or a Premier Dentist. Additionally, when you make an appointment for services you should always confirm with the Dentist's office that a listed Dentist is still a contracted PPO Dentist or a Premier Dentist.

PPO Dentist

The PPO program potentially allows you the greatest reduction in your out-of-pocket expenses. This select group of Dentists in your area will provide dental services at a charge that has been contractually agreed upon between Delta Dental and the PPO Dentist.

Premier Dentist

The Premier Dentist program, which includes specialists (endodontists, periodontists, or oral surgeons), includes Dentists who have not agreed to the features of the PPO program; however, you may still receive dental care at a lower cost than if you use a Non-Delta Dental Dentist.

Non-Delta Dental Dentist

If a Dentist is a Non-Delta Dental Dentist, the amount charged to you may be greater than that accepted by the PPO or Premier Dentists, and more than Delta Dental will cover. Non-Delta Dental Dentists can balance bill you for the difference between the Maximum Plan Allowance (MPA) and the Dentist's submitted charge.

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Additional Advantages to Using a Delta Dental Dentist

Using a Delta Dental Dentist will assure you the lowest possible out-of-pocket expenses. In addition, other advantages to using contracted dental providers include:

1. The PPO Dentist and Premier Dentist must accept assignment of Benefits. This means that PPO Dentists and Premier Dentists will be paid directly by Delta Dental, and the Participant does not have to pay up front for all dental charges. However, the dental office may require that a Participant pay up front for estimated out-of-pocket expenses.

2. The PPO Dentist and Premier Dentist will complete the dental Claim Form and submit it to Delta Dental for reimbursement on your behalf. You are not required to submit a claim.

3. The PPO Dentist and Premier Dentist will not charge you the difference, if any, between the charged fee and Delta Dental's Approved Amount.

You may access Delta Dental's National Dentist Directory on the Internet. Delta Dental's Internet address is www.deltadentalins.com. You may choose any Dentist, but Delta Dental does not guarantee that any particular Dentist will be available. You are responsible for verifying whether the treating Dentist is a contracted PPO Dentist or a Premier Dentist.

Claim Submission

Claims for Dental Benefits must be filed on a standard Claim Form, and submitted to the address shown below.

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

You or your Dentist may obtain Claim Forms directly from your Employer, Delta Dental, the National I.A.M. Benefit Trust Fund Office, or you may download a form by visiting the Fund's website at www.iambtf.org.

Automated Information Line

You may access Delta Dental's automated information line on regular business days to obtain eligibility and Benefits, claim status information, or to speak to a member services representative for assistance. The toll free number is 1-800-521-2651.

Complaints Concerning the Quality of Dental Care

This dental program recognizes the right of each Employee or Dependent to select a Dentist of his or her own choosing. Neither the Plan nor Delta Dental assumes any responsibility for the selection of Dentists or for the quality of dental care rendered by such Dentists. However, all of

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these parties are vitally interested in resolving questions that might arise concerning the availability of or quality of dental care. In fact, Delta Dental is committed to assuring that professional services provided under their programs meet Professionally Recognized Standards of dental care. This was a major contributing factor to the selection of Delta Dental for this program by the Board of Trustees.

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

When You Have a Complaint About Delta Dental

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

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

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

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

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INTERNATIONAL SOS

You can receive your covered dental care when you are outside of the United States through Delta Dental's partnership with International SOS Assistance, Inc. (I-SOS). I-SOS provides referrals to 3,200 Dentists or dental clinics in nearly 200 countries worldwide. English-speaking operators are available around the clock to help you find a Dentist. For more information, check our web site at www.deltadentalins.com or call 1-800-523-6586 from the United States. Once you leave the United States, you can call I-SOS **collect** at 1-215-942-8226.

When you see an I-SOS Dentist, you must pay for your treatment at the time of service and get a detailed receipt from the Dentist that you will then submit to Delta Dental. In addition to providing the Dentist's name and address (including country), this receipt should specifically describe the services performed by the I-SOS Dentist and indicate the tooth or teeth that were treated. It should also indicate whether the Dentist's charges were billed in U.S. dollars or another currency.

Once Delta Dental receives your claim, you will be reimbursed directly subject to the terms and conditions of your Dental Plan. Reimbursement is based on the out-of-network Benefits provided by the Plan. As with any dental plan, this reimbursement may not cover the entire cost of the treatment rendered.

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

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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 I.A.M. 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 I.A.M. Benefit Trust Fund on your behalf.

Retiree Eligibility

Some Employers provide Retiree coverage under this Dental Program. 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 I.A.M. 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 I.A.M. 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 make payments for continuation of coverage under COBRA as described later in this booklet.

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Dependent Eligibility

To become covered under the Plan as a Dependent, a person must qualify as a Dependent and must be enrolled.

