Los Angeles Machinist Benefit Trust

Plan for Active Employees

Summary Plan Description

(“SPD”)

January 1, 2021

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CONTACTS

The following chart provides a handy reference guide to telephone numbers and web addresses for companies and entities you'll see in this Summary Plan Description booklet ("SPD").

The Administrative Office for the Plan is Corcoran Administrators, whose contact information is:

Main Office:	3313 Vincent Rd. #216 Pleasant Hill, California 94523
Local Office:	5402 Bolsa Avenue Huntington Beach, California 92649
Phone Numbers:	(925) 954-1439 (main office), (714) 898-2200 (local office), (800) 499-8121
Email:	ccorcoran@corcoranadmin.com
Website:	www.lambt.org

ADMINISTRATIVE OFFICE (Corcoran Administrators)	
• Questions about eligibility, benefits, and claims	(714) 898-2200 or (800) 499-8121
• Claims forms	www.lambt.org/forms
ANTHEM BLUE CROSS PPO Medical Plan (If you're in an indemnity PPO medical plan)	
• Help finding preferred providers	www.anthem.com (or call the Administrative Office)
• Required pre-authorization for Hospital admissions	Have your Physician call (800) 274-7767
HMOS (CALIFORNIA) MEDICAL PLANS	
• Kaiser Permanente	(800) 464-4000 www.kaiserpermanente.org
• UnitedHealthcare	(800) 624-8822 www.MyUHC.com
Navitus (Prescription Drug services if you're in a PPO Indemnity Medical Plan)	
• Help finding participating pharmacies	866-333-2757
• Mail order pharmacy program	888-240-2211
MHN: Employee Assistance Program (EAP) referrals and treatment for mental health and substance use for Indemnity Medical Plan (Anthem Blue Cross) enrollees **MHN Claims** **P.O. Box 14621** **Lexington, KY 40512-4621** **(800) 327-7701** **Mental Health and Substance Use Plan referrals provided by MHN for Kaiser Permanente enrollees** **Optum: Employee Assistance Program (EAP) referrals and treatment for participants enrolled in a UnitedHealthcare (UHC) HMO plan**	
Contact MHN or Optum for pre-authorization, referrals for treatment, and review of Emergency admission to a non-contracting facility (call within 48 hours)	

DENTAL PLAN	
• CIGNA	(800) 244-6224 www.mycigna.com
CIGNA PPO Dental Plan	
	(800) 244-6224 www.mycigna.com
CIGNA DHMO Dental Plan	
If a prepaid dental plan is an option and you enroll in the prepaid Dental Plan	(800) 244-6224 www.mycigna.com
VISION PLANS (if you are eligible for one of the vision plans)	
• Medical Eye Service (MES)	(800) 877-6372 www.mesvision.com
• Vision Service Plan (VSP)	(800) 877-7195 www.vsp.com
LIFE INSURANCE (if you are eligible for Life Insurance Benefits)	
• Provided by Anthem Blue Cross	(800) 552-2137 www.lifeclaims@anthem.com
SHORT TERM DISABILITY (if you are eligible for Short Term Disability Benefits)	
• Provided by Anthem Blue Cross	(800) 813-5682 www.disability@anthem.com

IMPORTANT INFORMATION ABOUT THE PLAN AND THIS SPD

TO ALL ACTIVE EMPLOYEES:

This Summary Plan Description booklet (SPD) contains a description of the benefits available through the Los Angeles Machinist Benefit Trust for Active Employees and their Dependents as of January 1, 2021. It replaces any prior SPDs or benefit booklets.

The actual benefits to which you are entitled result from negotiations between the Union and your Employer. The negotiated benefits depend upon your current employer and your Collective Bargaining Agreement with that employer. The Schedule of Benefits summary for that employer is distributed during Open Enrollment and when you first become covered under that benefit plan. It is also available from the Administrative Office:

Los Angeles Machinist Benefit Trust
c/o Corcoran Administrators
Main Office: 3313 Vincent Rd. #216, Pleasant Hill, California 94523
Local Office: 5402 Bolsa Avenue, Huntington Beach, California 92649
Phone Numbers: (925) 954-1439 (main office), (714) 898-2200 (local office), (800) 499-8121
Email Address: ccorcoran@corcoranadmin.com
Website: www.lambt.org

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 Employer or the Administrative Office. Always refer to your Collective Bargaining Agreement to determine the benefits that apply to you.

What's in This SPD?
This SPD contains the following information for Active Employees:
(Retiree benefits are described in a separate SPD booklet)

- Information about eligibility, enrollment, and options for continuing coverage when eligibility is lost;
- Information about health care benefits such as medical care, which may also include vision benefits, dental benefits, weekly disability benefits, extension benefits when disabled, and life and Accidental Death and Dismemberment benefits; 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 SPD
Review the benefits available to you under your Collective Bargaining Agreement with your current employer, review the comparison of benefits provided for your employer, and review the following material before making a choice of plans and before using benefits:

- This SPD
- The Schedule of Benefits for your employer that shows your benefits and enrollment options based on the information the Trust received about the terms of the 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 material modifications 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.

Make sure you and your dependents are enrolled for the coverage you select (you may not be covered if you have not enrolled). If you have any questions about eligibility or who is enrolled or what your benefits are, contact the Administrative Office.

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, because benefits provided by that employer at a different location or even at the same location may be different than those of your former employer. Benefit payments are based on the benefits in effect for that employer under that Collective Bargaining Agreement on the date the treatment or service is received. To request a copy of the Schedule of Benefits applicable to you under your current or 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.

Remember to please use only the benefits that are necessary so that the Trust can continue to provide quality benefits to Plan participants and beneficiaries.

AVISO A LOS PARTICIPANTES QUE HABLAN ESPAÑOL: Si tiene alguna pregunta tocante este resumen plan descripción, o requiere alguna otra información tocante a su cobertura de salud, por favor no dude en comunicarse con la Oficina Administrativa al (800) 499-8121, donde habrá varios representantes bilingües que con gusto le ayudarán.

Sincerely,

Board of Trustees
Los Angeles Machinist Benefit Trust

PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) - GRANDFATHERED HEALTH PLAN STATUS

The Los Angeles Machinist Benefit Trust believes that, with respect to the "high option" plan of benefits available for eligible active (non-retired) Plan participants and their eligible dependents, the plan continues to be a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("ACA"). As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the ACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the ACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administrative Office for the Plan. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, by calling (866) 444-3272 or visiting www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

IMPORTANT INFORMATION ABOUT THE PLAN AND THIS SPD

Authorized Sources of Information

The only sources of authorized information are the SPD 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 Board of Trustees and its 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 Board of 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 Board of Trustees, at its discretion, has 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 to make changes required by law or for any other reason. Any changes made by the Board of Trustees may affect the payment of expenses incurred by you before the change is adopted. Benefit changes may result from changes to the Collective Bargaining Agreements.

