

# Retiree Medical Plan

**Boeing Medicare Supplement Plan  
Summary Plan Description/2006**

Retired Union Employees Formerly Represented by  
SPEEA (Professional and Technical Units, WEU)  
and Pilots Association



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July 2008

## Plan Information and Notice

The Boeing Company Retiree Health and Welfare Benefit Plan (Plan 502) (the “Plan”) provides the Boeing Medicare Supplement Plan for **eligible retired employees** and **dependents**. You are eligible for coverage under the Plan if you meet the conditions described in this booklet in “Who Is Eligible,” in Section 1.

Through this Plan, The Boeing Company (the “Company”) also provides different benefit plans to certain nonunion and other union groups. Because they have different benefits, those groups receive separate summary plan description booklets. (See “Other Groups That the Plan Covers,” in Section 5.)

### Summary Plan Description and Plan Document

The summary plan description for the Boeing Medicare Supplement Plan is this booklet, any summaries of material modifications (*Updates*), and the applicable pharmacy **provider** directories.

The actual Plan is a complex legal document that was written in accordance with Federal rules, including rules of the Internal Revenue Service. The Plan document is The Boeing Company Master Welfare Plan, applicable summary plan descriptions, insurance contracts and funding vehicles, and other “governing documents.”

The contents and delivery of this booklet are intended to comply with the Employee Retirement Income Security Act of 1974, as amended (ERISA). If there is any conflict between the information in this booklet and the official Plan document, the official Plan document will govern.

Any representations contrary to the Plan are not binding.

### Updates

Periodically, the Company may add to or change benefits in this Plan. If this happens, you will receive an *Update* describing the changes. Be sure to keep any *Updates* with this booklet.

### Notice of Company Rights

The Company fully intends to continue the Plan. However, the Company reserves the right to terminate, suspend, or modify any benefits described in this booklet, in whole or in part, at any time, and for any reason for employees, former employees, retirees, and their **dependents**. The Plan Administrator, the Boeing Service Center for Health and Insurance Plans (the “Boeing Service Center”), and the **service representatives** have the right to recover overpayments, regardless of the cause, nature, or source of the overpayments.

This summary plan description booklet does not guarantee current or future benefits.

For important terms used in this booklet, see Section 6, “Definitions.”

### Effective Date

This booklet highlights the benefits available to **eligible retired employees** and their **eligible dependents** under The Boeing Company Retiree Health and Welfare Benefit Plan as of July 1, 2006.

### Definition of Terms

Key terms used throughout this booklet are in bold. You can find the definitions for these terms in Section 6, “Definitions.”



## Whom do I contact with questions?

Throughout this booklet, you will be referred to three main sources for additional information:

- Boeing TotalAccess.
- The Boeing Service Center and its web site, Your Benefits Resources.
- Service representative.

**Boeing TotalAccess** is your gateway to benefits information. Boeing TotalAccess connects you directly with the Boeing Service Center and many of the service representatives.

You can contact Boeing TotalAccess 24 hours a day, seven days a week.

- On the World Wide Web: Log on to [www.boeing.com/express](http://www.boeing.com/express) using your BEMS ID number (or Social Security number) and your Boeing TotalAccess password.
- By telephone: Call 1-866-473-2016. TTY/TDD services are available at 1-800-755-6363. You must have your BEMS ID number (or Social Security number) and Boeing TotalAccess password. Request the service you are looking for, and the Boeing TotalAccess telephone system will direct you to the resources you need. Customer service representatives are available to assist you and answer questions Monday through Friday from 7 a.m. to 8 p.m. Central time. Self-service applications are available 24 hours a day, seven days a week.

**The Boeing Service Center and its web site, Your Benefits Resources**, provide information about your health care plan and costs. You can connect to

- The Your Benefits Resources web site on line through Boeing TotalAccess on the World Wide Web.
- The Boeing Service Center by calling Boeing TotalAccess.

You will need your Boeing TotalAccess password to access these services.

**Service representative:** The Company has engaged a third-party organization, called a service representative, to administer the plan, make benefit determinations, and pay claims. The service representative answers benefit and claim questions by telephone and provides a web site. Connect to the service representative by

- Calling Boeing TotalAccess.
- Connecting to the service representative's web site directly. (See Section 7.)

**Refer to "Where to Get More Information," in Section 7, for telephone numbers, addresses, and web sites.**

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## Who Is Eligible

The Boeing Medicare Supplement Plan is intended to cover you and your **dependents** who meet the eligibility requirements described in this section. Generally, if you meet these conditions, you are eligible to enroll yourself, your spouse, and your children as described in “When to Enroll or Make Changes,” in this section. To enroll your **eligible dependents**, you must enroll yourself in the plan.

The effective date of your coverage depends on when you enroll and the event initiating your enrollment, as described in “When Coverage Begins,” later in this section. In general, this summary plan description assumes that your retiree medical coverage started immediately after your employment with the Company ends. If you choose to begin your coverage at a later date, contact the Boeing Service Center through Boeing TotalAccess for details about your enrollment options.

See Section 4 regarding when your coverage ends.

## You

You are eligible for coverage under the retiree medical plan described in this booklet if you meet all of the following requirements:

- You were hired (or rehired) before January 1, 2007.
- You are age 65 or otherwise eligible for Medicare.
- You were an employee of The Boeing Company on the day you terminated and were represented by one of the following unions:

Lazy B Pilots Association

Society of Professional Engineering Employees in Aerospace

Professional Unit

Technical Unit

Wichita Engineering Unit

Wichita Technical and Professional Unit (before June 20, 2007)

- You were an active employee who terminated employment under any of these conditions:
  - Age 55 or older with 10 or more years of vesting service under the Company-sponsored retirement plan.
  - Eligible for disability benefits under the Company-sponsored retirement plan and age 50 or older with 10 or more years of vesting service at termination.
  - On an approved leave of absence, age 55 or older with 10 or more years of vesting service at termination, and retired under the Company-sponsored retirement plan directly from your approved leave of absence.
  - On layoff, age 55 or older with 10 or more years of vesting service at retirement, and retired under the Company-sponsored retirement plan within 6 years of your layoff date.

If you were hired (or rehired) on or after January 1, 2007, you are not eligible for the retiree medical plan described in this booklet. Contact the Boeing Service Center through Boeing TotalAccess for details.

