Los Angeles Machinist Benefit Trust

Plan for Retired Employees

Description of Benefits

January 2011

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Los Angeles Machinist Benefit Trust

6801 East Washington Boulevard
City of Commerce, California 90040
Local Telephone Number: 323-278-7030
Toll-free Telephone Number: 800-499-8121
Fax Number: 323-728-2982

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As of January 1, 2011

IMPORTANT TELEPHONE NUMBERS AND ADDRESSES*

The following chart provides a handy reference guide to phone numbers for organizations that you will see in this booklet.

Administrative Office (Zenith Administrators) *Questions about eligibility and benefits*	(323) 278-7030 or (800) 499-8121 Fax: (323) 728-2982
Medical Plan – HMOs	
Kaiser Permanente	(800) 464-4000 www.kaiserpermanente.org
UnitedHealthcare (PacifiCare)	(800) 624-8822 www.pacificare.com or www.uhcretiree.com
Mental Health and Substance Abuse Plan	
MHN (for UnitedHealthcare/PacifiCare , non-Medicare participants)	(800) 327-7701
Contact MHN for: • *Required pre-authorization and referrals for treatment, and* • *Review of emergency admission to a non-contracting facility (call within 48 hours)*	
Prepaid Dental Plan *United Concordia*	(866) 357-3304 www.ucci.com
Vision Care Plan *Medical Eye Service (MES)* *Appointments for vision care services*	(800) 638-3120

***The providers and contact information is current as of January 2011**

Organizations Named Are Subject to Change

This booklet mentions many of the organizations through which benefits are provided by name (Kaiser Permanente, MHN, etc.). These organizations are subject to change. Please keep any notices you receive about such changes with this booklet for reference.

Los Angeles Machinist Benefit Trust
6801 East Washington Boulevard
City of Commerce, California 90040
Phone Numbers: (323) 278-7030 or (800) 499-8121
Fax Number: (323) 728-2982

To All Retired Employees:

This new booklet provides you with a summary of the benefits available to you and your spouse as of January, 2011. This material replaces any previously issued benefits material.

What this Booklet Contains

- ***General information on eligibility and enrollment as well as options for your spouse to continue coverage in the event he or she outlives you;***
- ***Information on mental health and substance abuse benefits for non-Medicare eligible participants not enrolled in a Kaiser Permanente plan;***
- ***Reminders of where you can find information on the other benefit plans, the types of information you should look for;***
- ***Other important Plan information, including appealing a denial of benefits and your rights under the law (ERISA).***

How to Use This Booklet

This booklet (***Summary Plan Description*****)** should be used with the ***Retiree Schedule of Benefits*** that shows your benefit options, and the ***Retiree Medical Comparison*** that summarizes the services covered under the medical plans. You will also be receiving separate brochures describing in detail your medical, dental and vision benefits if you are eligible for them.

If changes are made to any of the benefits, or to the eligibility rules, you will receive updates. All announcements should be kept with this booklet so that you have the latest information whenever you need services.

- ***Retiree Summary Plan Description***
- ***Retiree Schedule of Benefits***
- ***Retiree Medical Comparison***
- ***Retiree Dental Plan (optional for all retiree classes)***
- ***Retiree Vision Plan (optional for all retiree classes)***
- ***Any Announcements***

You and your spouse should study this booklet and any inserts, notices, or brochures so that you will receive the appropriate covered treatment when it becomes necessary. *Please use only the benefits that*

are necessary so that the Trust can continue to provide quality benefits to its retirees and beneficiaries. Keep this booklet and other Plan materials for reference; payment of your benefits will be based on the latest information issued.

Questions?

If you have any questions after reviewing this booklet, please contact the Administrative Office.

Sincerely,

Board of Trustees

IMPORTANT INFORMATION ABOUT THE PLAN AND THIS BOOKLET

NATURE OF THIS BOOKLET

The text of this booklet is not a contract. It describes the eligibility rules and benefits in summary form. The rules for eligibility and benefits are adopted by the Board of Trustees and may change from time to time. Benefits and eligibility are subject to the provisions of the Trust Agreement and contracts in effect with various providers of service. This booklet contains only a summary of the Plan's benefits. A full description of the benefits is available in the governing Plan documents.

AUTHORIZED SOURCES OF INFORMATION

The only sources of authorized information are the benefit 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 Plan Administrator and authorized agents and legal representatives. Statements or representations made by individuals other than those designated personnel are not authoritative sources of information. Questions about 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 have been adopted by the 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.

The Trustees, at their discretion, have 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 and continue to provide benefits to all participants or for any reason at all. Any changes made by the Trustees may affect the payment of medical expenses incurred by you before the change is adopted.

The Trustees may terminate any of the benefits provided if money available is inadequate or for any reason at all. The union and the employers may also terminate the Trust through collective bargaining. If the Trust is terminated, all benefits will end after the assets of the Trust have been disbursed.

Participants and their spouses 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 their spouses covered under the Plan with respect to any benefits available subsequent to termination will be determined by the Board of Trustees.

IMPORTANT DISCLAIMER

For the Plan to carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the most equitable possible 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 rules 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 that have already been incurred,
- terminate this Plan even though such termination affects claims that have already been incurred,
- alter or postpone the method of payment of any benefit, or

- amend or rescind any other Plan provisions.

No lawsuit or action of any kind may be brought against the Trust based upon a denial of a claim for benefits without first exhausting the claims review and appeal procedures described in this booklet in Section 8.

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SECTION 1

OVERVIEW

Section 1 covers:

- General overview of benefits
- Role of Medicare
- Enrolling in Medicare
- Information on filing claims

Below is a general overview of the benefits described or referenced in this booklet. For information on the specific plans and options that apply to you, see your Schedule of Benefits.

If you have questions about your coverage, please contact the Administrative Office.

GENERAL OVERVIEW OF CLASS I, CLASS II AND CLASS III RETIREE BENEFITS

See your Schedule of Benefits for a listing of the benefits applicable to Class I, Class II and Class III Retirees:

Benefit	Available to	Options
Medical	If you live in California: • you, and • your legal spouse	If you are under 65, your choice of plans: • Kaiser Permanente HMO (low option or high option) • UnitedHealthcare formerly PacifiCare HMO (low option or high option) If you are over 65, your choice of plans: • Kaiser Permanente Senior Advantage (Medicare Advantage plan, low option or high option) • United Health Care/PacifiCare Secure Horizons (Medicare Advantage plan, low option or high option)
	If you are in Class I, but you do not live in California: • you, and • your legal spouse	• UnitedHealthcare formerly PacifiCare • UnitedHealthcare formerly PacifiCare
Mental health and substance abuse treatment	If you are not in a Kaiser Permanente plan or are not Medicare-eligible: • you, and • your legal spouse	MHN mental health and substance abuse rehabilitation services. If you are in a Kaiser Permanente plan, or are eligible for Medicare, any such benefits will be provided through your medical plan instead.

Benefit	Available to	Options
Dental *(Optional – only available for retirees in California)*	If you live in California: • you, and • your legal spouse	Prepaid United Concordia dental coverage (like an HMO for dental care)
Vision *(Optional for all classes)*	• you, and • your legal spouse	Exams, lenses, and frames at specified intervals through MES

ROLE OF MEDICARE

Medicare benefits are available for you or your spouse at age 65.

Any benefits payable under this Plan will be coordinated as though you were receiving the maximum Medicare coverage available, regardless of whether you are actually enrolled in Medicare and paying premiums. Thus, it is important that you enroll in Medicare in a timely manner (see following section).