The Board of 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 Plan through collective bargaining. If the Plan is terminated, all benefits will cease after the assets of the Plan 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 SPD 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 SPD in Section 15.

SECTION 1: OVERVIEW

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

This SPD 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 (CBA) 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 or more carriers – High, Medium and Low Option. Currently UnitedHealthcare (UHC) and Kaiser Permanente
Prescription Drug	• Indemnity plans: Walk-in pharmacy and mail order currently through Navitus • HMO: through HMO plan (may be walk-in and mail order)
Employee Assistance Program (EAP)	• All medical plans - referrals for help with personal problems provided through MHN for indemnity medical plans and Kaiser Permanente or Optum (for all UHC medical plans)
Mental Health and Substance Use Treatment	• MHN provides mental health and substance use benefits for Indemnity medical plan enrollees. Kaiser Permanente provides its own mental health and substance use benefits.
Dental	Choice of plans (High, Medium, and Low Options) through CIGNA. Plan depends upon the benefits negotiated in the CBA. The dental benefits may include an Indemnity plan (traditional fee-for-service plan) with a PPO option through CIGNA, or a Prepaid DHMO through CIGNA.
Vision	• Vision benefits are provided under two vision contracts. If negotiated, the vision benefits may be provided by MES or VSP. The frequency of benefits available and the copayments depend upon the contract negotiated.

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**
Weekly Disability	• Provided through Anthem (also called "Anthem Blue Cross"). There are two different weekly disability benefits available to collective bargaining parties - $85 per week or 35% of basic wages.
Disability Extension	• 12 or 18 months - (based on Collective Bargaining Agreement) for employee and Dependents
Life insurance	• For employees (includes death benefits for Dependents) • Provided by Anthem Blue Cross
Accidental Death and Dismemberment (AD&D) insurance	• Employee, only provided by Anthem Blue Cross

Filing Claims

See the information from Kaiser Permanente, United Health Care (UHC), Optum, MHN, CIGNA, VSP, or MES, as applicable, for information on filing claims for medical, mental health/substance use, 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.

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)
The Genetic Information Nondiscrimination Act (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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 active employment, meets the eligibility requirements as a Bargaining Unit Employee or a Non-Bargaining Unit Employee in 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. Upon your death, benefits are paid to the last person you listed as your Beneficiary.

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" or "CBA" 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. "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.

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

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

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

16. “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.

17. “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.

18. “Covered Expense” means a Reasonable expense incurred for necessary treatment received by an Eligible Individual from a Physician, Dentist, or dental hygienist under the supervision of a Physician or Dentist that, in the geographical area where treatment is rendered, is the usual and customary procedure for the condition being treated. A Covered 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.

19. “Deductible Amount,” means the amount listed in the Schedule of Benefits, which is the amount of Covered Expenses the Eligible Individual must pay before benefits become payable under the Plan. The Deductible Amount applies once each Calendar Year or for the period of time specified for the particular benefit which may include:

    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 to most Covered Expenses.

    d. In order that the Deductible Amount will not be applied late in one Calendar Year and soon again in the following year, most Covered 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.

    f. “Deductible,” with respect to Covered Expense for medical or dental services or supplies incurred by each Eligible Individual, is shown per person and per family in Schedule of Benefits. Any Covered Expense incurred during the last three months of a Calendar Year that applies to the Deductible will be applied toward the Deductible for the following Calendar Year.

20. “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 their license.

21. "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.

22. "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.

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

24. "Eligible Employee" means each Active Bargaining Unit and Non-Bargaining Unit Employee who has satisfied the rules for eligibility.

25. "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.

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

27. "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, as amended from time to time. ERISA also gives specific rights to the participants of welfare and pension plans.

28. "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; not covered under Medicare reimbursement laws, regulations, interpretations, or schedules; not in accordance with the commonly and customarily recognized principles of medical practice in the United States at the time practiced; recognized by the organized medical community in the United States as Experimental or investigational; or not an effective treatment for the nature of the diagnosed illness, injury, or condition being treated, as determined by the Board of 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.

29. "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 per 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 per 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, or a hotel or similar institution.

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

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

31. "Formulary" means the preferred pharmaceutical products designated by the pharmacy benefit manager contracting with the Plan. "Non-Formulary" means the Drug is not on the Formulary list of preferred Drugs.

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

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

34. "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.

35. "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 the term Hospital include an institution that is operated principally as a rest, nursing, or convalescent home, or for the care and treatment of Drug addiction or alcoholism, or an institution that is principally devoted to the care of the aged, or any institution engaged in the schooling of its patients.

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

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

38. "Industrial" means a work-related Illness or Injury.

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

40. MHN means the organization contracted by the Plan to provide referral services and/or benefits for emotional, mental, nervous, and substance use disorders for certain Eligible Individuals enrolled in a plan that provides these services through MHN.

41. “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.

42. “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.

43. “Non-Bargaining Unit Employee” means a person who is not covered by a Collective Bargaining Agreement that requires contributions to this Plan, but whose employer has an approved Participation Agreement with the Trust to provide benefits for the employer’s non-bargaining employees.

44. “Non-Contracting Provider,” “Non-PPO Provider,” or “Non-Network Provider” means a provider that does not have an agreement recognized by the Plan to provide health care services to Plan participants and beneficiaries at specified rates.

45. “Nonindustrial” means an illness or injury that is not related to work for pay or profit.

46. “Nurse” means a registered graduate Nurse (RN), a licensed practical Nurse (LPN), a Nurse Practitioner (NP), or a licensed vocational Nurse (LVN), who does not ordinarily reside in the Eligible Employee’s home and is not the Eligible Employee’s spouse, child, sibling, or parent.

47. “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 during each Open Enrollment period beginning in November for a January effective date.

48. “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.

49. “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 their license.

50. “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.

51. “Plan” means the Los Angeles Machinist Benefit Trust Plan. “Plan” also means the rules stated in this SPD, as revised from time to time by the Board of Trustees.

52. “Preferred Provider Organization” or “PPO” means the medical or dental benefits payable under the Plan for services received from providers that have an agreement recognized by the Plan to provide health care services to Plan participants and beneficiaries at generally discounted rates.

53. “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, revise 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.

54. “Qualified Medical Child Support Order” 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.

55. “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 and absolute discretion of the Board of Trustees in consultation with industry professionals retained to advise the Board. See also “UCR.”

56. “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.

57. “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.

58. “Treatment Course” means a specific time period recommended and outlined by a professional or facility during which the Eligible Individual receives counseling or treatment and if required by the treatment plan attends group sessions, special classes, and meetings.

59. “Trust Agreement” means the Trust Agreement establishing and maintaining the Los Angeles Machinist Benefit Trust, and any modifications, amendments, extensions, or renewals thereof.

