Los Angeles Machinist Benefits Trust

PLAN FOR ACTIVE EMPLOYEES DESCRIPTION OF BENEFITS

March 2012

Contacts

The following chart provides a handy reference guide to telephone numbers and web addresses for companies and entities you'll see in this booklet.

ADMINISTRATIVE OFFICE – Zenith American Solutions	
• Questions about eligibility, benefits, and claims • Requests for claim forms	323-278-7030 or 800-499-8121 Fax: 323-728-2982 www.lambt.org
BLUE CROSS PPO Medical Plan **(If you're in an indemnity PPO medical plan)**	
• Help finding preferred providers	www.bluecrossca.com (or call the Administrative Office)
• Required pre-authorization for Hospital admissions	Have your physician call 800-274-7767
HMOS (CALIFORNIA) MEDICAL PLANS	
• Kaiser	800-464-4000 www.kaiserpermanente.org
• UnitedHealthcare (formerly PacifiCare)	800-624-8822 www.pacificare.com or www.uhcwest.com
PRO Care RX. (Prescription Drug services if you're in a PPO Indemnity Medical Plan)	
• Help finding participating pharmacies • Mail order pharmacy program	800-699-3542 www.procarerx.com
MHN: Employee Assistance Program (EAP) services **(Mental health and Substance Abuse Plan)**	
Referrals for assistance with personal problems (for Non-Kaiser participants) • Required for pre-authorization and referrals for treatment, and • Review of Emergency admission to a non-contracting facility (call within 48 hours)	(800) 327-7701 www.mhn.com

PPO DENTAL PLAN (If you enroll in an Indemnity Dental Plan)	
United Concordia – (help finding network Dentists)	888-357-3304 www.ucci.com

PREPAID DENTAL PLANS	
• United Concordia	866-357-3304 www.ucci.com

VISION PLANS	
• Medical Eye Service (MES)	(800) 638-3120
• Vision Service Plan (VSP)	(800) 877-7195 www.vsp.com

LIFE INSURANCE AND SHORT TERM DISABILITY	
• Aetna Life Insurance	(800) 523-5065 www.aetna.com

March 2012

LOS ANGELES MACHINIST BENEFIT TRUST
1325 N. Grand Ave, Suite 200
Covina, California 91724
Local Telephone Number: 323-278-7030
Toll-free Telephone Number: 800-499-8121
Fax Number: 323-728-2982
Web site: http://lambt.org

TO ALL ACTIVE EMPLOYEES:

This booklet contains a description of the benefits available through the Los Angeles Machinist Benefit Trust Fund for Active Employees and their Dependents as of March 1, 2012. It replaces any prior booklets.

The actual benefits to which you are entitled result from negotiations between the Union and your Employer. The negotiated benefits depend upon the employer you are currently working for. The Schedule of Benefits (available from the Fund Administrator) summarizes benefits for employees of that employer. **If you change employers or you work at a different location for the same employer, you may not have the same benefits.** Be sure to get the most current Schedule of Benefits for your current employer from the Administrative Office.

Benefits for retirees are described in a separate booklet.

What's in This Booklet?

This booklet contains the following:

- *Information about eligibility, enrollment, and options for continuing coverage when eligibility is lost;*
- *Information about health care benefits, vision and dental benefits, weekly disability benefits, and life and accidental death and dismemberment insurance; and*
- *Important Plan information, how to file claims, claims appeals procedures, the Trust's privacy practices, and your rights under the law (ERISA).*

How to Use This Booklet (Summary Plan Description or SPD)

Review the following material before making a choice of plans and before using benefits. If you have any questions about eligibility or benefits, contact the Administrative Office.

- This Summary Plan Description
- The Schedule of Benefits for your employer that shows your benefits and enrollment options based on the information we received about the terms of your Collective Bargaining Agreement between the Union and your Employer.
- The Medical and Dental Comparisons that show coverage levels for a sampling of common benefits compared to benefits under the prepaid plans.

- Any amendments to the Plan since the last printing of the SPD. You should become familiar with the booklet, inserts, notices, or brochures so that you can receive the appropriate covered treatment when it becomes necessary.

If You Change Employers

If you start working for another employer covered through this Trust while you are eligible, be certain to get a copy of the applicable Collective Bargaining Agreement—benefits provided by that employer may be different from those of your old employer. Benefit payments are based on the benefits in effect on the date the treatment or service is received. To request a copy of the Schedule of Benefits applicable to you under your new employer, contact the Administrative Office.

Questions?

The specific benefits available to you and your eligible family members are determined by the terms of the applicable Collective Bargaining Agreement. You should refer to that document if you have questions as to the type of coverage you believe you are entitled to or the benefits that have been bargained on your behalf. You may also contact the Administrative Office for assistance in determining your benefits.

(*Please use only the benefits that are necessary so that the Trust can continue to provide quality benefits to its participants and beneficiaries.*)

Sincerely,

Board of Trustees

Important Information About the Plan and This Booklet

Authorized Sources of Information

The only sources of authorized information are the benefit booklet and booklet inserts, if any; the Trust Agreement; the rules, contracts, and other documents establishing the Plan; the contracts from the various provider organizations; and the written statements of the Trust Administrator and his authorized agents and legal representatives. Statements or representations made by individuals other than those designated personnel are not authoritative sources of information. Questions as to eligibility, benefits, and other matters should be submitted to the Administrative Office.

Benefit Changes and Plan Termination

The benefits available to you under this Plan were adopted by the Trustees based on the best information available as to the cost of benefits. Benefits in this form, or any form, are not guaranteed for any period of time.

The Trustees, at their discretion, have the right to change or eliminate any of the benefits under the Plan or change the eligibility rules as needed to maintain the financial stability of the Plan or they may make changes required by law or for any other reason. Any changes made by the Trustees may affect the payment of expenses incurred by you before the change is adopted.

The Trustees may terminate any of the benefits provided if the monies available are inadequate or if such a change is beneficial to the Plan. The Union and the employers may also terminate the Trust through collective bargaining. If the Trust is terminated, all benefits will cease after the assets of the Trust have been disbursed.

Participants and their dependents have no accrued or vested rights to benefits under this Plan. In the event the Plan is terminated by the Board of Trustees, the rights of all participants and dependents covered under the Plan with respect to any benefits available subsequent to termination will be determined by the Board of Trustees.

Important Disclaimer

The indemnity benefits described in this booklet are not insured by any contract of insurance, and there is no liability on the Board of Trustees or any individual or entity to provide payment over and beyond the amounts in the Trust collected and available for such purposes.

In order that the Plan may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the most equitable benefits for all participants, the Board of Trustees reserves the right at any time and from time to time, in its sole and absolute discretion:

- To terminate or amend the eligibility conditions with respect to any benefit, to terminate or change any benefit, or to add or modify any self-payment, even though such changes may affect claims which have already been incurred;
- To terminate this Plan even though such termination affects claims which have already been incurred;

- To alter or postpone the method of payment of any benefit; or
- To amend or rescind any other provisions of the Plan.

No lawsuit or action of any kind may be brought against the Trust based upon a denial of a claim for benefits hereunder without first exhausting the Claims Review Procedures described in this booklet in Section 15.

CONTENTS

Section 1: Overview

In this Section you'll find:
- General overview of benefits
- Information on filing claims

This booklet contains information about all of the benefits that are offered through the Los Angeles Machinist Benefit Trust. ***The Schedule of Benefits you receive shows which of the benefits are available to you under the terms of the Collective Bargaining Agreement between the Union and your Employer.***

If you have questions about your coverage, you should contact the Administrative Office or refer to your Collective Bargaining Agreement.

Benefits Offered Through the Los Angeles Machinist Benefit Trust **(the benefits you have may not include all of these items; refer to your collective bargaining agreement for a list of your benefits)**	
Benefits	**Description**
Medical	Choice of plans • Indemnity PPO plans – High and Medium option • HMO plan - 2 carriers – High, Medium and Low Option)
Prescription Drug	• Indemnity plans: Walk-in pharmacy and mail order • HMO: through HMO plan
Employee Assistance Program (EAP)	• All medical plans - referrals for help with personal problems
Mental health and substance abuse treatment	• Indemnity medical Plan and UHC: MHN (mental health and substance abuse) • Kaiser: through Kaiser
Dental	Choice of plans: (High, Medium and Low Options) • Indemnity plan (traditional fee-for-service plan): • Prepaid DHMO
Vision	Two providers based upon bargained benefits. • VSP or MES
Weekly disability	• Percent of Salary or flat amount per week – employee only
Disability Extension	• 12 or 18 months - employee only (based on negotiations)
Life insurance	• For employees and Dependents
Accidental death and dismemberment (AD&D) insurance	• Employee only

Filing Claims

See the information from Kaiser Permanente, UnitedHealthcare formerly PacifiCare, MHN, United Concordia, VSP or MES, as applicable, for information on filing claims for medical, mental health/substance abuse, dental, and vision benefits. See Section 4 for information on filing indemnity plan benefits.

Generally, when you use participating or Contracting Providers, you will pay any amount due from you at the time of your visit and will not have to file claims. If you receive any covered services from providers outside networks (where applicable), you will have to file claims.

For information on what to do if you disagree with the decision made concerning your claim, see "Claims Review Procedures" in Section 15.

Definitions

1. "Accident" means an unexpected, external, unusual, unforeseen, or unlooked for event or happening that causes or results in bodily injury.

2. "Accidental Death & Dismemberment" ("AD&D") means an Accident resulting in certain losses, including but not limited to dismemberment or death as a result of the Accident.

3. "Active Employee" means any person who, by reason of his active employment, meets the eligibility requirements as a Bargaining Unit Employee or a Non-Bargaining Unit Employee of the Plan described in Section 2.

4. "Administrative Office" or "Administrator" means the third party with which the Board of Trustees contracted to handle the day-to-day operations of the Plan.

5. "Attorney" means the legal firm selected by the Board of Trustees to provide legal advice and other services as may be needed for the operation of the Trust.

6. "Bargaining Unit Employees" means persons covered by a Collective Bargaining Agreement that requires contributions to this Plan.

7. "Beneficiary" means the person you name to receive life insurance or accidental death and dismemberments benefits when you die. You may name anyone as your Beneficiary and you may change your Beneficiary at any time.

8. "Board of Trustees" or "Trustees" means the persons designated in the Trust Agreement together with their successors designated and appointed in accordance with the terms of the Trust Agreement.

9. "Calendar Year" means January 1 through December 31 of each year.

10. "Chronic" means a disease or condition that develops slowly and persists over a long period of time.

11. "Collective Bargaining Agreement" is an Agreement between the Union and a Participating Employer that generally provides that the Employer will make contributions to the Plan for the purpose of enabling participation in the Plan. The relevant provisions of the Collective Bargaining Agreement determine the rate at which Employers contribute to the Plan and/or the benefits that are available to the Eligible Employees on whose behalf contributions are made, subject to the Plan's participation standards.

12. "Comprehensive Medical Expenses" means the Reasonable Charges for the services listed in this Plan Book that are certified by the attending Physician and

determined by the Plan to be Medically Necessary for the care and treatment of injury or sickness.

13. "Consolidated Omnibus Budget Reconciliation Act of 1985" or "COBRA" means the federal law by which an employee and dependents may continue to receive medical benefits available under the terms of the Plan after they no longer satisfy the Plan's eligibility requirements, provided that they would lose coverage.

14. "Contracting Pharmacy" means a pharmacy that has a contract with the Plan to provide Prescription Drug services to Eligible Individuals.

15. "Contracting Provider," "PPO Provider," or "Network Provider" means a provider that has a contract with the Plan to provide care at specified rates.

16. "Continued Stay Review" means the review of a Hospital admission to determine if it is Medically Necessary to continue to be a bed patient.

17. "Coordination of Benefits" or ("COB") means the payment policy of the Plan that states how benefits will be paid if employees or Dependents are covered under this Plan and another health plan, and/or how benefits will be paid if they have dual coverage under this Plan.

18. "Cosmetic Surgery" means surgery to change the shape or structure or otherwise alter a portion of the body solely or primarily for the purpose of improving appearance and not as a result of disease or conditions that, in accordance with accepted medical practice, requires surgical intervention to cure or alleviate pain or restore function, serving an esthetic rather than a useful or Medically Necessary purpose.

19. "Covered Dental Expense" means a Reasonable expense incurred for necessary treatment received by an Eligible Individual from a Dentist or dental hygienist under the supervision of a Dentist that, in the geographical area where treatment is rendered, is the usual and customary procedure for the condition being treated. A Covered Dental Expense is deemed to be incurred on the date on which the service or supply that gives rise to the expense is rendered or obtained.

20. "Deductible Amount," means the amount listed in the Schedule of Benefits. The Deductible Amount applies once each Calendar Year and includes:

    a. The payments made for any medical services and supplies paid for under any other benefits provided through the Plan;

    b. The value of any services and supplies provided under any government program – national, state, county or municipality, except Medicare; and

c. The Deductible Amount applies separately to comprehensive Non-PPO for care of several injuries or sicknesses during the year.

d. In order that the Deductible Amount will not be applied late in one Calendar Year and soon again in the following year, any Comprehensive Non-PPO Medical Expenses incurred during the last three months of a Calendar Year that apply toward the Deductible Amount (whether or not it is fully satisfied) may also be applied toward the Deductible Amount for the following Calendar Year.

e. Family Limit: the Calendar Year maximum cash deductible is shown in the Schedule of Benefits.

21. "Dental Deductible," with respect to Covered Dental Expense incurred by each Eligible Individual, is shown per person and per family in Schedule of Benefits. Any Covered Dental Expense incurred during the last three months of a Calendar Year that applies to the Dental Deductible will be applied toward the Dental Deductible for the following Calendar Year.

22. "Dentist" means an individual who is licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his license.

23. "Dependent" means the Eligible Employee's lawful spouse, Domestic Partner and Dependent children (but not the dependent children of your Domestic Partner) who satisfy the requirements for eligibility detailed in Part 2.

24. "Drug" means any article that may be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act, only upon written or oral prescription of a Physician or Dentist licensed by law to administer it.

25. "Durable Medical Equipment" means medical equipment that can withstand repeated use, is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness, and is not disposable or non durable.

26. "Eligible Employee" means each Active Bargaining Unit and Non-Bargaining Unit Employee.

27. "Eligible Individual" means each Active Employee and each of their eligible Dependents, if any, unless specifically excluded. With regard to special coverage provisions, such as COBRA or military continuation coverage, or the like, the term "Eligible Individual" in those sections refers to a person who is eligible for such special coverage.

28. "Emergency" means an acute medical condition or Accident that requires immediate treatment because it is life threatening, disabling or disfiguring.

29. "Employee Retirement Income Security Act of 1974" or "ERISA" means the legislative act defining the fiduciary responsibilities of the people engaged in the administration, supervision and management of welfare and pension plans. The act also gives specific rights to the participants of welfare and pension plans.

30. "Experimental" means any procedures, devices, services, drugs, or medicines, or the use thereof, which is: considered by any governmental agency to be unproven, Experimental, or investigational; or is not covered under Medicare reimbursement laws, regulations, or interpretations, or schedules; or is not in accordance with the commonly and customarily recognized principles of medical practice in the United States at the time practiced; or that is recognized by the organized medical community in the United States as Experimental or investigational; or does not constitute an effective treatment for the nature of the diagnosed illness, injury or condition being treated, as determined by the Trustees or the medical director or medical consultant retained by the Plan in accordance with the Plan's procedures for determining Experimental or investigational procedures, as well as the Plan's definition of Medical Necessity.

31. "Extended Care Facility" means an Extended Care Facility room, board and general nursing care. It must be an institution that is primarily engaged in providing inpatients with (1) skilled nursing care and related services for patients who require medical or nursing care, or (2) rehabilitation services for the rehabilitation of injured, disabled or sick persons, and which meets all the following requirements:

    a. It is regularly engaged in providing skilled nursing care for sick and injured persons under 24 hours a day supervision of a Physician and Surgeon (MD) or a graduate Registered Nurse (RN).

    b. It has available at all times the services of a Physician and Surgeon (MD) who is a staff member of a general Hospital.

    c. It has on duty 24 hours a day a graduate Registered Nurse (RN), Licensed Vocational Nurse (LVN), or skilled practical Nurse, and it has a graduate Registered Nurse (RN) on duty at least eight hours per day.

    d. It maintains a clinical record for each patient.

    e. It is not, other than incidentally, a place for rest, a place for custodial care, a place for the aged, a place for drug addicts, a place for alcoholics, a hotel or a similar institution.

f. It complies with all licensing and other legal requirements, and is recognized as an "Extended Care Facility" by the Secretary of Health, Education and Welfare of the United States, pursuant to Title XVIII of the Social Security Act.

32. "FMLA" means the Family and Medical Leave Act, governing the rights of employees to continued coverage during certain leaves of absence from work due to certain family and medical events.

33. "Formulary" means the preferred pharmaceutical products designated by the pharmaceutical company contracting with the Plan. "Non-Formulary" means the Drug is not on the Formulary list of preferred Drugs.

34. "He" and "His" have the same meaning as "She" and "Her" as used in this Plan Document.

35. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

36. "Home Health Care Agency" means an organization or agency that meets the requirements for participation as a "Home Health Care Agency" under Medicare.

37. "Hospice" or "Hospice Facility" means a Medicare certified and licensed facility and/or personnel to provide inpatient acute care services and outpatient services to terminally ill persons.

38. "Hospital" means an institution licensed, accredited or approved under the laws of the State of California, United States, or any other state, that is:

a. Primarily engaged in providing, for compensation from its patients, inpatient medical and surgical facilities for diagnosis and treatment of sickness or injury or the care of pregnancy, and

b. Operated under the supervision of a staff of Physicians, and continuously provides nursing services by registered graduate Nurses for twenty-four hours of every day, and

c. Operated legally in the jurisdiction where it is located.

d. In no event, however, shall this include any institution that is operated principally as a rest, nursing or convalescent home, or for the care and treatment of drug addicts or alcoholics, or any institution that is principally devoted to the care of the aged, or any institution engaged in the schooling of its patients.

39. "Indemnity Dental Benefits" means the dental benefits described in Section 8. that are self-insured by the Fund.

40. "Indemnity Medical Benefits" means the medical benefits described in Section 4. that are self-insured by the Fund.

41. "Industrial" means a work Related Illness or Injury.

42. "Licensed Pharmacist" means a person who is licensed to practice pharmacy by the governmental authority having jurisdiction over the licensing and practice of pharmacy.

43. "Maximum Calendar Year Benefit" refers to the maximum amount payable for the sum of Comprehensive Medical Benefit and Mental Health Benefit Expenses for each Eligible Individual during the Calendar Year as shown in the Schedule of Benefits.

44. "Medical Necessity" or "Medically Necessary" means that a prescribed medical procedure must be (1) one that is considered effective and that is normally used for that specified illness or injury and (2) does not exceed in scope, duration, or intensity the level of care needed to provide safe, adequate, and appropriate diagnosis or treatment.

45. "Membership Assistance Plan " or "(MAP)" means the organization contracted by the Plan to provide referral services for emotional, mental, nervous and substance abuse disorders.

46. "Medicare" means the program established under Title XVII of the Social Security Act (Federal Health Insurance for the Aged) as it is presently constituted or may hereafter be amended.

47. "Non-Bargaining Unit Employee" means a person who is not covered by a Collective Bargaining Agreement that requires contributions to this Plan.

48. "Non-Contracting Provider" "Non-PPO Provider" "Non-Network Provider" means a provider that does not have a contract with the Plan to provide care at specified rates.

49. "Nonindustrial" means an illness or injury that is not related to work for pay or profit.