## Events That Affect Eligibility

The following events affect eligibility for retiree medical benefits:

- **Termination of employment.**
  - If your employment with the Company ended and you were rehired on or after January 1, 2007, you are not eligible for retiree medical benefits unless you met the age and service requirements for retiree medical coverage described above on your original date of termination, or unless you meet one of the reemployment exceptions noted below.
  - If your employment with the Company ended before July 1, 2006, your pension benefit and retiree medical coverage must be started at the same time unless you waived retiree medical coverage because you had other employer-sponsored medical coverage. See “When You Have Deferred Benefits,” later in this section, for additional details.
  - If you waived retiree medical coverage because you had other employer-sponsored medical coverage (such as through your spouse’s employer) in effect on the date your employment with the Company ended, you may be eligible for retiree medical coverage if you lose that other coverage. See “Special Enrollment Events,” later in this section.
- **Disability.** If your employment with the Company ended because you became permanently and totally disabled, you are not eligible for retiree medical benefits unless you met the age and service requirements for retiree medical coverage described above on your disability retirement date.
- **Layoff.** If you were reemployed within 6 years of your layoff date, your prior vesting service and original hire date were recognized for retiree medical benefit purposes. If you were not reemployed within 6 years of your layoff date, you are not eligible for retiree medical benefits unless you were laid off at age 49 or older and met the service requirements for retiree medical coverage described above within 6 years of your layoff date.
- **Approved leave of absence.** If you were not reemployed immediately after an approved leave of absence, you are not eligible for retiree medical benefits unless you met the age and service requirements for retiree medical coverage described above by the date your leave of absence ended.
- **Death of employee.** If you die while an active employee and are eligible for retiree medical benefits, your surviving spouse and **dependents** may be eligible for benefits. See “Coverage for Your Surviving Spouse and Dependents,” later in this section, for additional details.

In any event, you must meet the conditions described above to be eligible to enroll for retiree medical benefits.

## Your Dependents

If you are enrolled in the plan as a retired employee, you also may cover your **eligible dependents**. Proof of dependent eligibility will be required. (Special rules may apply; see “When You and Your Spouse Both Are Eligible for Company-Sponsored Coverage,” later in this section.)

**Note:** When you reach age 65 or otherwise become eligible for Medicare, your eligible dependents may continue coverage in a Company-sponsored retiree medical plan designed for **participants** without Medicare coverage if

- You enroll in the Boeing Medicare Supplement Plan.
- Your dependents are not age 65 or otherwise eligible for Medicare.

Contact the Boeing Service Center through Boeing TotalAccess for details.



### What is my initial retiree medical eligibility date?

Generally, the date you are first offered an enrollment opportunity for retiree medical benefits is your initial retiree medical eligibility date. In most situations, this is the first day following your active health care coverage end date. For more information, contact the Boeing Service Center through Boeing TotalAccess.

## Your Spouse

Under this plan, “spouse” means

- Your legal spouse (as recognized under both applicable state law and the Internal Revenue Code).
- Your opposite-gender common-law spouse if your relationship meets the common-law requirements for the state where you entered the common-law relationship.

In some states, state law requires that insured health plans offer coverage to certain registered domestic partners. To find out if this applies to you, call the Boeing Service Center through Boeing TotalAccess.

## Your Dependent Children

Your **dependent** children are your natural children, adopted children, children legally placed with you for adoption, and stepchildren who are, in each case, under age 25, unmarried, and dependent on you for **principal support**. You also may cover unmarried children under age 25 who are dependent on you for principal support and are one of the following:

- Related to you either directly or through marriage (for example, grandchildren, nieces, nephews),
- Under your legal custody or guardianship (or for whom you have a pending application for legal custody or guardianship) and are living with you, or
- Children for whom the Company receives a qualified medical child support order. (QMCSOs are described later in this section.)

For details, contact the Boeing Service Center through Boeing TotalAccess.



### What is principal support?

Principal support means that you and/or your current or former spouse provides more than half the financial support for your child. (In determining this, you can exclude any scholarships for study at a regular educational institution unless the child is not your natural child, adopted child, or stepchild.) In most cases, if you claim the child as a dependent on your annual Federal taxes, then you provide principal support for the purposes of eligibility for the plan.

If you have never been married to the other parent of your child, then you must provide more than half the support for your child, regardless of the other parent's support. If you are divorced from the other parent of your child, special rules apply; contact your tax adviser. You also may want to review Internal Revenue Service Publication 502, *Medical and Dental Expenses*.

## Disabled Children

A disabled child age 25 or older may continue to be eligible (or enrolled if the child of a newly **eligible retired employee**) if he or she is incapable of self-support because of any mental or physical condition and the child became disabled before age 25. The child must be unmarried and dependent on you for **principal support**. Coverage may continue under the retiree medical plan for the duration of the disability as long as you continue to be eligible and enrolled in the plan and the child continues to meet these eligibility requirements.

Special applications for coverage are required for disabled **dependent** children age 25 or older.

## When You and Your Spouse Both Are Eligible for Company-Sponsored Coverage

If you and your spouse both are eligible for Boeing retiree medical coverage (either the same or different plans), special coverage provisions will apply. Generally, neither of you may enroll as a **dependent** under the other's plan. This provision applies even if either of you waived coverage under the retiree medical plan for which you were eligible.

Certain exceptions apply, as follows.

## Coverage for Your Spouse

If you are eligible for Boeing retiree medical coverage and your spouse is eligible for Boeing medical coverage (or another employer's plan) based on active employment, you may elect to be covered as a **dependent** under his or her plan and defer coverage under the Boeing retiree medical plan. Once your coverage under your spouse's plan ends, you must enroll in the Boeing Medicare Supplement Plan within 60 days. See "During the Year When Certain Life Events Occur," later in this section.

## Coverage for Your Dependent Children

If both you and your spouse are eligible for Boeing retiree medical coverage, you must enroll all **dependent** children in the same retiree medical plan (except as required by a QMCSO). For details, contact the Boeing Service Center through Boeing TotalAccess.

## Coverage for Your Surviving Spouse and Dependents

If you die while you are an active employee and eligible for retiree medical coverage, retiree medical for your surviving spouse and your **eligible dependent** children normally will start the first day of the second month after your death.

If you die during a period when you had deferred your retiree medical coverage, retiree medical for your surviving spouse and your eligible dependent children normally will start the first day of the month after your death.

In either case, your surviving spouse and eligible dependent children are subject to the same rules and requirements that would have applied to you had you survived and elected retiree medical coverage yourself.

Your spouse and eligible dependent children can elect to delay retiree medical participation until a future date if they have other employer-sponsored medical coverage or plan to delay the commencement of a survivor pension benefit. If you die while you are covered by the retiree medical plan, coverage for your eligible dependents will continue until the time indicated in "Coverage End Dates and Continuation of Coverage," in Section 4.

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## When to Enroll or Make Changes

When you become eligible for retiree medical coverage, you generally may enroll

- By the date printed on the enrollment worksheet you receive as a newly **eligible retired employee**.
- Within the specified time frames for a special enrollment event or status change during the year.  
(See the table "How and When to Enroll," later in this section.)

Each of these enrollment periods is explained here. If you choose to begin your retiree medical coverage at a date later than your initial retiree medical eligibility date following termination of employment, contact the Boeing Service Center through Boeing TotalAccess for details about your enrollment options and to confirm whether you will be able to enroll later.

## If You Are Newly Eligible

When you terminate employment, you will receive an enrollment worksheet by mail that shows your available retiree medical plan options, coverage levels, and costs. You also can find enrollment information on line at the Your Benefits Resources web site.