60. “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 Board of Trustees in its sole and absolute discretion and shall not refer to billed charges.

61. “Union” means the International Association of Machinists and Aerospace Workers (“IAM”), Local Lodge 1484, District Lodge 947, and District Lodge 725.

62. “USERRA” means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time, 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, including reserve and national guard duty under federal authority.

63. “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, 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.

64. “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 their 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 SPD 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 for Bargaining Unit Employees
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 CBA.

Benefits and Effective Date of Coverage for Bargaining Unit Employees
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. If you fail to enroll Dependents within the period allowed, you may have to wait until the next Open Enrollment period to add them.

Maintaining Eligibility for Bargaining Unit Employees
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 an employer stops contributing for its Bargaining Unit Employees, the employer's Non-Bargaining Unit Employees will no longer be covered; this loss of coverage will not be considered a qualifying event for COBRA continuation coverage.

Initial Eligibility for Non-Bargaining Unit Employees
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 for Non-Bargaining Unit Employees
The benefits to which you are entitled are determined by the agreement between the Trust and your employer. Generally, the benefits will be the same as those available to 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. If you fail to enroll Dependents within the period allowed, you may have to wait until the next Open Enrollment period to add them.

Continuing Eligibility for Non-Bargaining Unit Employees
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.
- 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);

  Note: coverage for a Domestic Partner is generally considered taxable under federal law; you will be responsible for the payment of taxes related to the benefits provided in advance of the date benefits are granted;
- Your children under 26 years of age (married or unmarried, regardless of student status or residence). 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
  - your stepchildren.

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

Proof of dependency is required for Dependent coverage. Acceptable proof of dependency includes a certified copy of your marriage certificate or proof of a registered domestic partnership for your partner or spouse; a birth certificate for your child; or a court order showing legal responsibility for a child.

Qualified Medical Child Support Orders (QMCSOs)
The Plan 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.

Medical child support orders shall be sent to the Administrative Office. When the medical child support order is received, the Plan will determine if the order meets the criteria for a Qualified Medical Child Support Order and notify you and the alternate recipient(s) named in the order of the Plan's determination. An alternate recipient is a child who is required to be covered under a group health plan with respect to a 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 for Dependents
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" below.

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 Dependents will not be covered for weekly disability benefits or the extension of benefits due to a disability unless they are the Eligible Employee for whom the benefit was negotiated.

Changes in Dependent Status
You must immediately notify the Administrative Office in writing when a Dependent status changes. This includes final dissolution of marriage, death, or an adult child reaching age 26. The changing of a participant's Beneficiary for death benefits is not acceptable notification of divorce or other change in dependent status.

If you do not immediately notify the Administrative Office and claims or premiums are paid on behalf of an ineligible dependent, you and the dependent are responsible for reimbursing the Plan for such overpayments, plus Attorney's fees, interest, and reasonable collection costs. The Plan 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. The participant and dependent may also be required to reimburse the Plan or the HMO for the value of 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 for Bargaining Unit Employees*:**
As a Bargaining Unit Employee, you will cease to be eligible for benefits on the earliest of the following:

- The last day of the month for which an Employer contribution was paid on your behalf. (For example, if the required contribution is paid on your behalf for January 2021, but not for February 2021, your eligibility for benefits will cease January 31, 2021.)

- The date the Plan terminates.

- The date you enter into full-time duty with the armed forces of any country, unless precluded by law (see coverage during a Family/Medical or Military Leave later in this SPD).

If loss of eligibility occurs, coverage may continue if you are entitled to any extension of benefits, make self-payments in accordance with the rules in effect on the date of loss of your active eligibility, or elect coverage under COBRA, if you qualify.

Termination of Eligibility for Non-Bargaining Unit Employees:
As a Non-Bargaining Unit Employee, you will cease to be eligible on the earliest of the following:

- The last day of the month for which an Employer contribution was paid on your behalf. (For example, if the required contribution is paid on your behalf for January 2021, but not for February 2021, your eligibility for benefits will cease January 31, 2021.)

- The date the Plan terminates.

- The date your employer no longer contributes on behalf of its bargaining unit employees.

- The date you enter into full-time duty with the armed forces of any country, unless precluded by law (see coverage during a Family Medical or Military Leave later in this chapter).

If loss of eligibility occurs, coverage may continue if you are entitled to any extension of benefits, make self-payments in accordance with the rules in effect on the date of loss of your active eligibility, or elect coverage under COBRA, if you qualify.

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

- the date Employee coverage ends.

- the date the Dependent enters into 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.

- the date the Dependent no longer meets the Plan's definition of an eligible Dependent (for example, by reaching age 26).

  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 due to age, 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 because of age,

  - the child is chiefly dependent on you for support and maintenance,

  - you submit proof of incapacity to the Administrative Office 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 two years have passed from the date the child would have lost eligibility due to 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 these options (see "Medical and Dental Plan Enrollment" below).

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 the date 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 the following rules:

This Plan covers employees and their eligible Dependents. However, if you decide not to enroll yourself or your eligible Dependents because they have other health coverage, you may be eligible to request immediate or retroactive enrollment for yourself and your eligible Dependents in this plan coverage if your eligible Dependents lose other health coverage. You must notify the Administrative Office and submit an enrollment application within 31 days after the other coverage ends. Otherwise, you must wait until Open Enrollment, which is generally in November for a January 1 effective date.

However, if you or your Dependents lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage or become eligible for a state subsidy for enrollment in this Plan under Medicaid or CHIP, you must properly enroll your eligible Dependents in this plan coverage within 60 days after coverage in Medicaid or CHIP ends or the date you or they became eligible for the subsidy. If you properly enroll yourself or your eligible Dependents within these periods, coverage will be retroactive to the date prior coverage ended. Otherwise, you must wait until Open Enrollment.

In addition, if you acquire a new eligible Dependent as a result of marriage, birth, adoption, or placement of a child with you for adoption, you can request enrollment for yourself and your new eligible Dependent retroactive to the date the Dependent attained eligible Dependent status as long as you notify the Administrative Office in writing within 31 days of the marriage, birth, adoption, or placement for adoption. Otherwise, you must wait until Open Enrollment.

If you enroll yourself and your Dependents under these HIPPAA rules for special enrollment, you will be given the opportunity at the time eligible Dependent enrollment occurs to change your medical benefit option to any other option available under this Plan to similarly situated participants in your geographical area. Please note, however, that your Dependents may only be enrolled under the medical benefit option that covers you. In other words, you can't be covered by one option and your Dependents covered by a different option.

To request special enrollment or obtain more information contact the Administrative Office at (714) 898-2200 or (800) 422-8121.

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 Plan 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 the Plan and lose eligibility for Medi-Cal (Medicaid) 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 the Administrative Office at (714) 898-2200 or (800) 422-8121, or Medicaid at (866) 298-8443, for information.

