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Los Angeles Machinist Benefit Trust

1325 N. GRAND AVE • STE 200 • COVINA, CA 91724

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

RE: OPEN ENROLLMENT PERIOD – EFFECTIVE JANUARY 1, 2014

Note: Class II Retirees are those retirees who retired from an employer that does not continue to contribute to the Retiree plan for retiree coverage, the spouses of such Class II retirees, and the surviving spouses of deceased Class I and Class II retirees.

It is Open Enrollment time again when you have the opportunity to change your hospital/medical and dental plans. The enclosed Benefit Comparisons summarize the benefit choices you have for the 2014 calendar year.

Read the comparisons and choices carefully!

IMPORTANT NOTE: THE TRUST IS PLEASED TO ANNOUNCE THAT WE HAVE SELECTED BLUE SHIELD OF CALIFORNIA TO REPLACE UNITED HEALTHCARE (UHC) FOR YOUR MEDICAL AND PHARMACY BENEFITS, EFFECTIVE JANUARY 1, 2014. THE TRUST HAS MADE THIS DECISION TO HELP CONTROL COSTS WHILE MAINTAINING THE SAME LEVEL OF BENEFITS FOR ITS MEMBERS.

PLEASE PAY CLOSE ATTENTION AS ACTION WILL BE NEEDED BY ALL MEMBERS MOVING TO BLUE SHIELD TO ENSURE YOUR COVERAGE WITH YOUR PHYSICIAN IS MAINTAINED.

WHAT ARE MY BENEFITS?

The Comparison Sheet(s) show your benefit plan choices. Your choices are pre-paid (HMO) medical plan coverage through Blue Shield (replacing United HealthCare) and Kaiser. You have a choice of a High HMO Option or Low HMO Option Plan. The amount you pay monthly is determined by the Plan. Review the cost and benefits before you make a selection.

In addition to the choices indicated above, any retiree who resides in the service area of the prepaid United Concordia Dental plan can elect coverage under the prepaid dental plan and self-pay for that coverage. The amount you pay monthly is determined by the Plan.

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WHAT ARE MY OPTIONS IF I AM ELIGIBLE FOR MEDICARE?

All Medicare eligible retirees enrolled in prepaid medical plans must either 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 prepaid medical plan (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.

WHAT ARE MY OPTIONS IF I AM NOT ELIGIBLE FOR MEDICARE?

As an "early retiree" or a retiree not eligible for Medicare, you will generally have the same benefits you had under the Active plan if you were enrolled in a prepaid plan (HMO). Be sure to review the benefits before you make your choice.

WHAT IS MY SELF-PAYMENT FOR COVERAGE?

	Non-Medicare		Medicare		One with Medicare/ One without Medicare
	Single	Two Party	Single	Two Party	
High Option - HMO					
Blue Shield	$537	$1,051	$165	$306	$678
Kaiser	$485	$970	$209	$418	$694
Low Option - HMO					
Blue Shield	$531	$1,037	$126	$228	$633
Kaiser	$415	$830	$167	$333	$581
Dental HMO United Concordia	$35	$35	$35	$35	$35
Vision Medical Eye Services	$12	$12	$12	$12	$12

WHAT DO I DO NOW?

Carefully review the Comparison Sheets. Discuss your choices with your family and decide which plan best suites your needs.

IF YOU DO NOT WISH TO MAKE ANY CHANGES TO YOUR CHOICE OF MEDICAL OR DENTAL PLANS, NO ACTION IS REQUIRED UNLESS YOU ARE ENROLLING IN BLUE SHIELD

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

IF YOU ARE ENROLLING IN BLUE SHIELD, YOU MUST COMPLETE THAT FORM AND ELECT A PRIMARY CARE PHYSICIAN.

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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, review the Retiree Summary Plan Description (SPD) and obtain important information about your benefit plans.

If you have questions about your coverage or the enrollment procedures, please contact the Trust Fund Administrative office at (800) 499-8121.

ALL PLAN CHANGES MUST BE RECEIVED AT THE ADMINISTRATIVE OFFICE BY DECEMBER 7, 2013.

Sincerely,

BOARD OF TRUSTEES

IMPORTANT NOTICES

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.

Annual Reminder Required by Federal Law – Regarding Mastectomies and Breast Reconstruction

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.

Newborns' and Mothers' Health Protection Act of 1996 Notice

We remind you that under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not, under federal law, 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 cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).