50. "Nurse" means a registered graduate Nurse (RN), a licensed practical Nurse (LPN), or a licensed vocational Nurse (LVN), who does not ordinarily reside in the Eligible Employee's home and is not the spouse, child, brother, sister or parent of the Eligible Employee or of the Eligible Employee's spouse.

51. "Open Enrollment" means the period of time when Eligible Employees may change from one plan to another. Following the Eligible Employees' initial enrollments, the Eligible Employees may change their medical and/or dental plan selection. Plan changes may be made following each 12-month enrollment period. Changes will become effective on the first day of the month following the selection of a new plan, and all family members will be enrolled in the plans selected.

52. "Participating Employer" means an employer that is required to make contributions for health and welfare benefits to this Plan under the terms of a Collective Bargaining Agreement or other written agreement requiring contributions to this Plan.

53. "Physician" or "Doctor" means an individual who is licensed to practice medicine and surgery as a Doctor of Medicine or Osteopathy, Physical Therapist, Podiatrist, Anesthesiologist, Chiropodist, Acupuncturist, Optometrist, or Chiropractor who is practicing within the scope of his license.

54. "Physician Assistant" means a healthcare professional who, after graduating from an approved program, is qualified to perform medical services under the supervision of a Physician, and who has been issued a Physician Assistant's license in the state in which services are rendered.

55. "Plan" means the Los Angeles Machinist Benefit Trust Plan. "Plan" also means the rules stated in this Plan Book, as adopted and amended by the Board of Trustees.

56. "Preferred Provider Organization" or "PPO" means the health benefits payable under the Plan for services received from providers that have contracted with the Plan to provide services at generally discounted rates.

57. "Prior Authorization" means the requirement that a plan or its designee be provided with justification, as a condition of coverage and reimbursement by the Plan, for the delivery of particular services, supplies, and/or medications to you or your Dependents prior to the actual provision of such services, supplies, and/or medications. The Plan or its designee may, from time to time, amend categories and specific medical services, supplies, and/or medications that require Prior Authorization under the Plan. Prior Authorization does not mean that benefits are guaranteed or payable or that the particular service is a benefit covered by the Plan. It means only that the service has been approved as Medically Necessary and appropriate.

58. "Qualified Medical Child Support Orders" and "QMCSO" mean a legal document issued by a court or other agency that orders an Employee covered under the Plan to enroll a child as a Dependent.

59. "Reasonable" means a charge that is not excessive in light of the cost to the provider in providing the services, and the market for such services, and therapeutic value to the patient, as determined in the sole discretion of the Board of Trustees in consultation with industry professionals it retains to advise it. See also "UCR"

60. "Residential Facility" means any licensed social rehabilitation facility, licensed group home, licensed family home, or similar licensed facility providing 24-hour nonmedical care to persons in need of personal services essential for sustaining the activities of daily living for the protection of the individual.

61. "Subrogation" means the Plan's right to require the Eligible Individual to repay the Plan if the Plan has paid expenses recouped by the Eligible Individual from a third party.

62. "Treatment Course" means a specific time period recommended and outlined by a professional or facility during which the Eligible Individual receives counseling and attends group sessions, special classes and meetings.

63. "Trust Agreement" means the Trust Agreement establishing the Los Angeles Machinist Benefit Trust and any modifications, amendments, extensions or renewals thereof.

64. "UCR" means the usual, customary and Reasonable charges in the area in which they are incurred, but not exceeding the charges that would have been made in the absence of the benefits provided under the Plan. The term "area," as it would apply to any particular item for which a Covered Charge may be incurred, means a city, county or such greater area as is necessary to obtain a representative cross-section of persons, Hospitals, prescription pharmacies, institutions or other entities furnishing such items. All references to payment of UCR and/or payment for non-PPO benefits shall mean a percentage of UCR or 100% of UCR, as determined and adjusted from time-to-time by the Trustees in their sole discretion, and shall not refer to billed charges.

65. "Union" means the International Association of Machinists and Aerospace Workers ("IAM"), Local Lodge #1484, and District Lodge 947.

66. "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, federal legislation governing the right to continued coverage and reestablishment of coverage when Active Employees are serving on active duty with the armed forces of the United States.

67. "Workers' Compensation" means the laws of any state that impose liability on an Employer of a person who is injured, becomes ill, or is killed as a result of, or in connection with, a work-related activity, or whose injury, illness, and/or death,

arise out of, or in the course of such employment, or which impose such liability on the Employer's Workers' Compensation insurance carrier.

68. “Work Related Illness or Injury” means any injury or illness that occurs while the Eligible Individual is at work, or an injury or illness that is a direct or indirect result of his job, or an illness or injury for which benefits are or would be payable under any state disability or Workers’ Compensation law.

Section 2: Eligibility and Enrollment

In this Section you'll find:

- Eligibility rules
- Enrollment
- Medical and dental plan enrollment
- Coverage during family/medical or military leave

Eligibility Rules

NOTE: This booklet contains general information about eligibility. Information on any probationary period for eligibility is covered in the applicable Collective Bargaining Agreement.

Bargaining Unit Employees—Flat Monthly Contributions

Establishing Eligibility

If you are a Bargaining Unit Employee, you will become eligible as an Active Employee on the first day of the month for which a contribution is received on your behalf, unless your Collective Bargaining Agreement states differently, in which case eligibility will start on the first day of the month designated in the agreement.

Benefits and Effective Date of Coverage

The benefits to which you are entitled are determined by the terms of your Collective Bargaining Agreement; refer to that document for a list of your benefits. You and your eligible Dependents must be enrolled in the same benefit plans. Coverage will begin on the date your eligibility starts. Your eligible Dependents will begin coverage on the same date or, if they are acquired later, on the date you provide timely application and proof of their dependency as required.

Maintaining Eligibility

You will continue to be eligible during each month for which a required contribution is received on your behalf.

Note: Since an employer contribution is required for your coverage, if the contribution has not been received by the date you obtain services, the provider will be advised that eligibility is not guaranteed until the required amount is received.

Non-Bargaining Unit Employees

When a Participating Employer first becomes contributory for its Bargaining Unit Employees, the employer may elect coverage for Non-Bargaining Unit Employees in accordance with terms prescribed by the Board of Trustees, provided the election for such coverage and the first payment is made within 60 days of the date coverage was made available. If the employer fails to elect such coverage, it will not be made available again unless the Board of Trustees votes to allow an Open Enrollment in the future. In addition, if your employer no stops contributing for its Bargaining Unit Employees, you will no longer be covered; your loss of coverage will not be considered a qualifying event under COBRA continuation coverage.

Initial Eligibility

If you are a Non-Bargaining Unit Employee, you will become eligible on the first day of the second month of your employment, provided the Participating Employer made the required 2 months' pre-payment for coverage prior to the first day of the month of coverage.

Benefits and Effective Date of Coverage

The benefits to which you are entitled are determined by the agreement between the Trust Fund and your employer. Generally, the benefits will be the same as those available to the Bargaining Unit Employees working for your employer.

You and your eligible Dependents must be enrolled in the same benefit plans. Coverage will begin on the date your eligibility starts. Your eligible Dependents will begin coverage on the same date or, if they are acquired later, on the date you provide timely application and proof of their dependency as required

Continuing Eligibility

You will remain eligible during each month a contribution has been made on your behalf for coverage.

Eligible Dependents

Your eligible Dependents include:

- the spouse to whom you are legally married and
- Your domestic partner for whom you provide a copy of the registered state Declaration of Domestic Partners coverage (contact the Administrative Office with any questions); and
- your children under 26 years of age (married or unmarried, regardless of student status, or residence) who are not eligible to enroll in another employer-sponsored group health plan. Dependent children include:
  - your natural children;
  - children who are legally adopted by or placed for adoption with you;
  - children for whom you are the legal guardian or have legal custody where legal documentation exists showing you are financially responsible for such children; and/or
  - your stepchildren.

Note: Eligible Dependents do not include children of your Domestic Partner. In addition, the spouse or domestic partner of a dependent child or the children of dependent children are not eligible Dependents.

Proof of dependency is required for Dependent coverage. Proof of dependency in the form of a certified copy of (1) your marriage certificate for your spouse; (2) a birth certificate for your children; or, (3) a court order showing legal responsibility for a child is acceptable proof.

Qualified Medical Child Support Orders (QMCSOs)

This Fund is required to provide benefits in accordance with the applicable requirements of a Qualified Medical Child Support Order. A Qualified Medical Child Support Order is a judgment or decree by a court of competent jurisdiction that requires a group health plan to provide coverage to the children of a plan participant pursuant to state domestic relations law.

Any medical child support order shall be delivered to the Administrative Office of this Fund. When the medical child support order is received, the Fund will determine whether or not the order meets the criteria to be considered a Qualified Medical Child Support Order and will notify you and the alternate recipient(s) named in such Order of the Fund's determination. An alternate recipient is any child of a participant who is required to be covered under a group health plan with respect to such participant.

For further details or a copy of the Plan's procedures regarding QMCSOs, free of charge, contact the Administrative Office.

Benefits and Effective Date of Coverage

Coverage for Dependents begins on the date you become eligible or on the date the Dependents are acquired, if later. In the case of adoption, a child will become eligible on the date of placement for adoption or the date financial responsibility by the Plan participant is assumed.

You must enroll new dependents within 31 days of the date they are acquired in order for coverage to be provided except as provided under "HIPAA Rules for Special Enrollment" under "Enrollment" on the next page.

Your Dependents will generally have the same benefits as you. However, the amount of life insurance will be lower, Dependents are not covered for Accidental Death and Dismemberment benefits and they will not be covered for weekly disability benefits.

Changes in Dependent Status

You must immediately notify the Administrative Office in writing when Dependent status changes occur. This includes final dissolution of marriage, death, an adult child reaching age 26 or becoming eligible for coverage under another employer-sponsored group health plan. The changing of a participant's Beneficiary for death benefits is not acceptable notification of divorce.

If you do not immediately notify the Administrative Office and claims and/or premiums are paid on behalf of an ineligible dependent, you and/or the dependent is responsible for reimbursing the Trust for such claims and/or premiums, including Attorney's fees, interest, and reasonable collection costs. The Trust may recover these amounts from future payments due for you or other eligible Dependents, through legal action, or otherwise as determined in the sole and absolute discretion of the Board of Trustees in accordance with procedures specified in the Trust Agreement. The participant and/or dependent may also be required to reimburse the Trust and/or the HMO for the value of any HMO benefits provided to the ineligible dependent.

The Administrative Office should also be notified of a change of address for any Plan participant or covered Dependent.

Termination of Eligibility

Termination of Eligibility – Bargaining and Non-Bargaining Unit Employees

You will cease to be eligible on the earliest of the following:

- the last day of the month following the month the last employer contribution was made on your behalf;
- the date the Plan terminates;
- for Non-Bargaining Unit Employees, the date the Participating Employer no longer contributes on behalf of its Bargaining Unit Employees, or;
- the date you enter into full-time military duty with the armed forces of any country, unless precluded by law. (See "Coverage During a Family/Medical or Military Leave" later in this Section)

If loss of eligibility occurs, coverage may be continued for all benefits (except for Weekly Disability and disability extension) by making self-payments in accordance with the rules in effect on the date of loss of your active eligibility or, you can continue a portion of your benefits by electing coverage under COBRA if you qualify. See Section 3 for more information

Termination of Eligibility - Dependents

Coverage for your Dependents will end on the earliest of the following dates:

- the date Employee coverage ends;
- the date the Dependent enters full-time military duty with the armed forces of any country unless precluded by law;
- the date the Plan terminates or coverage for Dependents ends; or
- the date the Dependent no longer meets the Plan's definition of an eligible Dependent (for example, for reasons of age).

If, however, an unmarried child is incapable of self-sustaining employment by reason of mental retardation or physical handicap on the child's termination date, the Plan will continue coverage for the child as long as your coverage remains in force and the incapacity continues, subject to the following conditions:

- the incapacity began before the child would have lost eligibility for reasons of age,
- the child is chiefly dependent on you for support and maintenance,
- you submit proof of incapacity to the Administrator within 31 days of the date the child's coverage would otherwise terminate, and
- you comply with any subsequent requests from the Administrative Office for proof of the child's incapacity and dependency. Such requests may be made at reasonable intervals during the period of continued coverage. When 2 years have passed from the date the child would have lost eligibility for reasons of age, the Trust may require proof of incapacity and dependency once every year.

A dependent who has lost coverage may be able to continue health care coverage under COBRA. See Section 3 for more information.

Enrollment

You, the Active Employee, must elect coverage and complete enrollment forms to be covered. This includes choosing a medical and dental plan if you have this option (see "Medical and Dental Plan Enrollment" on the next page).

Deadline for Enrolling Your Dependents

Your existing Dependents at the time you become eligible become eligible when you do. Any dependents you acquire after your initial eligibility must be enrolled within 31 days of when you acquire them. An exception is made only for the situation described in "HIPAA Rules for Special Enrollment" below.

When enrolling Dependents, you must provide the appropriate proof of dependent status, for example, a certified copy of your marriage certificate, a birth certificate for a child, a court order showing legal responsibility, or a copy of the registered state Declaration of Domestic Partners coverage.

HIPAA Rules for Special Enrollment

A law known as HIPAA (the Health Insurance Portability and Accountability Act) provides for enrollment after initial eligibility under two sets of circumstances

- **Loss of other coverage:** If you decline enrollment in the Plan for yourself or your Dependents (including a spouse) because of other health insurance coverage, you may be able to enroll yourself or your Dependents in this Plan in the future, provided you request enrollment within 30 days after the other coverage ends.

Acquisition of new dependents: In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Children's Health Insurance Program Reauthorization Act (CHIPRA)

CHIPRA provides special group health plan enrollment rights in situations involving:

- Employees who have opted out of Trust Fund coverage and have lost their comparable group health plan coverage;
- Employees who need to add a new dependent to their group health plan coverage;
- Employees and their Dependents who are eligible for, but not enrolled in a Trust Fund plan and:
  - Lose eligibility for Medi-Cal or coverage under a state Children's Health Insurance Program (CHIP coverage) known as Health Families, or
  -
  - Become eligible for a state premium assistance program available through Medicaid.

If you believe that one or more of these situations may apply to you, contact EBSD at (909) 387-5787 or Medicaid at (866) 298-8443 for information.

Medical and Dental Plan Enrollment

See your Medical Comparison and Dental Benefit Comparison for side-by-side looks at your plan options.

Your options for a medical and dental plan depend on three things:

- what options have been negotiated for you in the Collective Bargaining Agreement or in the signed agreement for non-bargaining unit coverage,
- where you live—to be eligible for a prepaid medical plan (an HMO) or a prepaid dental plan, you must live in the HMO's or prepaid dental plan's service area, and
- how long you've been eligible for benefits through the Fund. When you first become eligible, your only option is to be covered under an HMO and a prepaid dental plan, provided you live in the HMO's and prepaid dental plan's service areas.

Frequently Asked Questions

Q How long do newly eligible people have to stay in the HMO and prepaid dental plan?

A You will be able to make different plan selections during the first Open Enrollment (held in November) after your benefits start, for coverage starting the January 1 after that Open Enrollment.

Q How can I find out whether I live in an HMO's or prepaid dental plan's service area?

Service areas are determined by zip code. You can get a list of HMO service area zip codes from the Administrative Office.

Q How can I find out what Doctors and Dentists are in the PPO networks?

A The Administrative Office can provide you with copies of the most recent provider directories free of charge. You can also visit the websites shown in the "Contacts" list at the beginning of this booklet.

Plan Choices

The overview of plan choices below is designed to help you understand your health care coverage; your options may differ, depending on the Collective Bargaining Agreement or the non-bargaining unit agreement.

Before making a decision, look at your likely out-of-pocket expenses and the facilities/providers you can use. Review your Medical and Dental Benefit Comparisons and benefit details in this SPD, the materials provided by the HMOs and United Concordia, and the brochure(s) about the indemnity dental benefits. The Administrative Office can provide you with a description of coverage and can answer many of the questions you have about eligibility or coverage. However, the most accurate information about an insured plan will be provided by the insured plans' customer service departments.

Fee-For-Service ("Indemnity") Plans

The indemnity medical and dental plans are traditional fee-for-service vehicles: providers charge fees when you use their services. The plan pays a percentage of the Allowable Charges* (after

you have met the deductible, if applicable). You pay the remaining percentage (your co-insurance) plus any charges that are not considered Allowable Charges. You can use the providers of your choice, but you have lower out-of-pocket expense when you use Preferred Provider Organization (PPO) providers—hospitals, Doctors, Dentists, and other health care professionals that have contracted to accept reduced fees for services rendered by them. At the time this booklet was printed, the medical PPO network was being administered by Blue Cross and the dental PPO network was being administered by United Concordia.

All Indemnity Medical Plans contain managed care features that require pre-authorization for non-Emergency hospitalization.

*Payments for services or supplies obtained from an out-of-network provider are based on "Allowable Charges". The Allowable Charge for a service is established and updated regularly by the Trust Fund. Billed charges are generally higher than the Allowed Charges.

Health Maintenance Organizations (HMOs) and Prepaid Dental Plans (DHMOs)

Most Collective Bargaining Agreements provide for two prepaid medical options (HMO) and one prepaid dental plan option (DHMO).

Under these types of plans, care is usually provided at no charge or in exchange for a specified co-pay (a fixed dollar amount), and you will not have to worry about filling out claim forms. However, except in an Emergency, you may use only the health care professionals and facilities that are part of the HMO or DHMO. If you use other providers, no benefits will be paid.

At the time this booklet was printed, the Fund had HMO contracts in effect with Kaiser Permanente and UnitedHealthcare (formerly PacifiCare) for hospital and medical care and a contract with United Concordia for DHMO and PPO dental services. From time to time, there may be a change in the HMOs, DHMOs, or PPO plans under contract with the Fund. You will be notified of any such change in carriers in advance and will be given the opportunity to enroll in another plan.

To be eligible for an HMO or DHMO, you must reside in its service area.

Note regarding administrative review of disputes with an HMO or DHMO: Certain disputes that arise between a participant enrolled in an HMO or DHMO and the HMO or DHMO are subject to binding arbitration. By enrolling in an HMO or DHMO, you and your Dependents may be giving up your constitutional right to a jury or court trial to resolve any dispute that is subject to binding arbitration. Consult the text of the medical and group subscriber agreement available from the HMO or DHMO or the Administrative Office for the specific details of the arbitration provisions.

Frequently Asked Questions

Q Can I choose one plan for myself and a different plan for my Dependents?

A No, your family must be enrolled in the same medical and dental plan you select for yourself.

Q Do I need to have a medical exam before I can enroll in benefits?

A A medical examination is not required. Active Employees and their eligible Dependents will be covered regardless of their physical condition.

Q What happens to my benefits if I become disabled?

A If you lose eligibility as an Active Employee due to an injury or illness, you may become eligible as a disabled employee if a disability extension of benefits has been negotiated on your behalf. See "Disability Extension of Benefits" in Section 3 for more information.

Other options may be self-payment and COBRA continuation of health care coverage, both of which are also explained in Section 3.

Changing Plans—Open Enrollment

Once you are enrolled in the health plans you have selected, you may change plans only during the "Open Enrollment period" in the month of November each year. However, you may qualify for Special Enrollment rights under HIPAA (you may qualify for special enrollment rights if you are in an HMO or DHMO and move out of the service area). Coverage begins on January 1 for the enrollment options you select during Open Enrollment.

Coverage During a Family/Medical or Military Leave

Family or Medical Leave

If you qualify for a leave of absence from your employer in accordance with the provisions of the Family and Medical Leave Act of 1993 (FMLA) and the employer makes contributions to the Fund on your behalf, coverage may continue uninterrupted. Contact your employer for details of the requirements and benefits under the Family and Medical Leave Act. If you do not return to work when a leave of absence ends, you will be offered COBRA and you may be able to continue your coverage.

