

**SPEEA
15205 52nd Ave S
Seattle, WA 98188
206-433-0995 or 1-800-1.800.325.0811**

NOTICE OF GRANDFATHERED HEALTH PLAN STATUS

SPEEA believes this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. Grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. However, the Office of Consumer Information and Insurance Oversight, Office of Oversight has approved a waiver of the Annual Limits requirement for 2011.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the numbers listed above.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

January 2011

SPEEA MEDICAL PLAN SUMMARY MATERIAL MODIFICATION (SMM) NOTICE

This insert is an SMM to the 2006 Summary Plan Description (SPD). The following changes are effective January 1, 2011.

This Plan has assumed **Grandfather Status**- see the attached notice.

NEW ELIGIBILITY RULES FOR DEPENDENT CHILDREN

The eligibility requirements listed on page 2 of the Plan Booklet have changed. Eligible dependents are your:

- son or daughter,
- stepchild
- legally adopted child (or placed for adoption), and
- foster children placed by an authorized placement agency, judgment, decree, or court order

The child **does not** have to:

- be a student, or
- live at home, or
- be financially dependent on you, or
- be unmarried

Dependent children age 19 to age 26 can be enrolled in the Plan if they do not have access to other employer sponsored health coverage through their employment or their spouse's employment (if married). If they have access and do not enroll in their own or spouse's coverage, they are not eligible to be enrolled in this Plan.

SPECIAL ENROLLMENT RIGHTS

If you did not enroll your dependents because they had other health coverage you may be able to enroll them in this Plan if they lose their health insurance coverage. You must notify and request special enrollment within 30 days of the loss of coverage.

The following language on page 2 under "Dependent's Eligibility" has been eliminated: "If you fail to cover your dependents when they are first eligible, you will not be allowed to add them at a later date."

EXCLUSION FOR PRE-EXISTING CONDITION

The following language is added on page 3:

There is no exclusion for a pre-existing condition for enrollees under age 19.

LIFETIME MAXIMUM PLAN BENEFIT

The language on page 6 referencing a lifetime maximum plan benefit has been eliminated and replaced with the following:

ANNUAL MAXIMUM PLAN BENEFIT

The Annual Maximum Plan Benefit payable for each covered Employee and Eligible Dependent is \$10,000. That amount may be payable for all medical expenses.

Any reference in the SPD to a lifetime maximum plan benefit now refers to a maximum annual benefit.

MENTAL HEALTH SERVICES

The following language replaces the first bullet on page 9:

Outpatient mental health services provided by a physician, psychiatrist, or psychologist will be paid at 80% of the usual, customary, and reasonable charges. Biofeedback treatment is included in this benefit.

SUBSTANCE ABUSE TREATMENT

On page 9 the following language has been eliminated: The maximum benefit payable of \$3,000 per enrollee.

DEFINITIONS

On page 13 the following language has been added:

Provider – is a person licensed to treat illness or injury by the state in which the treatment is rendered. A physician or surgeon and any legally licensed podiatrist, chiropractor, dentist, psychologist, or optometrist performing services within the scope of their license is covered, provided charges submitted are covered by the plan.

If you have any questions regarding these changes please call the Claims Administrative Office at 206.301.4565 or 800.426.5980.

January 2011

**Medicaid and the Children’s Health Insurance Program (CHIP)
Offer Free Or Low-Cost Health Coverage To Children And Families**

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of November 3, 2010. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
ALASKA – Medicaid	COLORADO – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ARIZONA – CHIP	CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
Website: http://www.azahcccs.gov/applicants/default.aspx Phone (In state): 1-877-764-5437	
ARKANSAS – CHIP	FLORIDA – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-866-762-2237

GEORGIA – Medicaid	MONTANA – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Telephone: 1-800-694-3084
IDAHO – Medicaid and CHIP	NEBRASKA – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
INDIANA – Medicaid	NEVADA – Medicaid and CHIP
Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
IOWA – Medicaid	
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: https://www.khpa.ks.gov Phone: 800-766-9012	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-4238
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207	
MAINE – Medicaid	NEW MEXICO – Medicaid and CHIP
Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MASSACHUSETTS – Medicaid and CHIP	
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	
MINNESOTA – Medicaid	NEW YORK – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831

MISSOURI – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	Website: http://www.nc.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid	UTAH – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414
OKLAHOMA – Medicaid	VERMONT – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://ovha.vermont.gov/ Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	WASHINGTON – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
RHODE ISLAND – Medicaid	WEST VIRGINIA – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	WISCONSIN – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

To see if any more States have added a premium assistance program since November 3, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

MEDICAL PLAN FOR NEW HIRES



SPEEA
IFPTE LOCAL 2001

As a new employee, your Boeing coverage begins the first day of the month following your employment.

This means you could be without insurance for up to 30 days!

By joining SPEEA, you immediately receive a comprehensive medical insurance "bridge" policy for you and your dependents. This coverage is provided FREE to you by SPEEA-IFPTE Local 2001.

QUICK REFERENCE GUIDE

SOCIETY OF PROFESSIONAL ENGINEERS IN AEROSPACE

<p>Membership Services Department</p>	<p>15205 52nd Avenue South Seattle, WA 98188 (800) 325-0811 (206)433-0991</p>
<p>Preferred Provider Organization: <i>First Choice</i> To obtain a free copy of First Choice doctors and hospitals call the Contract Claims Administrator</p>	<p>Zenith Administrators, Inc. (206)-301-4565 (800) 426-5980</p>
<p>Question about Claims: Call the Contract Claims Administrator</p>	<p>Zenith Administrators, Inc. (206)-301-4565 (800) 426-5980</p>
<p>To file Urgent Care Claims: Contact the Contract Claims Administrator</p>	<p>Zenith Administrators, Inc. (206)-301-4565 or (800) 426-5980 <i>or</i> Fax: (206) 285-4437</p>
<p>To file claims Post Service Claim for services that have already been incurred mail the claim to the Contract Claims Administrator</p>	<p>Zenith Administrators, Inc. P.O. Box 91014 Seattle, WA 98111-9114</p>
<p>Privacy Officer Complaints regarding the Plan's use and protection of your Protected Health Information should be addressed to the Plan's Privacy Officer</p>	<p>The Privacy Officer Kristin Farr 15205 52nd Street South Seattle, WA 98188</p>

TABLE OF CONTENTS

INTRODUCTION TO SPEEA MEDICAL PLAN.....	1
ELIGIBILITY.....	2
Employee Eligibility:	2
Dependents' Eligibility:	2
Exclusion for Pre-Existing Condition	3
When your Coverage Ends.....	3
Extended Coverage After your Coverage Ends.....	3
CERTIFICATION OF COVERAGE WHEN COVERAGE ENDS.....	4
MEDICAL EXPENSE BENEFITS.....	4
ELIGIBLE MEDICAL EXPENSES	4
HEALTH CARE PROVIDER SERVICES:.....	4
DEDUCTIBLE	4
COINSURANCE.....	5
LIFETIME MAXIMUM PLAN BENEFIT	5
COVERED MEDICAL EXPENSES	5
PLAN LIMITATIONS AND EXCLUSIONS.....	8
DEFINITIONS.....	10
COORDINATION OF BENEFITS (COB).....	12
HOW MUCH THIS PLAN PAYS AS SECONDARY PAYER	12
THIRD PARTY LIABILITY	12
CLAIMS AND APPEALS PROCEDURES	13
GENERAL RULES.....	13
PROCEDURES FOR FILING A POST-SERVICE CLAIM APPEAL WITH THE PLAN SPONSOR.....	13
LEGAL PROCEEDINGS.....	14
MISCELLANEOUS PROVISIONS	14
USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION	15
YOUR INDIVIDUAL PRIVACY RIGHTS	18
THE PLAN'S DUTIES.....	19
HIPAA SECURITY.....	20
YOUR RIGHT TO FILE A COMPLAINT WITH THE PLAN OR THE HHS SECRETARY	21
IF YOU NEED MORE INFORMATION.....	21
GENERAL PROVISIONS AND INFORMATION REQUIRED BY ERISA.....	22
ERISA STATEMENT OF RIGHTS.....	23

INTRODUCTION TO SPEEA MEDICAL PLAN

Welcome to the ranks of SPEEA membership. As an employee of a company that is signatory to a Collective Bargaining Agreement with the Society of Professional Engineering Employees in Aerospace Local 2001, you will have a comprehensive health care package providing payments for most medical expenses. SPEEA is proud of that package as it was achieved through difficult labor negotiations between SPEEA, The Boeing Company, and other aerospace Employers.