Check your materials from Kaiser Permanente or UnitedHealthcare formerly PacifiCare for provisions governing Medicare eligibility. Most plans require you to switch to coverage designed for Medicare enrollees when you reach age 65. For example, if you are covered under the Kaiser Permanente HMO before Medicare eligibility, you may be required to switch coverage to Kaiser Permanente Senior Advantage (or another Medicare Advantage plan) when you become Medicare eligible.

ENROLLING IN MEDICARE

If you are receiving Social Security retirement or disability benefits or railroad retirement checks when you reach your Social Security full retirement age (generally age 65), you will automatically be enrolled in Medicare Parts A and B (unless you opt out of Part B). Most likely, you will not have to pay a premium for Part A, but you will have to pay a monthly premium for Part B.

If you are not receiving Social Security benefits or railroad retirement checks, you will need to apply for Medicare. Contact the nearest Social Security Administration Office in the three months before you turn age 65 to enroll in both Parts A and B. By enrolling promptly, you will avoid a possible delay in the start of your coverage and a possible increase in the premiums you will have to pay for Part B. This also applies to your spouse as he or she nears age 65.

If you have questions about Medicare, you can call the Social Security Administration at (800) 772-1213 or visit www.medicare.gov.

FILING CLAIMS

See the information from Kaiser Permanente, UnitedHealthcare formerly PacifiCare, MHN, United Concordia, or MES, as applicable, for information on filing claims for medical, mental health/substance abuse, dental, and vision 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 8.

See the materials from each provider regarding claims and appeal procedures for those benefits.

SECTION 2

ELIGIBILITY AND ENROLLMENT

Section 2 covers:

- Initial eligibility
- Maintaining eligibility
- Enrollment
- Paying for coverage
- When coverage begins

There are three classes of participants under the Plan. Your classification determines the benefits you are eligible for and the amount of your payments for coverage. See your Schedule of Benefits for more information.

In general, the Plan provides the same benefit options to all eligible participants. Vision and dental benefits are optional and available to all retiree classes.

Participants in all three classes must make payments for coverage. However, Class I participants may make partial payments.

INITIAL ELIGIBILITY

Eligibility requirements for the three Classes are described below:

CLASS I

In general, to be a Class I participant, you must retire from an employer that continues to contribute to the Plan for retiree coverage. You are eligible for benefits as a Class I participant if:

- you retire and receive a Social Security Disability award or a pension award from a qualified pension plan that contracts with a contributing employer making contributions to this Trust,
- employer contributions were made on your behalf for at least 24 of the last 36 months immediately before your retirement date, and
- you worked at least 120 months under a collective bargaining agreement for one or more participating employers for which your employer(s) contributed at least 120 months of contributions to the Trust for Class I coverage.

You do not have to meet the 120-month requirement if you worked for participating employers who continuously contributed to the Trust for retiree benefits from the date the benefit was negotiated until the date of your retirement.

CLASS II

In general, to be a Class II participant, you retire from an employer that does not continue to contribute to the Plan for retiree coverage. You are eligible for benefits as a Class II participant if:

- you retire and receive a Social Security Disability award or a pension award from a qualified pension plan that contracts with a contributing employer that makes contributions to this Trust,
- employer contributions were made on your behalf for at least 24 of the last 36 months immediately before your retirement date, and

- your employer at the time of your retirement is either contractually required to contribute to the Plan on behalf of active employees or no longer has a contractual obligation to contribute to the Plan and is no longer active in the trade.

Alternatively, you are eligible as a Class II participant if:

- you are a retired employee who would otherwise be eligible as a Class I or Class II participant but your former employer no longer contributes for retiree coverage,
- you would otherwise be eligible as a Class I retiree but do not have at least the 120 months of contributions, or
- you are the surviving spouse of a deceased Class I or Class II retired employee and, except for the death of the retiree, continue to meet the definition of a dependent.

CLASS III

In general, to be a Class III participant, you retire from an employer that never contributed to the Plan for retiree coverage. You are eligible for benefits as a Class III participant if:

- you retire and receive a Social Security Disability award or a pension award from a qualified pension plan that contracts with your employer,
- employer contributions were made on your behalf for at least 24 of the last 36 months immediately before your retirement date, and
- your employer at the time of your retirement is either contractually required to contribute to the Plan on behalf of active employees or no longer has a contractual obligation to contribute to the Plan and is no longer active in the trade.

Alternatively, you are eligible as a Class III participant if you are the surviving spouse of a deceased Class III retired employee and, except for the death of the retiree, continue to meet the definition of a dependent.

Eligible Spouses

Your (the retired employee's) legal spouse is an eligible dependent, provided you show a certified copy of your marriage license to the Administrative Office. Your spouse's coverage begins the date coverage begins.

If you get married after you retire, your spouse will become eligible for coverage within 30 days of the day that you marry, provided you show a certified copy of your marriage license to the Administrative Office within that time.

Children, yours or your spouse's, are NOT eligible for coverage under this Plan.

Change in Your Spouse's Dependent Status

You must immediately notify the Administrative Office, in writing, if your spouse dies, your marriage is dissolved or, any other event occurs that would make your spouse no longer eligible for coverage. Changing your beneficiary for death benefits is not acceptable notification of divorce or death.

If you do not immediately notify the Administrative Office and claims and/or premiums are paid on behalf of your ineligible dependent, you and/or your dependent will be responsible for reimbursing the Trust for such claims and/or premiums, including attorney's fees, interest, and reasonable collection costs, if any. The Trust may recover these amounts from future payments due for you or your spouse, through legal action, or otherwise as determined in the sole and absolute discretion of the Board of Trustees in accordance with procedures specified in the Trust Agreement. The participant and/or dependent may also

be required to reimburse the Trust and/or the provider for the value of any benefits provided for the ineligible dependent.

The Administrative Office should also be notified immediately of any change of address.

MAINTAINING ELIGIBILITY

To maintain eligibility for benefits as a retired employee, you must:

- demonstrate that your income is below the level that would disqualify you from getting a pension under the I.A.M. National Pension Fund or the pension plan that qualified you for a benefit from this Plan by submitting a copy of the applicable portion of your federal income tax form, and
- make the required payments on a timely basis (see "Paying for Coverage" later in Section 2).

ENROLLMENT

You, the retired employee, must elect coverage, complete enrollment forms, and make the required payment to be covered. This includes choosing a medical plan as well as the optional vision and/or dental plan if you are electing optional coverage. Remember, dental coverage is not available outside California.

You must apply for coverage within 180 days of the date of your retirement. If you do not apply for coverage within 180 days of retirement, you will not be eligible to enroll at a later date and you will no longer be covered under the Plan. The only exception is that medical coverage for Class I retired employees may be deferred, as explained later in this section under "Option to Defer or Drop Coverage for Class I Retirees."

The plans you may enroll in are dependent on your retiree classification, where you live, and whether or not you are eligible for Medicare, as described in the following sections.

Medical Benefits

If you are under age 65, you have your choice of HMOs — provided you live in the HMO's service area. As an enrollee in an HMO, you generally pay nothing or a low copayment (a set dollar amount) when you seek medical care, but you must use the HMO's facilities and professionals to be covered (except in an emergency).

