



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by contacting the Los Angeles Machinist Benefit Trust at its Administrative office: c/o Corcoran Administrators, Inc. – P.O. Box 6149, Gardena, California 92846, 1-800-499-8121, or Managed Health Network ("MHN") at 1-800-327-7701 or at www.members.mhn.com (access code: "lambt").

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0.	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. \$1,000 person / \$2,000 two-party/ \$3,000 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers ?	Yes. For a list of preferred providers , see www.members.mhn.com (access code "lambt") or call 1-800-327-7701.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network .
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 3. See your plan document for additional information about excluded services .

Questions: Call your Plan at 1-800-499-8121 or visit us at <http://lambt.org> and/or www.members.mhn.com (access code: "lambt"). If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at <http://lambt.org> or call 1-800-327-7701 to request a copy. You can also view the Glossary at www.dol.gov/ebsa/healthreform.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$15.00	Not covered	—————none—————
	Mental/Behavioral health alternate level of care services (including partial hospitalization, day treatment, and intensive outpatient)	\$50.00	Not Covered	—————none—————
	Mental/Behavioral health inpatient services	\$100.00	Not Covered	—————none—————
	Substance use disorder outpatient services	\$15.00	Not covered	—————none—————
	Substance use disorder alternate level of care services (including partial hospitalization, day treatment, and intensive outpatient)	No Charge	Not covered	—————none—————
	Substance use disorder inpatient services	\$100.00	Not Covered	—————none—————
If you need immediate medical attention	Emergency room services	\$100.00	No Charge	Waived, if admitted.
	Emergency medical transportation	No Charge	No Charge	—————none—————

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Court ordered treatment
- Electro-Convulsive Therapy (ECT) except as authorized by MHN according to MHN policies and procedures
- Experimental treatment
- Prescription Drugs
- Psychological testing except as conducted by a licensed psychologist for assistance in treatment planning, including medication management or diagnostic clarification and specifically excluding all educational, academic and achievement tests, psychological testing related to medical conditions or to determine surgical readiness and automated computer based reports.
- Treatment for biofeedback, acupuncture or hypnotherapy

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Applied Behavior Analysis
- Medication management

Your Rights to Continue Coverage:

If you lose coverage under this plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the Plan at its Administrative Office at 1-800-499-8121. You may also contact Managed Health Network ("MHN") at 1-800-327-7701. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: you can contact your Plan at its Administrative Office at 1-800-499-8121, MHN's Customer Contact Center at 1-800-327-7701, submit a grievance form through www.mhn.com, or file your complaint in writing to, MHN Appeals Unit, P.O. Box 10697, San Rafael, CA 94912. If you have a grievance against MHN, you can also contact the California Department of Managed Health Care, at 1-800-HMO-2219 or www.hmohelp.ca.gov. For information about group health care coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program may help you file your **appeal**. Contact California Department of Managed Health Care Help Center at 1-800-466-2219 or visit <http://www.healthhelp.ca.gov>. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform.

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Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-426-0023.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-426-0023.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-426-0023.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-426-0023.

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