The term "**Dependent**" means only:

1. Your lawful spouse;

2. Your unmarried child who is of an age within the age limits for Dependent children shown below.

The term "**Child**" means your natural born child, legally adopted child, and child placed with you for adoption. "Child" also means:

1. Any other child who is dependent upon you for more than one-half of his or her financial support; and

2. Qualifies in the current year for dependency tax status, or who has been reported by you as such on your most recent Federal income tax return; and

3. Resides with you in your household; and

4. Is related to you by blood or by marriage, or is under your legal guardianship.

For coverage, Dependent children must be under age 19; or under age 25 if the Dependent child is a full-time student at an accredited college, university, high school, or vocational, technical, or trade school.

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

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 19, and who is chiefly dependent on you for financial support, will not have his or her dental coverage terminated when he or she reaches age 19. The eligibility for such a child will continue as long as the child was covered by the Plan when he or she turned age 19, 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 19 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

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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 dental 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

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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.

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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

Continuation of Benefits

The Plan will not pay Benefits for any services received after your coverage ends. However, the Plan will pay for a Single Procedure incurred when you were covered, if such procedure is completed within 31 days of the date coverage ends. A dental service is incurred as follows:

1. For an appliance (or change to an appliance), at the time the impression is made;

2. For a Crown, Bridge or cast restoration, at the time the tooth or teeth are prepared;

3. For root canal therapy, at the time the pulp chamber is opened; and

4. For all other dental services, at the time the service is performed or the supply furnished.

Self-Pay Provision

If your coverage would terminate for one of the reasons specified below, you may continue your coverage in force for the applicable period specified below by paying a contribution each month for your coverage. The first such monthly payment must be paid before the first day of the month following the month in which your coverage otherwise would terminate. Subsequent monthly payments must be paid before the first day of each succeeding month. Failure to pay the required monthly contribution when it is due will cause your coverage to terminate at the end of the period for which the last contribution was made. The monthly amount of the payment is equal to the charge for COBRA payments.

You may self-pay for a period of six months if:

1. Your employment terminates for any reason other than by reason of entering the armed forces, retirement, or Disability due to Accident or Illness; or

2. Your Employer ceases to be a contributing Employer.

The required monthly contributions must be paid directly to the Trust Fund Office on a timely basis.

If your employment terminates by reason of retirement, or Disability due to Accident or Illness, you may self-pay until the earliest of the following dates:

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

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2. The date you cease to be Disabled or return to active work.

The required monthly contributions must be paid directly to the Trust Fund Office on a timely basis.

Any coverage being continued in accordance with this self-pay provision will terminate at the end of the month for which you last make a timely self-payment or otherwise cease to be eligible for this provision. Any rights you have under COBRA will be in addition to your rights under this Self-Pay Provision.

Family and Medical Leaves of Absence

The Family and Medical Leave Act of 1993 (FMLA) entitles Employees eligible under the Act to take up to 12 weeks of unpaid job-protected leave each year for the Employee's own Illness, or to care for a seriously ill child, spouse or parent. In addition, the FMLA provides leave for the birth or placement of a child with the Employee in the case of adoption or foster care. Employees eligible for leave under the FMLA are those who have been employed at least 12 months by the Employer and who have provided at least 1250 hours of service to the Employer. Any Employee at a work site at which there are less than 50 Employees is not eligible for FMLA leave unless the total number of Employees within a 75 mile radius of the Employer equals or is greater than 50.

Employers covered by the FMLA are required to maintain dental coverage for Employees on FMLA leave whenever such coverage was provided before the leave was taken, and on the same terms as if the Employee had continued to work. This means that your Employer will be required to continue making contributions to the Fund on your behalf while you are on FMLA leave. 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. Contact your Employer to determine whether you are eligible for FMLA leave.

If you have any questions about the FMLA, you should contact your Employer or the nearest office of the Wage and Hour Division, listed in most telephone directories under the U.S. Government, Department of Labor, Employment Standards Administration.

Coverage During Military Service

If you enter the Uniformed Services, as defined in the Uniformed Services Employment and Reemployment Rights Act (USERRA), for active military duty or training, inactive duty or training, full-time National Guard or Public Health Service duty, or fitness-for-duty examination, for 30 days or less, you and your eligible Dependents will continue to receive dental coverage for up to 30 days, in accordance with the USERRA.

If you are on active duty for more than 30 days, USERRA permits you to continue dental coverage for you and your eligible Dependents at your own expense for up to 24 months. This continuation right operates in the same way as COBRA. See the section on "Continuation of Coverage (COBRA)" for a full explanation of the COBRA coverage provisions. In addition,

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your Dependent(s) may be eligible for dental care coverage under the military's dental coverage plan, TRICARE, or its contractors.

Coverage will not be offered by the Plan for any condition determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the Uniformed Services. The Department of Veterans Affairs will provide care for such service-connected Disabilities.