## During the Year When Certain Life Events Occur

After you enroll, you may be able to add or change coverage during the year as a result of certain special enrollment events or status changes, as described below. You can drop retiree medical coverage at any time, as described below.

If you experience a special enrollment event or a status change and you would like to enroll or change your coverage, you must contact the Boeing Service Center through Boeing TotalAccess and request enrollment within the time frames specified in the tables, "How and When to Enroll," later in this section.

When you request enrollment or a change in coverage, you will be requested to provide required documentation to the Boeing Service Center. For more information, see “When Additional Documentation Is Required,” later in this section.

## Special Enrollment Events

If you declined coverage in the retiree medical plan for yourself and/or your **eligible dependents** when you were first eligible because you or your dependents had other employer-sponsored medical coverage, you may enroll yourself and/or your eligible dependents if you or your dependent experiences one of these special enrollment events:

- You or your dependent loses or becomes ineligible for other employer-sponsored medical coverage because of an event such as loss of dependent status under another employer’s plan (through divorce, legal separation, or dependent child reaching the limiting age), death, termination of employment, reduction in hours of employment, termination of employer contributions toward the coverage, elimination of coverage for the class of similarly situated employees or dependents, moving out of the plan’s service area with no other coverage available from the other employer, or reaching the lifetime limit on all benefits under the other employer’s plan.
- You or your dependent exhausts any continuation coverage from another employer; that is, coverage provided under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), ends.
- You gain a new dependent because of marriage, birth, adoption, or placement for adoption.

If you experience a special enrollment event, you can enroll yourself and/or your eligible dependents in a retiree medical plan as described above. You can enroll in any family status tier and any health plan option available to you.

Special enrollment is not available if you lose coverage because of failure to make timely premium payments or termination from the plan for cause (such as for making a fraudulent claim).

## Status Changes

If you already are enrolled for this retiree medical coverage, you may be able to add an **eligible dependent** if you experience one of the status changes described below. Any change to your coverage must be consistent with the status change that affects your or your dependent’s eligibility for Company-sponsored health care coverage or health care coverage that is sponsored by your eligible dependent’s employer.

Status changes include the following:

**Legal marital status.** You marry, divorce, legally separate, or your marriage is annulled, or your spouse dies.

**Number of dependent children.** You lose or gain a dependent child through death, birth, adoption, or placement of a child in your home for adoption.

**Employment status.** Your dependent’s eligibility for coverage is affected by a change in job situation such as termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, a change in work site, a transfer between a salaried and an hourly position, a transfer between a full-time and a part-time position, or a transfer between a nonunion salaried position and a union-represented position.

**Dependent child’s eligibility.** Your dependent child becomes eligible or ineligible for coverage (for example, if your child marries, no longer qualifies for **principal support**, exceeds the age limits, or becomes an employee and is covered by another employer-sponsored medical plan).

**Residence.** Your **covered dependent’s** place of residence changes, which affects access to health care within his or her current plan or restricts his or her ability to access **providers**.

**Cost of coverage.** You or your covered dependent experiences a significant change in the cost of employer-sponsored coverage (including **COBRA**).

**Significant change in coverage.** You or your dependent experiences a significant curtailment of employer-sponsored medical coverage or that coverage ends, including expiration of coverage under another employer's COBRA plan. Examples of curtailment include a significant increase in the **annual deductible** or **copayments**.

**Addition or improvement of a benefit option.** The Company adds a new benefit option or significantly improves an existing benefit option.

**Enrollment change in another plan.** Your dependent experiences a change in enrollment in another plan sponsored by the Company or another employer, including an annual enrollment election change.

**Entitlement to Medicare or Medicaid.** You or your dependent becomes eligible or ineligible for Medicare or Medicaid.

**Loss of governmental or educational coverage.** You or your dependent loses coverage under a group health plan sponsored by a governmental or educational institution.

**Judgment, decree, or order.** You receive a judgment, decree, or court order from a divorce, legal separation, annulment, or change in legal custody, including a QMCSO, that requires you to add or remove health care coverage for a dependent child.

### When Your Dependents Become Eligible for Medicare

You must notify the Boeing Service Center promptly if your **dependent** becomes eligible for Medicare for any reason (such as turning age 65 or because of a total and permanent disability award from Social Security).

If you are enrolled in the Boeing Medicare Supplement Plan when your dependent becomes eligible for Medicare, your dependent may be able to continue coverage under this plan. Contact the Boeing Service Center for details.

### Dropping Coverage

You may drop retiree medical coverage for you and/or your **dependents** effective at the end of any calendar month. If coverage is dropped, you will not be able to enroll yourself and/or your dependents again in Boeing-sponsored coverage unless the dropped **participant** had other continuous employer-sponsored coverage.

See "Special Enrollment Events," earlier in this section.

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## How to Enroll

### Enrolling in Retiree Medical Plan Benefits Immediately

You can begin the enrollment process on line up to 60 days before your expected last day of employment. Follow the instructions for "Initiating Retirement" under Life Events from the TotalAccess topics menu.

To do so, you will need

- Your Boeing TotalAccess password.
- Your BEMS ID number (or Social Security number) and birth date.
- Social Security numbers and birth dates for the **dependents** you are enrolling.
- Information about your spouse's employment and health care coverage, if any.

If you do not have access to a computer, you can enroll over the phone by calling the Boeing Service Center through Boeing TotalAccess.

## When You Have Deferred Benefits

If you do not enroll in retiree medical when you first leave Boeing, there are other specific enrollment opportunities within certain allowable time frames. See the following tables.

How and When to Enroll if You Terminated Employment Before July 1, 2006		
To enroll . . .	Enroll through the . . .	By the . . .
When you terminate employment and immediately commence your pension benefit and enroll in a Company-sponsored retiree medical plan	Your Benefits Resources web site*	Date shown on your enrollment worksheet
When you terminate employment and you defer your pension benefit and your retiree medical coverage to commence at a later date You may commence your retiree medical benefits upon commencement of your pension benefit <b>Note:</b> In this situation, losing other employer-sponsored medical coverage is not a requirement for enrollment in a Company-sponsored retiree medical plan	Your Benefits Resources web site	31st day after your pension benefit commences <b>Note:</b> If you do not take the opportunity to enroll at this time, you will not be able to enroll at a later date unless you declined enrollment because you had other employer-sponsored medical coverage and you lose that coverage
When you terminate employment and commence your pension benefit Retiree medical coverage election is deferred because you have other employer-sponsored medical coverage (such as through your spouse, as an active employee, or COBRA coverage) You can enroll in retiree medical coverage when you lose your other employer-sponsored medical coverage	Your Benefits Resources web site	60th day after losing your other coverage
Your eligible dependents because of a special enrollment event or status change (as defined in "During the Year When Certain Life Events Occur")	Your Benefits Resources web site	60th day after the event
A new dependent (if you are eligible to add new dependents) midyear because of marriage, birth, adoption, or placement for adoption when you already are enrolled in the plan (as defined in "During the Year When Certain Life Events Occur")	Your Benefits Resources web site**	120th day after the event
<p><b>Note:</b> If loss of coverage is due to reaching another plan's lifetime limit on all benefits, the event date is the day the claim exceeding the lifetime limit is incurred; the 60-day enrollment period starts when the other plan denies the claim, in whole or in part, because of reaching the lifetime limit.</p> <p>* You will find links for enrollment on the Your Benefits Resources web site only when enrollment is available to you immediately upon termination from employment.</p> <p>** To enroll your dependent after the 60th day, you must call the Boeing Service Center through Boeing TotalAccess and speak with a representative.</p>		

