



Los Angeles Machinist Benefit Trust

6801 EAST WASHINGTON BLVD. • CITY OF COMMERCE, CA 90040

TO: ALL CALIFORNIA CLASS I RETIRED EMPLOYEES COVERED UNDER THE LOS ANGELES MACHINIST BENEFIT TRUST

**RE: OPEN ENROLLMENT PERIOD –
EFFECTIVE JANUARY 1, 2012**

It is Open Enrollment time and you have the opportunity to change your medical plan. During this time, you can also add or terminate dental or vision plan coverage. The enclosed Benefit Comparisons summarize the benefit choices you have for the 2012 calendar year.

IF YOU DO NOT WISH TO MAKE ANY CHANGES TO YOUR CHOICE OF MEDICAL OR DENTAL PLANS, NO ACTION IS REQUIRED.

Please be advised that Class I Retirees are those who retired from an employer that continues to contribute to the Trust for retiree coverage.

Read the comparisons and choices carefully!

WHAT ARE MY BENEFITS?

You have a choice between two “HMO” medical plan options through UnitedHealthCare (formerly PacifiCare) or Kaiser. You may select the High HMO Option, or Low HMO Option Plan.

In addition to your medical plan options, any retiree who resides in the service area of the United Concordia DHMO Dental plan, can elect coverage under that dental plan and self-pay for coverage. As a Class I Retiree, you can also elect the prepaid vision benefit through Medical Eye Services (MES) and self pay for that coverage as well. The amount you pay for your coverage is determined by the Plan.

The Comparison Sheet(s) show your benefit plan choices. If you want information on provider networks or more details on the plan options, contact the Trust Fund Administrative Office or visit the Los Angeles Machinist Benefit Trust website at www.lambt.org. If you are changing to the Low Option plan or want to enroll in the High Option plan for the first time, you must re-enroll by completing the enclosed enrollment form.

WHAT ARE MY OPTIONS IF I AM ELIGIBLE FOR MEDICARE?

All Medicare eligible retirees must enroll in one of the Medicare HMOs. This means that you must assign your Medicare Part A and Part B premiums to the carrier. You must use the providers under contract with the selected “HMO” for benefits to be payable, except in authorized emergencies. If both the husband and wife are eligible for Medicare, both must be enrolled in the same plan. If only one of the members is Medicare eligible, the Medicare eligible member will be enrolled in the Medicare Choice plan and the other will be covered under the Non-Medicare retiree plan.

(over)

WHAT IS MY SELF-PAYMENT FOR COVERAGE?

MEDICAL	Non-Medicare		Medicare		One with Medicare/ One without Medicare
	Single	Two Party	Single	Two Party	
<u>High Option - HMO</u>					
PacifiCare	\$279	\$555	\$147	\$292	\$423
Kaiser	\$279	\$555	\$147	\$292	\$423
<u>Low Option - HMO</u>					
PacifiCare	\$234	\$464	\$103	\$204	\$334
Kaiser	\$234	\$464	\$103	\$204	\$334
Vision (MES)	\$11	\$11	\$11	\$11	\$11
Dental HMO (United Concordia)	\$35	\$35	\$35	\$35	\$35

WHAT DO I DO IF I HAVE QUESTIONS?

Many of your questions may be answered by visiting the Los Angeles Machinist Benefit Trust website at www.lambt.org. Here you can download enrollment forms and obtain important information about your benefit plans.

If you have additional questions about your coverage, contact the Trust Fund Administrative Office at (800) 499-8121. The Administrative Office will have a supply of Benefit Booklets that give detailed information on the plan choices. If you need more information before you make your decision, they will be happy to send the booklets to you.

WHAT DO I DO NOW?

IF YOU DO NOT WISH TO MAKE ANY CHANGES TO YOUR CHOICE OF MEDICAL OR DENTAL PLANS, NO ACTION IS REQUIRED

If you do wish to make a change, carefully review the Benefit Comparison Sheets and discuss the choices with your family to decide which plans best suit your needs. You do not need to fill out the enrollment form unless you are making changes to your plan coverage. If you do nothing, your existing coverage choices will continue.

If you'd like to change your medical plan, or add/delete dental or vision plan coverage, please indicate your preference on the attached enrollment form and return it in the enclosed return envelope.

If you need further information about any of the plan options, please contact the Administrative Office at (800) 499-8121 or visit the Los Angeles Machinist Benefit Trust Website at: www.lambt.org.

**THE LOS ANGELES MACHINIST BENEFIT TRUST IS A
“GRANDFATHERED HEALTH PLAN”**

The Board of Trustees of Los Angeles Machinist Benefit Trust believes this group health plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act 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 Affordable Care Act, 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 plan administrator at (800) 499-8121. You may also want to contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

WOMEN’S CANCER RIGHTS

A federal law called the Women’s Health and Cancer Rights Act of 1998 became effective for this Plan on September 1, 1999. Under this law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. In the case of a Participant or Beneficiary who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, the law requires coverage in a manner determined in consultation with the attending Physician and the Patient, for;

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

If you have any questions about Plan coverage of mastectomies or reconstructive surgery, please contact the Plan Administrative Office. If you are enrolled in the HMO option plan, please contact the HMO.

