Los Angeles Machinist Benefits Trust
Blue Shield HMO Low Option
Benefit Summary (For groups of 300 and above)
(Uniform Health Plan Benefits and Coverage Matrix)

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *EVIDENCE OF COVERAGE* AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Blue Shield of California

Highlights: A description of the prescription drug coverage is provided separately

Effective January 1, 2014

Calendar Year Medical Deductible	None
Calendar Year Copayment Maximum[1] (For many covered services)	$1,000 per Individual / $2,000 per 2-Persons / $3,000 per Family
LIFETIME BENEFIT MAXIMUM	None
Covered Services	**Member Copayment**
PROFESSIONAL SERVICES	
Professional (Physician) Benefits	
• Physician and specialist office visits (Note: A woman may self-refer to an OB/GYN or family practice physician in her Personal Physician's medical group or IPA for OB/GYN services)	$25 per visit
• Outpatient X-ray, pathology and laboratory	No Charge
Allergy Testing and Treatment Benefits	
• Office visits (includes visits for allergy serum injections)	$25 per visit
Access+ *Specialist*SM Benefits[1, 2]	
• Office visit, Examination or Other Consultation (Self-referred office visits and consultations only)	$30 per visit
Preventive Health Benefits	
• Routine physical exam, eye/ear screenings and immunizations	$25 per visit
Well-woman care	
• Mammogram and Pap test screening or other FDA-approved cervical cancer screening tests	No Charge
Well-baby care	
• Office visits and consultations Includes: eye/ear screenings, immunizations, vaccinations (for children under 2 years of age)	No Charge
OUTPATIENT SERVICES	
Hospital Benefits (Facility Services)	
• Outpatient surgery performed at an Ambulatory Surgery Center[3]	$50 per surgery
• Outpatient surgery in a hospital	$50 per surgery
• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	No Charge
HOSPITALIZATION SERVICES	
Hospital Benefits (Facility Services)	
• Inpatient Physician Services	No Charge
• Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care)	$100 per admission
• Inpatient Medically Necessary skilled nursing Services including Subacute Care[4, 5]	No Charge
EMERGENCY HEALTH COVERAGE	
• Emergency room Services not resulting in admission (The ER copayment does not apply if the member is directly admitted to the hospital for inpatient services)	$100 per visit
• Emergency room Physician Services	No Charge
AMBULANCE SERVICES	
• Emergency or authorized transport	No Charge
PRESCRIPTION DRUG COVERAGE	
Outpatient Prescription Drug Benefits	A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug summary that goes with this benefit summary, please contact your benefits administrator or call the Member Services number on your Identification card.

PROSTHETICS/ORTHOTICS	
• Prosthetic equipment and devices (Separate office visit copay may apply)	No Charge
• Orthotic equipment and devices (Separate office visit copay may apply)	No Charge
DURABLE MEDICAL EQUIPMENT	
• Breast pump	No Charge
• Other Durable Medical Equipment (member share is based upon allowed charges)	No Charge
MENTAL HEALTH SERVICES (PSYCHIATRIC)	
• Inpatient Hospital Services	Carved out to Managed Health Network (MHN)
• Outpatient Mental Health Services	
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)[6]	
• Chemical dependency and substance abuse services	Carved out to Managed Health Network (MHN)
HOME HEALTH SERVICES	
• Home health care agency Services (up to 100 visits per Calendar Year)	No Charge
• Medical supplies (See "Prescription Drug Coverage" for specialty drugs)	No Charge
OTHER	
Hospice Program Benefits	
• Routine home care	No Charge
• Inpatient Respite Care	No Charge
• 24-hour Continuous Home Care	No Charge
• General Inpatient care	No Charge
Pregnancy and Maternity Care Benefits	
• Prenatal and postnatal Physician office visits (For inpatient hospital services, see "Hospitalization Services.")	No Charge
Family Planning and Infertility Benefits	
• Counseling and consulting[7]	$25 per visit
• Infertility Services (member share is based upon allowed charges) (Diagnosis and treatment of cause of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT).	50%
• Tubal ligation[8]	$100 per surgery
• Elective abortion[8]	$75 per surgery
• Vasectomy[8]	$50 per surgery
• Intra-Uterine Device (IUD)	$50 per device
• Depo-Provera Medication (Limited to one Depo-Provera injection every 90 days)	$35 per injection
Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)	
• Office location (Copayment applies to all places of services, including professional and facility settings)	$25 per visit
Speech Therapy Benefits	
• Office Visit - Services by licensed speech therapists (Copayment applies to all places of services, including professional and facility settings)	$25 per visit
Diabetes Care Benefits	
• Devices, equipment, and non-testing supplies (member share is based upon allowed charges; for testing supplies see Outpatient Prescription Drug Benefits.)	No Charge
• Diabetes self-management training (by a registered dietician or registered nurse that are certified diabetes educators)	$25 per visit
Vision Benefits	
• Vision eye examination (One self-referred comprehensive eye examination per 12 administrator's consecutive months (no age limit) $25 copayment for services provided by our vision plan providers. For visits by non-participating providers the maximum reimbursement for an Ophthalmologic exam is $60 or $50 if the member has an Optometric exam.)	$25 per visit
Urgent Care Benefits (BlueCard® Program)	
• Urgent Services outside your Personal Physician Service Area	$25 per visit
Optional Benefits	Optional dental, vision, hearing aid, infertility, chiropractic or chiropractic and acupuncture benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided provided separately.