## How and When to Enroll if You Terminated Employment On or After July 1, 2006

To enroll . . .	Enroll through the . . .	By the . . .
When you terminate employment and immediately enroll in a Company-sponsored retiree medical plan	Your Benefits Resources web site*	Date shown on your enrollment worksheet Or you can begin the enrollment process on line up to 60 days before your expected last day of employment
When you terminate employment and you defer your pension benefit and your retiree medical coverage to commence at a later date You may commence your retiree medical benefits upon commencement of your pension benefit <b>Note:</b> In this situation, losing other employer-sponsored medical coverage is not a requirement for enrollment in a Company-sponsored retiree medical plan	Your Benefits Resources web site	31st day after your pension benefit commences <b>Note:</b> If you do not take the opportunity to enroll at this time, you will not be able to enroll at a later date unless you declined enrollment because you had other employer-sponsored medical coverage and you lose that coverage
When you terminate employment and your retiree medical coverage election is deferred because you have other employer-sponsored medical coverage (such as through your spouse, as an active employee, or COBRA coverage) You can enroll in retiree medical coverage when you lose your other employer-sponsored medical coverage	Your Benefits Resources web site	60th day after losing your other coverage
Your eligible dependents because of a special enrollment event or status change (as defined in "During the Year When Certain Life Events Occur")	Your Benefits Resources web site	60th day after the event
A new dependent (if you are eligible to add new dependents) midyear because of marriage, birth, adoption, or placement for adoption when you already are enrolled in the plan (as defined in "During the Year When Certain Life Events Occur")	Your Benefits Resources web site**	120th day after the event
<p><b>Note:</b> If loss of coverage is due to reaching another plan's lifetime limit on all benefits, the event date is the day the claim exceeding the lifetime limit is incurred; the 60-day enrollment period starts when the other plan denies the claim, in whole or in part, because of reaching the lifetime limit.</p> <p>* You will find links for enrollment on the Your Benefits Resources web site only when enrollment is available to you immediately upon termination from employment.</p> <p>** To enroll your dependent after the 60th day, you must call the Boeing Service Center through Boeing TotalAccess and speak with a representative.</p>		

## When Additional Documentation Is Required

To cover **dependents** or to enroll following loss of other employer-sponsored medical coverage, you will be required to submit more information or a coverage application to the Boeing Service Center.

If you do not submit the requested information or application by the date specified by the Boeing Service Center, your request to add or change coverage will be denied. The situations described below commonly require additional information. At the Plan Administrator's discretion, other situations also may require more information.

## Application for Disabled Children

Coverage for a disabled child normally ends on his or her 25th birthday. However, you may continue his or her coverage if a physician provides proof that the child is incapable of self-support because of disability. You may be required to confirm the disability from time to time.

If your eligible disabled **dependent** child is 25 or older and the disability started before age 25, you may enroll the child by completing a special application. Call the Boeing Service Center through Boeing TotalAccess for an application.

## Documentation for QMCSOs, Legal Custody, and Guardianship

You will be required to submit documentation to the Boeing Service Center if

- You are required to cover a child (called an alternate recipient) by order of a court through a qualified medical child support order (QMCSO).
- You assume legal custody or guardianship of a child.

## Proof of Marriage

If you enroll your spouse, you will be required to document your marriage or common-law marriage. For additional information, contact the Boeing Service Center through Boeing TotalAccess.

## Evidence of Loss of Other Employer-Sponsored Medical Coverage

If you enroll yourself and/or your **dependents** because of loss of other employer-sponsored medical coverage, you may be required to submit evidence of the type of coverage, date coverage ended, reason coverage ended, and family members who were covered under the other plan. The most convenient way to provide this information is to send a copy of the certificate of creditable coverage issued by the other health plan or to submit copies of other documents that contain the required information.

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## When Coverage Begins

The effective date of your coverage depends on when you enroll and what event initiates your enrollment.

If you terminated employment before July 1, 2006, your retiree medical coverage begins only when you start receiving your Company-sponsored pension benefit, unless you waived retiree medical coverage because you had other employer-sponsored medical coverage. This means if you terminated employment with the Company but chose to start your pension benefit at a later time, you could not enroll in the retiree medical plan until you began receiving your pension benefit.

If you terminated employment on or after July 1, 2006, you do not need to be receiving your Company-sponsored pension benefit to start your retiree medical coverage.

The following tables explain when coverage begins for you and your **dependents**.



### What if I am in the hospital when my new medical coverage is supposed to begin?

If you (or your dependent) are confined to a hospital or similar institution on the date coverage begins, this plan will be secondary to any other coverage you may have. When you are discharged from the facility or if that coverage ends, this plan will become primary.

If the previous medical plan (including a Company-sponsored medical plan) provides continued coverage during the hospitalization, the previous plan will be primary and the new plan will be secondary until hospitalization ends. (See Section 3, "Claims and Appeals.")

## Coverage for You

If you . . .	Your coverage will begin on . . .
Terminate from active employment with the Company and you are eligible for retiree medical benefits (and you make your election by the date indicated on your enrollment worksheet)	<ul style="list-style-type: none"> <li>• The first day of the second month after your active employment ends, if you terminated on or after July 1, 2006</li> <li>• The first day of the month after your active employment ends, if you terminated before July 1, 2006</li> </ul>
Terminated employment and deferred your retiree medical enrollment and your pension benefit commencement date under a Company-sponsored retirement plan	Your pension benefit commencement date
Terminated employment and deferred your retiree medical enrollment due to other employer-sponsored medical coverage and that coverage ends	The first day of the month after your other coverage ended if Boeing TotalAccess receives notification of the loss of coverage within 60 days
Terminate employment with the Company following a leave of absence	The first day of the month after the month you terminate employment
Enroll or change your coverage because of a special enrollment event (see “Special Enrollment Events,” in this section)	The special enrollment event date
Enroll or change your coverage because of a status change (see “Status Changes,” in this section)	The status change date
Become eligible for Medicare due to age or disability	First day of the month you become eligible for Medicare

## Coverage for Your Dependents

If you enroll your eligible dependents or change their coverage . . .	Their coverage will begin on the . . .
When you enroll yourself as a newly eligible retiree following termination of employment	Same day that your coverage begins (if applied for at the same time)
When you enroll in your retiree medical benefit concurrent with a Company-sponsored pension benefit commencement that was initially deferred	Your pension benefit commencement date
As a result of a special enrollment event (see “Special Enrollment Events,” in this section)	Special enrollment event date
As a result of a status change (see “Status Changes,” in this section)	Status change date
Following receipt of a QMCSO	First of the month the QMCSO is received or on the date specified in the QMCSO
When you become eligible for Medicare due to age or disability	First day of the month you become eligible for Medicare

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## What Coverage Costs

### How Much You Pay for Coverage

Generally, you and the Company share the cost of retiree medical coverage. The amount you pay toward the cost of your retiree medical coverage is called a contribution.