**ALL PLAN CHANGES MUST BE RECEIVED AT THE ADMINISTRATIVE OFFICE
BY DECEMBER 15, 2011.**

Please contact the Administrative Office at (800) 499-8121, or visit the Trust’s website at: www.lambt.org if you have questions about your choices or the enrollment procedures.

Sincerely,

BOARD OF TRUSTEES

**2012 MEDICAL PLANS COMPARISON
CALIFORNIA RETIREE BENEFITS - NON-MEDICARE RETIREES**

Benefit	UHC/PacifiCare High	UHC/PacifiCare Low	Kaiser High	Kaiser Low
Deductible	None	None	None	None
Ambulance	No charge	No charge	No charge	No charge
Durable Medical Equipment	No charge	No charge	No charge	No charge
Emergency Services	\$100/visit; waived if admitted	\$100 copay; waived if admitted	\$100 copay; waived if admitted	\$100 copay; waived if admitted
Home Health Care	\$3 copay	No charge	No charge; 100 2-hr visits/CY	No charge; 100 2-hr visits/CY
Hospital				
Inpatient	\$100 per admit	\$100 per admit	\$100 per admit	\$100 per admit
Outpatient	\$15 copay	\$25 copay	\$15 copay	\$25 copay
Maximums (lifetime and annual)	Unlimited	Unlimited	Unlimited	Unlimited
Mental Health				
Inpatient*	MHN: no charge up to 45 days/CY no day limit mental health parity. (services must be preauthorized by MHN)	MHN: no charge up to 45 days/CY no day limit mental health parity. (services must be preauthorized by MHN)	\$100 copay/admit; up to 45 days/CY no limit on mental health parity	\$100 copay/admit; 45 days/CY no limit on mental health parity
Outpatient*	MHN: no charge; 20 visits/CY; no day limit mental health parity. (services must be preauthorized by MHN)	MHN: no charge; 20 visits/CY; no day limit mental health parity. (services must be preauthorized by MHN)	\$15 copay/individual; \$7 copay group; 20 visits/CY; no day limit mental health parity	\$25 copay/individual; \$12 group; 20 visits/CY; no day limit - mental health parity
Outpatient Diagnostic-Xray and Laboratory	No charge	No charge	No charge	No charge
Physical exam	\$15 copay	\$25 copay	\$15 copay	\$25 copay
Physician Services -				
Office/Home visit	\$15 copay	\$25 copay	\$15 copay	\$25 copay
Prescription Drugs	Retail: \$10 copay/Generic; \$30 copay/ Brand; Mail - 2 x retail	Retail: \$10 copay/Generic; \$30 copay/ Brand; Mail - 2 x retail	Retail (100 day supply): \$10 copay Generic; \$30 copay Brand	Retail (100 day supply): \$10 copay - Generic; \$30 copay Brand;
Skilled Nursing Facility	No charge; 100 days/CY	\$100 copay; 100 days/CY	No charge; 100 days/CY	No charge; 100 days/CY
Substance Abuse				
Inpatient	Provided by MHN: No charge; \$750,000/CY (no lifetime max) based on medical necessity. (services must be preauthorized by MHN)*	Provided by MHN: No charge; \$750,000 max/CY (no lifetime max) based on medical necessity. (services must be preauthorized by MHN)	\$100 copay per admit; Detox only	\$100 copay/admit; Detox only
Outpatient	Provided by MHN: No charge; \$750,000 max/CY (no lifetime max) based on medical necessity. (services must be preauthorized by MHN)*	Provided by MHN: No charge; \$750,000 max/CY (no lifetime max) based on medical necessity. (services must be preauthorized by MHN)	\$15 copay individual; \$5 copay group	\$25 copay/individual; \$5 group

Note: This is only a summary of your benefits; Refer to the EOC or disclosure forms for HMO benefit details, and exclusions and limitations

RETIREE SCHEDULE OF BENEFITS

Benefit Plan Option	Class I Retiree*		Class II Retiree		Class III Retiree	
	High	Low	High	Low	High	Low
Medical Plan Option - Doctor Visit Copays - Kaiser (California only) UHC/PacificCare (California only)	\$15 copay \$15 copay ²	\$25 copay ¹ \$25 copay ¹	\$15 copay \$15 copay ²	\$25 copay ¹ \$25 copay ¹	\$15 copay \$15 copay ²	\$25 copay ¹ \$25 copay ¹
Prescription Drugs HMO Plans	Refer to Medical Comparison		Refer to Medical Comparison		Refer to Medical Comparison	
Dental Plans (Self-Pay) Prepaid (California only)	United Concordia		United Concordia		United Concordia	
Vision (Self-Pay) Prepaid (Optional)	Medical Eye Services (MES)		Medical Eye Services (MES)		Medical Eye Services (MES)	