[1] Copayments/Coinsurance marked with this footnote do not accrue to the calendar-year copayment maximum. Copayments/Coinsurance and charges for services not accruing to the member's calendar-year copayment maximum continue to be the member's responsibility after the calendar-year copayment maximum is reached. This amount could be substantial. Please refer to the Evidence of Coverage and the Plan Contract for exact terms and conditions of coverage.

[2] To use this option, members must select a personal physician who is affiliated with a medical group or IPA that is an Access+ provider group, which offers the Access+ Specialist feature. Members should then select a specialist within that medical group or IPA. Access+ Specialist visits for mental health services must be provided by a MHSA network participating provider.

[3] Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient surgery Services may also be obtained from a Hospital or from an ambulatory surgery center that is affiliated with a Hospital, and paid according to the benefit under your health plan's Hospital Benefits.

[4] For Plans with a facility deductible amount, services with a day or visit limit accrue to the calendar-year day or visit limit maximum regardless of whether the plan deductible has been met.

[5] Skilled nursing services are limited to 100 preauthorized days during a calendar year except when received through a hospice program provided by a participating hospice agency. This 100 preauthorized day maximum on skilled nursing services is a combined maximum between SNF in a hospital unit and skilled nursing facilities.

[6] Inpatient Services which are Medically Necessary to treat the acute medical complications of detoxification are covered under the medical benefits; see hospitalization services for benefit details. Services for acute medical complications of detoxification are accessed through Blue Shield using Blue Shield HMO providers.

[7] Includes insertion/removal of IUD, as well as injectable and implantable contraceptives for women.

[8] Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.

Plan designs may be modified to ensure compliance with state and federal requirements.

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Blue Shield believes this plan/policy 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 that law was enacted. Being a grandfathered health plan means that your plan or policy is not required to 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. Note, even though they are not required to be included, many of the protections of the Affordable Care Act are included in your current plan/policy.

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 Blue Shield at the telephone number on your identification card. If you obtain this plan/policy through your employer and your plan is subject to ERISA, you may also 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. If you obtain your coverage through a nonfederal governmental employer, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Los Angeles Machinist Benefits Trust
Custom Access+ HMO® Plans

Outpatient Prescription Drug Coverage
(For groups of 300 and above)

THIS DRUG COVERAGE SUMMARY IS ADDED TO BE COMBINED WITH THE ACCESS+ HMO OR ADDED ADVANTAGE POS PLANS UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX. THE *EVIDENCE OF COVERAGE* AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Blue Shield of California

Highlight: 3-Tier/Incentive Formulary
$0 Calendar Year Brand-Name Drug Deductible
$10 Formulary Generic/$30 Formulary Brand Name/$30 Non-Formulary Brand Name Drug - Retail Pharmacy
$10 Formulary Generic/$30 Formulary Brand Name/$30 Non-Formulary Brand-Name Drug - Mail Service

Covered Services	Member Copayment
DEDUCTIBLES (Prescription drug coverage benefits are not subject to the medical plan deductible.)	
Calendar Year Brand Name Drug Deductible	None
PRESCRIPTION DRUG COVERAGE[1,2]	**Participating Pharmacy**
Retail Prescriptions (up to a 30-day supply)	
• Formulary Generic Drugs	$10 per prescription
• Formulary Brand Name Drugs[3, 4]	$30 per prescription
• Non-Formulary Brand Name Drugs[3, 4]	$30 per prescription
Mail Service Prescriptions (up to a 90-day supply)	
• Formulary Generic Drugs	$10 per prescription
• Formulary Brand Name Drugs[3,4]	$30 per prescription
• Non-Formulary Brand Name Drugs[3, 4]	$30 per prescription
Specialty Pharmacies (up to a 30-day supply)[5]	
• Specialty Drugs[6]	$30 per prescription

1 Amounts paid through copayments and any applicable brand-name drug deductible do not accrue to the member's medical calendar-year copayment maximum. Please refer to the Evidence of Coverage and Plan Contract for exact terms and conditions of coverage. Please note that if you switch from another plan, your prescription drug deductible credit, if applicable, from the previous plan during the calendar year will not carry forward to your new plan.