You will be covered under your Employer's Medical Plan and other Benefit Plans on the date specified in the Collective Bargaining Agreement with your Employer. The waiting period for employer provided benefits varies by Employer and you should make sure you understand when you will be eligible for those benefits. You should discuss this with the personnel department staff at your place of employment.

The SPEEA MEDICAL PLAN described in this booklet is intended to provide you and your dependents with interim medical coverage for the time between your employment date and the effective date of your coverage with your Employer. If you have any other coverage, such as COBRA Continuation Coverage through your prior employment, we recommend that you continue that coverage. Benefits from this Plan will supplement any other medical and prescription coverage available to you.

The SPEEA MEDICAL PLAN is intended to prevent sudden medical emergencies (e.g. accidents, appendicitis) from financially crippling a SPEEA member at his or her most vulnerable moment. Now that you are a member of SPEEA and a participant of the SPEEA MEDICAL PLAN, please take the time to become familiar with the benefits that the program offers.

This document will help you understand and use the benefits provided by the SPEEA MEDICAL PLAN. You should review it and share it with those members of your family who are covered by the Plan. It will give all of you an understanding of the coverages provided; the procedures to follow in submitting claims; and your responsibilities to provide necessary information to the Plan. Be sure to read the Exclusions and Definitions chapters. **Remember, not every expense you incur for health care is covered by the Plan.**

SPEEA is committed to maintaining health care coverage for employees and their families at an affordable cost, however, because future conditions cannot be predicted, the Plan reserves the right to amend or terminate coverages at any time and for any reason. The benefits of the Plan are self-funded from SPEEA membership dues.

The Contract Claims Administrator pays claims for the Plan. If you have questions regarding your coverage or how benefits have been paid, you should call the Contract Claims Administrator (refer to the Quick Reference Guide at the front of this booklet).

IMPORTANT NOTICE

You or your Dependents must promptly furnish to the Contract Claims Administrator information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in status of a Dependent Child, Medicare enrollment or disenrollment or the existence of other coverage. Failure to do so may cause you or your Dependents to lose certain rights under the Plan.

ELIGIBILITY

EMPLOYEE ELIGIBILITY:

SPEEA-represented employees who join SPEEA within 10 calendar days of employment by a signatory Employer will be covered under this Plan. Coverage begins on the date a completed and signed Temporary Medical Coverage Application Form and SPEEA Membership Application are received in the SPEEA offices. If you are not actively employed by your signatory Employer on that date, your coverage will be postponed until the first day you begin active employment. Coverage will terminate on the date you are eligible for Medical Plan coverage with your Employer.

DEPENDENTS' ELIGIBILITY:

Coverage for your Eligible Dependents begins on the day you become eligible for your own medical coverage only if they are included on the member's application. If you fail to cover your dependents when they are first eligible, you will not be allowed to add them at a later date. If you acquire an Eligible Dependent, either by marriage, birth, adoption or placement for adoption, you must submit a completed enrollment form within 30 days. The form can be obtained from the SPEEA Office or from the Contract Claims Administrator and you must provide the Plan's required proof of Dependent status. Coverage for your Dependents terminates on the date your coverage terminates.

Definitions of your Eligible Dependents

Your Dependents are your legal Spouse or Domestic Partner and your Dependent Child(ren)).

Dependent Child(ren):

For the purposes of this Plan, a Dependent Child is any of the employee's unmarried children who have not reached their 19th birthday and who have the same principal place of abode as the employee and is chiefly dependent on the employee for support and maintenance, including:

- natural child, stepchild, legally adopted child, or child placed for adoption with the employee; (proof of adoption or placement for adoption may be requested) or
- child for whom the employee has legal guardianship under a court order (proof of guardianship may be requested); or
- foster child, lawfully placed with the employee, for whom health coverage is not provided by the State (proof of foster child placement may be requested);

In addition, unmarried children over the age of 18 will be covered if:

- a) the child has reached his or her 19th birthday but has not reached his or her 25th birthday **and** is enrolled as a full-time student in high school or in an accredited and state licensed technical school or institution of higher education. School vacation periods during any calendar year that interrupt but do not terminate a continuous course of study will be considered school attendance for those individuals who attend school on a full-time basis as long as the child has not reached their 25th birthday. The Plan may require initial and periodic proof of student; **OR**
- b) the child has reached his or her 19th birthday (and is not a full-time student) or his or her 25th birthday and the child is mentally or physically Handicapped such that the child is incapable of self-sustaining employment as a result of that handicap; and that handicap existed before the attainment of this Plan's age limit. This Plan may require initial and periodic proof of handicap.

A child named in a **Qualified Medical Child Support Order** (QMCSO) is also an eligible dependent under this Plan. The QMCSO must be approved by the Contract Claims Administrator. A QMCSO is a court order that complies with requirements of federal law requiring an employee to provide health care coverage for a Dependent Child, and requiring that benefits payable on account of that Dependent Child be paid directly to the Health Care Provider who rendered the services or to the custodial parent of the Dependent Child. A copy of the Plan's procedures for governing QMCSOs is available upon request from the Contract Claims Administrator.

Coverage of a Dependent Child ends at the end of the month in which that child:

- c) no longer meets the eligibility requirements of the Plan; or
- d) enters military or similar service anywhere; or
- e) becomes employed on a full-time basis by any other employer where coverage is offered.

ELIGIBILITY

Domestic Partner:

A Domestic Partner is a person of the same sex who has the same principal place of abode as the employee and both the employee and domestic partner meet the following requirements:

- f) both are of legal age to marry in the State in which the employee and domestic partner reside; and
- g) they are not related to each other by blood to the extent that it would prohibit them from legally marrying in the State in which they reside; and
- h) have lived with each other and share financial responsibilities as evidenced by jointly owned property, mortgage, lease or bank account for a consecutive period of at least one full year prior to the date of Initial Enrollment; and
- i) neither one is legally married to anyone else or in another domestic partnership; and
- j) they complete and the employee submits the Plan's required affidavit affirming domestic partnership status along with certain other required documentation.

EXCLUSION FOR PRE-EXISTING CONDITION

This Plan does not provide coverage for the first 12 months for any Pre-Existing Condition. A “**Pre-Existing Condition**” is any illness or injury (whether physical or mental) regardless of its cause, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on your enrollment in this Plan. Treatment includes an individual taking a prescribed drug within the 6-month period. Genetic information (in the absence of a diagnosis of a resulting condition) and pregnancy are not Pre-Existing Conditions for the purposes of this Plan. No exclusion of a Pre-Existing Condition may apply with respect to any condition of a newborn child who is enrolled for coverage under this Plan within 31 days of birth, or an adopted child who was enrolled within 31 days of adoption or placement for adoption.

Credit for Previous Coverage: However, the 12 month exclusion for any Pre-Existing Condition you or your Dependents may have will be reduced by any months of coverage for which you have immediately prior Creditable Coverage. You must submit a HIPAA Certificate of Creditable Coverage from any other health care plan or insurance policy in order to prove that you are entitled to a credit for the time you were covered under that other plan or policy in order to reduce the 12 month period of exclusion of coverage under this Plan's Pre-Existing Condition provision. You will NOT have Creditable Coverage if there has been a period of **63 consecutive days or more** between the date coverage ended under your other health care plan or insurance policy and the date your signed Temporary Medical Coverage Application Form is received at the SPEEA office. Your previous employer, insurer or plan is required by law to provide such a certification to you on your request. If you have difficulty obtaining a certification, this Plan will assist you. A leave of absence under the provisions of the Family and Medical Leave Act or the Uniformed Service Employment and Reemployment Rights Act will not be counted as a Break in Coverage.