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Medical and Dental Plan Enrollment

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

Your options for a medical and dental plan depend on two 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 prepaid dental plan you must live in the plan's service area, and

Frequently Asked Questions

Q How can I find out whether I live in an HMO'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 direct you on how to locate PPO Doctors and Dentists in your area by either referring to the applicable website or phone number.

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 non-bargaining unit coverage agreement. **You and your Dependents must be enrolled to receive benefits.**

Before you make 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 CIGNA, 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 may have about eligibility or coverage. However, the most accurate information about an insured plan

will be provided by the insured plan's customer service department.

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 their services. At the time this SPD was printed, the medical PPO network was being administered by Anthem Blue Cross and the dental PPO network was being administered by CIGNA.

All indemnity medical plans contain managed care features that require pre-authorization for non-Emergency hospitalization.

* The Allowable Charge for a service from a PPO provider is the amount specified in the contract between the PPO and the provider. The Allowable Charge for a service from a non-PPO provider is determined by the Plan. Billed charges are generally higher than Allowable Charges.

Health Maintenance Organizations (HMOs) and Prepaid Dental Plans (DHMOs)
Most Collective Bargaining Agreements provide for two prepaid medical options (HMOs) 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 fill 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 SPD was printed, the Trust had HMO contracts in effect with Kaiser Permanente and UnitedHealthcare for Hospital and medical care and a contract with CIGNA 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 Trust. You will be notified of any change in carriers in advance and 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 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 contact 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.

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. Also, 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 your employer makes contributions to the Trust on your behalf, coverage may continue uninterrupted. Contact your employer for details of the requirements and benefits under the FMLA. 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 government.) 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.

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) requires that the Plan provide you with the right to elect continued health coverage for up to 24 months if you are absent from employment due to military service in the Uniformed Services of the United States, including Reserve and National Guard Duty under federal authority, as described below.

Active Employees who enter in full-time active duty with the armed forces of the United States, and their eligible Dependents, may elect to continue their coverage under the Trust 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 the participant's 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 federal law (within 14 days of completing military service for a leave of 31 to 180 days, or within 90 days for a leave of more than 180 days), 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 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

The COBRA rules outlined below are subject to change depending on federal legislation. Please check with the Administrative office or refer to any notifications you have received about changes or your COBRA notice for current rules.

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;
  - 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, due to divorce or reaching age 26).
  - 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 the benefit has been negotiated in the Collective Bargaining Agreement.

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. This extension of benefits does not include disability benefits or weekly disability benefits.

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, be required 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 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.
- proof of the disability must be provided to the Administrative office within 60 days from the date of your disability.

Maximum Periods for a Disability Extension
There are two disability extensions benefits available for the negotiating parties: (1) benefits for the Employee and the Employee's Dependents are continued until the earlier of 12 months from the date eligibility would otherwise be lost or the date the disability ends, or (2) benefits for the Employee and Dependents are continued until the earlier of 18 months from the date eligibility would otherwise be lost or the date the disability ends.

Your Schedule of Benefits will tell you which maximum period, 12 months or 18 months, 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 CBA 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 below). 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 COBRA continuation coverage, you, your spouse, or your Dependent child must pay required monthly premiums directly to the Trust.

Important Information for Family Members
This section of this SPD 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 children read this section of the SPD carefully.**

Alternatives to COBRA Continuation Coverage

- **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 of the Self-Pay Option and COBRA	
Employees who lose coverage have two options for continuing coverage:	
Self-Pay Option	The employee can select this option, which covers the employee and all eligible Dependents. This option continues all coverage except disability extension and weekly disability benefits. If you elect this option, the number of months you continue coverage will reduce the number of months available under COBRA if you also take COBRA.
COBRA	The employee can elect this option for the employee or for the entire family. Or, each family member can make a separate election for individual coverage. You have the right to continue only those benefits that you had at the time of the qualifying event, but not include life insurance, weekly disability, or disability extension. The continued coverage may include only medical and prescription Drugs or all of the coverage except life insurance, weekly disability, and disability extension. Once you take COBRA, you forfeit your rights to the self-pay option.
	See also "Coordination of COBRA with Disability Extension" following the qualifying event chart below.

- Those entitled to elect COBRA continuation coverage may have more affordable or generous alternatives for coverage available to them. One option may be "special enrollment" in other group health coverage. Under the Health Insurance Portability and Accountability Act (HIPAA), upon certain events, group health plans and health insurance issuers are required to provide a special enrollment period. During that period, individuals who previously declined coverage for themselves and their dependents, and who are otherwise eligible, may enroll without waiting until the next open period for enrollment. One event that triggers special enrollment is when an employee or Dependent loses eligibility for other health coverage. For example, an employee who loses group health coverage may be able to special enroll in a spouse's health plan. The employee or Dependent must request special enrollment within 30 days of losing other coverage.

- Losing employment-based health coverage also gives the employee an opportunity to enroll in the Health Insurance Marketplace in their state of residence. The Marketplace allows individuals and small businesses to find and compare private health insurance options. Through the Marketplace, individuals may qualify for cost-sharing reductions and a tax credit that lowers monthly premiums.

- Being offered COBRA continuation coverage does not limit eligibility for coverage or for a tax credit through the Marketplace. The employee or Dependent must select Marketplace coverage within 60 days before or after the loss of other coverage; otherwise they will have to wait until the next Open Enrollment period. Through the Marketplace, individuals also can determine whether they or their dependents qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP).

- Eligible individuals can apply for and enroll in Medicaid and CHIP at any time. For more information about the Marketplace, including information about Medicaid or CHIP eligibility, visit www.HealthCare.gov. If an employee or Dependent chooses to elect COBRA, they can request special enrollment in another group health plan or the Marketplace once COBRA is exhausted. In order to exhaust COBRA coverage, the individual must receive the maximum period of COBRA coverage available without early termination.

Who Is Entitled to Continuation Coverage?
A group health plan must offer COBRA continuation coverage only to qualified beneficiaries and only after a qualifying event has occurred.

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, the spouse of an employee, or the Dependent child of an employee.

Note: COBRA coverage for Domestic Partners is not required under federal law. Under the Plan, your Domestic Partner may elect an extension of benefits similar to COBRA but it will not provide extensions that are required for legal Dependent spouses (such as extension of benefits due to marriage). The Plan does not cover children of Domestic Partners and therefore COBRA is not available to the children of your Domestic Partner that are not your legal Dependent children.