The HMOs being offered as of the printing of this booklet are:

- Kaiser Permanente:
  - If you are not Medicare-eligible, you have your choice of Kaiser Permanente's high or low option. Your copayments will be lower under the high option but your self-payment will be higher.
  - If you are Medicare-eligible, you **must** enroll in Kaiser Permanente's high or low option Medicare Advantage program (Senior Advantage). Your copayment will be higher but your self-payment will be lower. You must be a recipient of Medicare and enrolled in Medicare Parts A and B.
- UnitedHealthcare, formerly PacifiCare:
  - If you are not Medicare-eligible, you have your choice of UnitedHealthcare's (formerly PacifiCare) high or low option plan. Your copayments will be lower under the high option plan but your self-payment will be higher.
  - If you are Medicare-eligible, you **must** enroll in UnitedHealthcare's formerly PacifiCare high or low option Medicare Advantage program (Secure Horizons). Your copayments will be higher but your self-payment will be lower. You must be a recipient of Medicare and enrolled in Medicare Parts A and B.

If both you and your spouse are eligible for Medicare, you must both be enrolled in the same plan. If only one of you is Medicare-eligible, the Medicare-eligible member will be enrolled in the Medicare Advantage program and the other will be covered under the non-Medicare program through the same provider. In these situations, benefits may be different for the spouses.

If you enroll in a UnitedHealthcare, formerly PacifiCare, program and you are not eligible for Medicare, you are automatically enrolled for mental health and substance abuse benefits with MHN. If you are in a Kaiser Permanente plan, and/or are eligible for Medicare, mental health and substance abuse benefits will be provided through your medical plan.

Dental Benefits

You may elect to have prepaid dental benefits through **United Concordia**, if you live in the United Concordia California service area; retirees residing outside of California do not have a dental plan option. The prepaid plan is like an HMO for dental care—you pay nothing or only a copayment when you seek dental care, but you are required to use **United Concordia** participating dentists.

You will have to pay the entire cost of this coverage, regardless of your classification (i.e., Class I, II, or III). Contact the Administrative Office for information on the cost of the plan. Enrollment does not have to be continuous.

If you are eligible for Medicare, some dental coverage may also be available through the HMO Medicare Advantage plan, at no cost or at limited cost. You should check with the HMO you are considering to see if dental care is available, what the cost would be, and what benefits are provided before you make payments for the United Concordia plan.

Vision Benefits

Retirees in Class 1, Class II or Class III are eligible to receive vision benefits even if they reside outside of California. Retirees electing this coverage are required to pay the entire premium.

Frequently Asked Questions

Q How can I find out what doctors and dentists are in the networks?

A The Administrative Office can provide you with copies of the most recent provider directories free of charge. You can also visit the websites shown in the "Contacts" list at the beginning of this booklet.

Q What if I'm eligible for Medicare but my spouse isn't?

A In that case, your spouse will be enrolled in the closest counterpart for participants not eligible for Medicare (for example, the Kaiser Permanente HMO if you enroll in Kaiser Permanente Senior Advantage, the UnitedHealthcare formerly PacifiCare HMO if you enroll in PacifiCare Secure Horizons. You and your spouse can choose either the high or the low option under your program.

Q Can I enroll myself in Kaiser Permanente and my spouse in UnitedHealthcare formerly PacifiCare?

A No, you must either both be in Kaiser Permanente or both be in UnitedHealthcare formerly PacifiCare.

Q If I decide to get dental care though my HMO, can I enroll my spouse separately in United Concordia?

A No, you may enroll your spouse in United Concordia only if you enroll yourself.

Q Do I need to take a medical exam before I can enroll in benefits?

A No, no medical examination is required. Eligible retirees and their eligible spouses will be covered regardless of their physical condition.

How to Enroll

When you are initially eligible and each year during the open enrollment period, you will receive a comparison of your program options as well as an enrollment form. All you need to do is review your options and decide which option is best for you. Then complete and return our enrollment form as directed on the form.

When you are initially eligible for retiree coverage, you must submit your enrollment forms to the Administrative Office within 180 days of your retirement date. If you are married and are enrolling your spouse, you must submit a certified copy of your marriage license along with your forms.

Option to Defer or Drop Coverage for Class I Retirees

In general, you must enroll for retiree coverage within 180 days of retirement in order to be eligible for retiree coverage. However, if you are a Class I retired employee, you have the option to defer retiree coverage to a later date if you have other coverage available when you retire. In addition, if you initially elect coverage under the retiree program and other coverage becomes available later, you may be allowed to drop coverage under the retiree program and re-enroll at a later date. Other coverage could be coverage as an employee or as a dependent under your spouse's plan.

You are eligible to defer or drop coverage if you are covered under another plan immediately after you defer or drop retiree coverage. You may then enroll, or re-enroll if:

- you are losing the other plan coverage,
- your coverage under the other plan was continuous from the time you were enrolled in the Los Angeles Machinist Benefit Trust medical plan until the time you requested late enrollment or re-enrollment, and
- you have proof that the other coverage was continuous. Proof may be provided in the form of a Certificate of Creditable Coverage, as stipulated in the Health Insurance Portability and Accountability Act of 1996.

You may elect this option **only once.** Contact the Administrative Office for more information.

This option does not affect your prepaid dental coverage; only medical coverage.

Changing Plans—Open Enrollment

You may change from one option to another only during the annual open enrollment period (generally during the month of November each year), for coverage effective January 1. In addition, you may stop your United Concordia dental coverage whenever you like. However, you may only elect to restart the dental coverage during the open enrollment period.

To avoid any loss in coverage, upon approaching age 65, please call the Administrative Office for assistance.

Remember that your spouse's enrollment will change along with yours and that your and your spouse's eligibility for Medicare may affect your choices.

PAYING FOR COVERAGE

Payment Amounts

The amount of your monthly payment will depend on:

- your classification (i.e., Class I, Class II, or Class III),
- if you cover only yourself or yourself and your spouse,
- whether you and/or your spouse, if applicable, are eligible for Medicare,
- what medical option you choose (i.e., Kaiser Permanente high or low option, UnitedHealthcare formerly PacifiCare high or low option), and
- whether you elect prepaid dental and vision coverage.

Monthly payment amounts are established through the collective bargaining agreements and by the Board of Trustees, and are subject to change from time to time. You will be notified of the amount of your payment when you enroll for coverage.

Sending in Your Payments

Your first payment must be received by the Administrative Office by the 20th of the month following the month you are no longer eligible for active coverage. All subsequent payments must be received by the 20th of the month for which coverage is desired.

All checks should be made payable to "Los Angeles Machinist Benefit Trust" or "LAMBT."

Coverage Must Be Continuous

If your payment is not received on time, you will lose coverage and will not be eligible for coverage again unless you re-establish eligibility as an active employee and re-retire at a later date.

This does not apply to the United Concordia dental coverage, which may be stopped at any time but only restarted during the open enrollment period, or to the one-time deferral or dropping of medical coverage by Class I retirees.

WHEN COVERAGE BEGINS

Your benefits will begin on the first day of the month following the date you have satisfied the eligibility requirements for retiree benefits, provided your required payment is received in time.

NOTE: If you are still eligible for active employee benefits (as an active, self-pay, or disabled employee), the start of your retiree coverage will be delayed until you are no longer eligible for active employee benefits. Also, if you qualified for retiree coverage but elected COBRA continuation coverage or self-pay coverage under the plan for active employees, retiree coverage will begin when the other coverage ends. In all cases, coverage must be continuous.

Dependent coverage for your spouse will begin on the later of the date your coverage becomes effective or the date dependent status is established.