If you are honorably discharged from the Uniformed Services, Plan coverage for you and your eligible Dependents will be reinstated on the day you begin work with a contributing Employer to this Fund, provided:

1. Your cumulative length of the absence and all previous absences for Uniformed Services has not been longer than five years;

2. You or your representative give advance notice to the Employer of the impending service, unless notice is precluded by military necessity;

3. You begin work within ninety (90) days from the date of discharge if the period of service was more than one hundred eighty (180) days; or

4. You begin work within fourteen (14) days from the date of discharge if the period of service was thirty-one (31) days or more but less than one hundred eighty (180) days.

If you are hospitalized or convalescing from an Injury caused by active duty, these time limits are extended up to two years.

If you have any questions about taking military leave, please contact your Employer directly. If you have any questions about how a leave of absence for military affects your Benefits, please contact the Fund Office. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

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 Coverage (COBRA)

Federal law requires that group dental plans offer Employees and their Dependents the opportunity to elect a temporary extension of dental 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, and/or Dependent must make timely monthly payments directly to the Fund. An eligible Employee or

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eligible Dependent (either spouse or child, including a child born or placed for adoption after your COBRA coverage begins) who becomes eligible for COBRA coverage is called a qualified beneficiary.

COBRA Rules for Employees

As an Employee, you have the right to choose continuation of dental coverage for up to a maximum of 18 months if your loss of coverage is due to:

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.

If you are entitled to 6 months of self-payments under the Self-Pay Provision, you may elect to begin your 18 months of COBRA payments at the end of those 6 months of self-payments.

COBRA Rules for Dependents

If the Employee chooses not to purchase COBRA coverage, the Dependent spouse and/or Dependent children can separately purchase COBRA continuation coverage for themselves by making the election and the required monthly payments. COBRA coverage for Dependents can be continued 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, coverage can be continued 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 COBRA 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.

Disability Extension of COBRA Coverage

If you lose coverage under the Plan because of your reduction of hours or termination of employment and you or any of your eligible Dependents is determined by the Social Security Administration or the Railroad Retirement Board to be disabled, that person may be eligible for an extra 11 months of COBRA continuation coverage (up to 29 months). If you or anyone in your family is receiving COBRA continuation coverage and any covered member of your family is determined to be disabled by the Social Security Administration or the Railroad Retirement Board, you must notify the Fund Office of that fact in order to receive the 11-month extension of COBRA coverage. If the determination of disability was issued prior to the commencement of

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COBRA continuation coverage, such notice must be provided to the Fund Office within 60 days of the commencement of COBRA continuation coverage. If the determination of disability is issued after the start of COBRA continuation coverage, such notice must be provided to the Fund Office within 60 days of the date of the disability determination and prior to the expiration of the initial 18-month COBRA continuation coverage period. This notice must include a copy of the Social Security or Railroad Retirement disability determination letter.

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

Multiple Qualifying Events While Covered by COBRA

If, during an 18-month period of COBRA 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 COBRA continuation 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 COBRA continuation coverage.

This extended period of COBRA 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 COBRA continuation coverage is available to any child(ren) born to, adopted by, or placed for adoption with you (the active Employee) during the 18-month period of COBRA continuation coverage.

In no case are you entitled to COBRA continuation coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA continuation coverage period on account of disability). As a result, 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 COBRA may not be extended beyond 18 months from the initial, qualifying event.

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

If, while you are enrolled in COBRA continuation coverage, your Dependent spouse or Dependent child loses coverage under another group dental plan, you may enroll the Dependent for coverage for the balance of the period of COBRA 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 dental plan or had other dental 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 COBRA continuation coverage.

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The loss of coverage must be due to exhaustion of COBRA 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.

Application of COBRA to Retiree Coverage

Some Health and Welfare Plans of the National I.A.M. Benefit Trust Fund provide that Benefits will be payable to Retirees and their Dependents. If Retiree coverage is provided under this Dental Program, COBRA continuation options also will be available as follows:

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 dental coverage for an indefinite period of time, but not beyond the earlier of: (a) the date of your death; (b) the occurrence of other applicable COBRA termination events; or (c) the date the Plan terminates.

If you are the spouse of a retired Employee, you have the same continuation of coverage options based on the applicable qualifying events as described in the spouse section.

If you are the Dependent child of a retired Employee, you have the same continuation of coverage options based on the applicable qualifying events as described in the Dependent children section.

Benefits While on COBRA

If you choose to elect COBRA continuation coverage, the Trust Fund will provide you with extended dental coverage identical to that described elsewhere in this booklet.

Notification Requirements for COBRA Coverage

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

You or your eligible Dependent 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 COBRA Coverage provision above.

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

National I.A.M. 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 COBRA continuation coverage and the cost of the coverage.

Election of COBRA Continuation Coverage

When information is received by the Fund Office concerning the loss of dental coverage due to a qualifying event, the participating Employee or family member will be sent an individual COBRA notice explaining the right to continuation coverage. This individual COBRA notice will provide information on the coverage options available and the cost, and will include a COBRA election form. To elect COBRA 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 COBRA continuation coverage.