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 or domestic partner, and your Dependent children	18 months*
Your death	Your spouse or domestic partner and your Dependent children	36 months
Your divorce or legal separation from your spouse, or termination of your Domestic Partner relationship with your Domestic Partner	Your former spouse or domestic partner and your Dependent children	36 months

Qualifying Event	Who May Continue Coverage	Maximum Period of Continuation Coverage
Your child ceases to meet the Plan's definition of an eligible Dependent (for example, because of marriage or reaching age 26)	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 when 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 footnote to chart above). 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 self-pay 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: Samantha stops working (the first COBRA qualifying event) and enrolls herself and her family in COBRA continuation coverage for 18 months. Three months after her COBRA continuation coverage begins, Samantha's child turns 26 and no longer qualifies as a Dependent child under the Plan's definition. Samantha'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 events that total less than 36 months, you can apply for 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.***

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 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," above).

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 your Dependents from obtaining or extending COBRA coverage.

How to Notify the Administrative Office
To provide the Trust with notice of any of these five situations, you must complete and sign the Trust'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 (800) 499-8121 or (714) 898-2200 (Local office). Alternatively, you may send a letter to the Trust 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
c/o Corcoran Administrators
3313 Vincent Rd. #216
Pleasant Hill, CA 94523
(925) 954-1439

Customer Service Phone Numbers
(800) 499-8121
(714) 898-2200 (Local office)

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 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 latest 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 a 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 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 their 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 coverage is requested 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 that time (unless you move out of an HMO's or prepaid plan's service area). You may select 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 fail 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);

- 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 will not be provided by the 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 may be 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.

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 PPO 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 PPO 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
All services and supplies that you receive are payable only under the plan in which you are enrolled.

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

How the Plans Work

The PPO 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 the PPO medical plans, once 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 Calendar Year, provided the individual uses PPO providers (see "PPO Contracting Providers" below). Check your Medical Comparison to find out the "annual covered charges maximum" or the "out-of-pocket maximum" if a PPO medical plan has been negotiated and you elect enrollment in that plan. 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 separately 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.

PPO Contracting Providers

All Indemnity Medical Plans contain a Preferred Provider Organization (PPO) option. This means that the Trust 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 SPD was printed, the PPO network for the Indemnity Medical Plans was being administered by Anthem Blue Cross.

You will be given a listing of PPO 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.anthem.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 Trust'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 the usual, customary, and Reasonable (UCR) allowable provided by Anthem Blue Cross.

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 Anthem Blue Cross at the following phone 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 Anthem 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 Anthem 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 pre-authorization decision on a Hospital stay on an expedited basis. 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 SPD 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 Anthem 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 the usual, customary, and Reasonable (UCR) allowable provided by Anthem Blue Cross.

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 a referral from the patient's Physician indicating care and admission to a skilled nursing facility is medically necessary and is required due to the nature of the patient's illness or injury.

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 the usual, customary, and Reasonable (UCR) allowable provided by Anthem Blue Cross.

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 the usual, customary, and Reasonable (UCR) allowable provided by Anthem Blue Cross.

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 the usual, customary, and Reasonable (UCR) allowable provided by Anthem Blue Cross.

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 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 the usual, customary, and Reasonable (UCR) allowable provided by Anthem Blue Cross.

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 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, Nurse Practitioner, 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 (including air 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

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 or domestic partner)

- In vitro fertilization or any type of artificial insemination, any sex change counseling, treatment or surgery, ultrasound 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 or supplies provided by the spouse, child, sibling, or parent of the patient or the patient's spouse, or provided by a person who normally lives with the patient

- 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 use (*Substance use 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 Anthem 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 Anthem Blue Cross or the administrative office, Corcoran Administrators, 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 Anthem Blue Cross and if necessary Corcoran Administrators. 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 Anthem Blue Cross identification card to the admitting office and tell the admitting office that the claim must be submitted directly to Anthem Blue Cross electronically.

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 Anthem 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 latest CPT codes—the codes for Physician services and other health care services found in the latest edition of the *Current Procedural Terminology,* as maintained and distributed by the American Medical Association or HCPC code
- the latest ICD codes—the diagnosis codes found in the latest edition of the *International Classification of Diseases, 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
- Accident details, if treatment is due to an Accident
- information on other insurance coverage, if any, including coverage that may be available to your spouse through your spouse's employer

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

LOS ANGELES MACHINIST BENEFIT TRUST
P.O. Box 5030
Walnut Creek, CA 94596

Deadline for Submitting Claims
You should submit your claims **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 questions about submitting claims, contact the Administrative Office.

For information on what to do if you disagree with the decision made on a 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 are enrolled in an Indemnity PPO 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 PPO Medical Plan, your Prescription Drug benefits are administered by a Pharmacy Benefits Manager (PBM), currently Navitus.

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 for PPO Indemnity Medical 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 Plans	• 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.

The Two Prescription Drug Plans for PPO Indemnity Medical Plans *(See your Schedule of Benefits to see which of these plans has been negotiated for you)*		
	Walk-In Pharmacies	**Mail-Order Service**
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 medications.*** Maintenance medications are medications used to treat or prevent Chronic or long-term conditions such as diabetes, asthma, high blood pressure, and heart disease.

*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: 866-333-2757

Mail-Order Service
For mail-order service, you must use the Navitus mail service pharmacy. Call the Customer Service Center at 888-240-2211 at 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

Prescription Drug benefits will not be paid for the following:

- Most Injectable products
- 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 Navitus customer service at (866) 333-2757 to locate the Contracting Pharmacy nearest you.

SECTION 6: EMPLOYEE ASSISTANCE PROGRAM ("EAP") FOR INDEMNITY MEDICAL PLAN AND KAISER HMO PARTICIPANTS

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

The Employee Assistance Program is available to all eligible PPO medical plan enrollees and Kaiser Permanente HMO plan enrollees and their Dependents, regardless of what medical plan they are in.

Employees enrolled in a UnitedHealthcare HMO plan receive their EAP benefit through Optum. The Optum benefits are described in a separate brochure. You may contact Optum at: (866) 248-4096 for details of its EAP program.

The EAP Program - Provided by MHN

The Trust has contracted with MHN to provide Employee Assistance Program benefits to covered indemnity PPO medical plan and Kaiser Permanente HMO enrollees 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 Permanente medical plan, MHN will assist you in obtaining access to the appropriate care.
- If you are enrolled in an indemnity PPO 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 you with a referral to an outside agency.

In order to receive any EAP services for mental health or substance use benefits under the Trust, you should use the services of MHN for assistance in choosing the appropriate treatment for your condition or problem. If you are enrolled in an indemnity medical plan, MHN will suggest treatment though one of its contracted providers. You must use Kaiser Permanente facilities and providers if you are enrolled in a Kaiser Permanente plan but MHN can help you locate the appropriate treatment. If you are enrolled in a UnitedHealthcare plan, you should use the services of Optum for both EAP and other mental and nervous or substance use services.

How to File a Claim

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

You may incur charges if you use the services of the providers MHN or Optum 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 USE TREATMENT FOR ENROLLEES IN PPO INDEMNITY MEDICAL PLANS

In this Section you'll find:
- What's in the program
- Prior 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.