SECTION 3

WHEN COVERAGE ENDS

Section 3 covers:

- Termination of eligibility
- Continuation of coverage by a surviving spouse
- COBRA continuation coverage for your spouse
- Certificate of Creditable Coverage

TERMINATION OF ELIGIBILITY

Retired Employees

You will no longer be eligible for retiree coverage on the earliest of the following:

- the date the Plan is terminated by the Trustees,
- the date a required payment is not received from you in accordance with the rules established for payment for coverage,
- the date you are not longer eligible for your pension or Social Security Disability award,
- the date you become eligible for coverage under another group plan,
- the date it is determined that the income you have earned exceeds the maximum allowed for eligibility for retiree benefits,
- if you are in Class I, the date your former employer no longer contributes to the Plan for retired employees' coverage, unless an extension is provided for in the CMI merger agreement
- if you are in Class II or III, the date your employer at the time of your retirement fails to meet the employer requirement for Class II or III eligibility (such an employer must, at all times, be contractually required to contribute to the Trust on behalf of active employees or no longer have a contractual obligation to make contributions to the Trust and no longer be active in the trade).

If coverage is ending because of your death, your surviving spouse may continue coverage as explained under "Continuation of Coverage by a Surviving Spouse" or "COBRA Continuation Coverage for Your Spouse" below. Note: if you elect self-payment as the surviving spouse of a deceased retiree, you may not add a new spouse if you remarry.

Spouses

Coverage for your spouse will end on the earliest of the following:

- the date you and your spouse divorce or legally separate,
- the date the Plan, or dependent spouse coverage provided under the Plan, is terminated by the Trustees,
- the date you are no longer eligible for benefits (except that in the event of your death your surviving spouse may continue coverage as explained below), or
- the date the required payment is not received in accordance with the rules established for payment for coverage (i.e., in the event of your death, if your spouse is continuing coverage by making self-payments and misses a payment).

Coverage for a dependent spouse may be continued under COBRA if the individual qualifies.

CONTINUATION OF COVERAGE BY A SURVIVING SPOUSE

This section of the booklet is intended to inform your spouse of his or her option to continue the applicable class of coverage after your death by assuming the payment obligation. Please share this section with your spouse and urge him or her to read it carefully.

In the event of your death, your surviving spouse may continue benefits coverage by making the required payments as follows:

- If you were a Class I retiree, your surviving spouse will be able to continue coverage under the Class II program for retirees. The payments he or she will need to make will be at the level required for Class II retiree coverage rather than the partial payments required from Class I retirees.
- If you were a Class II retiree, your surviving spouse may continue Class II retiree benefits by making the required Class II payments.
- If you were a Class III retiree, your surviving spouse may continue Class III retiree benefits by making the required Class III payments.

Your spouse's first payment must be received by the Administrative Office by the 20th of the month following the month coverage would otherwise have ended because of your death. All subsequent payments must be received by the 20th of the month for which coverage is desired. All checks should be made payable to "Los Angeles Machinist Benefit Trust" or "LAMBT."

As an alternative, your surviving spouse has the option of continuing coverage for up to 36 months by electing COBRA continuation coverage, as explained later in this section. ***It is your spouse's responsibility to notify the Administrative Office of your death.***

Note that if your spouse elects COBRA continuation coverage, he or she may lose the right to continue coverage under the Plan. On the other hand, if your spouse elects to continue coverage under the Plan, he or she may lose the right to elect COBRA. Therefore, in the event of your death, it is important that your spouse contact the Administrative Office for assistance in making his or her decision.

COBRA CONTINUATION COVERAGE FOR YOUR SPOUSE

This section of this booklet is intended to inform your spouse of his or her rights and obligations regarding COBRA continuation coverage. Please share this section with your spouse and urge him or her to read it carefully.

A federal law, known as COBRA, requires that group health plans offer eligible dependent spouses the opportunity for a temporary extension of health care coverage (called COBRA continuation coverage) in certain instances (called qualifying events) where coverage under a plan would otherwise end.

All of your spouse's benefits may be continued under COBRA continuation coverage. To receive this COBRA continuation coverage, your spouse must pay the monthly COBRA continuation coverage premiums directly to the Trust.

Qualifying Events

For your spouse to be eligible for COBRA continuation coverage, the loss of coverage must be due to your death, divorce, or legal separation. Coverage may continue for up to a maximum of 36 months.

Coverage will end before 36 months if your spouse becomes covered under any other group plan (including Medicare) during the COBRA continuation coverage period. However, if the other group coverage (other than Medicare) contains a provision that would limit benefits for a pre-existing condition that affects your spouse, then COBRA continuation coverage is available until the date the condition is

covered under the other group coverage or the end of the maximum time allowed under COBRA coverage is reached, whichever occurs first.

See "Duty to Notify Administrative Office" later in this section regarding your responsibility to notify the Administrative Office that a qualifying event has occurred.

Qualified Beneficiaries

Under the law, only qualified beneficiaries are eligible for COBRA continuation coverage. A qualified beneficiary is any individual who was covered under the Plan on the day before the qualifying event. Under the Plan for retirees, this only includes the spouse of a retired employee.

If your spouse remarries during a COBRA continuation coverage period, he or she can add the new spouse to his or her COBRA continuation coverage (see "Special COBRA Continuation Coverage Enrollment Rights" later in this section). However, such a new spouse does not become a qualified beneficiary. If the marriage should cease, the added spouse would lose coverage immediately.

Duty to Notify Administrative Office

NOTE: You should keep a copy, for your records, of any notices you send to the Administrative Office.

You or spouse must inform the Administrative Office in writing within 60 days of a divorce or legal separation or your death. The Administrative Office should also be notified if your spouse becomes eligible for Medicare and of any change in address for you or your spouse during the COBRA continuation coverage period.

Failure to provide this notice within the timeframes and in the form described below may prevent you from obtaining COBRA continuation coverage.

How to Notify the Administrative Office

To notify the Administrative Office, you must complete and sign the appropriate Trust form. You can obtain a form by contacting the Administrative Office. If you have any questions about how to fill out this form, please contact the Administrative Office at (323) 278-7030 or (800) 499-8121. Alternatively, you may send a letter to the Trust containing the following information: your name or your spouse's 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 a qualifying event should be sent to the Administrative Office at:

Los Angeles Machinist Benefit Trust
6801 East Washington Boulevard
City of Commerce, California 90040

When to Notify the Administrative Office

If you are providing notice of a divorce or legal separation or a second qualifying event, you must send the notice **no later than 60 days after the later of the date:**

- of the qualifying event, or
- 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 or initial COBRA continuation coverage notice) of your responsibility to provide notice to the Administrative Office and the procedures for doing so.

You should also notify the Administrative Office of eligibility for Medicare.

Who Can Notify the Administrative Office

Notice may be provided by you or your spouse or any representative acting on behalf of you or your spouse.

Deadline for Election of COBRA Continuation Coverage

When the Administrative Office is notified that a qualifying event has occurred, the Administrative Office will send your spouse an election form and other information regarding COBRA continuation coverage. Your spouse will have 60 days to elect COBRA—60 days from the date coverage terminates under the Plan or, if later, from the date he or she receives the election form and COBRA continuation coverage information.

Your spouse will not have to show evidence of insurability to obtain COBRA continuation coverage.

Paying for COBRA Continuation Coverage

COBRA participants must pay for COBRA continuation coverage. The cost of coverage is based on the Trust's costs to provide coverage to eligible retirees and spouses. 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 before the month for which coverage is desired to avoid possible delays in claim payment and eligibility questions. 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 ended, 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 before the 20th day of the month preceding each coverage month to avoid possible delays in claim payments and eligibility problems.