Military Leave

On the date you enter full-time active duty with the armed forces of the United States, your eligibility for benefits will terminate. (Your coverage will be provided by the armed forces.) If you return to work with a contributing employer to the Plan within the time period required by law, you will be reinstated for benefits on the first day of your re-employment.

Active Employees, who enter into full-time active duty with the armed forces of the United States, and their eligible Dependents, may also elect to continue their coverage by submitting to the Administrative Office, within 60 days after the participant entered the armed services, a written election to continue coverage. The maximum period of coverage for the participant and his or her eligible Dependents is the lesser of (1) 24 months, or (2) if the participant does not return to work within the time period required by law, the period ending the day after the expiration of the time period. Participants (and their dependents) who elect to continue coverage must pay for such coverage in the same amount and in the same manner as provided for under

COBRA continuation coverage. For more information, see "COBRA Continuation of Health Care Coverage" in Section 3 or contact the Administrative Office.

Section 3: Coverage After Normal Eligibility is Lost

In this Section you'll find:

- Disability extension of benefits (if negotiated for you)
- Self-pay continuation of benefits
- COBRA continuation of heath care coverage
- Certificate of creditable coverage

As noted in Section 2,

- Active Bargaining Unit Employees will cease to be eligible for benefits on the earliest of the following:
  - the first day of the month for which any required contribution is not received on their behalf;
  - the date the Plan terminates; or
  - the date the employee enters into full-time military duty with the armed forces of any country, unless precluded by law.
- Non-Bargaining Unit Employees will cease to be eligible on the earliest of the following:
  - the last day of the month following the month the last employer contribution was made on their behalf;
  - the date the Plan terminates;
  - the date the Participating Employer no longer contributes on behalf of its Bargaining Unit Employees; or
  - the date the employee enters into full-time military duty with the armed forces of any country, unless precluded by law.
- Coverage for Dependents will end on the earliest of the following dates:
  - the date the employee's coverage ends;
  - the date the Dependent enters full-time military service;
  - the date the Plan terminates or coverage for Dependents ends; or
  - the date the Dependent no longer meets the Plan's definition of an eligible Dependent, for example, for reasons of divorce).
  - The date of termination of a Domestic Partner relationship.

This Section explains the circumstances under which some or all benefits may be temporarily continued after eligibility is lost.

Disability Extension of Benefits

This benefit applies if a disability extension has been negotiated for you (or for the Bargaining Unit Employees of your employer).

This extension of benefits for Active Employees and their Dependents is available to you ONLY if your Schedule of Benefits includes a disability extension of benefits.

What a Disability Extension Is

In the event you become disabled (on or off the job) and are unable to work while covered by the Plan, benefits for you and your eligible Dependents will stay in effect. You will be required to submit acceptable proof of disability to the Administrative Office. Call the Administrative Office for the necessary forms.

Some employers are also required to continue contributions for benefits for their employees before this disability extension begins. Refer to the applicable Collective Bargaining Agreement to determine your employer's obligation. If you have questions about your coverage, check with the Administrative Office or refer to the applicable Collective Bargaining Agreement.

Frequently Asked Questions

Q Do I have to pay anything for benefits during a disability extension?

A You do not have to pay anything toward the cost of coverage. You will, of course, have to pay any out-of-pocket expenses you incur if you use your health care benefits (deductibles, co-pays, etc.).

Proof of Disability

You must provide

- proof that your disability started during a period when you were working for a Participating Employer who contributes to this benefit,
- proof of entitlement to benefits under Workers' Compensation or State Disability, and
- a Doctor's written certification that as a result of illness or injury, you (the Active Employee) are unable to perform any and every aspect of your job.

Maximum Periods for a Disability Extension

Under the Trust, two disability extension benefit periods are available to negotiating parties:

- 12 months (if negotiated)

  OR

- 18 months (if negotiated)

Your Schedule of Benefits will tell you which period is applicable for you (if you are covered for this benefit). Remember that if you change employers, work for the same employer at a different location or a new contract is negotiated, you may not have the same coverage as before.

Termination of a Disability Extension

Disability extension coverage will continue until the earliest of the following:

- the date the maximum period of disability negotiated for you is reached,
- the date you are no longer disabled, or
- the date the Doctor provides written certification you are no longer disabled.

To re-qualify for a new period of disability extension, you must return to work for one full day for an employer who contributes for this benefit.

Coordination with COBRA

The period during which you continue benefits under a disability extension will count against the maximum number of months you could otherwise continue health care coverage under COBRA. See "Coordination with Disability Extension" under "COBRA Continuation of Health Care Coverage" later in this Section.

Self-Pay Continuation of Benefits

If you lose eligibility as an Active Employee or disabled employee, you may continue coverage for yourself and your eligible Dependents (excluding any disability extension or weekly disability benefits) by paying the cost of coverage yourself. Such "self-payments" are allowed on the following basis:

- Self-payments may be made for a maximum of 6 consecutive months.
- Each self-payment must be for the amount established by the Board of Trustees, which is sufficient to cover the cost of the coverage provided, plus the cost of administration, for one month.
- The first self-payment must be received by the Administrative Office before the first day of the month for which coverage is desired. Subsequent self-payments must be received in the Administrative Office prior to the first day of the month for which coverage is desired.
- Self-payments must remain continuous. Any break in self-payments will result in the loss of the right to self-pay unless you again establish eligibility as an Active Employee or disabled employee.

When you have exhausted the 6 months allowed for self-payment, you and your eligible Dependents may continue the health care portion of your coverage under the provisions of COBRA (see the following page). Your months of self-pay coverage will count against the maximum number of months you could otherwise continue health care coverage under COBRA.

COBRA Continuation of Health Care Coverage

A Federal law known as "COBRA" requires that group health plans offer covered employees and their families the opportunity for a temporary extension of health care coverage (called "COBRA continuation coverage") in certain instances (called "qualifying events") where coverage under the Plan would otherwise end.

To receive this continuation coverage, you, your spouse, or your Dependent child must pay the monthly premiums directly to the Fund.

Important Information for Family Members

This section of the booklet is intended to inform you and your family of your rights and obligations regarding COBRA continuation coverage. If you do not elect COBRA continuation coverage, your spouse and each eligible Dependent child will have a separate right to elect it. **Therefore, it is important that you, your spouse, and all children read this section of the benefit booklet carefully.**

How COBRA Compares to the Self-Pay Option

The following chart provides an overview of factors that might affect your selection of the self-pay option or COBRA for continuation of benefits.

Comparison and Coordination of COBRA with the Self-Pay Option

Employees who have been covered by the Los Angeles Machinist Benefit Trust have two options for extending coverage:

• the self-pay option for continuing benefits (this was described in the immediately preceding section)	*Only the employee can elect the self-pay option for himself and covered family members. The self-pay option continues all of the benefits provided to the Active Employee except any disability extension and/or weekly disability benefits.*
OR	
• COBRA continuation coverage	*Each family member may make a separate election for COBRA, or the employee may elect it for the family. Under COBRA, only certain benefits may be continued—medical, Prescription Drug, mental health and substance abuse, dental, and vision—and only if the participants had that coverage at the time of loss of eligibility.*

If you elect the self-pay option, the number of months that you receive benefits as a self-pay employee will be counted toward the maximum number of months available under COBRA.

If you elect COBRA continuation coverage, you forfeit your rights to the self-pay option.

See also "Coordination of COBRA with Disability Extension" following the qualifying event chart on the next page.

Qualified Beneficiaries

Under the law, only "qualified beneficiaries" are entitled to COBRA continuation coverage. A qualified beneficiary is any individual who was covered under the Plan on the day before the qualifying event by virtue of being on that day an employee (you), the spouse of an employee, or the Dependent child of an employee.

A child who becomes a Dependent child by birth, adoption, or placement for adoption with you during a period of COBRA continuation coverage is also a qualified beneficiary. A spouse who becomes your spouse during a period of COBRA continuation coverage is not a qualified beneficiary (in other words, is not eligible for the spousal options described), but you may add such a spouse to your coverage during the period you remain eligible for COBRA continuation coverage. (See "Special COBRA Enrollment Rights" later in this section.)

Qualifying Events

For you and/or your Dependents to be eligible for COBRA continuation coverage, your loss of coverage must be due to one of the qualifying events shown in the chart below.

Qualifying Event	Who May Continue Coverage	Maximum Period of Continuation Coverage
You (the employee) lose eligibility due to: • your voluntary resignation • termination of your employment (for reasons other than gross misconduct), or • a reduction in your hours	You, your spouse, and/or your dependent children covered under the Plan	18 months*
Your death	Your spouse and/or your dependent children covered under the Plan	36 months
You divorce or legally separate from your spouse	Your former spouse and/or your dependent children covered under the Plan	36 months
Your child ceases to meet the Plan's definition of an eligible Dependent (for example, because of marriage or a change in age)	The affected Dependent child who was covered under the Plan	36 months

* *Coverage for all enrolled family members may be continued an additional 11 months (for a total of 29 months) if you or a covered Dependent becomes totally disabled before or during the first 60 days of COBRA continuation coverage, receives a Social Security Disability determination before the initial 18 months of continuation coverage expires, and reports that determination to the Administrative Office within 60 days of the date the notice was received. If you are enrolled in an insured medical plan, you may apply for additional coverage under Cal COBRA to extend your coverage to a total of 36 months of coverage.*

If you were already enrolled in Medicare (Part A or Part B) when you voluntarily resigned, your employment was terminated, or your hours were reduced, your Dependents may continue COBRA coverage for 18 months (29 in the case of a disability extension) from the date they would have lost coverage because of that qualifying event or 36 months from the date you became enrolled in Medicare, whichever ends later.

If your qualifying event allows for fewer than 18 months of coverage and you are enrolled in an insured medical plan in the state of California, you may be eligible to continue your medical coverage under Cal COBRA (the coverage is directly through the carrier, not through the Trust) for a total of 36 months of coverage.

See "Duty to Notify Administrative Office" later in this section regarding your responsibility to notify the Administrative Office that a qualifying event has occurred or a disability has been determined to exist or has ended.

Coordination with Disability Extension

Any disability extension of benefits will apply toward your maximum period of COBRA continuation coverage.

A disabled employee would normally be entitled to up to 29 months of COBRA continuation coverage (see footnotes to chart on the preceding page). If a disability extension of benefits was negotiated for you and you have a disability extension of 12 months, you will be entitled to up to 17 months of COBRA continuation coverage following the end of your disability extension, for a total of 29 months of health care coverage after you lose eligibility as an Active Employee.

If a Second Qualifying Event Occurs

If your Dependents are in an 18-month COBRA continuation coverage period because of your voluntary resignation, the termination of your employment, or a reduction in your hours and one of the following qualifying events occurs, the maximum COBRA continuation period for your Dependents will switch to 36 months (provided you or a Dependent notifies the Administrative Office of the second qualifying event in writing within 60 days of when it occurs):

- you get divorced or legally separate from your spouse,
- you die, or
- your child ceases to meet the Plan's definition of an eligible Dependent (in this case, only the child may extend coverage for another 18 months).

For example . . . Sam stops working (the first COBRA qualifying event), and enrolls himself and his family in COBRA continuation coverage for 18 months. Three months after his COBRA continuation coverage begins, Sam's child turns 26 and no longer qualifies as a Dependent child under the Plan's definition. Sam's child can continue COBRA coverage for an additional 33 months, for a total of 36 months of COBRA continuation coverage.

You, the employee, are not entitled to COBRA continuation coverage for more than a total of 18 months (unless you are entitled to an additional 11 months' continuation coverage because of a disability). Even if you experience a reduction in your hours of covered work followed by a voluntary resignation or a termination of employment, the resignation or termination is not treated as a second qualifying event and you may not extend your coverage.

In no event will the COBRA continuation coverage extend beyond 36 months from the date of the first qualifying event, and it may end before the 18-, 29- or 36-month period expires, as explained later in this discussion. ***Except: If you are enrolled in an insured medical plan in California, and you have qualifying event that totals less than 36 months, you can apply for an additional months of coverage (for a total of 36 months) under Cal COBRA. This coverage is available directly through the insured medical plan, not the Trust Fund.***

See "Duty to Notify Administrative Office" below regarding your responsibility to notify the Administrative Office that a second qualifying event has occurred.

Duty to Notify Administrative Office

TAKE NOTE
You should keep a copy, for your records, of any notices you send to the Administrative Office.

You or your Dependents are responsible for providing the Administrative Office with timely notice of the following qualifying events:

- your (the covered employee's) divorce or legal separation from your spouse,
- loss of Dependent status by a child, or
- the occurrence of a second qualifying event while your Dependents are in an 18-month COBRA continuation period (see "If a Second Qualifying Event Occurs" on the preceding page).

You must also provide the Administrative Office with timely notice when

- you and your Dependents have experienced a qualifying event entitling you to COBRA continuation coverage with a maximum duration of 18 months and one of you is determined by the Social Security Administration to be disabled or
- the Social Security Administration determines that the person is no longer disabled.

You must make sure that the Administrative Office is notified of any of the five occurrences listed above. Failure to provide this notice within the form and timeframes described below may prevent you and/or your Dependents from obtaining or extending COBRA coverage.

How to Notify the Administrative Office

To provide the Fund with notice of any of these five situations, you must complete and sign the Fund's "COBRA Event Notification Letter." You can obtain a copy of the form by contacting the Administrative Office. (If you have any questions about how to fill out this form, please contact the Administrative Office at 323-278-7030 or 800-499-8121.) Alternatively, you may send a letter to the Fund containing the following information: your name, the event for which you are providing notice, the date of the event, and the date coverage would be lost because of the event.

Where to Send Your Notification

Notice of an event should be sent to the Administrative Office at the following address:

LOS ANGELES MACHINIST BENEFIT TRUST
1325 N. Grand Ave, Suite 200
Covina, California 91724

When to Notify the Administrative Office

If you are providing notice of a divorce or legal separation, a Dependent's losing eligibility for coverage, or a second qualifying event, you must send the notice no later than **60 days after the latest of the following:**

- the date of the qualifying event,

- the date coverage would be lost under the Plan as a result of the qualifying event, or
- the date you are informed (through the furnishing of a Summary Plan Description (SPD) or initial COBRA notice) of your responsibility to provide notice to the Administrative Office and the procedures for doing so.

If you are providing notice of a Social Security Administration determination of disability, you must send the notice no later than **60 days after the later of**:

- the date of the disability determination by the Social Security Administration or
- the date you are informed (through the furnishing of a Summary Plan Description or initial COBRA notice) of your responsibility to provide notice to the Administrative Office and the procedures for doing so, or
- the end of the first 18 months of continuation coverage.

If you are providing notice of a Social Security Administration determination that you or your Dependent is **no longer** disabled, notice must be sent no later than **30 days after the later of**

- the date of the determination by the Social Security Administration that you or your Dependent is no longer disabled, or
- the date you are informed (through the furnishing of a Summary Plan Description or initial COBRA notice) of your responsibility to provide notice to the Administrative Office and the procedures for doing so.

Who Can Notify the Administrative Office

Notice may be provided by you or your Dependents or any representative acting on behalf of you or your Dependents.

Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event. For example, if your spouse notifies the Administrative Office that your child has ceased to meet the definition of a Dependent under the Plan, that single notice would satisfy the notification requirement.

Notification of Other Qualifying Events or Developments

Your employer will give the Administrative Office information on other qualifying events. However, we encourage you and your Dependents to inform the Administrative Office promptly of any qualifying event to ensure prompt handling of COBRA rights.

You should also notify the Administrative Office of eligibility for Medicare.

Deadline for Election of COBRA Continuation Coverage

When the Administrative Office is notified that a qualifying event has occurred, it will send you and/or your Dependents an election form and other information regarding COBRA continuation coverage. You will have at least 60 days from the date coverage terminates under the Plan or, if later, 60 days from the date of the notice advising you and/or your Dependents of your right to make an election decision. You and/or your Dependents will not have to show that you are insurable to obtain COBRA continuation coverage.

You and your Dependents may each decide independently whether or not to continue coverage under COBRA.

Those electing COBRA continuation coverage will be entitled to the same health coverage that is provided to similarly situated Active Employees or family members in the Plan. However, coverage for life insurance, accidental death and dismemberment benefits, disability extensions of benefits, and weekly disability benefits is NOT provided under COBRA continuation coverage.

Special COBRA Enrollment Rights

If you marry, have a newborn child, adopt a child, or have a child placed with you for adoption while you are enrolled in COBRA, you may enroll your new spouse or child for coverage for the balance of the period of COBRA continuation coverage. You must enroll your new Dependent within 31 days of the marriage, birth, adoption, or placement for adoption.

In addition, if you are enrolled for COBRA continuation coverage and your spouse or Dependent child loses coverage under another group health plan, you may enroll that spouse or child for coverage for the balance of the period of COBRA within 31 days after the termination of the other coverage. To be eligible for this special enrollment right, your spouse or Dependent child must have been eligible for COBRA coverage on the date of the qualifying event but declined when enrollment was previously offered because he or she had coverage under another group health plan or had other health insurance coverage.

Adding a spouse or Dependent child may cause an increase in the amount you must pay for COBRA continuation coverage.

Payment Obligations

COBRA participants must pay for continuation coverage. The cost of coverage is based on the Trust's costs to provide coverage to eligible employees and Dependents. The current premium rate will be included in the materials sent to you after the Administrative Office is notified of a qualifying event.

Payment of the required premium must be made on the following basis:

- All payments must be made by check, cashier's check, or money order.
- The initial payment should be received by the Administrative Office no later than the 20th day of the month prior to the month for which you or your Dependent desires coverage to avoid possible delays in claim payment and eligibility problems. However, this initial payment will be accepted up to 45 days from the participant's election date. The initial payment must cover the number of months from the date coverage would otherwise have terminated, including the month in which the initial payment is made.
- After the initial payment is made, payments must be made monthly to continue coverage. Monthly payments should be mailed by the 20th day of the month preceding each coverage month to avoid possible delays in claim payments and eligibility problems.

Any shortage in COBRA premium payments must be made up within 31 days. Coverage will be conditional until payment is received. **Failure to make a monthly payment within 30 days of the beginning of the coverage month will result in termination of coverage at the end of the month for which payment was last made.**

Frequently Asked Questions

Q Will I get a monthly bill for my COBRA coverage?

A No, the Administrative Office will not send monthly bills or warning notices. It is the responsibility of the qualified participant to submit payments when due.

Q Can I choose to continue medical but drop my other health care benefits?

A No, your health care benefits are treated as a package. You may either continue all of the health care benefits you had at the time of the qualifying event or choose to let all such benefits end.

Q Can I change from one medical plan to another or from one dental plan to another?

A When you initially elect COBRA, you must remain in the plans you are in at the time (unless you move out of an HMO's or prepaid plan's service area). You may choose a different medical and/or dental plan during Open Enrollment in November, with the change effective for coverage starting the following January 1.

Termination of COBRA Continuation Coverage

Continuation coverage will terminate when the end of the maximum period, as described previously, has been reached. However, continuation coverage will terminate earlier than that date for any of the following reasons:

- your employer withdraws from the Trust (In such a case you may have the opportunity for coverage under other group health plans sponsored by your employer. If your employer does not offer coverage for any of its employees, you may remain under COBRA despite your employer's withdrawal.);
- you or your Dependent fails to pay a premium for COBRA continuation coverage on time;
- the person receiving the coverage obtains coverage under another group health plan as an employee, spouse, or Dependent of an employee (unless the group health plan contains a provision that would limit coverage for a pre-existing condition of that person, in which case COBRA continuation coverage will not cease until the date the condition is covered under the new plan or the end of the maximum time allowed under COBRA coverage is reached, whichever occurs first); Note: Pre-existing conditions limitations are no longer permitted for individuals under age 19.
- the Social Security Administration determines that an individual on extended disability coverage is no longer disabled *(this applies only to the 19th through 29th month of disability extended coverage)*.