Each qualified beneficiary who elects COBRA 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 COBRA coverage will expire and his or her Dental 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 COBRA coverage within the sixty (60) day period.

Cost of COBRA Coverage

The COBRA continuation coverage rates are set annually by the Board of Trustees 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 COBRA 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 COBRA notice that you will receive. The initial payment must be received by the Plan within forty-five (45) days after the date you elect COBRA coverage. This payment must cover the period of coverage from the date of the COBRA election retroactive to

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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 COBRA coverage through a failure to submit the correct payment in a timely fashion.

Termination of COBRA Coverage

COBRA continuation dental coverage will terminate when:

1. You have reached the last day of the applicable COBRA continuation period;

2. The self-payment for your continuation coverage is not paid in a timely manner;

3. You (as a spouse) remarry and obtain coverage under another group dental plan;

4. You obtain coverage, after the date of the COBRA election, as an employee under another employer-sponsored group dental plan;

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

6. This Plan terminates.

If your Employer stops participating in the Benefit Trust Fund, the Fund will continue to carry the COBRA obligations for you and your qualified Dependents only if the Employer does not substitute another plan. If the Employer establishes one or more group dental plans or starts contributing to another multi-employer group dental 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 the Plan immediately before the Employer's cessation of participation; and

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

COBRA and Other Extensions of Coverage

Some Health and Welfare Plans of the National I.A.M. Benefit Trust Fund provide for extensions of coverage if an Employee is terminated, or if the Employer ceases to participate, or if an Employee or Dependent is hospitalized. These extensions may be provided by the Trust Fund or may require an Employee self-payment. Refer to the other provisions of this booklet to obtain general information on what extensions may be available to you or your Dependents.

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The policy of the Trustees is that any extension provisions under this Plan will be made available to you first, followed by the COBRA continuation coverage options. In this manner, you and your Dependents will receive the maximum coverage period that can be provided.

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COMPREHENSIVE DENTAL COVERAGE

The Dental Program will pay Benefits for the types of dental services as described in the Covered Dental Charges list, but only for covered services. These services must be provided by a Dentist and must be Necessary and Customary under generally accepted dental practice standards. Delta Dental may use dental consultants to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices.

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

Dental Benefits

A "**Dental Benefit**" is the amount, if any, which will be paid for Covered Dental Charges incurred by you or your Dependent. The amount of a Dental Benefit is the amount Delta Dental calculates in the steps shown below:

1. The charges are tested against the Covered Dental Charge definition. Those that meet all of the tests are the Covered Dental Charges.

2. The Covered Dental Charges are multiplied by any applicable percentage payable.

3. If any part of the amount calculated exceeds an applicable Benefit maximum, then that part is subtracted and the remainder is the amount of the Dental Benefit.

Covered Dental Charges

A "**Covered Dental Charge**" is a charge that: (a) is made for a Necessary and Customary dental service that is furnished to a Participant; and (b) meets all of the tests listed below:

1. It is shown in the Covered Dental Charges List;

2. It is incurred while a Participant is eligible for Dental Benefits;

3. It is not listed as a Plan Exclusion; and

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

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Covered Charge Limits

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

Deductible

A "**Deductible**" is the amount of Covered Dental Charges a Participant must pay to his or her provider of service before Benefits are payable by the Plan.

This Dental Plan **does not** have a Deductible, so Benefits are payable immediately for Covered Dental Charges.

Family Deductible Maximum

This Dental Plan **does not** have a Deductible.

Percentage Payable

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

Patient Percentage

Plan Benefits are limited to the applicable percentage of Dentist's fees specified in the Schedule of Benefits. The Participant is responsible for paying the remaining applicable percentage of any such fees, known as the "**Patient Percentage**".

If the Dentist discounts, waives or rebates any portion of the Patient Percentage to the Participant, Delta Dental will be obligated to provide as Benefits only the applicable percentages of the Dentist's fees reduced by the amount of such fees that are discounted, waived or rebated.

Maximum Amounts

The Plan will not pay more than the calendar year maximum shown in the Schedule of Benefits for all Covered Dental Charges incurred by a Participant during any one calendar year. In addition, the Plan has certain maximums that apply on a yearly basis, a per service basis, or a lifetime basis for various Covered Dental Charges. Please refer to the Areas of Limited Coverage section for important information about Benefit limitations.

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COVERED DENTAL CHARGES LIST

The Plan will pay or otherwise discharge the percentage of Contract Allowance shown in the Schedule of Benefits for the following covered services. Please refer to the Areas of Limited Coverage section for applicable time limitations for various services.

If you or your provider of service have any question about coverage of a specific procedure or treatment plan, you should contact Delta Dental member services, or follow the instructions in the Predetermination of Benefits section found later in this booklet.

Diagnostic and Preventive Benefits

Diagnostic:	Procedures to assist the Dentist in choosing required dental treatment, including exams and x-rays.
Preventive:	Routine Prophylaxis, or cleaning (periodontal cleaning in the presence of gingival inflammation is considered a Basic Benefit for payment purposes); topical application of fluoride solutions; space maintainers.