If you're enrolled in a Kaiser Permanente HMO plan or in a UnitedHealthcare HMO plan, your mental health and substance use benefits will be provided under the plan in which you are enrolled. You should see the materials from Kaiser Permanente or UnitedHealthcare for these benefits.

The Program – Indemnity PPO Medical Plan Enrollees

A mental health and substance use 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 use rehabilitation at a Reasonable cost from a wide selection of exclusive providers within your community. It is not required that you use MHN providers but your out-of-pocket expenses are lower using a PPO provider.

The schedule of benefits for mental health and substance use is shown in the chart below.

Frequently Asked Questions

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

A Yes. To receive benefits for mental health or substance use treatment, Indemnity PPO medical plan enrollees should contact MHN to help them understand the benefits, types of provider that best suits their needs, and the venue where they can obtain the proper level of care.

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.

Mental Health and Substance Use Benefits for Enrollees in Indemnity Medical plans		
Benefit	**PPO**	**Non-PPO (OON)**
Calendar Year Deductible		
High Option PPO Plan	$100/person; $200 family combined PPO/OON Medium Option - $100/person; $200 family	
Medium Option PPO Plan	$100/person; $200 family combined PPO/OON Medium Option - $100/person; $200 family	
Out-of-pocket Maximum (OOP)		
High Option PPO Plan	$500/person	No OOP maximum
Medium Option PPO Plan	$7,100/person; $13,700 family	No OOP maximum No OOP maximum
Coinsurance*		
High Option Plan	0% coinsurance	20% coinsurance
Medium Option Plan	20% coinsurance	30% coinsurance

***Without Prior Authorization for hospitalization, benefits reduce by 15%**

How to Use MHN

If you need to use services for mental health or substance use, 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 (or 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 use 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 behavioral health treatment program. If you require inpatient treatment in a Hospital, you must obtain prior - authorization or the benefit payment amount will be reduced by 15%. See Prior Authorization below for details.

If you are in an **Emergency situation**, Prior 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," below, for the definition of an Emergency.

Time Frames for Response
Decisions on Prior 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

Some services described in this Section will be reviewed if the event is not an Emergency. See "How to Use MHN" below for information on how to obtain Prior Authorization.

If you don't get the necessary Prior Authorization, your benefit payments will be reduced by 15% of the amount that would have been payable for Covered Expenses.

The Providers You May Use – Indemnity PPO Medical Plan Enrollees

Inpatient, Residential, and Day Treatment

In **non-Emergency** situations, you **may** use MHN contracting facilities and providers for the highest benefit.

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, your benefit payment will be reduced by 15%.

If the services are considered Covered Expenses, 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 at the maximum level. MHN may suggest a transfer to a participating Hospital, as long as the move will 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 an MHN Contracting Provider in California would result in a serious deterioration to your health.

NOTE: For outpatient counseling services, you <u>should</u> go to an 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 should go to an MHN Contracting Provider for the highest benefit. MHN will work with you to find a provider who is conveniently located and well-suited to your needs.

Exclusions from Coverage – Indemnity PPO Medical Plan Enrollees

The following are specifically excluded from Covered Services, unless coverage is required by law:

- Treatment of detoxification in newborns.

- Treatment of congenital and/or organic disorders. This includes, without limitation, Alzheimer's disease, mental retardation (other than the initial diagnosis), organic brain disease, delirium, major neurocognitive disorder or dementia, amnesic disorders, and other cognitive disorders as defined in the Diagnostic and Statistical Manual of Mental Disorders (“DSM”).

- Treatment for chronic pain and other pain disorders, smoking cessation, nicotine dependence, nicotine withdrawal, and nicotine-related disorders.

- Treatment of obesity and eating disorders. This does not include the diagnosis of anorexia and bulimia nervosa as defined in the DSM.

- Court-ordered testing and treatment.

- Private hospital rooms and private duty nursing, unless determined to be a Medically Necessary service and Prior Authorization from MHN is obtained.

- Ancillary services such as:

    a. Vocational rehabilitation.
    b. Behavioral training.
    c. Speech or occupational therapy.

d. Sleep therapy and employment counseling.
e. Training or educational therapy for reading or learning disabilities.
f. Other education services.

- Testing, screening or treatment for:

  a. Learning disorders, expressive language disorders, mathematics disorder, phonological disorder, and communication disorders not otherwise specified.
  b. Motor skills disorders, and developmental coordination disorder.
  c. All disorders of infancy and early childhood and developmental disorders including, but not limited to, communication disorders, pervasive developmental disorders, autistic disorder, Rett's disorder, and Asperger's disorder.
  d. Disorders resulting from general medical conditions, including but not limited to, catatonic disorder due to general medical condition, personality change due to general medical disorder, narcolepsy, stuttering, stereotypic movement disorders, sleep disorders, Tic disorders, elimination disorders, sexual dysfunctions, primary insomnia.
  e. Personality disorders.
  f. Pedophilia.
  g. Primary sleep disorders, primary hypersomnia, and dyssomnia not otherwise specified.
  h. Age-related cognitive decline.

- Treatment of conditions which are medical in nature, even when such conditions may have been caused by a mental disorder.

- Treatment by Providers other than those within licensing categories then recognized by MHN as providing Medically Necessary services in accordance with applicable medical community standards.

- Treatment rendered for conditions not listed as an Axis I disorder (V Code diagnoses listed as an Axis I disorder are also excluded).

- Services in excess of those with respect to which Prior Authorization by MHN is obtained.

- Psychological testing except as authorized by MHN and 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.

- Missed appointments. MHN will consider one of the Eligible Individual's counseling sessions used if the Eligible Individual fails to cancel with the Provider at least 24 hours in advance, unless the appointment is missed because of an Emergency or circumstances beyond the Eligible Individual's control.

- All prescription or non-prescription Drugs and laboratory fees, except for Drugs and laboratory fees prescribed by a psychiatrist in connection with inpatient treatment.

- Medication management or other pharmacological services rendered by a non-psychiatrist provider.

- Inpatient services, treatment, or supplies rendered without Prior Authorization, if required, except in the event of an Emergency.

- Healthcare services, treatment, or supplies rendered in a non-Emergency by a non-Participating Provider, unless Prior Authorization by MHN has been received or as otherwise provided by the Plan.

- Damage to a Hospital or facility caused by the Eligible Individual.

- Healthcare services, treatment, or supplies determined to be Experimental by MHN in accordance with accepted mental health standards, except as otherwise required by law.

- Healthcare services, treatment or supplies:

  a. Provided as a result of any Workers' Compensation law or similar legislation.
  b. Obtained through, or required by, any governmental agency or program.
  c. Caused by the conduct or omission of a third party for which the Eligible Individual has a claim for damages or relief.