WHEN YOUR COVERAGE ENDS

The coverage of any employee or dependent under this Plan will terminate on the earliest of the following dates:

- k) The date of termination of the Plan; or
- l) The day they become covered under any of the regular health care benefit plans provided by The Boeing Company; or any other Signatory Contractor.
- m) Sixty calendar days after the date their coverage began; or
- n) The date of member's termination of employment with The Boeing Company; or other Signatory Employer.
- o) The date of member's termination of SPEEA membership.



EXTENDED COVERAGE AFTER YOUR COVERAGE ENDS

If you or your dependent are totally disabled when your eligibility for this Plan ends, benefits for the original condition for which you were disabled will continue for 90 days provided that the disability continues for that period of time. Only the condition which caused the disability will be covered and you must submit evidence of your disability through a letter from your physician, to the Contract Claims Administrator within 31 days after your coverage ends.

ELIGIBILITY

CERTIFICATION OF COVERAGE WHEN COVERAGE ENDS

When your coverage ends, you and/or your covered Dependents are entitled by law to and will automatically be provided (free of charge) with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. Such a certificate will be provided to you shortly after the Plan knows or has reason to know that coverage for you and/or your covered Dependent(s) has ended. You can present this certificate to your new employer/health plan to offset a pre-existing condition limitation that may apply under that new plan or use this certificate when obtaining an individual health insurance policy to offset a similar limitation.

Procedure for Requesting and Receiving a Certificate of Creditable Coverage: A certificate will be provided upon receipt of a written request for such a certificate that is received by the Contract Claims Administrator within two years after the date coverage ended under this Plan. The written request must be mailed or faxed to the Contract Claims Administrator and should include the names of the individuals for whom a certificate is requested (including spouse and dependent children) and the address where the certificate should be mailed. The address of the Contract Claims Administrator is in the Quick Reference Chart in the front of this document. A copy of the certificate will be mailed by the Plan to the address indicated. See the COBRA chapter for an explanation of when and how certificates of coverage will be provided after COBRA coverage ends.

MEDICAL EXPENSE BENEFITS

ELIGIBLE MEDICAL EXPENSES

You are covered for expenses you incur for most, but not all, medical services and supplies. The expenses for which you are covered are called “Eligible Medical Expenses,” and they are limited to those that are:

- p) determined by the Contract Claims Administrator or its designee to be “**Medically Necessary**,” but only to the extent that the charges are “**Usual and Customary**” (as those terms are defined in the Definitions chapter of this booklet); and
- q) **not services or supplies that are excluded** from coverage (as provided in the Exclusions chapter of this booklet); and
- r) **not services or supplies in excess** of the Lifetime Maximum Plan Benefit or any applicable Limited Overall Plan Benefits as shown under Covered Expenses and
- s) for the diagnosis or treatment of an injury or illness .

The Plan will not reimburse you for any expenses that are not Eligible Medical Expenses. That means you are responsible for paying the full cost of all expenses that are not determined to be medically necessary, determined to be in excess of the Usual and Customary charges, not covered by the Plan, in excess of the Lifetime Maximum Plan Benefit or in excess of any applicable Limited Overall Plan Benefits as shown under Covered Expenses.

HEALTH CARE PROVIDER SERVICES:

FIRST CHOICE: If you receive medical services or supplies from a Health Care Provider that is contracted with First Choice you will be responsible for paying less money out of your pocket. Health Care Providers who are under a contract with FIRST CHOICE have agreed to accept the discounted amount the Plan pays for covered services, plus any additional copayments or coinsurance you are responsible for paying, as payment in full. In addition, the Plan pays 100% of covered charges for certain services received from First Choice doctors, as described below.

Non-First Choice: When you receive services from Health Care Providers who are not contracted with First Choice, the Plan pays a lower coinsurance for some services. In addition they **may bill you a non-discounted amount** for any balance that may be due **in addition to** the allowed amount payable by the Plan. Your out-of-pocket expenses will be less when you use doctors and hospitals and other providers who are contracted with First Choice.

DEDUCTIBLE

Individual Deductible: Each individual must pay the first **\$100** of Eligible Medical Expenses before the Plan begins to pay benefits.

Family maximum deductible: However, your family will not have to pay more than **\$300** in total Eligible Medical Expenses as deductibles before the Plan begins to pay benefits for all covered individuals.

MEDICAL EXPENSE BENEFITS

COINSURANCE

Once you've met your Deductible, the Plan generally pays **80%** of the Eligible Medical Expenses and you are responsible for paying the rest. The 20% you pay is called the Coinsurance. There are certain exceptions and additional limitations that are described in the specific description of those benefits under "Covered Expenses."

No coinsurance for services from First Choice doctors: When you or your Dependents receive covered services from a **First Choice Preferred Physician**, including doctor's office visits, surgery services and anesthesiologist services, once the Deductible has been met all further professional services, diagnostic X ray or laboratory services ordered by the Preferred Physician will be paid in full, subject to the Lifetime Maximum Plan Benefit. A directory of participating Preferred Providers is available at the SPEEA Office or from the Contract Claims Administrator.

LIFETIME MAXIMUM PLAN BENEFIT

The Lifetime Maximum Plan Benefit payable for each covered Employee and each eligible Dependent is **\$10,000**. That amount may be payable for all medical expenses. Certain services are subject to a lower maximum payment as described in the specific description of those benefits under "Covered Expenses."

COVERED MEDICAL EXPENSES

Hospital Inpatient.

Inpatient admissions at hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are covered only when the necessary services can not safely be provided in a less intensive setting. Covered services include:

- Room & board facility fees in a semiprivate room with general nursing services. Private room charges are limited to the hospital's semiprivate rate;
- Specialty care units (e.g., intensive care unit, cardiac care unit);
- Lab/x-ray/diagnostic services;
- Rehabilitative services such as physical, speech or occupational therapy;
- Related medically necessary ancillary services including operating room, recovery room, drugs and medicines, and medical supplies provided during confinement.



Special Provision for Childbirth

This Plan complies with federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a Health Care Practitioner to obtain authorization from the Plan for prescribing a length of stay not in excess of those periods. However, federal law does not prohibit the mother's or newborn's attending Health Care Practitioner, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).

Emergency Room

Expenses for Emergency Room services are covered only when those services are for a **Medical Emergency**.

Emergency care means medical care and treatment provided after the sudden unexpected onset of a medical condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

- The patient's life or health would be placed in serious jeopardy.
- There would be a serious dysfunction or impairment of a bodily organ or part.
- In the event of a Behavioral Health Disorder, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Ambulance

Benefits are payable for Ambulance service are covered only when transport by other means would be detrimental to the patient's health status. The Plan covers:

- **Ground vehicle transportation** to the nearest appropriate facility as medically necessary for treatment of a medical Emergency (see above).

MEDICAL EXPENSE BENEFITS

- **Air transportation** only as medically necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the patient's health status.

Outpatient (Ambulatory) Surgery Facility

An Ambulatory Surgical center is a facility that is licensed as such by the regulatory authority responsible for licensing Health Care Facilities under the laws of the jurisdiction in which it is located.

The Plan encourages use of lower cost alternatives whenever possible. If you are contemplating having any non emergency elective surgery, please call the Contract Claims Administrator (refer to the Quick Reference Chart in the front of this booklet) before you enter the hospital or have the surgery performed. Benefits are payable for surgical procedures performed in the outpatient department of a hospital or an ambulatory surgical facility, when such procedures can safely be performed on an outpatient basis without adversely affecting the patient's health. In the absence of complicating underlying medical conditions, (e.g. cardiac failure, bleeding disorder, chronic pulmonary conditions, renal failure, etc.) such admissions include, but are not limited to, the following:

- Arthroscopy (examination and/or surgery of the joint);
- Biopsy (examination of tissue removed from a living person);
- Bronchoscopy (examination of the bronchial tubes);
- D&C (dilation of the uterus and scraping of the cervix);
- Laryngoscopy (examination of the vocal cords);
- Myringotomy (incision of the ear drum);
- Nasal Polyp (nasal growth);
- Sigmoidoscopy (examination of the colon with a speculum);
- Tenotomy (surgical cuffing of a tendon);
- Tooth extractions that for medical reasons can not safely be performed in a dentists office,
- Vasectomy and tubal ligation (surgical sterilization);
- Tonsillectomy and/or adenoidectomy;



Physician and Other Health Care Practitioner Services

Benefits are payable for professional fees when provided by a Physician or other covered Health Care Practitioner acting within the scope of his or her license in an office, hospital, emergency room (ER), urgent care facility, outpatient surgical facility or other covered health care facility location.