Contribution amounts are published each year. You can find your contribution amount in the information that will be mailed to you, or you can find out more through the Your Benefits Resources web site or by calling the Boeing Service Center through Boeing TotalAccess.

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## Payment Methods

Normally, your retiree medical coverage contributions, if any, are billed directly to you. Direct debit is also available for automatic monthly payment from your bank account. If you are receiving a Company-sponsored pension benefit, you may elect to have your retiree medical coverage contributions deducted from your monthly pension check. However, if the amount of your pension payment will not cover the cost of coverage, you will be billed directly for the amount due.

You may change your payment method at any time. Changes may require up to two billing cycles to take effect.

## Surviving Spouse

Normally, retiree medical contributions for your surviving spouse's coverage are billed directly to him or her. Direct debit is also available for automatic monthly payment from your bank account. If your surviving spouse is receiving a Company-sponsored pension benefit, he or she may elect to have retiree medical coverage contributions deducted from his or her monthly pension check. However, if the amount of the pension check will not cover the cost of coverage, your surviving spouse will be billed directly for the amount due.

If your surviving **dependent** child also is covered, the child's medical contribution will be added to your surviving spouse's medical contribution.

Your surviving spouse may change the payment method at any time. Changes may require up to two billing cycles to take effect.

Contact the Boeing Service Center through Boeing TotalAccess for more information.

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## Court-Ordered Child Support

The Company also will provide health care coverage to certain children (called alternate recipients) if directed to do so by a qualified medical child support order (QMCSO) that is issued by a court or state agency of competent jurisdiction.

A QMCSO is a "medical child support order" that is "qualified" under requirements of the Omnibus Budget Reconciliation Act of 1993, as amended.

## Medical Child Support Order

A medical child support order is any decree, judgment, or order (including approval of a settlement agreement) from a state court with jurisdiction over the child's support or an order or administrative notice from a state agency with such jurisdiction under state law that

- Recognizes the child as an alternate recipient for **plan benefits**.
- Provides, based on a state domestic relations law (including a community property law), for the child's support or health plan coverage.
- Specifically requires a health care plan to provide coverage.

## Qualified Medical Child Support Order

Not all medical child support orders are qualified. A QMCSO

- Meets all of the above conditions for a medical child support order,
- Creates or recognizes an alternate recipient's right to receive **plan benefits**, and
- Specifies
  - Your (the retired employee's) name and last known address.
  - Each alternate recipient's name and address (or, if the order provides, the name and address of a state official or agency instead of each alternate recipient's address).
  - Coverage to which the alternate recipient is entitled.
  - The coverage effective date.
  - How long the child is entitled to coverage.
  - That the health care plan is subject to the order.



### **What if I have to pay medical expenses after the QMCSO effective date but before the QMCSO has been approved by the Company?**

The health plans pay providers directly for covered services. When a covered charge has been paid by you, an alternate recipient, a custodial parent, or a legal guardian, the plan will reimburse the person who paid the expense. You must file a claim for reimbursement. For claim-filing instructions, see Section 3.

## How the Company Notifies You of a Medical Child Support Order

The Company promptly will notify you and the alternate recipient if it receives a medical child support order and will provide an explanation of the procedures used to determine whether the order is qualified. The Company then will decide, based on written procedures and within a reasonable time, whether the order is a QMCSO.

If the order is a QMCSO, the Company will

- Notify you and the alternate recipient of the plan's procedures for adding the alternate recipient to your coverage.
- Allow the alternate recipient an opportunity to designate a representative to receive copies of any notices due under the QMCSO.
- Begin coverage for the alternate recipient on the date specified in the QMCSO (which is not necessarily the first of the month).
- Begin billing you for any required contributions, including any contributions for coverage retroactive to the coverage effective date specified in the QMCSO. Alternatively, if you are receiving a Company-sponsored pension benefit, you may elect to have these required contributions deducted from your monthly pension check.

If the order is not a QMCSO, the Company will notify the retired employee and each alternate recipient, within a reasonable time, of the reasons and the procedures for submitting a corrected medical child support order.



### **How can I learn more about QMCSOs?**

For more information on QMCSOs, contact the Boeing Service Center through Boeing TotalAccess. You can obtain the Company's procedures governing medical child support orders at no charge by writing to the Employee Benefit Plans Committee, The Boeing Company, 100 North Riverside, MC 5002-8421, Chicago, IL 60606-1596.

## How the Boeing Medicare Supplement Plan Works

The Boeing Medicare Supplement Plan is designed to coordinate with Medicare Part A and Part B. The plan covers Medicare-recognized services and supplies necessary to treat accidental injury or illness as well as certain other charges, including preventive care and prescription drugs.



### Do I need to enroll in Medicare to be covered by the Boeing Medicare Supplement Plan?

Yes, for Part A and Part B. Because the Boeing Medicare Supplement Plan assumes enrollment in Medicare, it is important that you and your dependents enroll in Part A and Part B when eligible.

However, you do not need to enroll in the Medicare prescription drug coverage (Part D) to have prescription drug coverage under the Boeing Medicare Supplement Plan.

The Boeing Medicare Supplement Plan does not provide benefits to supplement any Medicare Advantage Plan (previously known as Medicare+Choice) or any Medicare prescription drug plan.

## Who Administers the Benefits

The Company has contracted a **service representative** to handle the day-to-day administration of this plan. The service representative answers benefit questions, makes benefit decisions, pays claims, processes claim appeals, and accounts for premiums, service fees, and claim costs. The current service representative for the Boeing Medicare Supplement Plan is Aetna, Inc.

See Section 7, “Contacts,” for information on how to contact the service representative.

The Company reserves the right to change the service representative at any time. If this happens, you will be notified in writing.



### What is a service representative?

A service representative is an agent, group, or organization with which the Company has contracted to handle the day-to-day administration of the plan.

## How Much You and the Plan Pay

Under the Boeing Medicare Supplement Plan,

- You and your **dependents** are responsible for paying an **annual deductible** before the plan will begin paying benefits. The deductible applies to charges for all **covered services** and supplies except the mail-order pharmacy.
- The plan then shares costs with you by paying a **coinsurance** percentage.
- You pay a **copayment** for mail-order prescriptions.
- An annual out-of-pocket maximum, to limit what you pay, and a lifetime maximum benefit, to limit the total amount the plan pays, also apply.

Each of these plan provisions is explained below.