- Healthcare services, treatment, or supplies for military service disabilities for which treatment is reasonably available under governmental healthcare programs.

- Treatment for biofeedback, acupuncture, or hypnotherapy.

- Healthcare services, treatment, or supplies rendered to the Eligible Individual which are not Medically Necessary services. This includes, but is not limited to, services, treatment, or supplies primarily for rest or convalescence, custodial or domiciliary care as determined by MHN.

- Services received before the Eligible Individual's effective date, during an inpatient stay that began before the Eligible Individual's effective date, or services received after the Eligible Individual's coverage ended, except as specifically stated herein.

- Services for which:

  a. The person is not legally obligated to pay.
  b. No charge is made to the person.
  c. No charge is made to the person in the absence of insurance coverage.
  d. It is provided without cost to the person by a local, state, or federal government agency.

- Services in connection with conditions caused by an act of war.

- Conditions caused by release of nuclear energy, whether or not the result of war.

- Emergency room services not provided by a psychiatrist directly related to the treatment of a mental disorder in accordance with the limitations listed above.

- Professional services received from a person who lives in the Eligible Individual's home or who is related to the Eligible Individual by blood or marriage.

- Any services or supplies to the extent they are covered under Parts A or B of Medicare if either:

  a. The Eligible Individual is enrolled in Part A of Medicare, whether or not the individual is enrolled in Part B of Medicare, or
  b. The Eligible Individual is entitled to enroll in Medicare and has made the required number of quarterly contributions to the Social Security System, whether or not the Eligible Individual has actually enrolled in Medicare or claimed Medicare benefits.

- Services performed in any Emergency room which are not directly related to the treatment of a mental disorder.

- Services received out of the Eligible Individual's primary state of residence except in the event of an Emergency and as otherwise authorized by MHN.

- Electro-Convulsive Therapy (ECT) except as authorized by MHN according to MHN policies and

procedures.

- All other services, confinements, treatments, or supplies not provided primarily for the treatment of specific covered benefits specifically included as Covered Services elsewhere in this Plan.

- County-based case management services.

How to File a Claim for Mental Health or Substance Use Benefits – Indemnity PPO Medical Plan Enrollees

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 Prior 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.

Prior Authorized Services
You will not need to file claims for prior 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 – PROVIDED THROUGH CIGNA

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 SPD 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 a choice of 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 Plan" below), 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 is a separate benefit and if that has been negotiated for you, there is 0 separate lifetime maximum benefit.

Prepaid Plan
The prepaid Cigna plan (DHMO) is like an HMOs for dental benefits. Most services are provided at no charge or in exchange for specified co-pay, but you may use only Cigna DHMO 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 Trust'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 SPD was printed, the PPO network was being provided through CIGNA.

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 Cigna at (800) 244-6224 or visit www.mycigna.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 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 SPD 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.

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 Cigna at the following address:

Cigna Dental
P.O. Box 188037
Chattanooga, TN 37422-8037

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 a 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 SPD 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.

The Plan contracts with both VSP and MES to provide vision benefits. If vision care benefits have been negotiated on your behalf, the Plan will pay benefits for an exam and eyeglass lenses once every 12 months and eyeglass 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 or because VSP benefits have been negotiated. In addition, some employees have negotiated an option of either MES or VSP vision 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 for the vison provider you have selected. 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 AND EXTENSION OF BENEFITS DURING DISABILITY

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

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

The short term weekly disability benefits are fully insured with Anthem Blue Cross. Two different plans are available for negotiations: one pays $85 per week during the disability for up to 26 weeks; the other pays 35% of your basic wages for up to 26 weeks. Refer to your collective bargaining Agreement (CBA) for the benefits you have.

Extension of Benefits during disability is self-insured by the Trust and provides two different periods of extended coverage – 12 months or 18 months.

Dependents are not eligible for weekly disability benefits under the Plan. However, if extended disability is bargained, the Dependents will also be covered while the employee is disabled and continues to be eligible for the extension.

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

Disability Extensions:

Benefit Amount	All benefits for which you and your dependents are covered on the date you become disabled are continued except weekly disability and disability extension, until the earliest of the date you are no longer disabled or 12 or 18 months depending upon the plan selected. No contribution is required for coverage during this period. If you are still disabled, you may qualify for COBRA extension.
When Benefits Begin	Coverage begins on the first day of the month following the date of disability provided you are covered for benefits during the month you become disabled and your employer has made contributions for this benefit.

Your employer may (as a result of collective bargaining) also be required to continue contributions for your coverage during the disability**.** If you have questions about your coverage, check with the Administrative Office or refer to the applicable Collective Bargaining Agreement.

How the Short Term Disability Benefits Work

This Short Term Disability 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 – Short Term Disability
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 Physician visit.

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
P.O. Box 6149
Garden Grove, CA 92846

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 the Physician's license, certify to: (a) your disability; (b) the probable duration of the disability; and (c) the medical facts causing the disability within the Physician's 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 Anthem Blue Cross.

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 living spouse
2. Your living children (in equal shares)
3. Your living parents (in equal shares)
4. Your living siblings (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 life 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 your life insurance 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 is expected to remain in such institution or a similar institution for the remainder of the person's life
  - after the person's effective date of coverage under this policy and
  - while this policy is in effect for such person

  An eligible institution is 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, 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
  - 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 the 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, they can request a review of the decision. Please alert your Beneficiary to the claims review information provided in Section 15 of this SPD.

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 26	$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 life 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 below.

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: The term "principal sum" means the amount of life insurance that has been negotiated on your behalf. For example, if your negotiated life insurance is $10,000 and your death is accidental, your Beneficiary will receive $20,000 ($10,000 for life and $10,000 for Accidental Death). If, however, you accidentally lost one of your hands, the AD&D policy would pay you $5,000 (1/2 of the $10,000 face amount).

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.

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 the armed forces 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 disagree 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 SPD. 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 though the Eligible Individual fails to claim their rights to such benefits or for which benefits of ay nature are recovered or found to be recoverable, whether by adjudication or settlement, under any worker's compensation 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; (b) for which the Eligible Individual is not required to pay; (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 by the spouse, child, sibling, 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.

If 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 must 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 interests of the Plan.

SECTION 15: OTHER IMPORTANT PLAN INFORMATION

In this Section you'll find:

- 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 the Plan 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 Board of Trustees of the Plan, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health Plan operations, 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 Board of Trustees.

The Plan also hires professionals and other companies to assist it in providing health care benefits. The Plan requires 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 U.S. 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 use benefits are coordinated if you are in an Indemnity Medical Plan or an HMO other than Kaiser Permanente, or UnitedHealthcare, see the materials provided by MHN or Optum.

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 SPD).

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 that parent 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, your spouse 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 the individual 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 primary 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 Trust for any monies paid by the Plan.