Payable Physicians and Health Care Practitioner professional fees include Surgeon; Assistant surgeon (if medically necessary); Anesthesiologist; Pathologist and Radiologist;

Special Provision for Breast Reconstruction After Mastectomy

This Plan complies with the Women's Health and Cancer Rights Act (WHCRA) that provides that for any Covered Individual who is receiving benefits in connection with a medically necessary mastectomy and who elects breast reconstruction in connection with it, coverage is provided for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications for all stages of mastectomy, including lymphedemas.

All Other Reconstructive Surgery is covered only if such procedures or treatment are intended to improve bodily function and/or to correct deformity resulting from disease, infection, trauma, or congenital anomaly that causes a functional defect.

Outpatient Diagnostic X-ray and Laboratory Services

Technical and professional fees are covered when ordered by a Physician or Health Care Practitioner for the diagnosis of an illness or injury. This Plan does not cover preventive services.

MEDICAL EXPENSE BENEFITS

Chemotherapy and Radiation Therapy

Benefit are payable for chemotherapy drugs and supplies administered under the direction of a Physician in a Hospital Out-Patient Department, other Health Care Facility, Physician's office or at home.

Benefits are payable for technical and professional fees for radiation therapy administered under the direction of a Physician in a Hospital Out-Patient Department or other Health Care Facility.

Blood Transfusions

Blood transfusions and blood products that are not replaced by voluntary donors and equipment for its administration are covered benefits.

Durable Medical Equipment;

Benefits are payable for Durable Medical Equipment only when its use is medically necessary and it is ordered by a Physician or other Health Care Practitioner.

Durable Medical Equipment is Equipment that can withstand repeated use; and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; is not disposable or non-durable and is appropriate for the patient's home. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

Benefit are payable subject to the following limitations:

- rental (but only up to the allowed purchase price of the Durable Medical Equipment);
- purchase of a standard model;
- repair, adjustment or servicing or medically necessary replacement of the Durable Medical Equipment due to a change in the covered person's physical condition or if the equipment cannot be satisfactorily repaired.
- Coverage is provided for medically necessary oxygen, along with the medically necessary equipment and supplies required for its administration.

Prosthetics and Corrective Devices

Benefits are payable for Prosthetics and Corrective Devices when medically necessary and ordered by a Physician or other Health Care Practitioner.

Prosthetic Appliances (or Devices) are designed to replace all or part of a missing body part, including, but not limited to, artificial limbs, heart pacemakers, or corrective lenses needed after cataract surgery.

Corrective Appliances are appliances or devices that support a weakened body part.

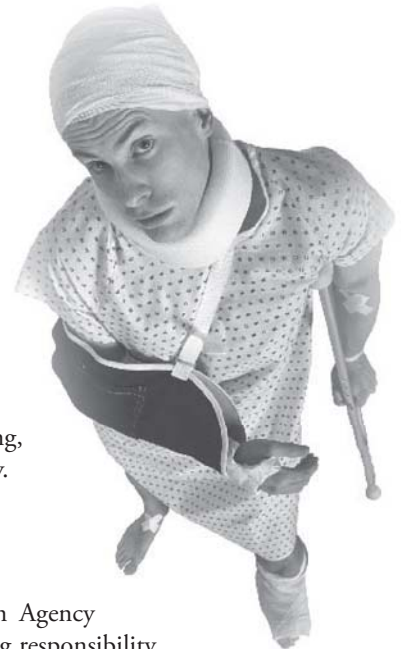
Home Health Care

Home Health Care services are covered only when ordered by a Physician and provided by an Agency approved by Medicare or licensed as a Home Health Care Agency by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located. A written treatment plan must be approved by the Contract Claims Administrator (refer to the Quick Reference Chart in the front of this booklet). Only part-time, intermittent Skilled Nursing Care or Rehabilitation services and medically necessary supplies to provide Home Health Care or home infusion services are covered. Custodial care and services which could be provided by a person without medical training are not covered.

Outpatient Rehabilitation Services

Short term active, progressive Rehabilitation Services (Occupational, Physical, or Speech Therapy) performed by licensed or duly qualified therapists and ordered by a Physician are covered when a bodily function has been restricted or diminished as a result of illness, injury or surgery, subject to the following limitation:

- Physical and Occupational therapy are covered only as long as the patient continues to demonstrate significant and measurable functional improvement.
- Speech therapy is covered if the services are provided to restore normal speech or to correct dysphagic or swallowing disorders lost due to illness, injury or surgical procedure. Speech therapy for functional purposes or childhood developmental speech delays and disorders are excluded from coverage.



MEDICAL EXPENSE BENEFITS

Skilled Nursing Facility

When ordered by the attending physician upon discharge from an acute care hospital, the Plan will pay 80% of charges for up to **90 days** for services in a licensed Skilled Nursing Facility. This benefit does not cover convalescent or rest facilities that are not licensed to provide rehabilitation care requiring the services of a registered nurse or other licensed rehabilitation professionals, such as physical or occupational therapists.

Mental Health Services

- **Outpatient Services:** The Plan will pay **50%** of the usual, customary and reasonable charges for outpatient mental health services from a physician, psychiatrist, or psychologist. The maximum outpatient benefit is **20 visits** per enrollee. Biofeedback treatment is included in this benefit.
- **Inpatient Care:** Inpatient psychiatric admissions are covered the same as any other illness. Psychiatric admissions which are primarily to control or change the patient's environment and/or during which psychiatric care could be safely and adequately provided on an outpatient basis or in a lesser facility than a hospital are not covered.



Substance Abuse Treatment

The Plan will pay 80% of the cost for a completed treatment program for alcohol or drug abuse therapy in an approved alcohol or drug treatment outpatient program or inpatient facility for services from a facility or program licensed to provide such services by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located. The maximum benefit payable is **\$3,000** per enrollee. No benefits are payable if the patient leaves the program against the advice of the health care professional in charge of the program or facility.

Outpatient Prescription Medicines

Coverage is provided for those pharmaceuticals approved by the US Food and Drug Administration (FDA) as requiring a prescription and are FDA approved for the patient's condition and are prescribed by a Physician or other Health Care Practitioner authorized by law to prescribe them. Insulin and diabetic supplies are also covered.

PLAN LIMITATIONS AND EXCLUSIONS

The following is a list of services and supplies or expenses not covered by the Plan. The Contract Claims Administrator has been delegated discretionary authority to determine the applicability of these exclusions.

- t) Any portion of the expenses for covered medical services or supplies that are determined by the Contract Claims Administrator to exceed the Usual and Customary Charge. Refer to the Definitions section of this booklet.
- u) Any portion of the expenses for covered medical services or supplies that exceed the Plan's \$10,000 Lifetime Maximum Benefits.
- v) Services for which claim was not made to the Contract Claims Administrator within one year of date of service.
- w) Expenses for any medical services, supplies, or drugs or medicines that are determined by the Contract Claims Administrator or its designee to be Experimental and/or Investigational not to be Medically Necessary. Refer to the Definitions section of this booklet.
- x) Expenses for services when benefits for them are provided to the Covered Individual under any plan or program (including, without limitation, Tricare and Veterans programs and Medicare Parts A and B) established under the laws or regulations of any government, including the federal, state, or local government, unless the governmental program provides otherwise.
- y) All expenses incurred by you or any of your covered Dependents arising out of or in the course of employment (including self-employment) if the injury, illness or condition is subject to coverage, in whole or in part, under any Workers' Compensation or occupational disease or similar law, whether or not a claim has been filed for benefits under such law.
- z) Expenses for services or supplies for which a third party is required to pay are not covered. Refer to the provisions relating to Third Party Liability in the section on Coordination of Benefits in this booklet.
- aa) Benefits that overlap or duplicate benefits for which the enrollee is eligible under any other group benefit plan, service plan contract, blanket, or franchise coverage, other prepayment plans, association or trustee plans. This Plan is intended

PLAN LIMITATIONS AND EXCLUSIONS

to be a supplement to any other medical coverage you may have.