## Annual Deductible

Generally, the **annual deductible** is the amount you must pay out of your own pocket for **covered services** each calendar year before the plan begins to pay benefits.

The deductible for each person covered by the Boeing Medicare Supplement Plan is the first \$200 of charges for covered medical services and supplies. Covered expenses that satisfy the Medicare deductible also may be used to satisfy this plan’s deductible.

Any expenses applied toward the deductible in the last three months of a calendar year also may be applied toward the deductible for the next calendar year.

Any amounts that were used to satisfy or apply against your deductible under another Company-sponsored medical plan before you were covered by this plan will satisfy or apply against your deductible under this plan in the same calendar year.

*The annual deductible applies to all covered expenses except mail-order drugs.*



### **How do I get credit for deductible expenses from another Company-sponsored medical plan?**

To receive credit for deductible expenses, send copies of the explanation of benefits (defined in Section 6) you received under the other plan to the service representative, showing that you have met all or part of that plan's deductible requirement.

## **Common Accident Deductible**

If you and one or more of your **dependents** are injured in the same accident, only one \$200 deductible will apply to all covered medical expenses. This common accident deductible applies during the calendar year in which the accident occurs as well as during the next calendar year.

## **Coinsurance Percentage**

After the level of benefits payable by Medicare is determined, the Boeing Medicare Supplement Plan generally pays 80 percent of **usual and customary charges** for covered medical expenses, once you meet the **annual deductible**.

**Coinsurance** percentages are shown in the tables under “How Part A Benefits Are Paid” and “How Part B Benefits Are Paid,” later in this section.

## **Copayment**

A copayment is a fixed dollar amount that you pay toward the cost of a particular **covered service** or supply when it is received. The plan pays the remainder of the cost.

Under the Boeing Medicare Supplement Plan, a copayment applies each time you purchase a prescription drug from the mail-order pharmacy service.

For copayment amounts, see “Filling Prescriptions by Mail Order,” later in this section.

## **Annual Out-of-Pocket Maximum**

This plan limits the maximum amount that you or your family must pay in any one benefit year for most services to which a **coinsurance** percentage applies. If you reach the out-of-pocket maximum, the plan will begin to pay most coinsurance percentages at 100 percent of the **usual and customary charge** (see definition in Section 6) for the rest of that benefit year. The annual out-of-pocket maximum is \$5,000 per person.

**Amounts That Do Not Count Toward the Annual Out-of-Pocket Maximum.** Amounts that you pay for the following are not applied toward the individual or family out-of-pocket maximums:

- **Annual deductibles.**
- Any balance remaining after you reach a benefit maximum.
- Any difference between the usual and customary charge and the **provider's** actual charge.
- **Covered services** that are paid in full or paid at 100 percent of usual and customary charges.
- Services or supplies that are paid at a reduced amount or denied if you do not meet pretreatment review program requirements.
- Services or supplies that the plan does not cover.

**Usual and Customary Charge.** The usual and customary charge is the maximum charge for a covered service or supply the **service representative** will consider for reimbursement from a provider. The service representative may refer to this as the “maximum reimbursable charge,” “maximum allowable charge,” “reasonable and customary charge,” “allowed amount,” or a similar term.

The usual and customary charge is the least of

- The provider’s actual charge for the service or supply,
- The provider’s normal charge for a similar service or supply, or
- A predetermined percentile (negotiated between each carrier and plan sponsor) of charges made by providers of a comparable service or supply in the geographic area where it is received.

To determine if a charge exceeds the usual and customary charge for medical services or supplies in situations involving unusual or complicated services or supplies, the nature and severity of the injury or sickness may be considered.

The service representative uses a database of provider charges to determine the usual and customary charge in an area. Information about the database and percentile used to determine the usual and customary charge can be obtained by contacting the service representative.

You pay any charges above the usual and customary amount.

## Lifetime Maximum Benefit

The Boeing Medicare Supplement Plan lifetime maximum benefit is \$1.5 million per individual. This maximum

- Limits the total amount this plan will pay over any one individual’s lifetime for all covered medical services and supplies.
- Applies separately to each Company-sponsored medical plan.

Any amounts that this plan pays toward **covered services** and supplies, except the mail-order pharmacy benefit, apply toward the lifetime maximum benefit.

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## Pretreatment Review

You and your physician can complete a claim form and submit it to the **service representative** before treatment to obtain information about

- Your share of the cost for a recommended surgery.
- Whether or not a specific condition or charge is covered under this plan.

Pretreatment review is not a guarantee of payment. Benefits will depend on whether or not Medicare covers the services, what treatment actually is performed, and whether or not you are covered by this plan at the time services are performed.

For information on how to contact the service representative, see Section 7, “Contacts.”

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## How Part A Benefits Are Paid

The following table shows how benefits are paid by Medicare Part A and the Boeing Medicare Supplement Plan. This Medicare Part A summary is for illustration only. (You can contact your local Medicare office or visit <http://www.medicare.gov> for more information.) This Boeing Medicare Supplement Plan summary illustrates the benefits payable for **covered services** and supplies after you meet the plan’s **annual deductible**.

Any service or supply that is not covered by Medicare will not be covered by the Boeing Medicare Supplement Plan except as listed in “Additional Covered Services and Supplies,” later in this section.

Medicare Hospital Insurance (Part A) Pays . . .	Boeing Medicare Supplement Plan Pays . . .
For the 1st through the 60th day in each benefit period, covered expenses for hospital inpatient care in excess of Medicare's Part A deductible	80% of Medicare's Part A deductible
For the 61st through the 90th day in each benefit period, covered expenses for hospital inpatient care less a daily coinsurance amount	80% of the daily coinsurance amount not paid by Medicare
After the 90th day in each benefit period, no coverage for hospital inpatient care unless Medicare's lifetime reserve days are used	80% of covered hospital inpatient expenses
If Medicare's lifetime reserve of up to an additional 60 days is used, covered expenses for hospital inpatient care less a daily coinsurance amount	80% of the daily coinsurance amount not paid by Medicare
Covered expenses for psychiatric hospital inpatient care on the same basis as other hospital inpatient care for a lifetime maximum of 190 days	Covered expenses for <ul style="list-style-type: none"> <li>• Effective inpatient treatment of alcoholism or drug abuse (including medical complications such as cirrhosis of the liver, delirium tremens, or hepatitis) and mental disorders</li> <li>• Facility treatment room and board (other than daily room and board in a private room) over the private room limit</li> </ul>
In each benefit period, covered expenses for skilled nursing facility inpatient care for up to 100 days less a daily coinsurance amount which begins on the 21st day (custodial care not covered)	80% of the daily coinsurance amount not paid by Medicare (custodial care not covered)
Covered expenses for limited medically necessary home health care less a coinsurance amount for durable medical equipment (custodial care not covered)	80% of the coinsurance amount not paid by Medicare (custodial care not covered)
In each benefit period, covered expenses for limited hospice care for up to 210 days less a coinsurance amount for outpatient drugs and respite care; room and board for inpatient respite care and short-term hospital stays	80% of the coinsurance amount not paid by Medicare; room and board for inpatient respite care and short-term hospital stays
Covered expenses for blood after the first three pints (you are not charged if you or someone else donates blood to replace what you use)	80% of the cost after the first three pints of blood



### Is there any limit on the type of accommodations covered in a hospital or skilled nursing facility?

Yes. The Boeing Medicare Supplement Plan covers a hospital's or skilled nursing facility's charge for ward or semiprivate room accommodations. If a private room is used, the plan covers only the hospital's or skilled nursing facility's average semiprivate room rate or, if none exists, the average semiprivate room rate for similar facilities in the area.