Benefits under the Plan due to injury or illness caused by the act or omission of another may be conditioned on the following:

- you agree, before any benefits are paid, to reimburse the Plan, to the extent of benefits provided by the Plan, immediately upon receipt of payments made by or on behalf of persons causing such injury. This provision shall be binding on the heirs, beneficiaries, personal representatives, or estates of the injured person, whether such payments are a result of judgment, settlement, compromise, or otherwise, and

- you execute and deliver to the Plan a lien, assignment, or similar writing to the extent of the dollar amount of benefits provided by the Plan. Such lien shall be a lien upon any proceeds which shall be received by the injured person, his or her heirs, beneficiaries, personal representatives, or estate, and which proceeds are paid by reason of any judgment, settlement, compromise, or otherwise. Such lien may be filed with any person, organization, or otherwise, including any court of competent jurisdiction, to protect the interests of the Plan.

The participant and/or injured person, their heirs, beneficiaries, personal representatives, attorneys, or estate, shall execute such documents as the Board of Trustees may require in order to acknowledge and evidence the rights of the Plan as set forth in this section, and shall do nothing to prejudice such rights.

The Board of Trustees may intervene directly in any pending judicial or administrative proceeding in order to protect the Trust's right to collect any monies due. 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 Board of Trustees has 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

In the event your claim and appeal is denied in whole or in part due to issues involving medical judgment or a rescission (retroactive termination or suspension) of coverage, you will be afforded, at no cost to you, an opportunity for an appeal before an independent, qualified external appeals body, whose decision on the appeal will be final and binding on all parties.

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 use benefits provided through MHN or Optum, one of the prepaid dental plans, or one of the vision plans, 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, Optum, Cigna, 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 claims 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 a dispute with a carrier.

Deadline for Filing Suit, and Forum for Suits involving the Plan
Any civil action brought under Section 502(a) of ERISA, challenging a denial of benefits or eligibility for benefits under this Plan, in whole or in part, must be filed within two years of the date of the Plan's denial of your appeal relating thereto. If no appeal was filed, even though appeals are required as a condition of filing suit, then suit must be brought within two years of the date of the Plan's denial of your claim.

Any civil action by a Plan participant, dependent, Beneficiary, alternate payee, or provider of benefits pursuant to an assignment of benefits, relating to or arising under the Plan, shall be brought and resolved only in the United States District Court for the Central District of California, and in any court in which appeals from such court are heard. Such court or courts shall have personal jurisdiction over any Plan participant, dependent, Beneficiary, alternate payee, or provider of benefits named in such action.

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 SPD. 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 use 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 (t*hese will not be considered claims even if they are referred to as "claims" by the Administrative Office*):

- 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 (h*owever, 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 Sections covering each type of benefit earlier in this SPD. 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 Anthem 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, your Doctor should make sure the representative who takes the call is advised of this.

  NOTE: If your admission involves mental health or substance use 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" above 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
  3313 Vincent Rd. #216
  Pleasant Hill, California 94523

- **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
  3313 Vincent Rd. #216
  Pleasant Hill, California 94523

- **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
  3313 Vincent Rd. #216
  Pleasant Hill, California 94523

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 filed as soon as it is received by the applicable review authority: Anthem 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, Anthem 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, Anthem 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, Anthem 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 Anthem 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 Anthem Blue Cross expects to make a decision.

  If an extension is needed because Anthem Blue Cross needs additional information from you, Anthem 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). Anthem 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 Anthem 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, Anthem 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 Anthem 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 Anthem 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 Anthem 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 when your claim is denied in whole or in part. 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 SPD, 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.

If you do not understand English and have questions about a claim denial, contact the Administrative Office.

- SPANISH (Español): Para obtener asistencia en Español, llame al (800) 499-8121.
- TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (800) 499-8121.
- CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 (800) 499-8121.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 499-8121.

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 did not receive a 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 SPD. 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 use 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 use 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 SPD unless you use Contracting Providers (also called "preferred" or "participating" providers). See the Sections on health care benefits (including mental health and substance use treatment) for more information.

- **Failure to submit claims timely.** 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 Trust 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 Board of Trustees has 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:

Corcoran Administrators
3313 Vincent Rd. #216
Pleasant Hill, California 94523
Local Telephone Number: (925) 954-1439
Toll-free Telephone Number: (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 shall be entitled to:

Receive Information About Your Plan and Benefits

- 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

- 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.

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 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 SPD 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

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 SPD was printed are shown below.

Agent for Service of Legal Process
Los Angeles Machinist Benefit Trust

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 above.

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

Corcoran Administrators
3313 Vincent Rd. #216
Pleasant Hill, California 94523
Local Telephone Number: (925) 954-1439
Toll-free Telephone Number: (800) 499-8121

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

Union Trustees

Mr. Kevin Kucera
Area Director/Business Representative
IAMAW D.L. 190, Local Lodge 1484
1261 Avalon Blvd.
Wilmington, CA 90744
310-835-6688

Mr. Salvador Vasquez
President/Directing Business Representative
IAMAW District Lodge 947
535 W Willow Street
Long Beach, CA 90806
562-427-8900

Mr. Jack Morck
c/o: Corcoran Administrators
3313 Vincent Rd., #216
Pleasant Hill, CA 94523
951 264-1725

Mr. Larry Olinger
Directing Business Representative
IAMAW District Lodge 725
5402 Bolsa Avenue
Huntington Beach, CA 92649
714-898-9141

Employer Trustees

Mr. Bill Bistline
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1281 Pier G Way
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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 5816 Corporate Avenue, Suite 190 Cypress, CA 90630 (800) 624-8822
Employee Assistance Program (EAP)	MHN – EAP for Indemnity medical plans and Kaiser Permanente enrollees 2370 Kerner Blvd. San Rafael, CA 94901 (818) 676-6032 Optum – EAP for all UnitedHealthcare Enrollees (866) 248-4096 www.liveandworkwell.com Access code: lambt
Mental Health and Substance Use treatment Plan for Participants in California Not Enrolled in Kaiser Permanente or United Health Care 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 Baker Street Costa Mesa, CA 92626 (800) 877-6372 Vision Service Plan (VSP) 333 Quality Drive Rancho Cordova, CA 95630 (800) 852-7600
Weekly Disability, Life Insurance, and Accidental Death and Dismemberment Insurance	Anthem Blue Cross

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	Anthem Blue Cross 21215 Burbank Blvd. Woodland Hills, CA 91367
Preferred Provider Organization for Dental Providers in the Indemnity Dental Plans	Cigna
Walk-in and Mail Order Prescription Drugs for Indemnity Medical Plan Participants	Navitus

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 SPD is intended to be a summary of the Trust'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 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.

Los Angeles Machinist Benefit Trust
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 Board of 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 SPD. 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.