National IAM Benefit Trust Fund
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www.iambtf.org

TO: **All Dental Plan Participants**

FROM: **Board of Trustees**

DATE: **April 30, 2010**

RE: **Dental Claims and Appeals**

Enclosed please find revised Dental Claims and Appeals procedures. Please retain this language with your Summary Plan Description.

If you have any questions regarding these Claims and Appeals procedures or any of the benefits provided by your Dental Plan, please feel free to contact the Benefit Trust Fund for assistance at 1-800-457-3481.

cc: Contributing Employers
Union Representatives

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 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.

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 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 at its next quarterly meeting following the first receipt of your appeal by either Delta Dental or the Fund Office. If your appeal is first received by Delta Dental or the Fund Office within 30 days of the quarterly meeting, your appeal will not be decided until the meeting after that one. If special circumstances require a further extension of time for processing, a determination will be made no later than the third meeting following the initial receipt of the appeal by Delta Dental or the Fund Office. If an extension is required, you will be notified of the extension and the reasons for it prior to the commencement of the extension.

Appeals Generally

Appeals received more than 180 days after your receipt of a claim denial will be denied as untimely. In presenting any appeal, you have the opportunity to submit written comments, documents, records, and other information relating to your claim for benefits. You are also entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. Personal appearances on appeals are not permitted.

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

The review of your appeal will take into account all comments, documents, records, and other information that you submit, without regard to whether such information was submitted to or considered in the initial determination. The reviewers will also not afford deference to the initial determination and will not be conducted by an individual who made the initial adverse benefit determination, nor the subordinate of such an individual.

In deciding an appeal of a benefit determination that was based, in whole or in part, on a 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.

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.