At the end of the 18-, 29- or 36-month continuation coverage period, you and your dependents will be allowed to convert to an individual insurance policy if that is provided under your coverage at that time. The conversion option, if any, will not apply if COBRA continuation coverage terminates before the end of the applicable 18-, 29- or 36-month period. In addition if you have an 18-month qualifying event and you are enrolled in an insured medical plan in California, you may apply for additional 18-months. (See below)

If you have any questions, please contact the Administrative Office. Also, if the qualified beneficiary changes marital status or adds new dependents, the Administrative Office should be notified.

Post-COBRA Coverage Under an HMO

If you are an HMO participant under the Plan living in California, you may have the right to continue COBRA-like coverage under State law, beyond the limited time periods described above. Check the HMO plan's benefit booklet or call Member Services at the HMO for more information on your rights and how to elect post-COBRA extended coverage under California law. This coverage is not provided by the Los Angeles Machinist Benefit Trust.

State law may also provide you with other or additional rights to receive or elect to receive benefits upon the termination of Plan coverage or COBRA coverage. Such benefits would not be provided by the Los Angeles Machinist Benefit Trust. Check with your HMO or contact the insurance commissioner or appropriate State government office.

Conversion to Individual Coverage (Applicable Only to HMO Participants)

Under certain circumstances, employees and eligible family members whose coverage through an HMO ends are allowed to purchase individual conversion coverage through their HMO without evidence of insurability. Individuals must apply for conversion coverage and pay the premium within 31 days of the loss of their coverage.

To take advantage of this provision, you must remain in the HMO plan.

For more information, contact your HMO.

Keep the Plan Informed of Address Changes

To protect your family's rights, you should keep the Administrative Office informed of any changes in the addresses of family members.

Certificate of Creditable Coverage

When your coverage terminates, you will receive a "Certificate of Coverage." The Certificate provides information regarding the period of coverage (including COBRA) under this Plan. This information may be used to reduce or eliminate a pre-existing condition limit period under a new group health plan covering you (provided the break between this coverage and the new coverage is less than 63 days). Note: Pre-existing condition limitations are no longer permitted for individuals under age 19.

You may request a copy of the Certificate at any time within 24 months after your coverage terminates.

If a Dependent loses eligibility separately from you and the Administrative Office is notified that the Dependent is no longer an eligible Dependent, a separate Certificate will be provided for that Dependent. This Certificate may also be requested within 24 months after the dependent's coverage has been terminated.

Section 4: Fee-for-Service ("Indemnity") Medical Plan Benefits

In this Section you'll find:

- How the plans work
- Deductible
- Calendar Year maximum
- PPO Contracting Providers
- Pre-authorization requirements
- Special provisions regarding women's health care
- Emergencies
- Covered expenses
- Exclusions from coverage
- Information on filing claims

This Section applies to you, if you elect enrollment in an indemnity medical plan instead of one of the HMO options.

(If you are enrolled in an HMO, see the materials from the HMO for information about your medical benefits.)

This Section provides general information about the Indemnity Medical Plans. See the current year's "Medical Comparison" for details on coverage for specific benefits as well as a side-by-side comparison of benefits under the Indemnity Medical Plan and benefits under your HMO options.

Exclusion of Payment of HMO Charges Under the Indemnity Plan

If you are enrolled in an HMO, you will not be reimbursed by the Fund's indemnity plan for co-pays or non-covered items and services you incur under your HMO plan. All services and supplies that you receive are payable only under the plan that you are enrolled in.

How the Plans Work

The indemnity plans are traditional fee-for-service plans. They generally work as follows: once you have met the deductible for the year (if applicable), you and the Plan each pay a percentage of the covered expenses. Your share is called your "co-pay" or "co-insurance." See the current year's Medical Comparison for the co-pays applicable to various services and supplies.

Under some plans, once your covered expenses for the year for an individual reach a certain dollar amount, the plan will pay 100% of allowable charges for that individual for the rest of the year, provided you use PPO providers (see "PPO Contracting Providers" on the next page). Check your Medical Comparison to find out whether such an "annual covered charges limit" (also called an "out-of-pocket maximum") applies to you. NOTE: Some services and supplies may be excluded from the co-pay limit feature.

Payment of benefits is subject to limits on specific services and supplies and to an overall Calendar Year Plan maximum.

Deductible

"Deductible" means the amount of covered expenses you must pay each year before the Plan starts paying benefits. The amount of your deductible, if any, is shown on your Medical Comparison.

Under this plan, the deductible applies for you and for each covered member of your family, with a maximum of three deductibles per Calendar Year per family.

Covered expenses applied toward the deductible in the last 90 days of a Calendar Year will be applied toward the deductible for the next Calendar Year.

Calendar Year Maximum

The maximum amount of benefits payable for any covered family member in any Calendar Year is shown in your Medical Comparison. Lifetime maximums were eliminated January 1, 2011.

PPO Contracting Providers

All Indemnity Medical Plans contain a Preferred Provider Organization (PPO) option. This means that the Trust Fund has contracted with a PPO network of various professionals (hospitals, Doctors, laboratories, etc.) to provide care to its members at reduced costs. By using the network providers, you save yourself and the Trust money.

At the time this booklet was printed, the PPO network for the Indemnity Medical Plans was being administered by Blue Cross.

You will be given a listing of Contracting Providers, and it will be updated from time to time. To get an updated listing, free of charge, call the Administrative Office. You can also get listings of network providers at the following website:

www.bluecrossca.com

Always remember to check with the provider before you receive services to make certain the provider is still under contract. Also, when being referred, remember to request a PPO Contracting Provider.

All Indemnity Medical Plans require that you use PPO Contracting Providers if you wish to receive the maximum benefits payable.

Payments to Non-PPO Providers

Check your Medical Comparison to see how the Plan pays benefits if you use Non-PPO Providers:

- If it shows a co-pay percentage that you pay, you will have to pay that percentage of allowable charges plus any charges that exceed the allowable amount. The Fund's payment is based upon a percentage of allowable charges for covered expenses.
- If it shows a percentage amount "per UCR," benefit payments to Non-PPO Providers will be based on the 90th percentile of usual, customary, and Reasonable (UCR) allowable provided by the Health Insurance Association of America (HIAA)..

  The HIAA data and fee schedule of allowances will be updated every six months. The updated index will allow for reimbursements to be automatically adjusted as medical costs increase with inflation.

If this applies to you, the payment of benefits when you use Non-PPO Providers will be based on the HIAA's schedule of allowable charges.

If your Doctor proposes that you be admitted to a hospital, you must comply with the Plan's requirements for pre-authorization if you want to obtain the maximum benefits available.

Have your Doctor call Blue Cross at the following number: 800-274-7767. If your Doctor thinks the request for pre-authorization needs expedited handling (see the definition of "Urgent Care Claims" under "Types of Claims" in "Claims Review Procedures" in Section 15), your Doctor should make sure the representative who takes the call is advised of this.

If you are hospitalized in an Emergency, you or someone acting on your behalf must call Blue Cross at 800-274-7767 within 24 hours of admission to request a review of the admission.

Note: Emergency admissions do not require Pre-authorization.

If you do not comply with these requirements regarding hospital admissions, your benefit payments will be reduced by 15%.

Exception for Childbirth Days

The requirement for pre-authorization or review does not apply to the following hospital stays for a mother or newborn following childbirth: a stay of up to 48 hours following a vaginal delivery or a stay of up to 96 hours following a delivery by cesarean section. See "Special Provisions Regarding Women's Health Care" later in this Section for more information.

Intent of Required Pre-Authorizations

Required pre-authorizations are intended to control your costs, for example, by preventing unnecessary hospitalization or hospital stays that extend beyond the time it is medically safe to discharge a patient. You should note, however, that:

- Neither the Plan nor Blue Cross is responsible for either the quality of health care services actually provided or for the results if a participant chooses not to receive health care services that are denied pre-authorization.
- All treatment decisions rest with you and your Doctor. You should follow whatever course of treatment you and your Doctor believe to be the most appropriate. (Benefits payable by the Plan may, however, be affected by the pre-authorization requirements.)
- The pre-authorization requirements are not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. Pre-authorization does not necessarily mean benefits will be paid. For example, benefits would not be payable

if your eligibility for coverage ended before the services were rendered or the maximum benefit had already been paid when you received the services.

If your hospital stay is denied by pre-authorization, you may still proceed with the admission or procedure. Be aware, however, that the Plan pays benefits only for services or supplies that are deemed to be Medically Necessary.

You may also appeal an adverse decision on a hospital stay. See "Claims Review Procedures" in Section 15 for more information.

If You Have Coverage Elsewhere

If you or your Dependents have medical coverage elsewhere, you should be aware that coverage provided under the benefits described in this booklet will be coordinated with that other coverage and that you cannot receive duplicate benefit payments or use dual coverage to get reimbursed for more than 100% of your expenses. See "Coordination of Benefits" in Section 15 for more information.

Special Provisions Regarding Women's Health Care

The Plan complies with Federal laws that guarantee certain rights to women:

- Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (for example, the Doctor), after consultation with the mother, discharges the mother or newborn earlier.

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

  In addition, a plan or issuer may not, under Federal law, require that a Doctor or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

- Under the Women's Health and Cancer Rights Act of 1998, all plans that cover mastectomies, such as the Indemnity Medical Plans**,** are also required to cover related reconstructive surgery. Available reconstructive surgery must include both reconstruction of the breast on which surgery was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. Coverage must also be available for breast prostheses and for the physical complications of mastectomy, including lymphedemas. These services are elective and are chosen by the patient in consultation with the attending physician. They are subject to the Plan's usual deductible and co-pay provisions.

Emergencies

In a medical Emergency, you should seek necessary treatment immediately.

Benefits for Emergency services are paid the same as benefits for other services. Remember, however, that you are required to call Blue Cross to report an Emergency hospitalization within 24 hours of admission if you want to avoid having your benefit payment reduced by 15%.

Covered Expenses

"Covered expenses" means the medical expenses incurred by you and your family for which medical expense benefits may be payable.

Charges for the following services and supplies will be considered covered expenses, provided the attending physician certifies they are necessary for treatment. See your Schedule of Benefits and your Medical Comparison for information on what share of covered expenses will be your responsibility (your co-pay) as well as limits on specific benefits.

Allowable Charges

The amount of billed charges that will be considered covered expenses will never be more than the "allowable charges." For PPO providers, allowable charges are the negotiated rates. For Non-PPO Providers, allowable charges are based on the 90th percentile of usual, customary, and Reasonable (UCR) fee schedule maintained by the Health Insurance Association (HIAA).

You will be responsible for payment of any amounts that exceed allowable charges. Non-PPO providers are under no obligation to limit their charges to amounts considered allowable charges under the Plan.

Hospital Care

NOTE: To avoid a reduction in benefits, you must comply with the Plan's requirements regarding pre-authorization of hospital stays. See "Pre-Authorization Requirements" earlier in this Section for more information.

Allowable charges for inpatient care will be limited to the following:

- For room and board: the hospital's most common charge for a semi-private room, after the deductible, if any, is satisfied
- For intensive care: up to two times the hospital's most common charge for a semi-private room

Covered Services and Supplies

Covered services and supplies include:

- Room and board and use of the intensive care unit, subject to the limits immediately above
- Use of operating and cystopic rooms
- Surgical and anesthetic supplies and anesthesia when supplied by the hospital as a regular service and administered by an employee wholly compensated by a fixed salary

- Casts, splints, and dressings
- Oxygen and all Drugs and medications listed and accepted in the "United States Pharmacopeia," "National Formulary," or "New and Non-Official Remedies" at the time they are prescribed and used during the furnishing of hospital care
- Take-home Drugs furnished by the hospital pharmacy
- Administration of blood plasma, but not including the cost of blood or blood plasma
- Laboratory and X-ray examinations, electrocardiograms, basal metabolism tests, physiotherapy, and hydrotherapy
- Fees of a roentgenologist for X-ray examinations, including therapy
- Fees of a pathologist for all ordinary clinical and pathological laboratory services
- Treatment you receive at a hospital on an outpatient basis

Skilled Nursing Care Facility

For benefits to be payable for a skilled nursing care facility's charges, you or your Dependent must have been confined in an acute care hospital for at least 5 consecutive days and then been transferred to a skilled nursing care facility for additional treatment or rehabilitation within 7 days of release from the hospital.

Surgical Benefit

When more than one surgical procedure is performed at the same time, specific rules of payment will apply. For example, full payment may be made only for the first procedure.

If your surgery requires the services of an assistant surgeon, the Plan will pay for such services up to 20% of the amount payable to the primary surgeon.

If Your Medical Comparison Mentions UCR for Non-PPO Providers

If your Medical Comparison shows a percentage amount "per UCR," benefit payments to Non-PPO Providers will be based on the 90th percentile of usual, customary, and Reasonable (UCR) allowable provided by the Health Insurance Association of America (HIAA).

Anesthesia Benefit

The full benefit available will be paid when an anesthetic is administered to you during surgery by a licensed physician or by someone other than the surgeon or assistant surgeon.

If anesthesia is administered by an operating surgeon or an assistant surgeon, the maximum amount payable will be 50% of the anesthesia benefit.

If Your Medical Comparison Mentions UCR for Non-PPO Providers

If your Medical Comparison shows a percentage amount "per UCR," benefit payments to Non-PPO Providers will be based on the 90th percentile of usual, customary, and Reasonable (UCR) allowable provided by the Health Insurance Association of America (HIAA).

Doctor Visit Benefit

Benefits are payable for the covered expenses of office visits or visits a Doctor makes to you in your home or the hospital.

If Your Medical Comparison Mentions UCR for Non-PPO Providers

If your Medical Comparison shows a percentage amount "per UCR," benefit payments to Non-PPO Providers will be based on the 90th percentile of usual, customary, and Reasonable (UCR) allowable provided by the Health Insurance Association of America (HIAA).

Diagnostic X-Ray and Laboratory Benefit

Only those charges made for diagnostic purposes due to an injury or illness will be considered covered expenses for diagnostic X-ray and laboratory services.

If Your Medical Comparison Mentions UCR Units for Non-PPO Providers

If your Medical Comparison shows a percentage amount "per UCR," benefit payments to Non-PPO Providers will be based on the 90th percentile of usual, customary, and reasonable (UCR) allowable provided by the Health Insurance Association of America (HIAA).

Wellness Benefits

Wellness benefits are negotiated under each bargaining unit agreement, and if negotiated, routine services covered through the Plan's annual wellness benefits, include:

- Routine physical examination
- OBGYN examination
- Pap smear
- Mammogram
- Routine lab tests
- Immunizations
- Routine hearing exam
- Routine colonoscopy

- Routine bone density test

The method of payment for wellness benefits is shown in the Schedule of Benefits. Refer to your Schedule of Benefits to see if wellness benefits have been negotiated for you.

Miscellaneous Services and Supplies

Other services and supplies for which benefits are payable include the following:

- Artificial limbs or eyes (excluding their replacement), casts, splints, trusses, or braces
- Rental of crutches or a wheelchair, hospital-type bed, iron lung, or other durable equipment used exclusively for treatment of injury or sickness, up to the Reasonable purchase price
- Services of a laboratory technician
- Outpatient treatment in connection with the following therapies, including acupuncture services : is covered up to the number of visits shown in the Schedule of Benefits:
  - Physical therapy
  - Speech therapy
  - Rehabilitation therapy
  - Respiratory therapy
  - Therapy that involves manual manipulation of the musculoskeletal system
  - Vision therapy
- Services of a Registered Nurse, provided the services rendered require the skill or training of a Registered Nurse, and services of a Licensed Vocational Nurse when ordered by a Doctor
- Use of X-ray, radium, or other radioactive substances
- Oxygen and rental of equipment for administration of oxygen
- Electronic heart pacemaker
- Orthopedic appliances, braces, and shoes that are an integral part of a leg brace when prescribed by a physician
- Local professional ambulance service to and from the nearest hospital when Medically Necessary where care and treatment of the injury or sickness can be given, provided such service is not solely for the convenience of the patient or for those responsible for the patient's care

Exclusions from Coverage

Exclusions

No medical expense benefits will be payable for the following, unless mandated by law:

- Any operation or treatment in connection with the fitting or wearing of dentures, the treatment of periodontal or periapical disease, any condition involving the surrounding tissue or structure, or any operation or treatment in connection with "Temporomandibular Joint Syndrome" (TMJ) (*Dental benefits are covered under a separate program—see Section 8*)

- Expense incurred for (1) dental X-rays; (2) treatment of the teeth; (3) treatment of the gums other than for tumors; (4) treatment of other associated structures primarily in connection with treatment or replacement of teeth; or (5) hospital charges incurred in connection with any dental treatment (*Dental benefits are covered under a separate program—see Section 8*)
- Any operation performed for cosmetic purposes, unless the operation is performed as a result of an accidental injury or it is for reconstructive surgery following a mastectomy
- Elective sterilization for a Dependent child (benefits for elective sterilization are provided only for you and your eligible spouse)
- Voluntary or elective abortions, except if the life of the mother is endangered and the attending physician verifies that the condition is life-threatening
- In vitro fertilization or any type of artificial insemination, any sex change counseling, treatment or surgery, ultra sound for ovulation, penile prostheses not Medically Necessary, or expenses incurred for reconstruction procedures or treatment to reverse prior sterilization procedures (unless Medically Necessary)
- Ultrasound, thermography, and amniocentesis when such tests are performed solely to determine the age of a fetus
- Any service in connection with a pregnancy of a Dependent child
- Routine well-baby care, except when negotiated as part of your plan of benefits
- Any charge for routine examinations, laboratory tests, analysis, X-rays, or supplies for purposes not related to the treatment of an illness or injury except when negotiated as part of your plan of benefits
- Routine eye examination related to the correction of refractive errors or eyeglasses (*Vision care benefits are covered under a separate program—see Section 9*)
- Radial keratotomy or any type of eye surgery to correct a refractive error
- Treatment or services not considered Medically Necessary or that are considered Experimental or not usual treatment
- Charges made for any laboratory test or other diagnostic medical procedures that are considered Experimental or not generally accepted by the professional medical community
- Services of a Registered Nurse who is a resident of the same household as the patient or related to the patient by blood, marriage, or legal adoption
- Hearing aids or related occupational therapy
- Orthotic inserts, arch supports, and plaster casting for impressions
- Treatment of exogenous obesity or stomach stapling or bypass
- Immunizations and vaccinations, unless negotiated as part of your plan of benefits
- Drugs administered in a Doctor's office, over-the-counter Drugs, birth control pills, or any other Drugs (*Prescription Drug benefits are covered under a separate program—see Section 5*)
- Vitamins or mineral supplements, even if recommended by your physician
- Disposable medical supplies that do not require a prescription

- Charges made in connection with Hospice care in excess of 30 visits per Calendar Year
- Any medical services and supplies provided under any governmental program—national, state, provincial, county, or municipal—unless payment is mandated by law
- Expenses in connection with marriage counseling and charges incurred for the assessment, diagnosis, prognosis, counseling, or psychotherapeutic treatment of family and child dysfunction, or other mental or nervous conditions (*Mental health benefits are covered under a separate program—see Section 7*)
- Expenses incurred in connection with the treatment of alcoholism or drug addiction or other treatment for substance abuse (*Substance abuse benefits are covered under a separate program—see Section 7*)
- Charges for services or supplies paid for under any other benefit provided under this Plan
- Charges for services or supplies not expressly stated as covered

NOTE: The Blue Cross PPO Prudent Buyer Plan covers charges for medical services covered by the Prudent Buyer Benefit Agreement which excludes co-payments, coinsurance and Deductible Amounts required by the plan. Charges that are NOT MEDICALLY NECESSARY are also excluded as are any charges not covered by the agreement. Participants should not agree in writing to pay for services not covered by the Plan or services not Medically Necessary. You may contact Blue Cross or the administrator, Zenith American Solutions, if you have any questions as to what is covered under the Plan.