- bb) Expenses incurred by any Covered Individual for injuries resulting from or sustained as a result of commission, or attempted commission of any illegal act.
- cc) Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.
- dd) Expenses arising from a Pre-Existing Condition during the period described in the Eligibility section of this booklet, unless off-set by prior Creditable Coverage.
- ee) Any cosmetic surgery or medical treatment to improve or preserve physical appearance, but not physical function except as specifically provided for under Covered Charges. Refer to the Definitions section of this booklet.
- ff) Expenses for Custodial Care regardless of where provided, including services of a personal care, sitter/companion or any services that can be learned to be provided by a family member who is not a physician, nurse or other skilled health care provider are not covered, even if they are medically necessary. Refer to the Definitions section of this booklet.
- gg) Expenses for Dental services or supplies of any kind, unless they are incurred for the repair or replacement of accidental injury to teeth or restoration of the jaw if damaged by an external object in an accident but not injury caused by biting or chewing.
- hh) Any expenses related to the treatment of Temporomandibular Joint (TMJ) Dysfunction or Syndrome.
- ii) Non-prescription drugs or medicines, except insulin or any drug not approved by the FDA for the condition, dose, route and frequency for which they are prescribed (i.e. are used “off-label”).
- jj) Vaccinations, immunizations, inoculations or preventative injections unless required for treatment of an injury or exposure to disease or infection (such as anti-rabies, tetanus, anti-venom, or immunoglobulin).
- kk) Any expenses for the diagnosis and treatment of infertility along with services to induce pregnancy and complications thereof, including, but not limited to surgical services, prescription drug, or devices to achieve fertility.
- ll) Charges for procedures for sterilization, reversal of surgical sterilization, or pregnancy termination. .
- mm) Expenses for routine foot care, including but not limited to trimming of toenails, removal or reduction of corns and calluses, treatment of fallen arches or other symptomatic complaints of the feet; or orthotics. The only exception is routine foot care from a podiatrist is payable for diabetic individuals with neurological or vascular insufficiency affecting the feet.
- nn) Expenses for and related to the purchase, servicing, fitting and/or repair of hearing aid devices, including, implantable hearing devices such as cochlear implants unless necessitated by damage to the natural ear as a result of accidental injury.
- oo) Expenses for diagnosis and treatment of refractive errors, including eye examinations, surgical correction of refractive errors, purchase, fitting and repair of eyeglasses or contact lenses; except when necessitated by damage to the natural eye as a result of accidental injury. However, one pair of eyeglasses or contact lenses is payable as a Prosthetic device following surgery to remove a cataract.
- pp) Expenses for speech therapy for functional purposes including, but not limited to a speech impediment, stuttering, lisp, tongue thrusting, stammering and conditions of psychoneurotic origin or for childhood developmental speech delays and disorders.
- qq) Expenses for prescription drugs (e.g. Viagra) and/or medical or surgical treatment of erectile dysfunction or inadequacy.
- rr) Expenses for medical, surgical or prescription drug treatment related to transsexual/gender reassignment (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures.
- ss) Expenses for tobacco/smoking cessation products such as nicotine gum or patches, or other services or programs.
- tt) Physical exams, tests, immunizations, including well baby care, screening exams and pap smears not connected with the care or treatment of an actual existing illness, disease or injury.
- uu) Educational services, even if they are required because of an injury, illness or disability, including supplies or equipment, programs/ services for behavioral training and intensive intervention programs for behavior change and/or treatment of developmental delays.
- vv) Treatment for obesity including surgery for morbid obesity or any complications of such surgery.

DEFINITIONS

Allowable Expense: A health care service or expense, including deductibles and coinsurance, that is covered in full or in part by any of the plans covering a Plan Participant, except as otherwise provided by the terms of this Plan or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an Allowable Expense.

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical, dental or surgical treatment intended to restore or improve physical appearance, as determined by the Contract Claims Administrator or its designee.

Custodial Care: Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of Custodial Care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk, or take drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel.

Experimental and/or Investigational: The Contract Claims Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational. A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Contract Claims Administrator or its designee, based on the information and resources available at the time the service was performed or the supply was provided, any of the following conditions were present with respect to one or more essential provisions of the service or supply:

- ww) The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the Health Care Provider that performs the service or prescribes the supply;
- xx) The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;
- yy) In the opinion of the Contract Claims Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States; and written by experts in the field; that shows that recognized medical or scientific experts: classify the service or supply as experimental and/or investigational; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;
- zz) With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will not be considered Experimental and/or Investigational if it is:
 - approved by the FDA as an “investigational new drug for treatment use”; or
 - classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a “life threatening disease” as that term is defined in FDA regulations; or
 - approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.

The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; or Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

In determining if a service or supply is or should be classified as Experimental and/or Investigational, the Contract Claims Administrator or its designee will rely only on the following specific information and resources that are available at the time the service or supply was performed, provided or considered:

- Medical records of the covered person;
- The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
- Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;
- Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person’s diagnosis, including, but not limited to “United States Pharmacopeia Dispensing Information”; and “American Hospital Formulary Service”;

DEFINITIONS

- The published opinions of: the American Medical Association (AMA), such as “The AMA Drug Evaluations” and “The Diagnostic and Therapeutic Technology Assessment (DATTA) Program, etc.; or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or the American Dental Association (ADA), with respect to dental services or supplies.
- Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
- The latest edition of “The Medicare Coverage Issues Manual.”

Medically Necessary: A medical service or supply will be determined to be “Medically Necessary” by the Contract Claims Administrator or its designee if it:

- aaa) is provided by or under the direction of a Physician or other duly licensed Health Care Practitioner who is authorized to provide or prescribe it; and
- bbb) is determined by the Contract Claims Administrator or its designee to be necessary in terms of generally accepted American medical standards; and
- ccc) is determined by the Contract Claims Administrator or its designee to meet all of the following requirements:
 - It is consistent with the symptoms or diagnosis and treatment of an illness or injury; and
 - It is not provided solely for the convenience of the patient, Physician, Hospital, Health Care Provider, or Health Care Facility; and
 - It is an “Appropriate” service or supply given the patient’s circumstances and condition; and
 - It is a “Cost-Efficient” supply or level of service that can be safely provided to the patient; and
 - It is safe and effective for the illness or injury for which it is used.

A medical service or supply will be considered to be “Appropriate” if:

- It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the illness or injury involved and the patient’s overall health condition.
- It is care or treatment that is as likely to produce a significant positive outcome as and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient’s overall health condition.

A medical service or supply will be considered to be “Cost-Efficient” if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

The fact that your Physician may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be medically necessary for the medical coverage provided by the Plan.

Usual and Customary Charge (U&C): The charge for medically necessary services or supplies will be determined by the Contract Claims Administrator or its designee to be the lowest of:

- ddd) With respect to a First Choice Health Care Provider, the fee set forth in the agreement between the Participating Health Care Provider and First Choice; or
- eee) The Health Care Provider’s actual charge; or
- fff) The usual charge by the Health Care Provider for the same or similar service or supply.
- ggg) The “Prevailing Charge” of most other Health Care Providers in the same or similar geographic area for the same or similar health care service or supply will be determined by the Contract Claims Administrator using proprietary data that is provided by a reputable company or entity and is updated at the Contract Claims Administrator’s discretion.