Any shortage in COBRA continuation coverage premium payments must be made up within 31 days. Coverage will be conditional until payment is received. **Failure to make a monthly payment within 31 days of the beginning of the coverage month will result in termination of coverage as of the end of the month for which payment was last made.**

Special COBRA Continuation Coverage Enrollment Rights

If your spouse marries while he or she is enrolled in COBRA continuation coverage, he or she may enroll the new spouse for coverage for the balance of the period of COBRA continuation coverage (unless the marriage terminates before that time). The new dependent spouse must be enrolled within 31 days of the marriage.

Please note that adding a spouse may cause an increase in the premium for COBRA continuation coverage.

Termination of COBRA Continuation Coverage

COBRA continuation coverage will end on the last day of the 36-month maximum period of coverage. However, it may end earlier if:

- the Plan discontinues retiree coverage,
- your spouse does not pay the premium for COBRA continuation coverage on time,
- your spouse obtains coverage under another group health plan (as an employee or spouse or other dependent of an employee) unless the new plan has a provision limiting coverage for a pre-existing condition of your spouse, in which case COBRA continuation coverage will not end until the date the condition is covered under the new plan (provided this is before the end of the 36-month maximum COBRA continuation coverage period), or
- your spouse becomes eligible for Medicare.

Conversion Option

At the end of the 36-month continuation coverage period, your spouse may be able to convert to an individual insurance policy if that is provided under his or her coverage at that time. The conversion option, if any, will not apply if COBRA continuation coverage ends before the end of the 36-month maximum period. Your spouse must apply for conversion coverage and pay the premium within 31 days of the loss of their coverage. For more information, your spouse should contact the HMO.

Keep the Plan Informed of Address Changes

To protect your spouse's rights, you should keep the Administrative Office informed of any changes in address.

Questions?

If there are any questions, please contact the Administrative Office.

Also, if you or your spouse changes addresses (or your spouse remarries or becomes eligible for Medicare), the Administrative Office should be notified.

Frequently Asked Questions

Q Can a spouse who's already eligible for Medicare elect COBRA continuation coverage?

A Yes. However, if your spouse becomes eligible for Medicare after electing COBRA continuation coverage, the COBRA continuation coverage will end.

Q Will my spouse get a monthly bill for COBRA continuation coverage?

A The Administrative Office will send you a coupon booklet when you elect COBRA. You should include the coupon with your remittance when paying for COBRA. You will not get monthly bills or warning notices. It is your spouse's responsibility to submit payments when due.

Q Can my spouse change from one medical plan to another?

A Not at the time of initially electing COBRA continuation coverage. If another option is available, your spouse may change plans during Open Enrollment in November, with the change effective for coverage starting the following January 1.

CERTIFICATE OF CREDITABLE COVERAGE

When coverage ends, you, or your spouse, will receive a Certificate of Creditable Coverage. The Certificate provides information regarding the period of coverage (including COBRA continuation coverage) under this Plan. This information may be used to reduce or eliminate a pre-existing condition limit under a new group health plan covering you or your spouse (provided the break between this coverage and the new coverage is less than 63 days).

You or your spouse may request a copy of the Certificate at any time within 24 months after your coverage ends.

If your spouse loses eligibility separately from you and the Administrative Office is notified that your spouse is no longer an eligible dependent, a separate Certificate will be provided for him or her. This Certificate may also be requested within 24 months after your spouse's coverage ends.

SECTION 4

MEDICAL PLANS

Be sure to see the materials from Kaiser Permanente or UnitedHealthcare formerly PacifiCare for information on such matters as:

- how medical benefits work,
- how benefits are handled if you are eligible for Medicare,
- any deductibles you have to meet,
- what services and supplies are covered (your "Medical Comparison" sheet shows highlights of coverage),
- any maximum benefits, limits on visits or services, or exclusions from coverage,
- what providers you can use and how to get a listing of those providers,
- how to change your primary care physician if your Plan requires you to have one,
- pre-authorization requirements,
- what you should do in an emergency or if you become ill or injured while traveling,
- what walk-in and mail order service you have for prescription drugs,
- how your Plan handles your private health information,
- how benefits are handled if you have other coverage or are eligible for payments from a third party,
- how to file any necessary claims,
- procedures for appealing claims or treatment decisions, and
- any mediation or arbitration provisions regarding disputed claims.

If you do not find the information you are looking for, contact Kaiser Permanente or UnitedHealthcare formerly PacifiCare directly.

Enrolling in Medicare

See Section 1 for information on enrolling in Medicare.

SPECIAL PROVISIONS REGARDING WOMEN'S HEALTH CARE

All the medical plans available to participants comply with federal laws that guarantee certain rights to women:

- Under the Women's Health and Cancer Rights Act of 1998, all plans that cover mastectomies are also required to cover related reconstructive surgery. Available reconstructive surgery includes both reconstruction of the breast on which surgery was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. Coverage is also 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 copayment provisions.

- 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).

SECTION 5

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Section 5 gives you information about:

- Mental health and substance abuse
- Pre-authorization requirements
- How to use MHN
- Providers you may use
- Exclusions
- Filing mental health or substance abuse claims

The mental health and substance abuse benefits described in this Section apply to you and your spouse only if:

- you live in California, and are enrolled in the UnitedHealthcare formerly PacifiCare HMO,
- you are not yet eligible for Medicare, and
- you are not enrolled in the Kaiser Permanente HMO.

All other participants should see their materials from Kaiser Permanente or UnitedHealthcare (formerly PacifiCare) as applicable, for information on their mental health and substance abuse benefits.

ABOUT THE PROGRAM

The Plan provides mental health and substance abuse benefits for you and your spouse through MHN. With the MHN plan, you and your spouse are eligible to receive quality inpatient and outpatient mental health and substance abuse treatment at a reasonable cost from a wide selection of providers within your community. Please note that substance abuse benefits are often referred to as chemical dependency benefits. In addition, sometimes mental health and/or substance abuse benefits are referred to as behavioral health benefits.

The following charts show the schedule of benefits for mental health and substance abuse benefits.

Mental Health Services	
Inpatient Deducible *Inpatient Per Admission Fee*	None None
*Inpatient, Partial and Day Treatment**	Up to 45 days per calendar year. Covered at 100%.
Outpatient Mental Health	Up to 20 visits per calendar year, No copay per visit.
Chemical Dependency Services	
All Levels of Care (Including Detox)	No copayment. Covered at 100%. $750,000 annual maximum
Severe Mental Illness Benefit	
Inpatient Deductible Inpatient Per Admission Fee	None None
*Inpatient, Partial and Day Treatment**	Unlimited days covered at 100%.

Annual Maximum Benefit for Inpatient Treatment	None
Outpatient Mental Health Treatment	Unlimited visits. No copay per visit.
Lifetime Maximum for Parity Diagnosis	Applied to Medical Plan lifetime dollar maximum benefit
* Residential: Non-inpatient, 24-hour live in programs for the treatment of mental health or substance abuse disorders. Day Treatment: A structured program of treatment in which the participant is involved from four to twelve hours per day. Two day treatment days count as one full inpatient day.	

If You Have Coverage Elsewhere or Are Medicare Eligible

Please inform MHN if you or your spouse has mental health and/or substance abuse 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.

You should also notify MHN if you or your spouse are eligible for Medicare.

PRE-AUTHORIZATION REQUIREMENTS

All services described in this Section must be pre-authorized by MHN (except in an emergency). See "How to Use MHN" in the following section for information on how to obtain pre-authorization.

If you do not get the necessary pre-authorization, you will be responsible for all charges for the services you receive.