Participants should be very careful about what they agree to pay for in advance and in writing, and if they feel afterward that they are being charged for anything they did not agree to cover in advance and in writing, they should follow up with Blue Cross and if necessary Zenith American Solutions. Participants should also be sure to keep copies of anything they sign, for future use.

How to File a Claim for Indemnity Medical Benefits

NOTE: The discussion below applies to "post-service claims"—claims you submit after you have received a service. The following are also considered claims: requests for required pre-authorization of Hospital admissions and concurrent review of Hospital stays. See "Pre-Authorization Requirements" earlier in this Section and "Claims Review Procedures" in Section 15 for more information.

Hospital Claims

If you are admitted to a Hospital, show your Blue Cross identification card to the admitting office and tell the admitting office that the claim must be submitted directly to Blue Cross electronically.

NOTE: You should submit your claim within 90 days from the date of service. Claims will be considered for payment only if they are submitted within 1 year of the date the charges were incurred.

Other Claims

Your health care providers should have standard claim forms that can be used for submitting claims.

If you use a participating provider, show your Blue Cross identification card. The provider will usually file the claim for you.

If you use a non-participating provider, you will usually need to file a claim yourself. Check the claim form to be certain that all applicable portions of the form are completed and that the following information is included:

- your name and ID number
- the patient's name, date of birth, and relationship to you
- the date of service
- the CPT-4 codes—the codes for physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition*, as maintained and distributed by the American Medical Association or HCPC code
- the ICD-9 codes—the diagnosis codes found in the *International Classification of Diseases, 9th Edition, Clinical Modification*, as maintained and distributed by the U.S. Department of Health and Human Services
- the billed charges (bills must be itemized with all dates of physician visits shown)
- the number of units (for anesthesia and certain other claims)
- the Federal taxpayer identification number (TIN) of the provider
- the provider's billing name, address, telephone number, and professional degree or license
- the provider's signature
- if treatment is due to an Accident, Accident details
- information on other insurance coverage, if any, including coverage that may be available to your spouse through his or her employer

Your completed claim should be mailed to the Fund at the following address:

LOS ANGELES MACHINIST BENEFIT TRUST
1325 N. Grand Ave, Suite 200
Covina, CA 91724

Deadline for Submission

You should submit your claim **within 90 days** from the date of service. Claims will be considered for payment only if they are submitted within 1 year of the date the charges were incurred.

Questions?

If you have any questions about submitting your claim, contact the Administrative Office.

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims Review Procedures" in Section 15, "Other Important Plan Information."

Section 5: Prescription Drug Benefits for Indemnity Medical Plan Participants

In this Section you'll find:

- How the benefits work
- What pharmacies you can use
- What is covered
- Limits and exclusions
- Information on filing claims

This Section applies to You, if you have enrolled in an Indemnity Medical Plan instead of one of the HMO options.

(If you are enrolled in an HMO, see the materials from the HMO for information about your Prescription Drug benefits.)

How the Benefits Work

If you are enrolled in an Indemnity Medical Plan, your Prescription Drug benefits are administered by a Pharmacy Benefits Manage (PBM), currently ProCare Rx.

You will receive an identification card that you can take to participating walk-in pharmacies. The walk-in pharmacy service is intended for medications you need on a short-term basis.

The program also includes a mail-order service for maintenance medications (those you take for more than 30 days). When you use the mail-order service, you receive up to a 60-day supply for the same price you would pay for a 30-day supply at a walk-in pharmacy. Use of the mail-order service may be mandatory under your plan. If it is, you will be allowed up to three 30-day supplies of any new maintenance Drug through walk-in service before you are required to change to the mail-order service; this will allow you to make certain the Drug is appropriate for your medical needs.

When filling a prescription, you pay a co-pay. The co-pays applicable to you depend on what plan has been negotiated for you. Two plans are possible, as shown in the following chart:

The Two Prescription Drug Plans *(See your Schedule of Benefits to see which of these plans has been negotiated for you)*		
	Walk-In Pharmacies	**Mail-Order Service**
High Option Plan	• Generic: You pay $2 for up to a 30-day supply. • Brand-name Drug*: You pay $2 for up to a 30-day supply. Brand-name Drugs are not covered except when medically indicated or when a generic version is unavailable.	• Generic: You pay $2 for up to a 60-day supply. • Brand-name Drug*: You pay $2 for up to a 60-day supply. Brand-name Drugs are not covered except when medically indicated or when a generic version is unavailable. Use of the mail-order service is not mandatory under the High Plan.
Low Option Plan	• Generic: You pay $10 for up to a 30-day supply. • Brand-name Drug*: You pay $30 for up to a 30-day supply. Brand-name Drugs are not covered except when medically indicated or when a generic version is unavailable.	• Generic: You pay $10 for up to a 60-day supply. • Brand-name Drug*: You pay $30 for up to a 60-day supply. Brand-name Drugs are not covered except when medically indicated or when a generic version is unavailable. ***Use of the mail-order service is mandatory under the Low Plan for maintenance medication.*** Maintenance medications are those medications that are used to treat common indication for the treatment of a Chronic disease state such as diabetes, asthma, cholesterol medications, etc.
* You pay the full difference in cost between the generic and brand-name Drug if not Medically Necessary.		

What Pharmacies You Can Use

Walk-In Service

To locate the Contracting Pharmacy nearest you, check your Prescription Drug program brochure. You may also call the following number:

Customer Service Center: 800-699-3542

Mail-Order Service

For mail-order service, you must use the ProCare Rx mail service pharmacy. Call the Customer Service Center at 800-662-0586 for more information.

What Is Covered

The Prescription Drug plan covers the following:

- All Federal Legend Drugs, including new Drugs approved by the Federal Food and Drug Administration
- Insulin, insulin syringes and needles, and the following diabetic supplies:
  - Glucose strips
  - Glucose device control solution
  - Lancets
  - Alcohol swabs
  - Urine test strips
- Compound medications if at least one ingredient requires the Federal Legend
- Smoking deterrents

Exclusions

The following exclusions apply to all Prescription Drug benefits.

Exclusions

Prescription Drug benefits will not be paid for the following:

- Any injectable products (except insulin)
- Over-the-counter Drugs
- Investigational or Experimental Drugs
- Therapeutic devices
- Anorexiants

- Immunization agents
- Syringes (except those for insulin)
- Cosmetic agents such as but not limited to Rogaine, Retin A, etc. (over 26 years old)
- Drugs for erectile dysfunction, including but not limited to Viagra, Cialis and Levitra
- Charges for services or supplies not expressly stated as covered

How to File a Claim for Prescription Drug Benefits

There is no need to file a claim for Prescription Drug benefits. You pay the applicable co-pay each time you fill or refill a prescription at a participating pharmacy, and the Plan pays the remainder of the cost.

NOTE: Contact ProCare Rx's customer service at 800-699-3542 to locate the Contracting Pharmacy nearest you.

Section 6: Employee Assistance Program (EAP)

This booklet provides only brief information about the EAP. For more details, see the separate EAP brochure that is given to all employees.

The Employee Assistance Program is available to all eligible employees and their Dependents, regardless of what medical plan they are in.

The Program

The Trust Fund has contracted with MHN to provide Employee Assistance Program benefits to covered individuals when they are faced with personal problems.

You may reach MHN at the following number:

800-327-7701

When you contact MHN, the representative who takes your call will determine what type of help you need and where it can be obtained:

- If you are enrolled in a Kaiser medical plan, MHN will assist you in obtaining access to the appropriate care.
- If you are enrolled in any other medical plan, if required and appropriate, MHN will assist you in accessing care through the program (see Section 7).
- If services are not available through your medical plan, MHN can direct and assist with referral to an outside agency.

In order to receive any mental health or substance abuse benefits under the Trust Fund, you must use the services of MHN or Kaiser.

How to File a Claim

MHN will not charge you for its services, so there is no need to file a claim for EAP benefits.

You may incur charges if you use the services of the providers MHN helps you access; any claims for those charges should be submitted according to the provisions of the plan covering the services of those providers.

Section 7: Benefits for Mental Health and Substance Abuse Treatment

In this Section you'll find:

- What's in the program
- Pre-authorization requirements
- How to use MHN
- The providers you may use
- Exclusions from coverage
- Information on filing claims

This section applies to you if you're enrolled in an Indemnity Medical Plan or an HMO plan other than Kaiser.

(If you're enrolled in a Kaiser HMO plan, your mental health and substance abuse benefits will be provided under that plan and you should see the materials from Kaiser for information.)

The Program

A mental health and substance abuse plan for you and your Dependents is available through MHN.

With the MHN plan, you and your Dependents will be eligible to receive quality inpatient and outpatient mental health care and substance abuse rehabilitation at a Reasonable cost from a wide selection of exclusive providers within your community.

The schedule of benefits for mental health and substance abuse is shown in the chart on the next page.

Frequently Asked Questions

Q Can I get mental health and substance abuse benefits through the medical plan?

A No. To receive benefits for mental health or substance abuse treatment, non-Kaiser participants must use the Employee Assistance Program's MHN services (see Section 6) or the program described in this Section—no mental health or substance abuse benefits will be paid under any other Trust Fund program.

Mental Health and Substance Abuse Benefits	
Maximum lifetime benefit per person	Unlimited
Mental Health	
Inpatient, residential, and day treatment*—up to 45 days per Calendar Year:	
• **First treatment episode**	For days 1 – 14: No charge For days 15 – 45: You pay 25% co-pay
• **Subsequent treatment episodes within 12 months of start of first treatment episode**	*(To the extent allowed by the limit on covered days)* For days 1 – 14: You pay 10% co-pay For days 15 – 45: You pay 25% co-pay
Outpatient treatment—up to 20 days per Calendar Year	For private sessions: You pay $10 per visit For group therapy: You pay $5 per visit
Substance Abuse (also called "Chemical Dependency")	
Inpatient, residential, and day treatment*	Plan pays 100% for an unlimited number of days per year
Outpatient treatment	Plan pays 100% for an unlimited number of visits per year (as clinically appropriate under the Plan's guidelines for medical necessity)
Penalty if you leave your treatment program before the Case Manager has authorized your discharge or transfer	The Plan will pay 70% instead of 100%

* "Residential" treatment means you stay at the facility and participate in treatment programs but do not receive medical treatment such as medications. "Day" treatment means you receive the type of inpatient mental health or substance abuse care provided at a Hospital or other facility during the day but spend the night elsewhere, usually at home.

One residential treatment day counts as 7/10 of a full inpatient day, and one day treatment day counts as 6/10 of a full inpatient day.

If You Have Coverage Elsewhere

Please inform MHN if you or your Dependents have behavioral health care coverage elsewhere. The MHN services and benefits described in this Section will be coordinated with those of the other coverage to avoid duplicate payment or overpayment. If MHN pays more benefits than appropriate, it will have the right to recover the excess benefit payments.

How to Use MHN

If you need to use the MHN plan, you may first call MHN (see Section 6) or you may follow the steps below:

1. Call MHN toll-free at 800-327-7701.
2. Tell the phone counselor you are covered under the Los Angeles Machinist Benefit Trust and provide your (the eligible employee's) name and Social Security number. Explain the problem you have, and MHN will help determine the type of treatment needed.

   If substance abuse or psychiatric disorder services are Medically Necessary, you or your Dependent will be referred to an appropriate Contracting Provider—Doctor, Hospital, or treatment center—within your community.
3. Call the Contracting Provider's office to make an appointment.

   MHN will contact the practitioner or facility regarding the initial authorized behavioral health treatment program. After your first visit, your MHN participating provider will get approval for any additional services you need that are covered under the plan.

If you are in an **Emergency situation**, pre-authorization for inpatient treatment is not necessary; however, MHN must be contacted within 48 hours of an Emergency admission (or as soon as is reasonably possible after your condition is stable). See "Inpatient, Residential, and Day Treatment" under "The Providers You May Use" on the following page for the definition of an Emergency.

Time Frames for Response

Decisions on pre-authorization will normally be made within 5 business days. If you think your condition poses an imminent and serious threat to your health and your case needs expedited handling, please be sure to advise the phone counselor.

See your "Combined Evidence of Coverage & Disclosure Form" from MHN for more information, including an explanation of how to appeal a denial of treatment authorization.

Pre-Authorization Requirements

All services described in this Section must be pre-authorized by MHN (except in an Emergency). See "How to Use MHN" below for information on how to obtain pre-authorization.

If you don't get the necessary pre-authorization, you will be responsible for all charges for the services you receive.

The Providers You May Use

Inpatient, Residential, and Day Treatment

In **non-Emergency** situations, you **must** use MHN contracting facilities and providers.

Treatment received in a facility that does not contract with MHN may be covered at the same payment rate as treatment received in a contracting facility if such treatment is received on an Emergency basis.

An "Emergency" is a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson would expect that the absence of immediate behavioral health services could result in any of the following:

- immediate harm to yourself and others,
- placing your health in serious jeopardy,
- serious impairment of your functioning, or
- serious dysfunction of any bodily organ or part.

If the admission does not meet those "Emergency" criteria, you will be responsible for charges made by the non-contracting facility.

MHN must be notified that you are in a non-contracting facility within 48 hours of the admission (or as soon as reasonably possible after your condition is stable).

Emergency services are covered only as long as the condition continues to be an Emergency—once the condition is under control and you can be safely transferred or discharged, additional charges incurred through the Emergency facility will not be covered. MHN reserves the right to transfer you to a participating Hospital, as long as the move would not harm your health.

The following will also be considered an Emergency: you experience a situation requiring behavioral health services while you are temporarily outside of California, and a delay in treatment from a MHN Contracting Provider in California would result in a serious deterioration to your health.

NOTE: For outpatient counseling services, you must go to a MHN Contracting Provider. MHN will work with you to find a provider who is conveniently located and well-suited to your needs.

Outpatient Care

For outpatient counseling services, you **must** go to a MHN Contracting Provider. MHN will work with you to find a provider who is conveniently located and well-suited to your needs.

Exclusions from Coverage

No payment will be made under mental health and substance abuse benefits for any of the following:

- Any confinement, treatment, service, or supply not authorized by MHN , except in the event of an Emergency
- Services received before the start date of your coverage, after the time coverage ends, or at any time you are ineligible for coverage
- Services or treatments that, in the judgment of MHN , are not Medically Necessary
- Any confinement, treatment, service, or supply that is provided under Workers' Compensation law or similar laws

- Any confinement, treatment, service, or supply obtained through or required by a governmental agency or program
- Treatment for a reading disorder, mental retardation, a motor skills disorder, or a communication disorder
- Treatments that do not meet national standards for mental health professional practice
- Non-organic therapies, including, but not limited to, the following: bioenergetics therapy, confrontation therapy, crystal healing therapy, educational remediation, EMDR, guided imagery, marathon therapy, primal therapy, Rolfing, sensitivity training, transcendental meditation, Lovaas' Discrete Trial Training, Facilitated Communication, and EEG biofeedback (neurofeedback)
- Organic therapies, including, but not limited to, the following: aversion therapy, carbon dioxide therapy, environmental ecological treatment or remedies, herbal therapies, hemodialysis for schizophrenia, vitamin or orthomolecular therapy, and rapid anesthesia opiate detoxification
- Treatments designed to regress you emotionally or behaviorally
- Personal enhancement or self-actualization therapy and other similar treatments
- Routine, custodial, and convalescent care, long-term therapy, and/or rehabilitation (*Individuals should be referred to appropriate community resources such as school district or regional center for such services*)
- Any services provided by non-licensed providers
- Pastoral or spiritual counseling
- Dance, poetry, music, or art therapy, except as part of a behavioral health treatment program
- Thought field therapy
- School counseling and support services, home-based behavioral management, household management training, peer support services, recreation, tutor and mentor services, independent living services, supported work environments, job training and placement services, therapeutic foster care, wraparound services, Emergency aid to household items and expenses, services to improve economic stability, and interpretation services
- Genetic counseling
- Community care facilities that provide 24-hour non-medical residential care
- Weight control programs and treatment for addictions to tobacco, nicotine, or food
- Counseling for adoption, custody, family planning, or pregnancy in the absence of a DSM-IV diagnosis
- Counseling associated with or in preparation for a sex change operation
- Sexual therapy programs, including therapy for sexual addiction, the use of sexual surrogates, and sexual treatment for sexual offenders/perpetrators of sexual violence
- Private room and/or private duty nursing unless MHN determines that they are Medically Necessary

- All non-prescription and Prescription Drugs not prescribed by a MHN provider as part of your inpatient treatment at a MHN contracting facility and all non-prescription and Prescription Drugs that are prescribed during outpatient treatment
- Surgery or acupuncture
- Services that are required by a court order as a part of parole or probation, or instead of incarceration, that are not Medically Necessary
- Neurological services and tests, including, but not limited to, EEGs, Pet scans, beam scans, MRIs, skull X-rays, and lumbar punctures
- Treatment sessions by telephone or computer Internet services
- Evaluation or treatment for education, professional training, employment investigations, fitness for duty evaluations, or career counseling
- Charges for services or supplies not expressly stated as covered

How to File a Claim for Mental Health or Substance Abuse Benefits

NOTE: The discussion below applies to "post-service claims"—claims submitted after you have received a service. The following are also considered claims: requests for pre-authorization from MHN and the decisions made by MHN in its review of stays in non-contracting Hospitals after Emergency admissions. See your "Combined Evidence of Coverage & Disclosure Form" from MHN for more information about those types of claims.

Pre-Authorized Services

You will not need to file claims for pre-authorized services. When MHN sends you to a Contracting Provider, you pay the applicable co-pay, and the Plan pays the remainder of the cost of the covered services.

Services from a Non-Contracting Facility (Emergency Admission)

You should not need to become involved in this type of claim, either. If an Emergency admission to a non-contracting facility has been approved, the non-contracting facility must submit itemized bills within 90 days of the date of service to:

MHN Claims
P.O. Box 14621
Lexington, KY 40512-4621

Section 8: Dental Expense Benefits

In this Section you'll find:

- What plans can be negotiated
- How the benefits work
- Preferred provider network for the Indemnity Dental Plans
- What the benefits are
- Coverage of orthodontia
- Information on filing claims

Review this Section if dental benefits have been negotiated for you.

This booklet provides only brief information about the fee-for-service "indemnity" dental plans and the prepaid dental plans. For more details, see the applicable brochure (there is a separate brochure for each type of plan). The brochures describe the benefit coverage, amounts payable, procedures not covered, and plan maximums.

If both a prepaid plan and an indemnity plan have been negotiated for you, see the current year's "Dental Benefit Comparison" for a side-by-side comparison of highlights of the two plans.

NOTE: The dental plan brochures describe the benefit coverage, amounts payable, procedures not covered, and plan maximums.

How the Benefits Work

Indemnity Dental Plans

The Indemnity Dental Plans are traditional fee-for-service plans. They work as follows:

- Each year, each covered participant is eligible for benefits up to the annual maximum shown in the Dental Benefit Comparison.
- When you go to a PPO contracting Dentist (see "Preferred Provider Network for the Indemnity Dental Plans" on the next page), the Plan pays a percentage of the covered expenses (subject to the annual maximum). The percentage payable by the Plan is shown on your Dental Benefit Comparison opposite "Dental Preferred Provider."
- When you go to a non-contracting Dentist, the Plan will pay up to a specific amount for each service or supply (subject to the annual maximum). The specific amounts payable for common dental services are shown in your Dental Benefit Comparison (if you have questions about items not shown there, contact the Administrative Office). You are responsible for any amounts in excess of the amounts payable by the Plan.