Basic Benefits

Denture Repair:	Repair to partial or complete dentures, including rebase procedures and relining.
Endodontics:	Treatment of the tooth pulp; root canal therapy.
General Anesthesia:	When administered by a Dentist in connection with a covered oral surgery procedure.
Oral Surgery:	Extractions and other dental surgical procedures, including pre- and post-operative care; surgical preparation for dentures.
Palliative Care:	Treatment to relieve pain.
Periodontics:	Treatment of gums and bones supporting teeth; crown lengthening; periodontal cleaning.
Restorative:	Amalgam, synthetic porcelain, and plastic fillings, and prefabricated stainless steel restorations for treatment of Carious Lesions.
Other Basic Services:	Repair and recementation of fixed prosthodontic appliances; repair and recementation of Crowns.

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Major Benefits

Crowns, Jackets and Cast Restorations:	Treatment of Carious Lesions where teeth cannot be restored with amalgam, synthetic porcelain, and plastic fillings, or prefabricated stainless steel restorations.
Prosthodontics:	Procedures for construction of fixed Bridges and partial or complete dentures; denture adjustments.

Orthodontic Benefits

Orthodontics:	This Plan provides no coverage for Orthodontic treatment.

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AREAS OF LIMITED COVERAGE

Limitations on Diagnostic and Preventive Benefits

- Routine oral examinations and cleanings (including periodontal cleanings) are limited to once each six (6) month period. Please note that routine cleanings are covered as a Diagnostic and Preventive Benefit and periodontal cleanings are covered as a Basic Benefit.

- Complete full-mouth x-rays or panographic x-rays are limited to once every three (3) years.

- Bitewing x-rays are limited to once every six (6) months.

- Topical application of fluoride is limited to Dependent children under age 19.

- Space maintainers are limited to the initial appliance only for Dependent children under age 14.

Limitations on Basic Benefits

- Periodontal cleaning - See Diagnostic and Preventive Benefit limitation for routine oral examinations and cleanings.

- The Plan will not pay to replace a filling or prefabricated stainless steel restoration within 24 months of prior treatment if the same Dentist provides the service.

- The Plan limits payment for fillings on posterior teeth to amalgam restorations.

- The Plan limits payment for stainless steel Crowns under this section to services on baby teeth. However, after consultant review, the Plan may allow stainless steel Crowns on permanent teeth as a Major Benefit.

Limitations on Major Benefits

- The Plan will not pay to replace any Crowns, jackets, or cast restorations that were covered by the Plan within the previous five (5) years.

- The Plan will not pay to replace any Bridge or denture that was covered by the Plan within the previous five (5) years. An exception is made if the Bridge or denture cannot be made satisfactory due to a change in supporting tissues or because too many teeth have been lost.

- The Plan will not pay to replace any prosthodontic appliance that was not originally provided by the Plan unless Delta Dental determines it is unsatisfactory and cannot be made satisfactory.

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- The Plan limits payment for dentures to a standard partial or denture. A standard partial or denture means a removable appliance to replace missing natural, permanent teeth, that is made from acceptable materials by conventional means.

- The Plan will not pay for Implants, their removal, or any other associated services, supplies, or procedures. However, the Plan will allow the cost of a Crown or standard full or partial denture toward the cost of Implants and related services, subject to applicable time limitations.

Limitations on All Benefits

"Optional Services" are services that are more expensive than the form of treatment customarily provided under accepted dental practice standards. Optional Services also include the use of specialized techniques instead of standard procedures. In all cases in which a Participant selects a more expensive plan of treatment than is customarily provided, the Plan will pay the applicable percentage of the lesser course of treatment, and the patient will be responsible to pay the entire remainder of the Dentist's fee. Some examples include, but are not limited to, selection of:

- A Crown where a filling would restore the tooth – The Plan will allow the filling;

- A composite restoration instead of an amalgam restoration on posterior teeth – The Plan will allow the amalgam restoration;

- An inlay or onlay where an amalgam restoration would restore the tooth – The Plan will allow the amalgam restoration;

- A precision denture or partial where a standard denture or partial could be used – The Plan will allow the standard denture or partial;

If you receive Optional Services, Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. You will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

Use of Dental Consultants

In making specific determinations as to what particular dental services are Optional Services, within the rules stated above, the Plan utilizes the services of one or more dental consultants. If a Dentist is advised that part or all of a course of treatment for a Plan Participant involves Optional Services and that only less expensive procedures will be allowed, the Dentist has the right to review the matter with the dental consultant and, further, to appeal the determination with the consultant according to the appeal procedures.

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HOW TO USE THE PROGRAM

As explained earlier in this booklet, you may obtain treatment from any licensed Dentist that you choose, but you will have lower out-of-pocket expenses if you use a Delta Dental participating Dentist. You may access Delta Dental's National Dentist Directory on the Internet at www.deltadentalins.com or you may visit the Fund's website at www.iambtf.org to find a Delta Dental Dentist.