HOW TO USE MHN

If you need to use MHN services, follow the steps below:

- Call MHN toll-free at (800) 327-7701.
- Tell the MHN staff member who takes your call that you are covered under the Los Angeles Machinist Benefit Trust and provide your name and the eligible subscriber's Social Security number. Explain the problem you have, and MHN will help determine the type of treatment needed.

  The phone counselor will take down the information you provide. If services are medically necessary, you or your spouse will be referred to an appropriate contracting provider—doctor, hospital, or treatment center—within your community.
- Call the contracting provider's office to make an appointment.
- Call MHN back to confirm which provider you have secured an appointment with. MHN will issue an authorization and will contact the practitioner or facility regarding the initial authorized treatment program.

If you are in an **emergency situation**, pre-authorization for inpatient treatment is not necessary; however, MHN must be contacted within 48 hours of an emergency hospital admission (or as soon as is reasonably possible after your condition is stable. See "Inpatient, Residential, and Day Treatment" below for the definition of an emergency.

Time Frames for Response

Decisions on pre-authorization will normally be made within five 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 and Disclosure Form (EOC) from MHN for information on when you can expect a decision on your request for pre-authorization of services. Your EOC will also tell you how to appeal a denial of treatment pre-authorization.

PROVIDERS YOU MAY USE

Inpatient, Residential, and Day Treatment

In **non-emergency** situations, you **must** use MHN contracting facilities and providers for treatment to be covered.

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 treatment 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 an admission does not meet these emergency criteria, you will be responsible for charges made by the non-contracting facility.

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. MHN reserves the right to transfer you to a contracting hospital, as long as the move would not harm your health.

If you experience a situation requiring mental health and/or substance abuse 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, this will be considered an emergency situation.

Outpatient Care

For outpatient counseling services, you **must** go to a MHN contracting provider. MHN will work with you to find a provider who is conveniently located and well-suited to your needs.

Frequently Asked Questions

Q What happens if I go to a provider that is not part of the MHN network?

A You will have to pay the entire cost of treatment. Your benefits will not cover treatment at a non-contracting provider, except in the case of an emergency, as explained under “Providers You May Use” above.

Q What if I need help in the evening? Or over a weekend?

A Call MHN. The phone lines are staffed around the clock.

EXCLUSIONS

No payment will be made under mental health and substance abuse benefits for any of the following:

- Court-ordered testing and treatment, except when Medically Necessary and within the allowable visits under the Plan contract.
- Private Hospital rooms and/or private duty nursing, unless determined to be a Medically Necessary Service and Authorization from MHN is obtained.
- Ancillary services such as:
    a. vocational rehabilitation and other rehabilitation services
    b. behavioral training
    c. speech or occupational therapy
    d. sleep therapy and employment counseling
    e. training or educational therapy or services
    f. other education services
    g. nutrition services
- 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.
- Services in excess of those with respect to which Authorization by MHN is obtained.
- Psychological testing except as conducted by a licensed psychologist for assistance in treatment planning, including medication management or diagnostic clarification and specifically excluding all educational, academic and achievement tests, psychological testing related to medical conditions or to determine surgical readiness and automated computer based reports.
- All prescription or non-prescription drugs and laboratory fees, except for drugs and laboratory fees prescribed by a Practitioner in connection with Inpatient treatment.
- Inpatient services, treatment, or supplies rendered without Authorization, except in the event of Emergency Services and Care.
- Healthcare services, treatment, or supplies rendered in a non-Emergency by a provider who is not a Participating Provider, unless Authorization by MHN has been received or as otherwise provided by the Plan.
- Damage to a hospital or facility caused by the Member.
- Healthcare services, treatment or supplies determined to be Experimental by MHN in accordance with accepted mental health standards, except as otherwise required by law.
- Treatment for biofeedback, acupuncture or hypnotherapy.
- Healthcare services, treatment, or supplies rendered to the Member which are not Medically Necessary Services. This includes, but is not limited to, services, treatment, or supplies primarily for rest or convalescence, Custodial Care or Domiciliary Care as determined by MHN.
- Services received before the Member's effective date, during an Inpatient stay that began before the Member's effective date or services received after the Member's coverage ended, except as specifically stated herein.
- Professional services received from a person who lives in the Member's home or who is related to the Member by blood or marriage.
- Services performed in any emergency room which are not directly related to the treatment of a Mental Disorder.

- Services received out of the Member's primary state of residence except in the event of Emergency Services and Care 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 outlined in the Exhibit A and/or specifically included as Covered Services elsewhere in this Plan

FILING MENTAL HEALTH OR SUBSTANCE ABUSE CLAIMS

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 pre-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 and Disclosure Form (EOC) from MHN for further information.

Pre-Authorized Services

You will not need to file claims for pre-authorized services. When MHN sends you to a contracting provider, you pay the applicable copayment, and the Plan pays the remainder of the cost of covered services.

Services from a Non-Contracting Hospital (Emergency Admission)

You should not need to become involved in this type of claim, either. If an emergency hospitalization in a non-contracting hospital has been approved, the non-contracting hospital must submit itemized bills within 90 days of the date of service to:

MHN Claims
P.O. Box 14621
Lexington, KY 40512-4621

If a bill for emergency treatment is sent to you, you should make a copy for yourself and then send the bill to MHN at the address above.

If a claim for emergency hospitalization is denied, you may appeal it. See the information on the appeals process in your Combined Evidence of Coverage and Disclosure Form from MHN.

SECTION 6

PREPAID DENTAL PLAN

(available for an additional charge)

The prepaid dental plan is available to all Class I, Class II and Class III members residing in California at an additional charge. If you have decided to enroll in the prepaid dental plan, see your materials from United Concordia for information on:

- how dental benefits work,
- how to make appointments,
- what services and supplies are covered,
- limits on how often you are eligible for particular services or at what intervals certain items can be replaced,
- what services are excluded from coverage,
- what dental offices and dentists you can use and how to get a listing of those offices and dentists,
- any requirements for pre-authorization of treatment plans,
- what you should do in a dental emergency or if you receive services out of state,
- what happens if you lose your eligibility for benefits when a treatment plan is in progress,
- how benefits are handled if you have other coverage or you are eligible for payment from a third party,
- how United Concordia handles your private health information,
- how to file any necessary claims,
- procedures for appealing claims or treatment decisions, and
- any mediation or arbitration provisions regarding disputed claims.

If you do not find the information you are looking for, contact United Concordia directly.

IF YOU ARE MEDICARE ELIGIBLE

If you are in an HMO Medicare Advantage program (Kaiser Permanente Senior Advantage or UnitedHealthcare PacifiCare Secure Horizons), dental coverage may also be available, at no cost or at limited cost, through your HMO. Call member services at Kaiser Permanente or UnitedHealthcare for information.

SECTION 7

VISION CARE BENEFITS

(available for an additional cost)

The vision care benefits referenced in this Section are optional benefits available to Class I, Class II and Class III retired employees.

COVERED BENEFITS

Vision care benefits are available through Medical Eye Service (MES) for an additional charge. Generally, the Plan will cover 100% of allowable expenses for the following, with no copayment required from you, when you use providers in the MES network:

- an eye exam once every 12 months,
- lenses once every 12 months, and
- frames once every 24 months.

MORE INFORMATION

See the materials from Medical Eye Service (MES) for more information, including:

- how vision care benefits work,
- how to make appointments,
- how to find network providers and how to get a listing of those providers,
- what specific services and materials are covered,
- how choosing contact lenses affects your benefits,
- what happens if you use out-of-network providers,
- how MES handles your private health information,
- procedures for appealing claims or coverage decisions, and
- any mediation or arbitration provisions regarding disputed claims.