- Orthodontia, if that has been negotiated for you, has a separate maximum benefit.

Prepaid Plan

The prepaid United Concordia plans (DHMOs) are like HMOs for dental benefits. Most services are provided at no charge or in exchange for specified co-pay, but you may use only United Concordia participating Dentists.

Exclusion of Payment of Prepaid Plan Charges Under the Indemnity Plan

If you are enrolled in a prepaid dental plan, you will not be reimbursed by the Fund's indemnity plan for co-pays or non-covered items and services you incur under your prepaid plan. All services and supplies which you receive are payable only under the plan that you are enrolled in.

Preferred Provider Network for the Indemnity Dental Plan

The Indemnity Dental Plan contains a Preferred Provider Organization (PPO) option. This means the Trust has contracted with a PPO network of various dental care professionals to provide care to plan members at reduced costs. At the time this booklet was printed, the PPO network was being provided through United Concordia.

More of the cost of your dental expenses will be covered if you use a network Dentist than if you use a non-network Dentist.

You can obtain a current listing of network Dentists free of charge by calling the Administrative Office. You can also call United Concordia at (866) 357-3304 or visit the website **www.ucci.com** to find a network Dentist.

What the Benefits Are

Both the indemnity and the prepaid plans generally cover basic dental care—exams, X-rays, cleanings, fillings, and extractions—as well as other, more intensive treatment such as oral surgery, crowns, bridges and dentures, and periodontics.

See your plan brochure for details.

Coverage of Orthodontia

Indemnity Dental Plan

If you are covered for indemnity dental benefits, you do not automatically receive orthodontia benefits. Orthodontia benefits are negotiated separately from other dental coverage under the indemnity plan. Your Schedule of Benefits and your Dental Benefit Comparison will indicate if you have orthodontia coverage under the Indemnity Dental Plan.

Orthodontia benefits are described in a separate brochure.

Prepaid Dental Plan

If you have coverage under one of the prepaid dental plans, you will also be eligible for orthodontia from that prepaid plan. See your Dental Benefit Comparison and your prepaid dental plan brochure for information on your share of the costs and the conditions of coverage.

If You Have Coverage Elsewhere

If you or your Dependents have dental coverage elsewhere, you should be aware that coverage provided under the benefits described in this booklet will be coordinated with that other coverage—you cannot receive duplicate benefit payments or use dual coverage to get reimbursed for more than 100% of your expenses. See "Coordination of Benefits" in Section 15 for more information.

How to File a Claim for Dental Benefits

Indemnity Dental Plans

Your Dentist's office should have standard claim forms that can be used for submitting claims.

If you use a network Dentist, the Dentist's office will usually file the claim for you.

If you use a non-network Dentist, you will usually need to file a claim yourself. Check the claim form to be certain that all applicable portions of the form are completed and that the following information is included:

- the patient's full name
- the date or dates the service was rendered
- the nature of the treatment plan
- the type of service or supply furnished
- itemized charges
- the name, address, and signature of the Dentist providing services

Your completed claim should be mailed to United Concordia at the following address:

UCCI Dental Claims
P.O. Box 69421
Harrisburg, PA 17106-9421

Deadline for Submission

You should submit your claim **within 90 days** from the date of service. Claims will be considered for payment only if they are submitted within 1 year of the date the charges were incurred.

Questions?

If you have any questions about submitting your claim, contact the Administrative Office.

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims Review Procedures" in Section 15, "Other Important Plan Information."

Prepaid Dental Plans

There are no claim forms if you are enrolled in a prepaid dental plan.

Section 9: Vision Care Benefits

This section applies to you if vision care benefits have been negotiated for you (or for the Bargaining Unit Employees of your employer).

This booklet provides only brief information about vision care benefits. For more details, see the separate vision care benefits brochure provided to employees who are covered for this benefit.

If vision care benefits have been negotiated on your behalf, the Plan will pay benefits for an exam and lenses once every 12 months and frames once every 24 months.

Your Schedule of Benefits will tell you whether you have vision care benefits, which vision provider is contracted to provide your benefits and, whether you have a co-pay for the exam.

For most employees, vision care benefits are provided through MES. A limited number of employees have vision care benefits through Vision Service Plan (VSP), under arrangements for maintaining certain benefits. If you use a provider that does not participate in the MES network (or the VSP network, as applicable), the Plan will pay benefits only up to the amounts in the maximum allowance schedule. You will need to pay any costs beyond those amounts.

More detailed information on vision care benefits can be found in the separate brochure provided to employees covered for this benefit.

How to File a Claim for Vision Care Benefits

Network Provider

There is no need to file a claim for vision care benefits if you use a provider in your plan's network. You will receive covered services and materials either at no charge to you or for a small co-pay (depending on your plan), and the remaining costs are prepaid.

The cost of any services or materials outside of what the Plan covers will be your responsibility.

Non-Network Provider

See your materials from MES (or VSP, as applicable) for information on how to file a claim if you use a provider that does not participate in your plan's network.

Section 10: Weekly Disability Benefits

In this Section you'll find
- How the benefits work
- Exclusions
- Information on filing claims

This Section applies to you, if weekly disability benefits have been negotiated for you (or for the Bargaining Unit Employees of your employer).

Dependents are not eligible for weekly disability benefits under the Plan.

If you are entitled to receive weekly disability benefits as a result of collective bargaining, your Schedule of Benefits will tell you the amount of weekly benefit you are entitled to. You should refer to the Collective Bargaining Agreement or call the Administrative Office if you have questions regarding your coverage.

The chart below shows the two types of weekly disability benefits available through the Trust.

Weekly Disability Benefits	
Maximum period of benefit	26 weeks
Waiting period	• 0 days for accidental injury • 3 days for illness
Benefit amount	Depending on the Collective Bargaining Agreement, either • $85 per week **OR** • 35% of basic weekly salary, exclusive of overtime payments and bonuses

Frequently Asked Questions

Q Will my other benefits continue during the time I'm disabled?

A If a disability extension has been negotiated for you (or for the Bargaining Unit Employees of your employer), your benefits can be continued for up to 12 months or up to 18 months, whichever has been negotiated. Check your Schedule of Benefits to see whether a disability extension is included and see "Disability Extension of Benefits" in Section 3 for more information.

Your employer may also be required to continue contributions for your coverage before a disability extension begins. If you have questions about your coverage, check with the Administrative Office or refer to the applicable Collective Bargaining Agreement.

How the Benefits Work

This benefit is provided through a contract with an insurance company.

If, while eligible, you become wholly and continuously disabled as a result of an accidental injury or a sickness and you are prevented from performing any and every duty pertaining to your employment, you will receive the amount shown in your Schedule of Benefits.

See "How to File a Claim for Weekly Disability Benefits" below for information on establishing proof of disability.

Benefit Period

Benefits for a disability caused by an accidental injury can start on the first day of your disability. If your disability is due to an illness, benefits can start on the fourth day of your disability. No disability will be considered to have begun more than 3 days before you first visit a physician or a physician visits you regarding the condition causing the disability.

You may receive disability benefits for up to 26 weeks.

Successive periods of disability separated by less than 2 weeks of continuous active employment will be considered one continuous period of disability unless they arise from different and unrelated causes. In this case, return to active work for at least 1 day is required.

Frequency of Payments

Once your claim is approved for payment, accrued benefits will be paid twice a month during the period of disability.

If your disability ends and you return to work, any disability benefits due for the period that includes your return to work will be paid at the termination of that period.

Exclusions

No benefits are payable for any period of disability during which you are not under the direct care of a physician, and no disability will be considered to have begun more than 3 days prior to the first visit of or to a physician.

In addition, no benefits will be payable unless the Administrative Office is in receipt of proof of disability. See "How to File a Claim for Weekly Disability Benefits" below for information on establishing proof of disability.

How to File a Claim for Weekly Disability Benefits

To file a claim for weekly disability benefits, you must establish proof of your disability. Call the Administrative Office for the necessary form.

You will need to provide

- proof that your disability started during a period when you were working for a Participating Employer who contributes for this benefit,
- proof of entitlement to benefits under Workers' Compensation or State Disability, and
- a Doctor's written certification that as a result of illness or injury you (the Active Employee) are unable to perform any and every aspect of your job.

Mail your claim with the required proof and certification to the Trust at the following address:

LOS ANGELES MACHINIST BENEFIT TRUST
1325 N. Grand Ave, Suite 200
Covina, California 91724

The Trust reserves the right to arrange for an independent examination of you by a qualified physician to determine the existence of total disability at any time during the period of disability.

The insurance company may, at its option, request that you provide proof of disability. When requested by the insurance company, the treating physician must, within the scope of his license, certify to: (a) your disability; (b) the probable duration of the disability; and (c) the medical facts causing the disability within his knowledge.

Questions?

If you have any questions about submitting your claim, contact the Administrative Office.

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims Review Procedures" in Section 15, "Other Important Plan Information."

Section 11: Employee Life Insurance

In this Section you'll find

- How the benefit works
- Beneficiary
- Conversion privilege
- Accelerated benefit payment for terminal illness
- Information on filing claims

This Section applies to your life insurance benefits if the benefit has been negotiated for you (or for the Bargaining Unit Employees of your employer).

(see Section 12 for information regarding Dependent life insurance).

Your Schedule of Benefits will tell you whether you have employee life insurance and, if so, what the benefit amount is. You should refer to the applicable Collective Bargaining Agreement or call the Administrative Office if you have questions regarding your coverage.

At the present time, this benefit is fully insured and underwritten by Aetna.

How the Benefit Works

In the event of your death, the employee life insurance amount shown in your Schedule of Benefits will be paid to your Beneficiary.

NOTE: At age 70, if you are still insured, your death benefit will be reduced by 50%.

Beneficiary

Your Beneficiary is the person or persons who will receive your life insurance benefits in the event of your death.

To name a Beneficiary, you must complete a Beneficiary card, which is available at the Administrative Office, and return it to the Administrative Office. If you wish to change your Beneficiary, simply fill out another card. Death benefits can be paid only to the Beneficiary named on the card on file with the Administrative Office on the date of your death.

If you do not name a Beneficiary, or if your Beneficiary dies before you, your life insurance benefits, in the event of your death, will be paid to the first applicable member of the following classes of beneficiaries:

1. Your spouse
2. Your children (in equal shares)

3. Your parents (in equal shares)
4. Your brothers and sisters (in equal shares)
5. Your executor or administrator

Conversion Privilege

If you are no longer eligible for life insurance benefits because you no longer belong to an eligible insured class or if you terminate your employment, you may convert those benefits to any form of individual life insurance offered by the insurance company (except term insurance).

You will not need a medical examination, but you must complete the application form and send it with the first premium payment to the insurance company no later than 31 days after your group life insurance is terminated.

The face value of your new policy cannot be more than the amount you had under the group plan less any amount for which you become eligible under this policy or any other group policy within 31 days of the date of termination. The rate you pay will depend on your age (at the nearest birthday to the date of issue of the individual policy), your class of risk at the time of your conversion, and the face value of your new policy.

Conversion Under Other Circumstances

You may also convert if you have been covered under the group plan for at least 5 years and your life insurance benefits terminate because the policy terminates or because life insurance benefits for your class terminate. In this case, you may convert the LESSER of the following amounts:

- the amount of life insurance you had under this Plan, less any new amount you may have or for which you may become eligible under another group plan within 31 days of the termination or
- the face amount of your life insurance policy.

If You Should Die During the Period Allowed for Conversion

If you should die during the 31-day period after your group life insurance has terminated, the insurance company will pay the amount of life insurance benefits you could have converted to the last Beneficiary you named, whether or not you applied for an individual life insurance policy.

Accelerated Benefit Payment for Terminal Illness

If, as an Active Employee, you have been continuously insured for at least 2 years and it is determined that you suffer from a terminal illness and have a life expectancy of 6 months or less, up to 50% of your life insurance benefits may be paid in a lump sum to you or a designated party prior to your death.

Conditions for Which Accelerated Benefits Are Payable

Accelerated benefits will be payable for the following conditions:

- A terminal illness that results in a life expectancy of not more than 6 months
- A medical condition that requires extraordinary medical intervention, such as, but not limited to, a major organ transplant or conditions for artificial life support without which death would result
- A medical condition that requires continuous confinement in an eligible institution if the person has been confined a minimum of 6 months and such person is expected to remain in such institution or a similar institution for the remainder of his or her life
    - after the person's effective date of coverage under this policy and
    - while this policy is in effect for such person

  "Institution" means a nursing home or skilled nursing facility that is licensed as such by the state and that provides skilled nursing care by registered graduate Nurses, under the direction of at least one physician.
- A medical condition that would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span. Such conditions may include, but are not limited to, one or more of the following:
    - coronary artery disease that results in acute infarction or that requires surgery,
    - permanent neurological deficit that results from cerebral vascular accident,
    - end-stage renal failure, or
    - Acquired Immune Deficiency Syndrome (AIDS).

Applying for the Accelerated Benefit Payment

For you to be considered for such an accelerated benefit payment, you or your legal representative must submit a request for an accelerated benefit payment in writing to the Administrative Office. The Administrative Office has an application for benefits you can use for this purpose.

At your own expense, you must supply proof satisfactory to the Plan (e.g., clinical, radiological, laboratory evidence, etc.) of the diagnosis and of limited life expectancy. The diagnosis must be made by a licensed, qualified physician. The physician cannot be a member of your family, and the diagnosis must have been made after you became eligible.

If the Plan does not agree with the diagnosis, it may require an additional medical examination. If the Plan's physician disagrees with your physician, the physicians will jointly select a third physician to perform an examination. The decision of that physician will be final and binding upon all parties.

In addition, you must supply the Plan with a written consent of an assignee or irrevocable Beneficiary.

Frequently Asked Questions

Q Would my taking an accelerated benefit affect the amount my Beneficiary would receive after my death?

A Yes. Once the accelerated benefit has been paid, your life insurance amount will be reduced by the amount of the accelerated benefit payment. For example, if your life insurance benefit

is $10,000 and you take $5,000 as an accelerated benefit, your Beneficiary will receive $5,000 after your death.

Restrictions on Payment of Accelerated Benefits

Only one accelerated benefit payment will be paid.

The maximum accelerated benefit is 50% of your life insurance benefit. The minimum accelerated benefit is $5,000.

Accelerated benefits will NOT be paid under the following circumstances:

- for any reason other than as specifically provided under conditions for which benefits are payable above,
- for accidental death or dismemberment benefits,
- when all, or a portion, of your life insurance benefits are to be paid as part of a divorce settlement,
- if you have been eligible for life insurance benefits less than 2 years,
- if you are considered "totally disabled," as that term is defined by the insurance company
- if you are required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise,
- if you are required by a governmental agency to use this benefit to apply for, obtain, or keep a government benefit or entitlement, or
- if the terminal medical condition is caused by an injury you've intentionally inflicted on yourself or by attempted suicide.

Termination of the Option

This accelerated benefit option will be terminated upon the date of death or if you retire or are otherwise not covered for life insurance.

The accelerated benefit may not be converted to an individual policy.

How to File a Claim for Employee Life Insurance

See "Applying for the Accelerated Benefit Payment" earlier in this Section for information on how to file a claim for early payment of part of your benefit in the case of terminal illness.

In the event of your death, your Beneficiary should contact the Administrative Office as soon as possible. The Administrator will send the appropriate forms to the claimant, who must complete and return them, along with a certified copy of the death certificate. The Administrative Office will forward the materials to the insurance company for payment of the claim.

If your beneficiary disagrees with the payment decision made in regard to the claim, he or she can request a review of the decision. Please alert your beneficiary to the claims review information provided in Section 15 of this booklet.

Section 12: Dependent Life Insurance

In this Section you'll find
- What the benefit is
- Conversion privilege
- Information on filing claims

If you are eligible for life insurance, you are also eligible for Dependent life insurance. Refer to your Collective Bargaining Agreement or call the Administrative Office to determine if you have life insurance benefits or you have questions about your benefits.

What the Benefit Is

In the event of the death of an eligible Dependent, the following benefit will be paid to you:

Eligible Dependent	Benefit Amount
Spouse	$1,000
Each child	
• **Birth to age 6 months**	$100
• **6 months to age 19 (or to age 23 if a full-time student)**	$1,000

Conversion Privilege

If your eligibility terminates while the master group insurance policy remains in force, or if you die, any life insurance then in effect on the Dependent's life may be converted to any type of individual life insurance policy then being offered by the insurance company (except term insurance or any policy containing disability benefits). No evidence of good health will be required.

To convert the insurance, you or your Dependent must make application to the insurance company within 31 days from the date of termination of the Dependent's insurance. The premium will be the same as the Dependent would ordinarily pay if he or she applied for an individual policy at that time.

Should you again become eligible, your spouse may not avail himself/herself of this conversion if any individual policy is in effect as a result of a previous conversion.

If the death of your spouse occurs during the period in which application for conversion may be made, the life insurance benefit for your spouse will be paid. The life insurance benefit will be paid for any Dependent who dies within 31 days of losing eligibility because you have lost eligibility.

Frequently Asked Questions

Q Does Dependent life insurance include accelerated benefits in cases of terminal illness?

A No, the accelerated benefits program described in Section 11 is available only for employees.

How to File a Claim for Dependent Life Insurance

In the event of your dependent's death, you should contact the Administrative Office as soon as possible. The Administrator will send you the appropriate forms, which you must complete and return along with a certified copy of the death certificate. The Administrative Office will forward the materials to the life insurance carrier for payment of the claim.

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims Review Procedures" in Section 15, "Other Important Plan Information."

Section 13: Accidental Death and Dismemberment (AD&D) Insurance

In this Section you'll find:

- Who receives the benefit
- What the benefits are
- Losses that are not covered
- Information on filing claims

This section applies to you if employee life insurance benefits have been negotiated for you. (If you have employee life insurance, you will automatically have AD&D insurance, too.)

Dependents are not eligible for AD&D coverage under the Plan.

Your Schedule of Benefits will tell you whether you have AD&D insurance and, if so, what your "principal sum" is. (The principal sum is the amount on which any benefit payment is based, as explained in "What the Benefits Are" below.) You should refer to the applicable Collective Bargaining Agreement or call the Administrative Office if you have questions regarding your coverage.

NOTE: AD&D insurance pays a benefit in the event of your death or other eligible loss as described in the table on the following page.

Who Will Receive the Benefit

For loss of life, the benefit will be paid to the Beneficiary named for your life and AD&D insurance benefits on the Beneficiary card you have on file with the Administrative Office at the time of your death.

For any other loss, the benefit will be paid to you.

What the Benefits Are

The benefit payable is either the full principal sum or one-half of the principal sum shown on your Schedule of Benefits, as follows:

Description of Loss	Benefit Payable
Your death	Principal sum
Loss of both of your feet	Principal sum
Loss of both of your hands	Principal sum
Loss of sight in both of your eyes	Principal sum
Loss of one of your hands and one of your feet	Principal sum
Loss of one of your hands and sight in one of your eyes	Principal sum
Loss of one of your feet and sight in one of your eyes	Principal sum
Loss of one of your hands	One-half of the principal sum
Loss of one of your feet	One-half of the principal sum
Loss of sight in one of your eyes	One-half of the principal sum
Loss of a hand or foot means that the hand or foot is severed at or above the wrist or ankle joint, respectively. *Loss of sight means the total and irrecoverable loss of sight.*	

NOTE: At age 70, the principal sum will be reduced by 50%.

If you suffer more than one loss in any one Accident, payment will be made for that loss for which the largest amount is payable.