2 Drugs obtained at a Non-Participating Pharmacy are not covered, unless Medically Necessary for a covered emergency.

3 Select formulary and non-formulary drugs require prior authorization by Blue Shield for Medical Necessity, or when effective, lower cost alternatives are available.

4 If the member requests a brand-name drug and a generic drug equivalent is available, the member is responsible for paying the generic drug copayment plus the difference in cost to Blue Shield between the brand-name drug and its generic drug equivalent.

5 Specialty Drugs are specific Drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancers, and other conditions that are difficult to treat with traditional therapies. Specialty Drugs are listed in the Blue Shield Outpatient Drug Formulary. Specialty Drugs may be self-administered in the home by injection by the patient or family member (subcutaneously or intramuscularly), by inhalation, orally or topically. Specialty Drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration by Blue Shield's Pharmacy & Therapeutics Committee, be obtained from a Blue Shield Specialty Pharmacy and may require prior authorization for Medical Necessity by Blue Shield. Infused or Intravenous (IV) medications are not included as Specialty Drugs.

6 Specialty drugs are covered only when dispensed by select pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency.

Note: This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan's prescription drug coverage is creditable, you do not have to enroll in a Medicare prescription drug plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more anytime after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Part D premium.

Important Prescription Drug Information

You can find details about your drug coverage three ways:

1. Check your *Evidence of Coverage.*
2. Go to **blueshieldca.com** and log onto My Health Plan from the home page.
3. Call Member Services at the number listed on your Blue Shield member ID card.

At Blue Shield of California, we're dedicated to providing you with valuable resources for managing your drug coverage. Go online to the *Pharmacy* section of **blueshieldca.com** and select the *Drug Database and Formulary* to access a variety of useful drug information that can affect your out-of-pocket expenses, such as:

- Look up non-formulary drugs with formulary or generic equivalents;
- Look up drugs that require step therapy or prior authorization;
- Find specifics about your prescription copayments;
- Find local network pharmacies to fill your prescriptions.

TIPS!

Using the convenient mail service pharmacy can save you time and money. If you take a consistent dose of a covered maintenance drug for a chronic condition, such as diabetes or high blood pressure, you can receive up to a 90-day supply through the mail service pharmacy with a reduced copayment. Call the mail service pharmacy at (866) 346-7200. Members using TTY equipment can call TTY/TDD 866-346-7197.

Plan designs may be modified to ensure compliance with state and federal requirements.

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Los Angeles Machinist Benefits Trust Additional Hearing Aid and Ancillary Equipment Benefit

Attachment to Benefit Summary (Uniform Benefits and Coverage Matrix)

Additional coverage for Access+ HMO® Plans

How the Plan Works

In addition to the benefits set forth in the Benefit Summary (Uniform Benefits and Coverage Matrix), your group has added hearing aid benefits to your benefit plan. Coverage includes hearing aid services, subject to the conditions and limitations listed below. This rider provides a $5,000 allowance every 24 months towards the purchase of hearing aids and ancillary equipment. The Calendar-Year Deductible does not apply to the Services provided in this hearing aid Services Benefit and are not included in the calculation of the Subscriber's Maximum Calendar-Year Copayment Responsibility.

Coverage Details

The hearing aid allowance includes:

- A hearing aid instrument, monaural or binaural, including ear mold(s)
- Visit for fitting, counseling, and adjustments
- The initial battery
- Cords
- Other ancillary equipment

Benefit Plan Design

Plan Options	Benefit Allowance
Access+ HMO® Plans	$5,000 allowance every 24 months

The following services and supplies are not covered:

- Purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase
- Charges for a hearing aid which exceed specifications prescribed for correction of a hearing loss
- Replacement parts for hearing aids, repair of hearing aid after the covered warranty period and replacement of a hearing aid more than once in any period of 24 months
- Surgically implanted hearing devices

All benefits are subject to the general provisions, limitations and exclusions listed in your *Evidence of Coverage*.

Notice on the availability of language assistance services to accompany vital documents issued in English

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda gratuita, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198.
(Spanish)

重要通知：您能讀懂這封信嗎？ 如果不能，我們可以請人幫您閱讀。
這封信也可以用您所講的語言書寫。 如需幫助，請立即撥打登列在您的Blue Shield ID卡背面上的會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。
(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198.
(Vietnamese)