If you do not find the information you are looking for, contact MES directly.

Check Your Medical Plan, Too

Your medical plan may also include some vision benefits. Call member services at Kaiser Permanente or UnitedHealthcare formerly PacifiCare for information.

SECTION 8

OTHER IMPORTANT PLAN INFORMATION

Section 8 includes:

- Confidentiality of your private health information
- Coordination of benefits
- Third-party liability reimbursement
- Recovery of benefit payments made in error
- Claims review procedures
- Factors that could affect your receipt of benefits
- Your ERISA rights
- General Plan information

CONFIDENTIALITY OF YOUR PRIVATE HEALTH INFORMATION

A federal law, the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), requires that health plans, like the Los Angeles Machinist Benefit Trust, protect the confidentiality of private health information. A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was distributed to you upon enrollment and 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 Plan Sponsor, the Board of Trustees, will not use or further disclose information that is protected by HIPAA (protected health information) except as necessary for treatment, payment, health plan operations, and plan administration or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or discloses protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

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 Department of Health and Human Services (HHS) if you believe your privacy rights have been violated.

COORDINATION OF BENEFITS

If you or your spouse has health care coverage under more than one group benefit plan, the amount of benefits payable under each plan will be coordinated so that the total benefits payable will not exceed 100% of the covered expenses incurred. If you are eligible for Medicare, your benefits will also be coordinated with Medicare.

See the materials from your HMO or United Concordia, if you elected prepaid dental coverage, for information on how your benefits will be coordinated. For information on how mental health and substance abuse benefits are coordinated, see the materials provided by MHN**.**

THIRD-PARTY LIABILITY REIMBURSEMENT

Should you or your spouse be injured through the act or omission of a third party and receive payment from that person (or insurance company), you will be required to reimburse the Trust for any amounts paid by the Plan.

The Trustees may intervene directly in any pending judicial or administrative proceeding to protect the Trust's right to collect any amounts due. The Trustees may, as a condition of furnishing benefits, require you or your spouse to sign a lien, assignment, or similar writing promising reimbursement to the Trust for any amounts collected (up to the benefits provided by the Fund). Amounts may also be withheld from future payment due to you or your spouse's medical or dental care if payment was received by you but never repaid to the Trust.

If the injured person dies, the heirs, beneficiaries, and personal representatives are bound by these obligations.

RECOVERY OF BENEFIT PAYMENTS MADE IN ERROR

In the event a benefit payment has been made in error, the Trust has the right to recover the erroneous payment by demand for immediate repayment, offset from future benefit payments for you or your spouse, or any other legal means. The Trust will also be entitled to reasonable attorney's fees and costs of suit.

NOTE: You must always inform the Administrative Office of a change in your spouse's dependent status (i.e., if you divorce or legally separate).

CLAIMS REVIEW PROCEDURES

NOTE: The information provided here is a general explanation of how claims and appeals procedures work. The time frames mentioned (which are summarized in a chart at the end of the discussion) are the maximums allowed by law.

For HMOs, mental health and substance abuse benefits provided by MHN , United Concordia prepaid dental, and vision benefits, it is not necessary to file a claim when services are rendered by a provider in the applicable network. See the materials from these providers for information on what to do if you receive covered services from a non-network provider. These organizations also have their own review and appeals procedures, which are described in their materials. The Trust cannot make an appeal on your behalf to any of these organizations. You may, however, appeal to the Board of Trustees for assistance in the handling of any dispute with a carrier.

The carriers may also have provisions regarding mediation or arbitration of disputed claims.

The following provisions apply only to claims or appeals that pertain to eligibility under any of the Trust's benefit plans,

Different claims and appeals procedures apply to the HMO medical, vision, and prepaid dental plans. For those procedures, please refer to the evidence of coverage/disclosure booklet issued by the plan in question.

Types of Claims

There are four types of health care claims:

- **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).

  If you do not get pre-authorization when it is required, you may receive reduced benefits or no coverage at all. Pre-authorization is required for non-emergency mental health and substance abuse treatment, see the materials from MHN for information on those claims.

- **Urgent care claims:** Your request for required pre-authorization is 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 review, 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 initial pre-authorization was made, resulting in a reduction, termination, or extension of a benefit. For example, an inpatient hospital stay originally pre-authorized for five days is subjected to concurrent care review after three days to determine if the full five 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 pre-authorized 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 is a post-service claim.

What is NOT a Claim

The following are not considered claims and are not subject to the requirements and time frames described in this section. These will not be considered claims even if they are referred to as claims by the Administrator or anyone working on behalf of the Administrator:

- simple inquiries about eligibility, enrollment, or Plan's provisions that are unrelated to any specific benefit claim,
- a request for an advance determination regarding coverage of a treatment or service that does not require pre-authorization, or
- a prescription you present to a pharmacy to be filled. However, if your request for a prescription is denied, in whole or in part, you may file an appeal regarding the denial.

Filing a Claim

See the materials from your organization (Kaiser Permanente, UnitedHealthcare formerly PacifiCare, MHN, United Concordia, or Medical Eye Service) for information on the following:

- **Pre-service and urgent care claims (claims requiring pre-authorization):** Will your doctor or other health care professional take care of getting pre-authorization for you, or is it your responsibility? Can the request be made by phone, or does it have to be made in writing? If your condition warrants handling of your request as an urgent care claim, how should the reviewing authority be alerted?

"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" on page __ for an explanation of when a request for pre-authorization might need to be handled as an urgent care claim.

- Post-service claims: Generally, if you use a provider that participates in the applicable network of your organization (Kaiser Permanente, UnitedHealthcare formerly PacifiCare, MHN, United Concordia, or Medical Eye Service), you do not need to file claims. See the materials from your organization about how to file a claim if you have obtained services from a non-participating provider. Authorized Representatives

An authorized representative, such as your spouse, may submit a claim for you if you are unable to do so and have previously designated the individual to act on your behalf. A form can be obtained from the carrier or the Administrative Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf.

Even if you have designated an authorized representative to act on your behalf, generally you must personally sign a claim form and file it with the carrier or the Administrative Office at least annually. ***You should check with the carrier to determine the rules that apply to authorizations.***

When Claims Must Be Filed

Your claim will be considered to have been filed as soon as it is received by the applicable reviewing authority.

Pre-service health care 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 by the deadline specified in the materials you have received from your organization **(**Kaiser Permanente, UnitedHealthcare formerly PacifiCare, MHN, United Concordia, or MES), as applicable.

Notification That Pre-Service or Urgent Care Claim Has Not Been Filed Properly

If your **pre-service** claim has been improperly filed, you will be notified as soon as possible, but no later than **five 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, you will be notified 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. Unless the claim is re-filed properly, it will not constitute 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 the claim is submitted. 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 claim has been properly filed, you will be notified of a 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 the applicable reviewing authority. 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 the reviewing authority expects to make a decision.

If an extension is needed because the reviewing authority needs additional information from you, the reviewing authority 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 provider 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). The reviewing authority 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 phone as soon as possible, taking into account the exigencies of your situation, but no later than **72 hours** after receipt of the claim by the reviewing authority. 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, the reviewing authority 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 provider must respond to this request within **48 hours**. Notice of a decision will be provided no later than **48 hours** after the reviewing authority 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 the reviewing authority 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 the reviewing authority within **24 hours** of receipt of the claim, provided the claim is received at least 24 hours before the expiration of the pre-authorized 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 reviewing authority 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 reviewing authority. 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 reviewing authority expects to make a decision.