Losses That Are Not Covered

No AD&D benefit is payable if your death or other loss is caused directly or indirectly, wholly or partly, by any of the following:

- bodily or mental illness or disease or medical or surgical treatment of any kind, unless caused by an infection which results directly from the injury or surgery needed because of the injury.
- Ptomaine or bacterial infections, except infections caused by pyogenic organisms that occur with and through an accidental cut or wound, unless caused by an infection which results directly from the injury or surgery needed because of the injury.
- intentional self-destruction or injury you intentionally inflict on yourself, while sane or insane
- war or an act of war, whether declared or undeclared, or your taking part in a riot or insurrection
- service in any military, naval, or air force of any country while such country is engaged in war
- Commission of or attempting to commit a criminal act
- Inhalation of poisonous gases

- Intended or accidental contact with nuclear or atomic energy by explosion and/or release

How to File a Claim for AD&D Benefits

You or your Beneficiary should notify the Administrative Office as soon as possible in the event of a loss. The necessary forms will then be sent to the claimant. They should be completed and returned promptly to the Administrative Office. They will then be forwarded to the insurance company for claim payment.

If you or your Beneficiary disagrees with the payment decision made in regard to the claim, it can be appealed as explained in "Claims Review Procedures" in Section 15 of this booklet. Please alert your Beneficiary to the existence of that information in this booklet.

Section 14: General Exclusions and Limitations

This Plan will not provide benefits for:

1. Any bodily injury or sickness for which the Eligible Individual (Active Employee or Eligible Dependent) is not under the care of a Doctor or Dentist;
2. Any condition arising out of occupational injuries or illnesses even through the Eligible Individual fails to claim his or her rights to such benefits or for which benefits of ay nature are recovered or found to b e recoverable, whether by adjudication or settlement, under any worker's compensate in or occupational disease law;
3. Conditions caused by or arising out of an act of war, armed invasion or aggression whether declared or undeclared;
4. Any supplies or services (a) for which no charge is made; or (b) for which the Eligible Individual is not required to pay, or (c) furnished by a Hospital or facility operated by the united States Government or any authorized agency thereof or furnished at the expense of such Government or agency; or (d) which are provided without cost by any municipal, county, or other political subdivision, unless mandated by law;
5. Charges for expenses incurred outside of the United States, unless such expense are for Emergency care received while traveling on business or vacation;
6. Charges for services received by an Eligible Individual which are performed b y the spouse, child, brother, sister or parent of the Eligible Individual or of the Eligible Individual's spouse;
7. Expenses for services required as a result of injury of illness sustained in the commission of a felony or engagement in an illegal activity;
8. Non-prescribed drugs;
9. Charges for care and treatment in any penal institution; and
10. Charges resulting from intentionally self-inflicted actions, whether the Eligible Individual is sane or insane, unless mandated by law.

The Plan will not be liable to provide benefits for medical services or supplies not reasonably necessary for the care and treatment of bodily injuries or sicknesses or dental services or supplies not reasonably necessary for dental health unless specifically provided for. Furthermore, the Plan will not provide benefits for services, treatments or supplies for the care and treatment of bodily injuries or sicknesses which are in excess of the Reasonable Charge therefore.

In any payments are made to or on behalf of any Eligible Individual for illness or injury caused by the negligence of a third party, and the Eligible Individual receives Worker's Compensation or insurance benefits, the Plan will be subrogated to such Eligible Individual's claim to the extent of the payments made or to be made by reason of the foregoing. Upon settlement of the Eligible Individual's claim, the Eligible Individual will reimburse the Plan to the extent of the benefits provided by the Plan. The Eligible Individual will agree in writing to provide the Plan with a lien, to the extent of benefits by the Plan, which lien may be filed with the person whose act caused the injury or illness, that person's agent, the Court , or otherwise as necessary to protect the interest of the Plan.

Section 15: Other Important Plan Information

This Section includes:

- Confidentiality of your private health information
- Coordination of Benefits
- Third-party liability reimbursement
- Claim payments made in error
- Claims review procedures
- Factors that could affect your receipt of benefits
- Statement of your rights under ERISA
- General Plan information

Confidentiality of Your Private Health Information

A Federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans like the Los Angeles Machinist Benefit Trust protect the confidentiality of your private health information. A complete description of your rights under HIPAA is available from the Administrative Office. This statement is not intended and cannot be construed as the Plan's Notice of Privacy Practices.

This Plan, and the Plan Sponsor, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health Plan operations, and Plan administration or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan also hires professionals and other companies to assist it in providing health care benefits. The Plan has required these entities, called "Business Associates" to observe HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates. It will describe your rights with respect to benefits provided by that company.

Under Federal law, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances amend the information. You have the right to request reasonable restrictions on disclosure of information about you and to request confidential communications. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services if you believe your rights have been violated.

Coordination of Benefits

NOTE: The following information applies to the indemnity health care plans. If you are in one of the HMOs or prepaid dental plans, see the materials from that plan for information on how your benefits will be coordinated. For information on how mental health and substance abuse benefits are coordinated if you are in an Indemnity Medical Plan or an HMO other than Kaiser, see the materials provided by MHN.

The benefits provided by the Trust are "coordinated" with any benefits under any other group plan or government plan that covers you or your Dependents.

Coordination of Benefits means that one plan pays benefits first (the primary payer) and one pays second (the secondary payer), with the combined total of benefits not to exceed the maximum covered expenses.

If the Trust is the primary payer, it pays its benefits for you first, without regard to any other plan. If the Trust is the secondary payer, it will pay the amount of covered charges not covered by the primary plan (subject to co-pay, benefit and lifetime maximums, and other provisions described in this booklet).

In no event will the benefit paid by the Trust exceed the amount the Trust would have paid if you did not have the other coverage.

Order of Payment

This order applies only if your other plan has a coordination-of-benefits provision. If it does not, your other plan will always be primary.

Primary and secondary payers are as follows (NOTE: Coordination with Medicare and prepaid plans has different provisions, which are explained later below):

- **Employee vs. dependent:** The plan covering a participant as an employee will be primary and will pay benefits first. The plan covering a participant as a dependent will be secondary and will pay benefits second.
- **Active employee vs. retired or laid-off employee:** The plan covering a person who is neither laid-off nor retired (or that person's dependents) pays benefits first. The plan covering a person as a laid-off or retired employee pays benefits second.
- **Dependent children of parents *not* separated or divorced**: The plan of the parent whose birthday falls earlier in the calendar year (regardless of birth year) will be primary. If the birthdays of the parents fall on the same day, the plan that has covered a parent longer will be primary and the plan that has covered a parent for a shorter period of time will be secondary.
- **Dependent children of separated or divorced parents:** Benefit payments are first determined in accordance with any court decree. Otherwise, the plans pay benefits for the child in the following order:
  - the plan of the parent with custody pays first,
  - the plan of the stepparent—the spouse of the parent with custody, if he or she has remarried—pays second, and
  - the plan of the parent without custody pays last.

If none of the rules outlined here apply, the plan that has covered someone for a longer period will pay first.

Coordination of Medical Benefits with Medicare

The following special rules apply to coordination of an active employee's benefits with Medicare:

- **Employees:** If you are an Active Employee covered under this Plan and you are age 65 or older, you have the option of selecting either this Plan or Medicare as your primary coverage. This Plan will automatically provide you with primary coverage unless you notify the Administrative Office in writing that you wish to select Medicare as your primary coverage.
- **Dependent spouse:** If your spouse is age 65 or older, he or she will be eligible for the same benefits as you. If you select Medicare as your primary coverage, your spouse's coverage will also be provided by Medicare. If you do not select Medicare as your primary coverage, your spouse's primary coverage will be provided under this Plan.
- **Totally disabled participants:** If you or your Dependent becomes totally disabled, as determined by the Social Security Administration, while you are an Active Employee and you are eligible for Medicare, this Plan will still be primary.
- **Participants with End-Stage Renal Disease:** If you or any of your covered Dependents becomes eligible for Medicare on the basis of end-stage renal disease (ESRD) while you are an Active Employee, benefits for the individual with ESRD will be coordinated with Medicare for 30 months.

  Medicare will be secondary for 30 months; after that, Medicare will be primary. These 30 months begin the earlier of:

  - the month in which Medicare ESRD coverage begins or
  - in the case of an individual who receives a kidney transplant, the first month in which he would be eligible for ESRD benefits.

  Beginning with the 31st month (or the 34th month, in the case of a transplant patient), Medicare will become the first payer whether or not the individual is still entitled to coverage under this Plan.

Coordination with Prepaid Plans

If your other coverage is a prepaid plan (an HMO or similar program), the prepaid plan's benefits are typically available only if you use that plan's providers. Choosing how you receive services—from the prepaid plan's providers or from other providers—determines which plan is responsible for benefits. If you use the prepaid plan's providers, benefits payable by this Plan will be limited to reimbursement of the co-pays you are required to make when you use the prepaid plan's providers. This will be true regardless of which plan is primary.

Third-Party Liability Reimbursement

Should you or your eligible Dependent be injured through the act or omission of a third party and receive payment from that person (or the insurance company), you will be required to reimburse the Fund for any monies paid by the Plan.

The Trustees may intervene directly in any pending judicial or administrative proceeding in order to protect the Fund's right to collect any monies due. The Trustees may, as a condition of furnishing benefits, require you or your Dependents to sign a lien, assignment, or similar writing promising reimbursement to the Fund for any monies collected (up to the benefits provided by the Fund). Monies may also be withheld from future payment due to your family's medical or dental care if payment was received by you but never repaid to the Trust.

Claim Payments Made in Error

In the event a benefit payment has been made in error, the Trustees have the right to recover the payment by a demand for immediate repayment, offset from future benefit payments for you or any Dependent, or any other legal means and will be entitled to reasonable Attorneys' fees and costs of suit.

NOTE: You must always inform the Administrative Office of a change in a Dependent's status.

Claims Review Procedures

NOTE: The information provided here is applicable only to benefits provided under the indemnity health care plans and the Plan's disability, life insurance, and accidental death and dismemberment benefits.

If you are covered under one of the HMOs, the mental health and substance abuse benefits provided through MHN, one of the prepaid dental plans, or the vision plan, it is not necessary to file a claim when services are rendered by a provider in the applicable network. See the materials from the HMO, MHN, United Concordia, or MES or VSP for information on what to do if you receive services from a non-network provider and such services are covered. Those organizations also have their own review and appeals procedures, which are described in their materials. The Trust cannot make an appeal on your behalf. You may, however, appeal to the Board of Trustees for assistance in the handling of any dispute with a carrier.

Discussed below are the various types of claims associated with Plan benefits, procedures for filing claims, and the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision. The times mentioned in the discussion are summarized in the charts at the end of the discussion.

Types of Claims

There are six types of claims applicable to the benefits described in this booklet. Four of them have to do with health care:

- **Pre-service claims:** A pre-service claim is a request for authorization of care or treatment that requires approval in whole or in part before the care or treatment is obtained (also called "pre-authorization").

  Under this Plan, prior approval of services is required for non-Emergency Hospital admissions. (*It is also required for all non-Emergency mental health and substance abuse treatment, but see the materials from MHN for information on those claims.*)

  If you fail to get prior approval for non-Emergency Hospital admissions, your benefits may be reduced.

- **Urgent care claims:** Your request for a required pre-authorization will be considered an urgent care claim if applying the time frames allowed for a pre-service claim (*generally 15 - 30 days for a request submitted with sufficient information*)

  - could seriously jeopardize your life or health or your ability to regain maximum function or
  - in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

  The applicable urgent care claim reviewer, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, will determine whether your claim is an urgent care claim. Alternatively, any claim that a physician with knowledge of your medical condition determines is an urgent care claim within the meaning above will be treated as an urgent care claim.

- **Concurrent care (ongoing treatment) decisions:** A concurrent care decision is a decision that is reconsidered after an initial approval was made, resulting in a reduction, termination, or extension of a benefit. (For example, an inpatient Hospital stay originally pre-approved for 5 days is subjected to concurrent review at 3 days to determine if the full 5 days are appropriate.) In this situation, a decision to reduce, terminate, or extend treatment is made concurrently with the provision of treatment. This category also includes requests by you or your provider to extend care or treatment approved under an urgent care claim.

- **Post-service claims:** Any other type of health care claim is considered a post-service claim—for example, a claim submitted for payment after health services and treatment have been obtained.

The other two types of benefit claims under this Plan are as follows:

- **Disability claims:** A disability claim is a claim for weekly disability income benefits or a claim for a determination of disability (for example, to qualify for a disability extension of benefits, if that benefit has been negotiated for you).

- **Other claims:** The category "other claims" includes claims for life insurance and employee accidental death and dismemberment (AD&D) insurance benefits.

What is NOT a "Claim?"

The following are not considered claims and are thus not subject to the requirements and time frames described in this section (*These will not be considered claims even if they are referred to as "claims" by the Administrator or anyone working on behalf of the Administrator*):

- Simple inquiries about eligibility, enrollment, or the Plan's provisions that are unrelated to any specific benefit claim
- A request for an advance determination regarding the Plan's coverage of a treatment or service that does not require pre-authorization
- A prescription you present to a pharmacy to be filled (*However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using the procedures in this section*)

Filing a Claim

Information on how to file a claim is included in the Parts covering each type of benefit earlier in this booklet. A brief summary of the information presented there is provided below. Unless otherwise specified below, all claims for benefits must be submitted on claim forms available from or acceptable to the Administrative Office. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims.

- **Pre-service or urgent care claims for Hospital admissions:** Have your Doctor call Blue Cross at 800-274-7767 to request pre-authorization. If your Doctor thinks your condition warrants handling of your request as an urgent care claim, he or she should make sure the representative who takes the call is advised of this.

  NOTE: If your admission involves mental health or substance abuse treatment, you must call MHN at 800-992-5465 for pre-authorization instead.

"Urgent Care Claim" Does Not Mean Emergency Care or Care at an Urgent Care Facility

Urgent care claims should not be confused with Emergency care or treatment at an urgent care facility, which do not require pre-authorization. See "Urgent Care Claims" under "Types of Claims" on the previous page for an explanation of when a request for pre-authorization might need to be handled as an urgent care claim.

- **Post-service health care claims:** Post-service claims for health care benefits should be sent to the following address:

LOS ANGELES MACHINIST BENEFIT TRUST
1325 N. Grand Ave, Suite 200
Covina, California 91724

- **Disability claims:** Call the Administrative Office for the form necessary to establish disability. Return the form with the required proof and certification of your disability to the following address:

LOS ANGELES MACHINIST BENEFIT TRUST
1325 N. Grand Ave, Suite 200
Covina, California 91724

- **Other claims:** To initiate a claim for life insurance or AD&D benefits, you or your Beneficiary should notify the Administrative Office of the loss. The necessary forms will then be sent to the claimant, who should complete them and return them with any required documentation to the following address:

  LOS ANGELES MACHINIST BENEFIT TRUST
  1325 N. Grand Ave, Suite 200
  Covina, California 91724

  Terminally ill employees who have a life expectancy of less than 6 months and want to apply for accelerated life insurance benefits should contact the Administrative Office for an application for benefits and return the completed application to the address above.

Using an Authorized Representative

An authorized representative, such as your spouse, may complete a claim submission for you if you are unable to complete it yourself and have previously designated the individual to act on your behalf. The Plan may request additional information to verify that this person is authorized to act on your behalf.

When Claims Must Be Filed

Your claim will be considered to have been filed as soon as it is received by the applicable review authority: Blue Cross for pre-service claims, urgent care claims, and concurrent care decisions involving Hospital admissions or the Administrative Office for post-service health care claims, disability claims, and other claims.

Pre-service and urgent care claims must be filed before services are obtained. *(Remember that an urgent care claim is not to be confused with Emergency care or care received at an urgent care facility.)*

You must submit all other health care claims **within 90 days** of when expenses are incurred. Claims will be considered for payment only if they are submitted within 1 year of the date the charges were incurred.

Notification That Your Pre-Service or Urgent Care Claim Has Not Been Properly Filed

If your **pre-service** claim has been improperly filed, Blue Cross will notify you as soon as possible but no later than **5 days** after receipt of the claim of the proper procedures to be followed in filing a claim.

If your **urgent care** claim has been improperly filed, Blue Cross will notify you as soon as possible but no later than **24 hours** after receipt of the claim of the proper procedures to be followed in filing a claim.

You will receive notice that you have improperly filed your claim only if the claim includes your name, your specific condition or symptom, and a specific treatment, service, or product for which approval is requested. Unless the claim is re-filed properly, it will not constitute a claim.

Timing of Initial Claims Decisions

A determination on your claim will be made within the following time frames:

- **Pre-service claims:** If your pre-service health care claim has been properly filed, Blue Cross will notify you of its decision within **15 days** from the date your claim is filed, unless additional time is needed. The time for response may be extended by up to **15 days** if necessary due to matters beyond the control of Blue Cross. If an extension is necessary, you will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which Blue Cross expects to make a decision.

  If an extension is needed because Blue Cross needs additional information from you, Blue Cross will notify you as soon as possible, but no later than **15 days** after receipt of the claim, of the specific information necessary to complete the claim. In that case you and/or your Doctor will have **45 days** from receipt of the notification to respond. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either **45 days** or the date you respond to the request (whichever is earlier). Blue Cross then has **15 days** to make a decision and notify you of the determination.

- **Urgent care claim:** You will be notified of a determination by telephone as soon as possible, taking into account the exigencies of your situation, but no later than **72 hours** after receipt of the claim by Blue Cross. The determination will also be confirmed in writing.

  If your urgent care claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, Blue Cross will notify you as soon as possible, but no later than **24 hours** after receipt of the claim, of the specific information necessary to complete the claim. You and/or your Doctor must respond to this request within **48 hours**. Notice of a decision will be provided no later than **48 hours** after Blue Cross receives your response, but only if it is received within the required time frame.

- **Concurrent care decision:** A reconsideration that involves the termination or reduction of payment for a treatment in progress (other than by Plan amendment or termination) will be made by Blue Cross as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

  A request by you to extend approved urgent care treatment will be acted upon by Blue Cross within **24 hours** of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment.

- **Post-service claims:** Ordinarily, you will be notified of the decision on your post-service health care claim within **30 days** of the date the Administrative Office receives the claim. This period may be extended one time by up to **15 days** if the extension is necessary due to matters beyond the control of the Administrative Office. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which the Administrative Office expects to make a decision.

  If an extension is needed because the Administrative Office needs additional information from you, the Administrative Office will notify you as soon as possible, but no later than **30 days** after receipt of the claim, of the specific information necessary to complete the claim. You and/or your Doctor or Dentist will have **45 days** from receipt of the notification to respond. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days have passed or the date

you respond to the request (whichever is earlier). The Administrative Office then has **15 days** to make a decision on your post-service claim and notify you of the determination.

- **Disability claims:** The Administrative Office will ordinarily make a decision on the claim and notify you of the decision within **45 days** of receipt of the claim. This period may be extended by up to **30 days** if the extension is necessary due to matters beyond the control of the Administrative Office. If an extension is necessary, you will be notified before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the Administrative Office expects to make a decision. A decision will then be made within **30 days** of when the Administrative Office notifies you of the delay. The period for making a decision may be extended an additional **30 days**, provided the Administrative Office notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Administrative Office expects to make a decision.

  If an extension is needed because the Administrative Office needs additional information from you, the Administrative Office will notify you as soon as possible, but no later than **45 days** after receipt of the claim, of the specific information necessary to complete the claim. You will have **45 days** from receipt of the notification to respond. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days have passed or the date you respond to the request (whichever is earlier). The Administrative Office then has **30 days** to make a decision on your claim and notify you of the determination.

- **Other claims:** The insurance company will ordinarily make a decision on a claim for life or AD&D insurance within **90 days** of receipt of the claim. This period may be extended by up to **90 days** if the extension is necessary due to matters beyond the control of the insurance company. If an extension is necessary, you will be notified before the end of the initial 90-day period of the circumstances requiring the extension and the date by which the insurance company expects to make a decision.