When you visit the Dentist, you should provide the Dentist with a copy of your Delta Dental ID card, which identifies you as a Participant of this Plan. If you visit a Non-Delta Dental Dentist, you may also be asked to provide a Claim Form. You can obtain a Claim Form from your Employer or the Fund Office, or you may visit the Fund's website at www.iambtf.org to print one.

Your Dentist will perform an examination and develop a course of treatment. It is recommended that you discuss this course of treatment and the anticipated fees with your Dentist. You will be required to pay any applicable Patient Percentage of covered services, as well as any amount that is not paid by the Plan, and, of course, you will be wholly responsible for all elective care and for any excluded items. In addition, if you use a Non-Delta Dental Dentist you will be responsible for the balance of charges that exceed Delta Dental's allowance.

If your recommended course of treatment involves certain select procedures as noted in the Predetermination of Benefits Section found later in this booklet, you should ask your Dentist to submit a Claim Form to Delta Dental for Predetermination. Predetermination will help you to identify any out-of-pocket expenses prior to treatment and enable you to make an intelligent decision as to whether to proceed with the work, discuss alternatives and, if necessary, make arrangements for less expensive procedures where possible, or develop a payment plan that is acceptable to your provider.

When your work is completed, a Delta Dental PPO or Premier Dentist will automatically bill Delta Dental for payment under the Plan. A Non-Delta Dental Dentist may require that you submit your claim. Delta Dental will pay your PPO or Premier Dentist directly and notify you of the amount paid and the balance due, if any. Delta Dental will follow assignment instructions on your claim from a Non-Delta Dental Dentist. If you did not already pay anticipated out-of-pocket expenses at the time of treatment, the Dentist will bill you for any balance due after Delta Dental payment.

PLEASE NOTE - Possession of a Delta Dental ID card and/or this Summary Plan Description does not establish a patient's eligibility for Benefits. If you or your Dentist wish to verify eligibility before undertaking treatment, you can do so by contacting Delta Dental member services at 1-800-521-2651. You may also contact the Fund Office for eligibility confirmation at 1-800-457-3481.

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PREDETERMINATION OF BENEFITS

Any Dentist may submit a Claim Form to Delta Dental in advance of treatment, showing the services to be provided to a Participant. Delta Dental will predetermine the amount of Benefits payable by the Plan for the listed services. When treatment is completed, Benefits will be processed according to the terms of the Plan on the date that the treatment is performed.

Recommended Predeterminations

Your Plan does not *require* Predetermination for any procedure; however, Delta Dental recommends that you obtain Predetermination for Crowns (except stainless steel), Bridges, gold restorations (inlays or onlays), space maintainers, root canal therapy, Periodontics, dentures (full or partial), and oral surgery (other than simple extractions).

Predetermination will help you to identify any out-of-pocket expenses prior to treatment and enable you to make an intelligent decision as to whether to proceed with the work, discuss alternatives and, if necessary, make arrangements for less expensive procedures where possible, or develop a payment plan that is acceptable to your provider.

Time Limit on Predeterminations

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

1. The date the Plan terminates *;
2. The date the Participant's coverage ends; or
3. The date the PPO Dentist's or Premier Dentist's agreement, if any, with Delta Dental ends.

* Note – a change in the Plan of Benefits under which you are covered could affect the Deductible and/or payment percentage that applies on a predetermined claim, but it does not change the services that are covered.

You or your provider may contact Delta Dental directly at 1-800-521-2651 if you have any questions about the Predetermination process.

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EXCLUSIONS

This Dental Program does not cover all dental charges or pay for all dental services. Exclusions include, but are not limited to, the following:

1. Treatment of an Injury or Illness that is covered under Workers' Compensation or Employers' Liability Laws, or treatment of an Injury or Illness that arises out of or in the course of any past or present employment or occupation for compensation or profit.

2. Charges for services, supplies, or treatments that are furnished, paid for, or otherwise provided without cost by any local, state, or Federal Government agency, program, or institution, except as otherwise provided by law.

3. 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.

4. Treatment of any condition that results from an act of declared or undeclared war, the Participant's commission of a crime, or non-therapeutic release of nuclear energy.

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

6. Treatment rendered by a (a) person who ordinarily lives in the Participant's home or (b) by a spouse, child, parent, or sibling of the Participant or of the Participant's spouse.

7. Treatment performed by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision.

8. Any Single Procedure started prior to the date the Participant became covered for such services under this program.

9. Charges incurred on a date when no eligibility exists, except where provided herein under the Continuation of Benefits section.

10. Services, supplies, or treatments that are not Necessary and Customary for the condition being treated.

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

12. Expenses for any services, supplies, or treatments that are unreasonably priced or that exceed the Maximum Plan Allowance (MPA).