COORDINATION OF BENEFITS (COB)

When you or your covered Dependents are entitled to health care benefits under this Plan and also entitled to recover all or part of your health care expenses from some other source, the other source will be the primary plan or program and pay benefits or provide services before this Plan will pay any benefits. The SPEEA Medical Plan pays some or all of the difference between the total cost of those services and payment by the primary plan or program. To the extent allowed by federal law, this Plan will pay secondary to all other sources of payment available to you and your Dependents, including:

- Another group or individual health care plan or prepaid health service plan (including but not limited to a plan which provides the Covered Individual with COBRA continuation coverage); or
- Medicare; or
- Other government program, such as Medicaid, Tricare/CHAMPUS, or a program of the U.S. Department of Veterans Affairs, motor vehicle including but not limited to no-fault, uninsured motorist or underinsured motorist coverage for medical expenses or loss of earnings that is required by law, or any coverage provided by a federal, state or local government or agency.

HOW MUCH THIS PLAN PAYS AS SECONDARY PAYER

Secondary Liability of this Plan: When this Plan pays second, it will pay the same benefits that it would have paid had it paid first, **less** whatever payments were actually made by the plan (or plans) that paid first. This has the effect of maintaining this Plan's deductibles, coinsurance and exclusions. As a result, when this Plan pays second, you may not receive the equivalent of 100% of the total cost of the covered health care services.

To administer COB, the Plan reserves the right to:

- exchange information with other plans involved in paying claims;
- require that you or your Health Care Provider furnish any necessary information;
- reimburse any plan that made payments this Plan should have made; or
- recover any overpayment from your Hospital, Physician, other Health Care Provider, other insurance company, you or your Dependent.

THIRD PARTY LIABILITY

The covered Employee **and/or** any covered Dependent(s) must sign and deliver a reimbursement agreement (hereafter called the "**Agreement**") in a form provided by or on behalf of the Plan. If the injured Dependent(s) is a minor or incompetent to execute that Agreement, that person's parent (in the case of a minor dependent child) or spouse or legal representative (in the case of an incompetent adult) must execute that Agreement upon request by the Contract Claims Administrator.

If the Agreement is not executed the Plan may refuse to make any Advance Payment on the injured persons claims, but if, at its sole discretion, the Plan makes an Advance Payment in the absence of an Agreement, **that Advance Payment will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights.**

By accepting an Advance Payment, regardless of whether or not an Agreement has been executed, the covered Employee and/or covered Dependent(s) each agree to:

- hhh) reimburse the Plan for all amounts paid or payable to the covered Employee and/or covered Dependent(s) or that third party's insurer for the entire amount Advanced Payment; and
- iii) do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Plan's reimbursement rights; and
- jjj) notify and consult with the Contract Claims Administrator or designee before starting any legal action or administrative proceeding against a third party based on any alleged negligent or wrongful act that may have caused or contributed to the injury or illness that resulted in the Advance Payment, or entering into any settlement Agreement with that third party or third party's insurer based on those acts; and
- kkk) inform the Contract Claims Administrator or its designee of all material developments with respect to all claims, actions, or proceedings they have against the third party.

CLAIMS AND APPEALS PROCEDURES

A claim for benefits is a request for Plan benefits made in accordance with the Plan's claims procedures, which are described in the section.

GENERAL RULES

Types of Claims and How to File Claims and Appeals

The Department of Labor regulations divide claims into the following separate categories:

Urgent Care Claims, which are defined to be claims for medical care with respect to which a delay of up to 15 days in making decisions could severely jeopardize the life or health of the claimant. Urgent care claims must be initially determined within 72 hours, and appeals must likewise be decided within 72 hours. Urgent Care **medical claims** must be filed with the Contract Claims Administrator (refer to the Quick Reference Chart in the front of this booklet).

Concurrent Care Decisions can occur when an ongoing course of treatment has been approved. Any decision to reduce the course of treatment must be given sufficiently in advance to allow for an appeal. Concurrent Care appeals must be decided prior to termination of the benefit.

Concurrent Care **medical claims** must be filed with the Contract Claims Administrator by phone or fax (refer to the Quick Reference Chart in the front of this booklet).

Pre-Service Claims, which are claims for benefits which must be approved by the Plan in advance of receiving the care in order to receive maximum benefits. The initial determination of such claims must be made within 15 days, and any appeal within 30 days. Under the terms of this Plan, there are no Pre-Service Claims.

Post-Service Claims are requests for payments for services already provided, i.e. any claims which are not Urgent, Concurrent or Pre-Service claims.

Post-Service **medical claims** must be filed with the Contract Claims Administrator by mail at the address shown in the Quick Reference Chart in the front of this booklet. File your claim promptly. If the Contract Claims Administrator does not receive your claim within one year after you incur the expense, your claim will NOT be covered.

Submit itemized bills for each service or supply received. The bills should include the:

- patient's name
- date of service
- provider of the service or supply
- description service or supply provided
- itemized charges
- Explanation of Benefits from any other insurance plan which covers the claim.
- Bills for prescription drugs must include the name of the medication, prescription number, date filled, quantity and days' supply.

The initial determination is to be made within 30 days. If the extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specify the required information and the Claimant will be given 45 days from receipt of the notice to provide the information.

Contents of Notifications

In accordance with Department of Labor regulation, a claimant must be given specific reasons for the decision, specific references to the Plan provisions on which the decision is based, and any additional material necessary for the claimant to perfect his claim. In addition, an initial claims denial must include a statement that a claimant can sue if his appeal is denied. This same information is required to be included in appeals denials, plus a statement that the claimant is entitled to free access to all documents, records and other information relevant to his claim, whether or not they were relied upon by the Plan.

PROCEDURES FOR FILING A POST-SERVICE CLAIM APPEAL WITH THE PLAN SPONSOR

Timing of Post-Service Claims Appeals.

All Appeals of Post-Service Claims must be made in writing within 180 days after receipt of a final adverse benefit determination by the Contract Claims Administrator. Failure to file an appeal within the 180-day period will constitute a waiver of the Claimant's right to review the denial of his claim.

CLAIMS AND APPEALS PROCEDURES

How the Appeals Process Works

All appeals must be in writing and clearly state why the Claimant disagrees with the adverse benefit determination. The Claimant may provide additional information to support his appeal.

Upon written request to the Contract Claims Administrator, Claimant will be provided, free of charge, reasonable access to and copies of any documents, records and other information if they (a) were relied upon in making the initial determination, (b) were submitted, considered or generated in the course of making the benefit determination even if not relied upon, (c) demonstrate that the Plan provisions have been followed and applied consistently with respect to similarly situated individuals, or (d) constitute a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, whether or not relied upon.

The Plan Sponsor will take into account all comments, documents, records, and other information submitted by Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial determination. They will not afford deference to the initial determination.

In deciding an appeal based in whole or in part on a medical judgment, the Plan Sponsor shall consult with a health care professional who has appropriate training and experience in the field of medicine involved, which individual shall not be either an individual consulted in connection with the initial adverse determination nor the subordinate of any such person.

Upon written request, the Contract Claims Administrator will identify any medical or vocational experts whose advice was obtained in connection with the initial determination, whether or not it was relied upon.

Notification of Appeals Decision

The Plan Sponsor will provide the Claimant with a final determination on their appeal within 60 days of receipt of the appeal by the Contract Claims Administrator.

Adverse benefit determinations on appeal shall set forth, in a manner calculated to be understood by the Claimant, the following information:

- lll) The specific reason or reasons for the decision.
- mmm) Reference to the specific Plan provisions on which the appeal is based.
- nnn) A statement that the Claimant is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the Claimant's claim.
- ooo) If an internal rule, guideline, protocol or other similar criteria was relied upon in deciding the appeal, a statement that such document will be provided free of charge upon request.
- ppp) If the appeal is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claimant's medical circumstances will be provided free of charge upon request.
- qqq) A statement of the Claimant's right to bring a court action under ERISA §502(a).

LEGAL PROCEEDINGS

Claimants may pursue their claims for benefits in court under ERISA §502(a) but only after they exhaust their administrative remedies as provided in these claims procedures. Failure of a Claimant to exhaust his or her administrative remedies will preclude further judicial review.

The Plan Sponsor is given full discretionary authority (a) to finally determine all facts relevant to any claim, (b) to finally construe the terms of the Plan and all other documents relevant to the Plan, and (c) to finally determine what benefits are payable from the Plan.