Denied Claims (Adverse Benefit Determinations)

You will be provided with written notice of an adverse benefit determination, whether your claim is denied in whole or in part (by fax, if you wish). This notice will include the following:

- the specific reason(s) for the determination
- reference to the specific Plan provision(s) on which the determination is based and reference to and copies of any internal rules or guidelines that are not in the Plan
- a description of any additional information needed for approval of your claim and an explanation of why the information is needed
- a brief description of the appeals procedures and applicable time limits and a reminder that a complete description of the claims and appeals procedures may be found in this booklet, copies of which are available without charge from the Administrative Office.
- notice of your right to file a lawsuit if your appeal of the adverse benefit determination is denied
- if the denial is based on a Plan exclusion, information on how to request an explanation of how the exclusion was applied and why

For urgent care claims, the notice will describe the expedited review process applicable to urgent care claims. For urgent care claims, the required determination may be provided orally and followed with written notification.

For pre-service and urgent care claims, you will receive notice of the determination even when the claim is approved.

Request for Review of an Adverse Benefit Determination

If you disagree with the decision made on a claim, you may ask for a review (appeal the decision). Your request for review must be made in writing to the Administrative Office as follows:

- within **180 days** after you receive the notice of denial for a claim involving health care or disability (or, in the case of a concurrent care decision, within a reasonable time, given the exigencies of your situation)
- within **60 days** after you receive the notice of denial for other claims

You may request an expedited appeal of denial of an urgent care claim orally or in writing, and all necessary information may be exchanged by telephone, fax, or other expeditious method.

When appealing, you may submit any written records you wish to be reviewed.

Review Process

The review process works as follows:

You have the right to review documents relevant to your claim. A document, record, or other information is relevant if it was relied upon in making the decision; it was submitted, considered, or generated (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or it constitutes a statement of Plan policy regarding the denied treatment or service.

Your appeal will be decided by an individual or individuals who did not take part in the original claim denial and are not subordinates of the person who originally denied the claim. No deference will be given to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments as may be submitted by you.

If your claim involves a medical judgment, a health care professional trained in the relevant field of medicine will be consulted (one who did not take part in the claim denial and who is not the subordinate of such a person). You may also request the names of medical professionals who gave advice on your claim denial.

Notice of Decision on Appeal

You will receive notice of the decision made on your appeal according to the following timetable:

- **Pre-service claims:** You will be sent a notice of a decision on review within **30 days** of receipt of the appeal by the Administrative Office.
- **Urgent care claims:** You will be sent a notice of a decision on review within **72 hours** of receipt of the appeal by the Administrative Office.
- **Concurrent care decisions:** You will receive notice of a decision on review within a reasonable amount of time for the type of care.

- **Post-service health care claims:** Ordinarily, decisions on appeals will be made **at the next regularly scheduled meeting** of the Board of Trustees that is held at least 30 days after your written appeal is received. In special circumstances, an extension until the third regularly scheduled meeting following receipt of your request for review may be necessary. If such an extension is necessary, you will be advised in writing of the special circumstances and the date by which a decision will be made before the extension begins.
- **Disability claims:** Decisions on appeals will be made at Board of Trustees meetings. Timing and procedures are the same as those described immediately above for post-service health care claims.
- **Other claims:** Decisions will ordinarily be made within **60 days** of receipt of appeal by the Administrative Office. The period for making a decision may be extended by up to **60 days**, provided the Administrative Office notifies you, prior to the expiration of the first 60 days, of the circumstances requiring the extension and the date as of which the Administrative Office expects to make a decision.

If Your Appeal is Denied

If your appeal is denied, you will receive written notice (or electronic notice, as permitted by law), including the specific reason(s) for the decision and reference to the specific Plan provision(s) on which it is based.

You may have access to all records that were used in reaching the decision. If an internal rule, guideline, protocol, or other similar criterion was used in the appeal denial, you will be told about it and may have a copy of it. If the denial is based on medical necessity or the treatment's being Experimental or the like, you may have a copy of whatever scientific or clinical explanation was used in the determination.

If you are not satisfied with the decision made on your appeal, you may file a lawsuit in Federal court against the Plan. However, no legal or equitable action for benefits under this Plan shall be brought unless and until you have

- submitted a claim for benefits,
- been notified that the claim is denied (or the claim is deemed denied),
- filed a written appeal for review, and
- been notified in writing that the denial of the claim has been confirmed (or the claim is deemed denied on review).

("Deemed denied" means that you filed a claim or an appeal and had not received any response by the expiration of the response time allowed for the type of claim.)

Maximum Times for Processing of Health Care Claims *(Times are suspended during waits for additional information requested of you)*				
	Pre-Service Claims	**Urgent Care Claims**	**Concurrent Care Decisions**	**Post-Service Claims**
Administrative Office makes initial determination (provided all necessary information is submitted)	Within 15 days of claim's receipt (can be extended for another 15 days)	Within 72 hours of claim's receipt	In time for you to appeal before a reduction or termination Within 24 hours of request for extension of urgent care	Within 30 days of claim's receipt (can be extended for another 15 days)
Administrative Office notifies you claim has been improperly filed	Within 5 days of claim's receipt	Within 24 hours of claim's receipt	Not applicable	Not applicable
Administrative Office requests additional information	Within 15 days of claim's receipt	Within 24 hours of claim's receipt	Not applicable	Within 30 days of claim's receipt
You respond to request for information	Within 45 days of request	Within 48 hours of request	Not applicable	Within 45 days of request
Administrative Office makes determination after requesting additional information	Within 15 days of your response or expiration of the time allowed	Within 48 hours of your response or expiration of the time allowed	Not applicable	Within 15 days of your response or expiration of the time allowed
You make request for appeal	Within 180 days of receiving notice of denial	Within 180 days of receiving notice of denial	Within a reasonable time for your situation	Within 180 days of receiving notice of denial
Administrative Office or Board makes decision on appeal	Within 30 days of receiving your request for appeal	Within 72 hours of receiving your request for appeal	Within a reasonable time for the type of care decision	At next regular Board meeting at least 30 days after receiving your request for appeal (or no later than third such meeting)

Maximum Times for Processing of Disability and Other Claims *(Times are suspended during waits for additional information requested of you)*		
	Disability Claims	**Other Claims**
Administrative Office or insurance company makes initial determination (provided all necessary information is submitted)	Within 45 days of claim's receipt (can be extended for another 30 days and an additional 30 days after that)	Within 90 days of claim's receipt (can be extended for another 90 days)
Administrative Office requests additional information	Within 45 days of claim's receipt	Not applicable
You respond to request for information	Within 45 days of request	Not applicable
Administrative Office makes determination after requesting additional information	Within 30 days of your response or expiration of the time allowed	Not applicable
You make request for appeal	Within 180 days of receiving notice of denial	Within 60 days of receiving notice of denial
Board makes decision on appeal	At next regular Board meeting at least 30 days after receiving your request for appeal (or no later than third such meeting)	Within 60 days of receipt of your request for appeal (can be extended another 60 days)

Factors That Could Affect Your Receipt of Benefits

Many of the points below specifically reference indemnity health care and other plans discussed in this booklet. If you are in one of the HMOs or prepaid dental plans, see also the materials provided by that plan for information about factors that might affect your receipt of benefits. If you have your mental health and substance abuse benefits through MHN, see also the materials from MHN.

Certain factors could interfere with payment of benefits from the Plan (result in your disqualification or ineligibility, denial of your claim, or loss, forfeiture, or suspension of benefits you might reasonably expect). Examples of such factors include the following:

- **Failure to follow the Plan's requirements for pre-authorization.** If you are enrolled in an Indemnity Medical Plan and you wish to receive the maximum benefits available, you must follow the requirements described in Section 4 for Hospital admissions and Section 7 for mental health and substance abuse treatment. (The Section 7 requirements also apply to HMO enrollees, other than those enrolled in a Kaiser HMO.)

- **Failure to use Contracting Providers.** You will not receive the highest level of coverage available for many of the health care services described in this booklet unless you use Contracting Providers (also called "preferred" or "participating" providers). See the Sections on health care benefits (including mental health and substance abuse treatment) for more information.
- **Failure to submit claims in a timely way.** You should submit all health care claims within 90 days from the date on which covered expenses were incurred. Claims will be considered for payment only if they are submitted within 1 year of the date the charges were incurred.
- **The Plan's provisions for coordination of health care benefits.** If you or a Dependent has health coverage under another plan, payment of benefits will be coordinated with payment of benefits by that other plan. See "Coordination of Benefits" earlier in this Section for more information.
- **The Plan's provisions regarding payment from another source.** You will be required to reimburse the Fund for benefits it pays if you or a Dependent is injured by the acts of a third party and you collect payment for that injury from another source. Amounts not repaid may be withheld from future benefit payments. See "Third-Party Liability Reimbursement" earlier in this Section for more information.
- **The Plan's provisions regarding payments made in error.** The Trustees have the right to recover benefit payments made in error (for example, if you have failed to inform the Administrative Office of a change in a Dependent's status). Such right includes entitlement to legal fees incurred in the recovery. Amounts may be offset from future benefit payments. See "Claim Payments Made in Error" earlier in this Section for more information.
- **Failure to update your address.** If you move, it is your responsibility to keep the Administrative Office informed about where it can reach you. Otherwise, you may not receive important information about your benefits.

Any factors affecting your receipt of benefits will depend on your particular situation. If you have questions, contact the Administrative Office at (323) 278-7030 or (800) 499-8121.

See also Section 2 for information on eligibility and termination of eligibility.

Statement of Your Rights Under ERISA

As a participant in the Los Angeles Machinist Benefit Trust, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights:

Receive Information About Your Plan and Benefits

You have the right to:

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

and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

You have the right to:

- Continue health care 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 SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, or when your 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 your coverage. Note: pre-existing condition limitations are no longer allowed for persons under age 19.

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 employee benefit plans. 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 or ignored, in whole or in Section, 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 a copy of Plan documents or the latest annual report from the Plan and do not receive it within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

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

costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your 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, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory. Alternatively, you may obtain assistance by calling EBSA toll-free at 866-444-EBSA (3272) or writing to the following address:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may obtain certain publications about your rights and responsibilities under ERISA by calling 800-998-7542 or contacting the EBSA field office nearest you.

You may also find answers to your plan questions and a list of EBSA field offices at the website: www.dol.gov/ebsa.

Nothing in the foregoing Statement is meant to interpret or extend or change in any way the provisions expressed in the Plan.

The Board of Trustees reserves the right to amend, modify, or discontinue all or part of this Plan at any time and for any reason, in its sole and absolute discretion in accordance with procedures specified in the Trust Agreement.

General Plan Information

Name of Plan	Los Angeles Machinist Benefit Trust
Type of Plan	Employee welfare benefit plan maintained for the purpose of providing life, accidental death and dismemberment, disability, Hospital, medical, dental, and vision care benefits in the event of sickness or Accident for eligible participants and their covered Dependents
Plan Number	501
Funding Medium	Benefits of the Plan are provided under service agreements or insurance contracts or directly from the Trust's assets, which are accumulated under the provisions of the Collective Bargaining Agreements and the Trust Agreement and are held for the purpose of providing benefits to covered participants and defraying reasonable operating costs. For more information, see "Organizations Through Which Benefits Are Provided" later in this Section.
Source of Contributions	The benefits described in this booklet are provided through employer contributions to this Plan or through self-payment. The amount of employer contributions to this Plan is determined by the Board of Trustees or the provisions of the Collective Bargaining Agreements requiring contributions to this Plan and may be made at a fixed rate per month worked.
Plan Year	The fiscal records of the Plan are kept separately for each Fiscal Plan Year. The Fiscal Plan Year begins on July 1 and ends on June 30.
Contributing Employers	Upon written request, the Administrative Office will provide you information as to whether a particular employer or union is contributing to this Plan on behalf of participants in the Plan and, if the employer or union is a contributor, the address of the employer or Union.
Employer Identification Number (EIN)	The number assigned to the Plan by the Internal Revenue Service is 95-2755074.
Plan Administrator	Board of Trustees Los Angeles Machinist Benefit Trust 1325 N. Grand Ave, Suite 200 Covina, California 91724 Local Telephone Number: 323-278-7030 Toll-Free Telephone Number: 800-499-8121 Fax Number: 323-728-2982 The Board of Trustees is the Plan Administrator. This means that the Board of Trustees is responsible for seeing that information regarding the Plan is reported to government agencies and disclosed to Plan participants and beneficiaries in accordance with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). Names and addresses of the Trustees as of the date this booklet was printed are shown on the following page.

Agent for Service of Legal Process	Los Angeles Machinist Benefit Trust 1325 N. Grand Ave, Suite 200 Covina, California 91724 Legal process may also be served on the Board of Trustees or an individual Trustee.

Administration of the Plan

The Plan is administered by the Board of Trustees, on which employers and employees are equally represented by employer and Union representatives, selected by the employers and Union, in accordance with the Trust Agreement that relates to this Plan.

If you wish to contact the Board of Trustees, you may do so at the address and phone number shown opposite "Plan Administrator" in the chart on the previous page.

The routine functions of the Plan are performed by Zenith American Solutions, a third party administrator (TPA) which functions by contract as the Administrative Office for the Plan:

Zenith American Solutions
1325 N. Grand Ave, Suite 200
Covina, California 91724
Local Telephone Number: 323-278-7030
Toll-free Telephone Number: 800-499-8121

Trustees

The names and addresses of the Trustees as of the date this SPD was printed are listed below.

Union Trustee

Kevin J. Kucera
Organizer/Business Representative
Local Lodge No. 1484
1261 Avalon Blvd.
Wilmington, CA 90744

Richard Sanchez
Directing Business Representative
District Lodge 947 IAM & AW
319 West Broadway
Long Beach, CA 90802

Kenneth Cormier
District Lodge IAM & AW
535 West Willow Street
Long Beach, CA 90806

Jack Morck
c/o Zenith American Solutions
1325 N. Grand Ave, Suite 200
Covina, CA 91724

Employer Trustees

David W. Armstrong
c/o Zenith American Solutions
1325 N. Grand Ave, Suite 200
Covina, CA 91724

Laurence Bear
c/o Zenith American Solutions
1325 N. Grand Ave, Suite 200
Covina, CA 91724

Bill Bistline
c/o Zenith American Solutions
1325 N. Grand Ave, Suite 200
Covina, CA 91724

Marty Greco
c/o Zenith American Solutions
1325 N. Grand Ave, Suite 200
Covina, CA 91724

Organizations Through Which Benefits Are Provided

The benefits shown in the following chart are fully insured.

Fully Insured Benefits

Benefit	Identity of Provider
Prepaid medical plans	Kaiser Permanente 3100 Thornton Ave. Burbank, CA 91504 (818) 525-4370 UnitedHealthcare (formerly PacifiCare) 5816 corporate Avenue, Suite 190 Cypress, CA 90630 (714) 226-2796
Employee Assistance Program (EAP)	MHN 2370 Kerner blvd. San Rafael, CA 94901 (818) 676-6032
Mental health and substance abuse plan For participants in California not enrolled in Kaiser Permanente and not eligible for Medicare	MHN 2370 Kerner blvd. San Rafael, CA 94901 (818) 676-6032
Prepaid dental plan	United Concordia 21700 Oxnard Street, Suite 500 Woodland Hills, CA 91367 626-403-1924
Vision	Medical Eye Service (MES) 345 Banker Street Costa Mesa, CA 92626 (909) 948-6861
Vision	Vision Service Plan 333 Quality Drive Rancho Cordova, CA 95630 800-852-7600
Weekly disability, life insurance, and accidental death and dismemberment insurance	Aetna Life Insurance 510 S. Flower St., Suite 505 Los Angeles, CA 90071 (800) 523-5065

The benefits described in the chart below are provided directly by the Plan itself, or through providers with which the Plan has contracted, pursuant to administrative services agreements, and are not fully insured. Payment of benefits is not guaranteed by the Trust, nor does the provider insure or guarantee any of the benefits described.

Administrative Services for Benefits Paid Directly by the Trust

Area of Administration	Identity of Provider
Preferred Provider Organization for Hospital/medical providers in the Indemnity Medical Plans	Blue Cross 21555 Oxnard Street Woodland Hills, CA 91365 Location AC-PC 818-234-3925
Preferred Provider Organization for dental providers in the Indemnity Dental Plans	United Concordia 21700 Oxnard Street, Suite 500 Woodland Hills, CA 91367 626-403-1924
Walk-in and mail order Prescription Drugs for Indemnity Medical Plan participants	ProCare Pharmacy Care 3891 Commerce Parkway Miramar, FL 33025 800-662-0586

Determining Documents

If you are eligible under the Plan, your rights can be determined only by:

- the Trust's rules, contracts, and other documents establishing the Plan for Hospital and medical reimbursement benefits and dental reimbursement benefits provided directly by the Trust;
- the Group Medical and Hospital Service Agreements relating to the Hospital and medical benefits provided by Health Maintenance Organizations;
- contracts with the prepaid vision and dental plans; and
- Carrier contracts covering any insured benefits.

The information earlier in this booklet is intended to be a summary of the Fund's eligibility rules and benefits. However, the provisions of current governing plan documents shall prevail in any dispute. Copies of current governing plan documents may be requested from the Administrative Office. Separate brochures are provided covering prepaid medical and dental plans, the Indemnity Dental Plans, indemnity orthodontia benefits, vision benefits, Prescription Drugs, the Employee Assistance Program, and life and AD&D insurance.

The providers who provide fully insured benefits identified previously pay claims and handle claims appeals related to their program of benefits. These organizations will supply you, upon written request, written materials concerning the nature of services provided, conditions pertaining to eligibility to receive such services (other than general conditions pertaining to eligibility for participation in the Trust) and circumstances under which such services may be denied, the procedures to be followed in obtaining such services, and the procedures available for the review of claims for services which are denied in whole or in part. Requests for such material may be addressed to the Plan Administrator at the address given previously in this Section.

Collective Bargaining Agreements

The Los Angeles Machinist Benefit Trust is maintained pursuant to Collective Bargaining Agreements in effect between the Union and the employers. Contributions to this Plan are made on behalf of each Active Employee in accordance with the individual Collective Bargaining Agreement.

Copies of any of the Collective Bargaining Agreements may be obtained upon written request to the Administrative Office (a reasonable charge may be made) and are available for examination at the Administrative Office during regular business hours. A copy of any of the Collective Bargaining Agreements will also be available for inspection within 10 calendar days after written request at any of the local Union offices or at the office of any contributing employer to which at least 50 Plan participants report each day.

Trust Fund

The Trust's assets and reserves are held in trust by the Board of Trustees of the Los Angeles Machinist Benefit Trust and are invested in various bank savings accounts and short-term bank investments, government and corporate bonds, and certain other investments approved by the Trustees.

Full and Final Authority of the Board of Trustees

Only the Board of Trustees of the Los Angeles Machinist Benefit Trust is authorized to interpret the Plan described in this booklet. All rights to benefits shall be determined in accordance with the rules, contracts, and other documents establishing the Plan, as interpreted by the Board of Trustees. The Board's discretionary authority to interpret the documents establishing the Plan and to decide any factual question related to Plan benefits is broad and shall be final and binding on all parties.

The Board of Trustees reserves the right to amend, modify, or discontinue all or part of this Plan at any time and for any reason, in its sole and absolute discretion in accordance with procedures specified in the Trust Agreement. The provisions of the Plan cannot be modified or amended in any way by any statement or promise made by any other person, including employees of the Union or any employer. The Board of Trustees has full discretion and authority to determine questions concerning the interpretation or administration of the Plan including, without limitation, all questions relating to eligibility for Plan benefits, and the determination of the Board shall be final and binding as to all persons and for all purposes.