¹ Non-Medicare Retirees - \$25 copay

² Non-Medicare Retirees - \$15 copay



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NOTICE ABOUT THE EARLY RETIREE REINSURANCE PROGRAM

November 1, 2011

You are receiving this notice because you are a plan participant, or are being offered the opportunity to enroll as a plan participant, in the *Los Angeles Machinist Benefit Trust*, which is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses Los Angeles Machinist Benefit Trust for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, the Los Angeles Machinist Benefit Trust may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the Los Angeles Machinist Benefit Trust chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and Los Angeles Machinist Benefit Trust chooses to use the reimbursements for this purpose.

Los Angeles Machinist Benefit Trust may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employee and their families.



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IMPORTANT NOTICE

DATE: NOVEMBER, 2011

TO: ALL ELIGIBLE RETIRED PLAN PARTICIPANTS

**FROM: BOARD OF TRUSTEES OF LOS ANGELES MACHINIST
BENEFIT TRUST**

RE: DOMESTIC PARTNER ELIGIBILITY

This Important Notice clarifies the eligibility requirements for registered domestic partners of active and retired plan participants. This information is important. Please take time to read it carefully and keep a copy of this notice with your benefit booklet and other important Plan information.

DOMESTIC PARTNERS POLICY CLARIFICATION

Effective November 1, 2011, domestic partner coverage is available to active and retired participants with HMO medical plan coverage, provided the domestic partnership is properly registered in accordance with the state registry system of the principal state of residence. Eligible domestic partners shall be treated as an eligible “spouse” for all eligible coverages and for purposes of eligibility under the Trust, including with respect to eligibility and coverage of children. However, participants will be responsible for declaring and paying taxes on the value of domestic partner coverage for federal and any state tax purposes in accordance with applicable law.

To establish eligibility for your domestic partner, you must submit to the Administrator, a copy of your certificate of registration of domestic partnership issued by the applicable department in your state of residence. If you’re a California resident and need further information on how to register your domestic partner, please visit <http://www.sos.ca.gov/dpreistry/> or contact the California Secretary of State at (916) 653-3984.

As noted above, there are significant tax considerations for adding a domestic partner. For further information, please contact the IRS or a licensed tax professional.

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MEDICAL (PLEASE CHOOSE ONE): DENTAL (PLEASE CHOOSE ONE):
 INDEMNITY INDEMNITY
 KAISER UNITED CONCORDIA
 PACIFICARE

Elect only the applicable Plan that has been negotiated for you or call 800-499-8121 to verify.

PLEASE PRINT

YOUR NAME	Last Name		First Name		Initial	<input type="checkbox"/> NEW ENROLLMENT <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> CHANGE/UPDATE EFFECTIVE DATE:					
	Street Address		Apt#	Social Security Number							
YOUR HOME ADDRESS	City and State		Zip Code	Occupation		Phone Number					
	NAME OF EMPLOYER			Date Employed Mo. Day Year		Division					
YOUR DATE OF BIRTH	Mo.	Day	Year	CHECK ONE	Male	Female	CHECK ONE	Married	Single	Widowed	Divorced

TO ENROLL DEPENDENTS → **List ALL Eligible Family Members**

Relationship	Last Name	First Name	Initial	Date of Birth			Social Security Number
				Mo.	Day	Year	
<input type="checkbox"/> Husband <input type="checkbox"/> Wife							
<input type="checkbox"/> Son <input type="checkbox"/> Daughter							
<input type="checkbox"/> Son <input type="checkbox"/> Daughter							
<input type="checkbox"/> Son <input type="checkbox"/> Daughter							
<input type="checkbox"/> Son <input type="checkbox"/> Daughter							
<input type="checkbox"/> Son <input type="checkbox"/> Daughter							
<input type="checkbox"/> Son <input type="checkbox"/> Daughter							
<input type="checkbox"/> Son <input type="checkbox"/> Daughter							

FOR ADDITIONAL DEPENDENTS USE OTHER SIDE

Beneficiary Information PLEASE PRINT (Complete this section only when GROUP LIFE INSURANCE provided)

NAME	Last Name		First Name		Initial
	Street Address		Apt#	Relationship	
HOME ADDRESS	City and State		Zip Code	Phone Number	

I HEREBY APPLY for the enrollment of myself and those eligible members of my family listed above for participation in the Group Health Plan provided by the Los Angeles Machinist Benefit Trust.
 I UNDERSTAND that it is my responsibility to report any change in the eligibility of my dependants; and that the benefits of this plan are coordinated with those provided by any other group hospital or medical benefits.

Date Signed _____ 20____ YOUR SIGNATURE _____