No decision of the Plan Sponsor shall be revised, changed or modified by any arbitrator or court unless the party seeking such action is able to show by clear and convincing evidence that the decision of the Plan Sponsor was an abuse of discretion in light of the information actually available to it at the time of its decision.

MISCELLANEOUS PROVISIONS

Authorized Representatives. A Claimant may appoint in writing an Authorized Representative to act on his behalf in pursuing a claim or appeal under these claim procedures. A form for appointing and Authorized Representative is available from the Fund Office.

CLAIMS AND APPEALS PROCEDURES

Plan Records. The Fund Office shall maintain records designed to ensure and verify that determinations are made in accordance with Plan documents and that where appropriate, the Plan provisions have been followed and applied consistently with respect to similarly situated Claimants. Plan participants' privacy will be protected at all times.

Rights of the Plan Sponsor. Plan Sponsor retains the right to interpret and amend these Claims Procedures. Furthermore, if these procedures are ambiguous or do not provide an explicit procedure for a specific circumstance, the Board is authorized to adopt such rules as it, in its sole discretion, deems necessary and appropriate to provide Claimants with appropriate initial determinations and an opportunity for a full and fair review of any adverse benefit determination.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective April 14, 2004, a federal law, the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**, requires that health plans like the SPEEA Medical Plan for New Hires (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**).

- The term "**Protected Health Information**" (**PHI**) includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- **PHI does not include** health information contained in employment records held by Society of Professional Engineering Employees in Aerospace in its role as an employee association representing members in their relations with Signatory Employers, including but not limited to health information on disability, work-related illness/injury, sick leave, Family and Medical leave (FMLA).

The Plan, and the Plan Sponsor (the Society of Professional Engineering Employees in Aerospace), will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. **In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.** The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

The Plan's Use and Disclosure of PHI:

The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

- **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to coordination of benefits with a third party and consultations and referrals between one or more of your health care providers.
- **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:
 - rrr) Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing employee contributions for coverage;
 - sss) Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, billing, collection activities and related health care data processing, and claims auditing;
 - ttt) Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.
- **Health Care Operations** includes, but is not limited to:
 - uuu) Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies and quality assessment,

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

- vvv) Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions,
- www) Underwriting, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities,
- xxx) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,
- yyy) Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

Additional Use or Disclosure of Your PHI for Which Consent, Authorization or Opportunity to Object Is Not Required

The Plan is allowed under federal law to use and disclose your PHI without your consent or authorization, and without giving you an opportunity to object, under the following circumstances:

- zzz) As required by HHS. The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Plan's compliance with the privacy regulations.
- aaaa) Disclosure to the Plan's Sponsor. The Plan may also disclose PHI to its Plan Sponsor for purposes related to, but not limited to, treatment, payment, and health care operations, and has amended the Plan Documents to permit this use and disclosure as required by federal law. The "Plan Sponsor" of this Plan is the Society of Professional Engineering Employees in Aerospace. For example, the Plan may disclose protected health information to the Plan Sponsor for reviewing your appeal of a benefit claim or for other reasons regarding the administration of this Plan, including review of a subrogation claim.
- bbbb) When required by applicable law.
- cccc) Public health purposes. To an authorized public health authority if required by law or for public health and safety purposes. For example, the Plan may disclose your PHI when necessary to enable product recalls or repairs. The Plan may also use or disclose your PHI if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- dddd) Domestic violence or abuse situations. If a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence, the Plan may report information about abuse, neglect or domestic violence to public authorities (1) when required by law; (2) if you agree to such disclosure; or (3) when the Plan is authorized by law and the disclosure is necessary to prevent serious harm to you or other potential victims. In such case, the Plan will promptly inform you or your Personal Representative that such a disclosure has been or will be made unless that would place you at a risk of serious harm or if the Plan would be informing a Personal Representative that it reasonably believes is responsible for the abuse. In the case of child abuse, it is not necessary for the Plan to inform the child of such disclosure.
- eeee) Health oversight activities. To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers); civil, administrative, or criminal proceedings or actions; and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).
- ffff) Legal proceedings. When required for judicial or administrative proceedings, as authorized by law. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.
- gggg) Law enforcement health and emergency purposes. We may disclose PHI to law enforcement officials for the following purposes:
 - When required for law enforcement purposes (for example, to report certain types of wounds or other physical injuries);
 - Identifying or locating a suspect, fugitive, material witness or missing person;
 - Disclosing information about an individual who is or is suspected to be a victim of a crime. This only applies if the Plan is unable to obtain the individual's agreement because of incapacity or other emergency circumstances;
 - Disclosing information about an individual for purposes of alerting law enforcement officials of that individual's death if we suspect that the death may have resulted from criminal conduct;

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

- Disclosing PHI which we believe constitutes evidence of criminal conduct that occurred on Plan premises;
 - When providing emergency health care not on Plan premises, we may disclose PHI if necessary to alert law enforcement to the commission and nature of the crime; the location or victim(s) of the crime; or the identity, description and location of the perpetrator of the crime.
- hhhh) Determining cause of death and organ donation. When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation and transplantation purposes.
- iiii) Funeral purposes. When required to be given to funeral directors to carry out their duties with respect to the decedent, after or in reasonable anticipation of the individual's death.
- jjjj) Research. For research, subject to certain conditions.
- kkkk) Health or safety threats. When, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat or it is necessary for law enforcement authorities to identify or apprehend an individual.
- llll) Workers' compensation programs. The Plan may disclose PHI to your employer and others, when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
- mmmm)
- nnnn) Specialized government functions. When certain conditions are met, for military and veterans activities, to the appropriate military authority if individuals are Armed Forces personnel; to federal officials for lawful national security and intelligence activities; or a correctional institution or law enforcement official having lawful custody of an individual under certain circumstances.

When the Disclosure of Your PHI Requires Your Written Authorization

Generally the Plan will require that you sign a valid authorization form (available from the Contract Claims Administrator) in order for the Plan to use or disclose your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations.

Except as otherwise indicated in this Notice or as permitted by law, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization in writing.

Use or disclosure of Psychotherapy Notes. Although the Plan does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Plan will use or disclose psychotherapy notes about you. However, the Plan may use and disclose such notes when needed by the Plan to defend itself against litigation filed by you.

Psychotherapy Notes. Psychotherapy notes are separately filed notes in any medium about your conversations with your mental health professional during a private, group, joint, or family counseling session. Psychotherapy notes do not include medication prescription and monitoring, results of clinical tests, or any summary information about your mental health diagnosis, functional status, symptoms, prognosis, progress or treatment.

Use or Disclosure of Your PHI to Relatives and Friends

Disclosure of your PHI to family members, other relatives, your close personal friends, and any other person you choose to identify is allowed under federal law if:

- oooo) The information is directly relevant to the family member, other relatives, or a close personal friend's involvement with your care or payment for that care, or
- pppp) The information is used or disclosed to notify, or assist in the notification of, a family member, Personal Representative, or another person responsible for your care, of your location, general condition, or death.
- qqqq) If you are present for, or otherwise available prior to a use or disclosure permitted above, and you have the capacity to make health care decisions, the Plan will not use or disclose your PHI to your family and friends unless it:
 - obtains your agreement,
 - provides you with an opportunity to object to the use and disclosure of your PHI and you express no objections to such use and disclosure,
 - or the Plan can reasonably infer from the circumstances that you do not object to such use and disclosure.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

YOUR INDIVIDUAL PRIVACY RIGHTS

You May Request Restrictions on PHI Uses and Disclosures

You may request the Plan to:

- Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or
- Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Plan may comply with your request at the discretion of the Contract Claims Administrator or the Privacy Officer. The Plan is not required to agree to a requested restriction. If the Plan agrees to a restriction you have requested, it may terminate the restriction under certain circumstances. Make such requests in writing to the Privacy Officer or the Contract Claims Administrator's office (refer to the Quick Reference Chart in the front of this booklet).

You May Request Confidential Communications

The Plan will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual.

You or your Personal Representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to the Privacy Officer specified above.

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a Designated Record Set (defined below) for as long as the Plan maintains the PHI, subject to certain exceptions.