13. Cosmetic surgery or dentistry for purely cosmetic reasons.

14. Services for Orthodontic treatment.

SAMPLE

15. Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for cleft lip or cleft palate.

16. Treatment to restore tooth structure lost from wear, erosion or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize the teeth. Examples include but are not limited to: equilibration, periodontal splinting or occlusal adjustment.

17. Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

18. Charges for anesthesia, other than by a licensed Dentist for administering general anesthesia in connection with covered oral surgery services.

19. Services incurred in connection with TMJ disorders.

20. Services related to Implants, including their removal and any other associated procedures (alternate Benefits may be allowed as noted under "Limitations on Major Benefits").

21. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.

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

23. Services or supplies related to Sealants.

24. Charges incurred for oral hygiene instruction, a plaque control program, dietary instruction, x-ray duplications, cancer screening or broken appointments.

25. Prescribed drugs, medication, or painkillers.

26. Telephone, e-mail, and Internet consultations.

27. Services or supplies covered by any other I.A.M. Health Plan, except that this Dental Program will pay primary Benefits for surgical extractions that are also covered for secondary payment under some I.A.M. Medical Plans.

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

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

30. Any services, supplies, or treatments not shown as covered, or any Benefits not otherwise provided herein.

SAMPLE

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.

SAMPLE

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 any other group benefit plans or insurance plans, including another Delta Dental plan. Coordination means that benefits from the Plan described in this booklet and from other benefit plans and insurance plans cannot exceed 100% of the allowable expenses for each Participant 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 Participant and to any coverage under the Plan. You should file all claims with each plan under which you are eligible for coverage.

Effect on Benefits

When a Participant is entitled to 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 Participant, then its benefits will be determined without taking into account the benefits or services of any other plan.

2. Is not the principal plan, then its benefits may be reduced. 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 Participant. 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 Participant.

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

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

SAMPLE

The term "plan" shall also include "no-fault" motor vehicle insurance. It does not include a blanket school accident policy.

Principal Plan. With respect to any two plans that cover a Participant 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 Participant. 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

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

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

1. If the other plan is not primarily a dental plan, this Plan is primary.

2. The Plan that covers the Participant through present employment instead of a Plan that covers the Participant 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.

3. The Plan that covers the Participant other than as a Dependent.

SAMPLE

4. The Plan that covers the Participant 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.

5. The Plan that has covered the Participant for the longer period of time.

6. 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 4. If the Participant is a Dependent child of parents who are divorced or separated, then the following rules will be used in place of Rule 4:

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

To meet the intent of the Coordination of Benefits provisions or an Anti-Duplication provision of any other plan, the Fund Office and Delta Dental may, in any way allowed by law, give or get any information that is needed to decide the benefits that are payable. A Participant must declare coverage under any other plans and give to the Fund Office the information it needs to meet the intent of this provision.

Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this Coordination of Benefits section have been made by any other plan, Delta Dental will have the right, exercisable alone in its sole discretion, to pay over to any organizations making such other payments any amounts it will determine to be warranted in order to satisfy the intent of this Coordination of Benefits section and amounts so paid will be deemed to be Benefits paid under this Plan and, to the extent of such payments, Delta Dental will be fully discharged from liability under this Plan.

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Right of Recovery

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.

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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 homeowners 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 if you later receive payment from the third party for that Injury. Any settlement that you make against the third party must be approved by the Trustees. You must agree to help the Fund in pursuing your claims against the third party, or to allow the Fund to pursue the claims on your behalf before any benefits are paid from the Fund.

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

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

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CLAIMS AND APPEALS

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

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

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

All benefits are payable to you. However, Delta Dental Dentists file claims directly with Delta Dental on your behalf, and Delta Dental pays the Dentist directly. Please make sure that you present your benefit identification card to each Dentist before you receive services since it identifies you as a Delta Dental network Participant. Non-Delta Dental Dentists may require that you pay them first and seek reimbursement by filing your own claim with Delta Dental. Payment for Non-Delta Dental Dentists will be made to the Employee unless the Employee requests, when filing a proof of loss claim, that the payment be made directly to the Dentist providing the services.

Filing Claims for Dental Benefits

All Participant claims for Dental Benefits under this Plan are considered Post Service Claims. Post Service Claims involve the payment or reimbursement of costs of dental 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. Predetermination is recommended by Delta Dental for some services, but is not a requirement for coverage.

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

Delta Dental will notify you of its determination on your dental claims within a reasonable period of time, but no later than 30 calendar days after its receipt of your claim. This period may

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be extended by one 15-day period, if special circumstances beyond the control of Delta Dental require that additional time is needed to process your dental claim. If an extension is needed, Delta Dental will notify you prior to the expiration of the initial 15-day period of the circumstances requiring an extension and date by which Delta Dental expects to reach a decision. If Delta Dental 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. Delta Dental'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

Be sure to use your member ID and account number when you file Delta Dental's Claim Forms, or when you call your Delta Dental claim office. Your member ID is your social security number. Your account number is the 8-digit group number shown on your benefit identification card. 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 Dental Benefits is denied, in whole or in part, Delta Dental 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 Dental Claims Denied by Delta Dental

If you disagree with Delta Dental's decision on any of your claims for Dental Benefits, you must submit a request for appeal in writing to Delta Dental 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 or documentation that supports your appeal.