  If an extension is needed because the reviewing authority needs additional information from you, the reviewing authority 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 provider 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). The reviewing authority then has **15 days** to make a decision on your post-service claim and notify you of the determination.

Denied Claims (Adverse Benefit Determinations)

You will be provided with written notice of an adverse benefit determination, whether 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 review 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 of where a complete description of the claims and appeals procedures may be found,
- notice of your right to file a lawsuit if your appeal of the adverse benefit determination is denied, and
- 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.

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 and must be made **within 180 days** after you receive the notice of denial (or, in the case of a concurrent care decision, within a reasonable time, given the exigencies of your situation).

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 phone, 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 appeals reviewing authority.
- **Urgent care claims:** You will be sent a notice of a decision on review within **72 hours** of receipt of the appeal by the appeals reviewing authority.
- **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 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.

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 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. However, no legal or equitable action will 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 had not received any response by the expiration of the response time allowed for the type of claim.

Maximum Times for Processing 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***
Reviewing authority 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)
Reviewing authority 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
Reviewing authority 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

Reviewing authority 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
Reviewing authority 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 type of care decision	At the next regularly scheduled quarterly Board of Trustees meeting held at least 30 days of receiving your request for appeal (can be extended to next quarterly meeting)

FACTORS THAT COULD AFFECT YOUR RECEIPT OF BENEFITS

NOTE: See the materials from your organization (Kaiser Permanente, UnitedHealthcare formerly PacifiCare, MHN, United Concordia, and MES), as applicable, for specific information about factors that might affect your receipt of benefits.

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 requirements for review and pre-authorization.** If you wish to receive unreduced benefits coverage (or any coverage at all, in many cases) for any service or treatment requiring review or pre-authorization, you must comply with those requirements.
- **Failure to use contracting providers.** You will not receive coverage (or will not receive the highest level of coverage available) unless you use providers participating in your Plan's network.
- **Failure to submit claims in a timely way.** You should submit any claims by the deadline specified in the materials from your organization (Kaiser Permanente, UnitedHealthcare formerly PacifiCare, MHN, United Concordia, and MES), as applicable.
- **Provisions for coordination of benefits.** If you or your spouse has health care coverage under another plan, coverage or payment of benefits will be coordinated with payment of benefits by that other plan.
- **The Plan's provisions regarding payment from another source.** You will be required to reimburse the Fund for benefits it pays if you or your spouse are 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 Trustees have the right to recover benefit payments made in error (for example, if you failed to inform the Administrative Office of a change in your spouse's status). Such right includes entitlement to legal fees incurred in the recovery. Amounts may be offset from future benefit payments. See "Recovery of Benefit 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 (323) 278-7030 or (800) 499-8121.

See Sections 2 and 3 for information on eligibility and termination of eligibility.

YOUR ERISA RIGHTS

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 are entitled to the following rights.

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the plan administrator office and at other specified locations, such as worksites and union halls, all documents governing the plan. These documents include insurance contracts, 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, 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 your spouse if there is a loss of coverage under the plan as a result of a qualifying event. You or your spouse may have to pay for such coverage. Review this booklet and the documents governing the plan on the rules governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ends, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in new coverage.

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 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 part, 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. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. 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 any 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 NW
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA. For single copies of publications, contact the EBSA brochure request line at (800) 998-7542 or contact 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 of EBSA at www.dol.gov/ebsa.

Nothing in the foregoing statement is meant to interpret, 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. You will receive written notice of any Plan changes.

GENERAL PLAN INFORMATION

Plan Name

Los Angeles Machinist Benefit Trust

Plan Type

Welfare benefit plan maintained for the purpose of providing hospital, medical, dental and vision care benefits in the event of sickness or accident for eligible participants and their covered spouses.

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" below.

Contribution Source

The benefits described in this booklet are provided through employer contributions to this Plan and through self-payment contributions. 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. Dental and Vision benefits are optional and are paid entirely by the participant.

Plan Year

The fiscal records of the Plan are kept separately for each fiscal plan year. The fiscal year begins on July 1 and ends on June 30.

Plan Sponsor

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
6801 East Washington Boulevard
City of Commerce, California 90040
Phone Numbers: (323) 278-7030 or (800) 499-8121
Fax number: (323) 728-2982

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 booklet was printed are shown on page 37.

Agent for Service of

Legal Process

Becky Placek
Los Angeles Machinist Benefit Trust
6801 East Washington Boulevard
City of Commerce, California 90040

Legal process may also be served on a Plan Trustee.

Plan Administration

The Plan is administered by the Board of Trustees, on which employers and employees are 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 on page __.

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

Zenith Administrators
6801 East Washington Boulevard
City of Commerce, California 90040
Phone Numbers: (323) 278-7030 or (800) 499-8121

Trustees

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

Union Trustee	***Employer Trustees***
Kevin J. Kucera Organizer/Business Representative Local Lodge No. 1484 1261 Avalon Blvd. Wilmington, CA 90744	David W. Armstrong c/o Zenith Administrators 6801 East Washington Boulevard City of Commerce, CA 90040
Richard Sanchez Directing Business Representative District Lodge 947 IAM & AW 319 West Broadway Long Beach, CA 90802	Joseph Kaspar c/o Zenith Administrators 6801 East Washington Boulevard City of Commerce, CA 90040
Kenneth Cormier District Lodge IAM & AW 535 West Willow Street Long Beach, CA 90806	Bill Bistline c/o Zenith Administrators 6801 East Washington Boulevard City of Commerce, CA 90040
Union Trustees	***Employer Trustees***
Jack Morck c/o Zenith Administrators 6801 East Washington Boulevard City of Commerce, CA 90040	Marty Greco c/o Zenith Administrators 6801 East Washington Boulevard City of Commerce, CA 90040

Organizations Through Which Benefits Are Provided

The following benefits are fully insured:

Benefit	Identity of Provider
Prepaid medical plan	Kaiser Permanente 3100 Thornton Ave. Burbank, CA 91504 (818) 525-4370
	UnitedHealthcare formerly PacifiCare 5816 Corporate Avenue, Ste 190 Cypress, CA 90630 (714) 226-2796
Mental health and substance abuse plan For participants in California not enrolled in Kaiser Permanente 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 care plan	Medical Eye Services (MES) 345 Banker Street Costa Mesa, CA 92626 (909) 948-6861

The Trust is fully liable for the benefits described above. The benefits are administered by the provider, but the provider does not otherwise insure or guarantee any of the benefits described.

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 benefits provided directly by the Trust;
- group medical and hospital service agreements relating to the hospital and medical benefits provided by health maintenance organizations; and
- contracts with the prepaid vision and dental plans.

The information earlier in this booklet is intended to be a summary of the Fund's eligibility rules and benefits. However, the provisions of current governing Plan documents will 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 and vision benefits.

The providers who provide fully insured benefits, identified above, 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), 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 that are denied in whole or in part. Requests for such material may be addressed to the Plan Administrator at the address given above.

Collective Bargaining Agreements

Contributions to this Plan are made on behalf of each employee for Class I retired employees' benefits in accordance with many collective bargaining agreements.

The Administrative Office will provide you, upon written request, a copy of any collective bargaining agreement and/or a list of contributing employers.

Trust Fund

The Trust's assets and reserves are held in trust by the Board of Trustees of the Los Angeles Machinist Benefit Trust.