## How Part B Benefits Are Paid

The following table shows how benefits are paid by Medicare Part B and the Boeing Medicare Supplement Plan. If your physician has agreed to accept an **assignment** of Medicare benefits, the plan pays 80 percent of the 20 percent **coinsurance** Medicare requires you to pay. If your physician has not agreed to accept an assignment of Medicare benefits, the plan pays 80 percent of the difference between Medicare's **limiting charge** and what Medicare pays.

This Medicare Part B summary is for illustration only. (You can contact your local Medicare office or visit <http://www.medicare.gov> for more information.) This Boeing Medicare Supplement Plan summary illustrates the benefits payable for **covered services** and supplies after you meet the plan's **annual deductible**.

Any service or supply that is not covered under Medicare will not be covered under the Boeing Medicare Supplement Plan except as listed in "Additional Covered Services and Supplies," later in this section.



### What does limiting charge mean?

Limiting charge refers to the highest amount you can be charged for a covered service by a provider who does not accept assignment of Medicare benefits. The limiting charge is 15 percent over Medicare's approved amount. The limiting charge applies only to certain services and not to supplies or equipment.

<b>Medicare Medical Insurance (Part B) Pays . . .</b>	<b>Boeing Medicare Supplement Plan Pays . . .</b>
<p>Generally, 80% of covered expenses for physician services and other covered services and supplies in excess of Medicare's Part B deductible, including</p> <ul style="list-style-type: none"> <li>• Ambulance services to nearest hospital or skilled nursing facility (when required by patient's condition)</li> <li>• Arm, leg, back, or neck braces</li> <li>• Blood (the first three pints)</li> <li>• Chiropractic services for manipulation of the spine to correct subluxation</li> <li>• Clinical trials (in some cases)</li> <li>• Diabetic supplies (such as glucose control solutions, glucose testing monitors, test strips and lancets, and therapeutic shoes in some cases)</li> <li>• Diagnostic X-ray and laboratory tests</li> <li>• Durable medical equipment (such as oxygen, walkers, and wheelchairs)</li> <li>• Hospital emergency room and outpatient services</li> <li>• Insulin pumps (in some cases)</li> <li>• Kidney dialysis</li> <li>• Medical supplies (such as casts, ostomy bags, splints, and surgical dressings)</li> <li>• Mental health treatment (outpatient)</li> <li>• Physical, occupational, and speech therapy</li> <li>• Physician assistant and nurse practitioner treatment</li> <li>• Prosthetic and orthotic devices (such as artificial limbs and eyes)</li> <li>• Second surgical opinions (in some cases)</li> <li>• Transplants (in some cases)</li> <li>• Urgent care</li> <li>• Vision services (when medically necessary, including one set of eyeglasses after cataract surgery)</li> </ul>	<p>80% of Medicare's Part B deductible, then 80% of the coinsurance amount not paid by Medicare for the services and supplies listed at the left, except this plan pays</p> <ul style="list-style-type: none"> <li>• 80% of the cost for the first three pints of blood</li> <li>• 80% of the cost for effective treatment of alcoholism, drug abuse, or mental disorders</li> </ul>

Medicare Medical Insurance (Part B) Pays . . .	Boeing Medicare Supplement Plan Pays . . .
Preventive services, including <ul style="list-style-type: none"> <li>• Bone mass measurements</li> <li>• Cardiovascular screening blood tests</li> <li>• Colorectal cancer screenings</li> <li>• Diabetes screenings</li> <li>• Diabetes self-management training (when requested by your physician)</li> <li>• Glaucoma screenings (for high-risk participants)</li> <li>• Mammograms</li> <li>• Pap tests and pelvic examinations</li> <li>• Prostate cancer screenings and Prostate Specific Antigen tests</li> <li>• Vaccinations for flu and pneumonia; hepatitis B vaccinations (for medium- to high-risk participants)</li> <li>• <i>Welcome to Medicare</i> physical examination (for participants whose Part B benefits start on or after January 1, 2005)</li> </ul>	80% of Medicare's deductible, then 80% of the coinsurance amount not paid by Medicare



### What amount is covered if my physician accepts or does not accept Medicare assignment?

Many physicians have an arrangement with Medicare called “assignment.” If your physician accepts Medicare assignment, Medicare pays your physician directly, and your physician agrees not to charge you more than Medicare’s approved amount.

If your physician participates in Medicare but does not accept Medicare assignment, your physician will send your bill to Medicare but will not accept payment directly from Medicare. Medicare will send its benefit payment to you. In this case, your physician generally may charge up to 15 percent more than Medicare’s approved amount. This fee (including the extra 15 percent), Medicare’s limiting charge, is covered under the Boeing Medicare Supplement Plan up to the service representative’s usual and customary amount.



### What amount is covered if my physician does not participate in Medicare?

If your physician does not participate in Medicare, has opted out of Medicare, or has been excluded from Medicare, Medicare will not accept your physician’s charges or pay benefits for services or supplies you receive from the physician. The Boeing Medicare Supplement Plan will not accept or cover the physician’s charges. You will be responsible for the full amount of your physician’s charges.

## Reconstructive Breast Surgery

If you have had or are going to have a mastectomy, you may be entitled to certain benefits. For individuals receiving mastectomy-related benefits, coverage will be provided, in a manner determined in consultation with the attending physician and the patient, for

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductible, **copayment**, and **coinsurance** applicable to other medical and surgical benefits provided under this plan. Additional information regarding benefit coverage levels can be found in this booklet.

If you would like more information on these benefits, call the **service representative** at the telephone number shown in Section 7.

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## Additional Covered Services and Supplies

In addition to services and supplies covered by Medicare, the Boeing Medicare Supplement Plan reimburses 80 percent of **usual and customary charges** for these services and supplies (after you meet the **annual deductible**):

- Hair prostheses up to \$500 per year for **participants** who are undergoing chemotherapy or radiation therapy.
- Hospital, physician, and other necessary medical services received outside the United States, from licensed **providers**, for emergency treatment of an accidental injury or sudden illness.
- Registered nurse (R.N.) services for noncustodial care provided by a nurse other than one who ordinarily resides in your home or who is a member of your or your spouse's family.
- Jobst stockings.