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Your appeal will be reviewed by someone at Delta Dental who was neither involved in the initial decision nor the subordinate of such individual. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a Dentist who has appropriate training and experience. The identity of such dental consultant is available upon request whether or not the advice was relied upon.

Delta Dental will respond in writing to your appeal within 30 calendar days of receipt of your appeal, unless additional information or time is needed. If Delta Dental needs more time or information to determine your level one appeal, Delta Dental will notify you in writing to request an extension of up to 15 calendar days to specify any additional information needed to complete the review.

If Delta Dental denies your appeal, in whole or in part, the appeal file will be forwarded to the Fund Office, and the matter will be automatically reviewed further by the Appeals Committee of the Board of Trustees of the National I.A.M. Benefit Trust Fund, which will make a decision within 60 days of the first receipt of your appeal by either Delta Dental or the Fund Office. If more time or information is needed for the Appeals Committee to make its determination, you will be notified in writing of the need for the extension and the reasons for it. The extension can only be for a period of up to 60 additional days.

Appeals Generally

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

SAMPLE

In deciding an appeal of a benefit determination that was based, in whole or in part, on a dental judgment (including determinations about whether a particular service is experimental, investigational, or not necessary or appropriate), the reviewer will consult with a Dentist who has appropriate training and expertise in the particular field of dentistry, and who was not consulted in connection with its determination. On request, you will also be provided with the identity of any dental 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.

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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.

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GENERAL INFORMATION

Plan Name

This Plan is known as the National I.A.M. Benefit Trust Fund Dental Program.

Type of Plan

This Plan is a multi-employer Health and Welfare Plan that provides Dental Benefits.

Plan Identification Numbers

The employer identification number ("EIN") is: 36-6562520
The Plan number is: PN 502

Fund Office Administration

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

National I.A.M. Benefit Trust Fund
1300 Connecticut Avenue, NW, Suite 300
Washington, DC 20036
Phone: 202-785-8148
Fax: 202-728-0585

Claims Administrator

Claims for Dental Benefits are processed by the Claims Administrator, which is Delta Dental Insurance Company (Delta Dental). Dental Claims should be sent to the address on the front of your benefits identification card and inquiries should be made to the phone number on the front of your benefits identification card.

Plan Sponsor and Administration

The Board of Trustees is both the legal Plan Sponsor and the legal Plan Administrator under the Employee Retirement Income Security Act. The Board of Trustees consists of Employer and Union Representatives, selected in accordance with the Trust Agreement. If you wish to contact the Board of Trustees you may do so at the Fund Office's address above. The Board of Trustees has designated a Fund Director to supervise the daily functions of the Benefit Trust Fund. The 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.

SAMPLE

Trustees of the Plan

UNION TRUSTEES

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

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

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

EMPLOYER TRUSTEES

Alfred Nelson
INDYNE, Inc.
P.O. Box 21211
Kennedy Space Center, Florida 32815

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

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

Preferred Providers

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

The Board of Trustees currently has a contract with the following organization for a PPO Program:

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

Funding of Benefits

The benefits under the Plan are funded and provided by the National I.A.M. 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.

There is no liability on the Board of Trustees to pay any benefits or premiums above and beyond the amounts in the Fund collected and available for such purpose. Should contributions not

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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.

The benefits described in this booklet are self-insured by the National I.A.M. Benefit Trust Fund. Delta Dental provides only claims administration, and it does not insure any of the benefits described in this booklet.

Agent for Service

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

Source of Plan Contributions

The contributions necessary to finance the Plan are made by the Employers and, in some instances, Employees. The amount of contributions and the Employees on whose behalf contributions are made are determined by the provisions of the Collective Bargaining Agreements or other agreements, as approved by the Trustees. The Employer must make the required payments for a month in order for coverage to be provided to you. The Trustees reserve the right to terminate the participation of any Employer at any time for any reason.

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

Some plans of the National I.A.M. 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 I.A.M. 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.

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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 I.A.M. 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 conditions 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 I.A.M. 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 Dentist or other provider of dental 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 dentistry, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or over any dental care services provided or delivered to anyone by any dental care provider. Neither the Benefit Trust Fund, the Board of Trustees, nor any of their designees, have

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any liability whatsoever for any loss or Injury caused to anyone by any dental care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Right to Amend

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

Erroneous Payments

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

Misrepresentation or Fraud

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

No Assignment of Benefits

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

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

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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.

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STATEMENT OF ERISA RIGHTS

As a Participant in the National I.A.M. 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 Dental Plan Coverage

You also have the right to:

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group dental plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage free of charge, from your group dental plan, 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.

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Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 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.

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