Designated Record Set includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

The Plan must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your Personal Representative will be required to complete a form to request access to the PHI in your Designated Record Set. A reasonable fee may be charged. Requests for access to PHI should be made to the Privacy Officer, specified above.

If access is denied, you or your Personal Representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Plan and the United States Department of Health and Human Services.

You Have the Right to Amend Your PHI

You or your Personal Representative have the right to request that the Plan amend your PHI or a record about you in the Designated Record Set for as long as the PHI is maintained in the Designated Record Set subject to certain exceptions. You may request a copy of the Plan's Right to Amend Policy for a list of exceptions.

You or your Personal Representative should make your request to amend PHI to the Privacy Officer, specified above. You or your Personal Representative will be required to complete a form provided by the Plan to request amendment of your PHI.

The Plan has 60 days after receiving your request to act on it. The Plan is allowed a single 30-day extension if the Plan is unable to comply with the 60-day deadline. If the Plan denies your request in whole or part, the Plan must provide you with a written denial that explains the basis for the decision. You or your Personal Representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI. You may also file a complaint with the Plan and/or HHS. See the section titled YOUR RIGHT TO FILE A COMPLAINT WITH THE PLAN OR THE HHS SECRETARY.

You Have the Right to Receive an Accounting of the Plan's PHI Disclosures

At your request, the Plan will also provide you with an accounting of certain disclosures of your PHI by the Plan. The Plan will not provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing. You may review the Plan's Accounting for Disclosure Policy for a more complete list of disclosures for which an accounting is not required.

You should direct your request to the Privacy Officer specified above.



USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan has 60 days to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

PERSONAL REPRESENTATIVE

You may exercise your rights through your Personal Representative. Your Personal Representative will be required to produce evidence of authority to act on your behalf before the Personal Representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be: (1) a completed, signed and approved Appointment of Personal Representative form; (2) a notarized power of attorney for health care purposes; or (3) a court-appointed conservator or guardian. You may obtain the Appointment of Personal Representative form by calling the Fund Office.

The Plan retains discretion to deny access to your PHI to a Personal Representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Plan will recognize certain individuals as Personal Representatives without you having to provide proof of authority as described above. For example, the Plan will consider a parent or guardian as the Personal Representative of an unemancipated minor unless applicable law requires otherwise. A minor's parent may act on an individual's behalf, including requesting access to their PHI.

Unemancipated minors may, however, request that the Plan restrict information that goes to family members as described in the section Titled *You May Request Confidential Communications* under YOUR INDIVIDUAL PRIVACY RIGHTS above.

You may also review the Plan's Policy and Procedure for the Recognition of Personal Representatives for a more complete description of the circumstances where the Plan will automatically consider an individual to be a Personal Representative.

THE PLAN'S DUTIES

Maintaining Your Privacy

The Plan is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices.

Plan Sponsor's Right to Amend

This provision is effective beginning on April 14, 2003. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to you and to all past and present participants and beneficiaries for whom the Plan still maintains PHI via mail.

A notice of revision will be distributed within 60 days of the effective date of any material change to:

- rrrr) The uses or disclosures of PHI,
- ssss) Your individual rights,
- tttt) The duties of the Plan, or
- uuuu) Other privacy practices stated in this section. .

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- vvvv) Disclosures to or requests by a health care provider for treatment,
- wwww) Uses or disclosures made to you,
- xxxx) Uses or disclosures made pursuant to authorization where authorization was required,
- yyyy) Disclosures made to the Secretary of the United States Department of Health and Human Services pursuant to its enforcement activities under HIPAA,

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

- zzzz) Uses or disclosures required by law, and
- aaaaa) Uses or disclosures required for the Plan's compliance with the HIPAA privacy regulations.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health Plan. Summary health information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Disclose PHI to the Plan Sponsor

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

- bbbb) Not use or disclose the information other than as permitted or required by the Plan Document or as required by law,
- cccc) Ensure that any agents, including subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules.
- dddd) Not use or disclose the information for employment-related actions and decisions,
- eeee) Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices).
- ffff) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,
- gggg) Make PHI available to the individual in accordance with the access requirements of HIPAA,
- hhhh) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,
- iiii) Make available the information required to provide an accounting of PHI disclosures,
- jjjj) Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA, and
- kkkk) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:

- Staff designated by the Contract Claims Administrator;
- Business Associates under contract to the Plan including but not limited, preferred provider organization network and utilization management company;
- The Privacy Officer.

The persons described above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance.

Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy

HIPAA SECURITY

Effective April 21, 2006 in compliance with **HIPAA Security** regulations, the Plan Sponsor will:

- llll) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

- mmmmm) Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
- nnnnn) Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
- ooooo) Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

YOUR RIGHT TO FILE A COMPLAINT WITH THE PLAN OR THE HHS SECRETARY

If you believe that your privacy rights have been violated, you may file a complaint with the Plan in care of the Privacy Officer (refer to the Quick Reference Chart in the front of this booklet).

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services (“HHS”). Please contact the nearest office of the Department of Health and Human Services, listed in your telephone directory, visit the HHS website at www.hhs.gov, or contact the Privacy Officer for more information on how to file a complaint.

The Plan will not retaliate against you for filing a complaint.

IF YOU NEED MORE INFORMATION

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Officer, specified above, at the Fund Office.

CONCLUSION

The federal Health Insurance Portability and Accountability Act, known as HIPAA, regulates PHI use and disclosure by the Plan. You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This section attempts to summarize the regulations. The regulations will supersede this section if there is any discrepancy between the information in this section and the regulations.

GENERAL PROVISIONS AND INFORMATION REQUIRED BY ERISA

NAME OF THE PLAN

SPEEA Medical Plan for New Hires

NAME AND ADDRESS OF ORGANIZATION MAINTAINING THE PLAN

Society of Professional Engineering Employees in Aerospace
15205 52nd Avenue South
Seattle, WA 98188

EMPLOYER IDENTIFICATION NUMBER

91-0583387

PLAN NUMBER

Medical expense benefits (501);

TYPE OF ADMINISTRATION

SPEEA Medical Plan for New Hires is a self-funded group health plan administered through the Membership Services Department of SPEEA. Claims for benefits are administered by an independent Contract Claims Administrator. The funding for the benefits is derived solely from the dues paid by SPEEA members. The Plan is not insured.]

PLAN ADMINISTRATOR

Society of Professional Engineering Employees in Aerospace
15205 52nd Avenue South
Seattle, WA 98188

For enrollment and eligibility information contact Membership Services

Contract Claims Administrator

The Contract Claims Administrator is shown in the Quick Reference Guide at the front of this booklet.

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made on the Plan's General Counsel:

Kristin Farr
15205 52nd Street South
Seattle, WA 98188

PLAN YEAR

The Plan's fiscal records are kept on a Calendar Year basis beginning on January 1 and ending on December 31.

PLAN AMENDMENTS OR TERMINATION OF PLAN

The Plan Sponsor reserves the right to amend or terminate this Plan, or any part of it at any time. Amendments may be made in writing by the Plan Sponsor and become effective on such date as specified in the document amending the Plan.

DISCRETIONARY AUTHORITY OF THE PLAN SPONSOR

In carrying out their respective responsibilities under the Plan, the Plan Sponsor, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan. Any interpretation or determination under such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.



ERISA STATEMENT OF RIGHTS

As a participant in the SPEEA Medical Plan for New Hires you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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.

Group Health Plan Coverage

Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights. Your coverage under this Plan is terminated upon your eligibility for coverage under the benefit plan provided by your signatory employer under the terms of the Collective Bargaining Agreement; therefore, COBRA continuation rights do not generally apply to this Plan.

Reduction or elimination of exclusionary periods of coverage for preexisting 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, when your COBRA continuation coverage ceases, 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 preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your 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 the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in 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 materials from the plan and do not receive them 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 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 domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have 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, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

199350v1/00252.013

SPEEA
IFPTE LOCAL 2001

Seattle Hall
(206) 433-0991

Everett Hall
(425) 355-2883

Wichita Hall
(316) 682-0262

www.speea.org