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## Prescription Drug Coverage

Under the Boeing Medicare Supplement Plan, you and your **dependents** can buy prescription drugs through

- An Aetna Pharmacy Management **participating pharmacy** for short-term or immediate prescriptions (covered under general terms of the plan), or
- The Aetna Home Delivery mail-order pharmacy service for maintenance prescription drugs taken on an ongoing basis for a chronic medical condition (not subject to the plan's **annual deductible** or general payment levels).

This benefit covers medically necessary drugs and medicines required by Federal or state law to be prescribed in writing by a physician and dispensed by a licensed pharmacist, including contraceptives, insulin, and needles and syringes when prescribed with insulin or other covered injectables.

## Your Prescription Drug Coverage and Medicare Part D

You do not need to enroll in Medicare Part D to receive prescription drug benefits. Prescription drug coverage under this plan is considered creditable coverage for the purposes of Medicare Part D. Here are some important points about Medicare prescription drug coverage:

- You do not have to enroll in Medicare Part D to keep your retiree medical prescription drug coverage. No action is required on your part if you want your Boeing coverage to continue.
- Because your retiree medical plan coverage is, on average, better than standard Medicare prescription drug coverage, you can keep your Boeing coverage and not pay a "late enrollment" penalty if you decide to enroll in Medicare Part D coverage later.
- If you plan on keeping your Boeing coverage, you typically will not improve your overall coverage by joining a Medicare prescription drug plan. Your retiree medical plan will not cover any prescription covered by a Medicare Part D plan, even if the Medicare Part D plan does not pay for the prescription because of a deductible or other plan provision.
- If you are a retiree with limited annual income and resources, you may want to consider enrolling in Medicare Part D while keeping your Boeing coverage. Contact Social Security at 1-800-772-1213 about this financial help.



### Do any prescriptions require preapproval?

Yes. Certain dosages, quantities, and medications require preapproval by the service representative. Specific drugs are reviewed by the service representative at the point of sale to determine if your prescription is covered by the plan, clinically appropriate, and consistent with usage guidelines.

The service representative will apply standards based on FDA-approved labeling and clinical guidelines. The service representative will ensure that you receive the most appropriate prescription for your condition by reviewing

- Possible interactions with other current prescriptions.
- Cost-effectiveness.
- Whether the prescription is age appropriate.
- Whether the dosage and quantity are appropriate.

In certain situations, it may be more clinically appropriate to take a stronger dose once a day than to take a lower dose twice a day. If this opportunity exists, the service representative may ask your physician to approve the changes to the dosage and strength before authorizing payment with your pharmacist.

## Filling Prescriptions at a Participating Pharmacy

You can fill a prescription for short-term or immediate needs at any pharmacy that participates in the Aetna Pharmacy Management network. The **service representative** engages in contracts with these pharmacies to provide discounts on prescription drugs.

After you enroll in the Boeing Medicare Supplement Plan, you will receive an information packet that contains a list of **participating pharmacies**. You also can find a participating pharmacy near you by

- Calling the service representative.
- Accessing the service representative’s web site.
- Asking your local pharmacist whether the pharmacy participates in this plan’s pharmacy network.

The Boeing Medicare Supplement Plan does not cover prescriptions purchased at a **nonparticipating pharmacy**.

The maximum supply is 30 days. However, the supply of certain medications may be limited by clinically established guidelines and/or Federal dispensing standards.

When you go to a participating pharmacy, present your medical ID card with your prescription. Your prescription will be filled with a generic alternative of the brand-name drug, if available and medically appropriate, unless you or your physician specifies otherwise.

You will pay the discounted price of the prescription. You then can send a claim, with a copy of your receipt, to the service representative’s claim office for reimbursement. After you have satisfied your **annual deductible** (medical and participating pharmacy expenses combined), the plan will reimburse a percentage of the cost of your prescription, as shown below.

For this type of prescription drug . . .	After the annual deductible, the plan will pay . . .
Generic	90%
Formulary brand-name	80%
Nonformulary brand-name	70%



### What is a formulary?

- A formulary is a list of medications that are
- Approved by the U.S. Food and Drug Administration (FDA).
  - Determined effective in treatment and cost.
  - Manufactured by major drug companies.

An independent group of practicing physicians and pharmacists developed the formulary and reviews it routinely. When clinical data show that several drugs are equally effective, the most cost-effective drug usually is chosen.

A nonformulary drug also may be effective for treatment, but it is not as cost-effective as formulary or generic prescription drugs.

Be sure to tell your physician that your medical plan uses a formulary.



### Are generic drugs as effective as brand-name drugs?

Yes. Generic and brand-name drugs are chemically and therapeutically equivalent, which means they produce the same effect on the body. Both types of drugs are approved by the FDA and must meet the same safety and reliability standards.

The name of a generic drug is its chemical name. Brand-name drugs are known by their trade names.

Your prescription will be filled with a generic alternative of a brand-name drug, if available and medically appropriate, unless you or your physician specifies otherwise.

## Filling Prescriptions by Mail Order

If you take maintenance prescription drugs for the treatment of a long-term or recurring condition, you can obtain up to a 90-day supply per prescription through the mail.

You pay only one **copayment** for each drug that you order from Aetna Home Delivery, as listed below, yet the supply you receive is three times larger than what you can purchase at a **participating pharmacy**:

For this type of prescription drug . . .	Your mail-order copayment will be . . .
Generic	\$10
Formulary brand-name	\$30
Nonformulary brand-name	\$60

The **annual deductible** does not apply to mail-order drugs.

The **service representative** provides two convenient ways for you to submit orders for new or renewal prescriptions:

- **By U.S. mail.** Complete the mail-order pharmacy form and submit it with your prescription.
- **By fax.** Ask your physician to complete the fax request form and submit it directly to the service representative. The service representative must receive the forms and prescriptions from a secure fax machine that is associated with the physician’s office and will verify them.

After you enroll in the Boeing Medicare Supplement Plan, the service representative will send you an information kit, which will contain the mail-order and fax request forms. To request additional forms, contact the service representative or print them directly from the service representative’s web site.

If you place your order by mail, you generally will receive new prescriptions within 7 to 11 days. Orders placed by fax may be received faster. You should have at least a 14-day supply when you place your order.

For contact information, see Section 7, “Contacts.”



### How do I order refills from the mail-order pharmacy?

You can order refills by telephone, on line, and by mail. To order refills by mail, use the special mail-order form that the service representative sent to you with your first order. If you order on line or by telephone, you must provide your member number and the prescription number, which is found on the medication container and the refill slip.



### Does the annual deductible apply to prescription drug purchases?

The annual deductible applies to prescription drugs you purchase at a participating pharmacy. It does not apply to mail-order prescription drug purchases.

## Covered Prescriptions

To be covered, the prescription drug or device must

- Be approved by the FDA.
- Be dispensed by a licensed pharmacist.
- Be prescribed on an outpatient basis by a doctor or other licensed prescriber.
- Not be sold over the counter.
- Not be specifically excluded by the plan.

Most kinds of prescription drugs are covered as long as they meet the above criteria, including the following drugs and supplies:

- Insulin, as well as test strips and lancets.
- Needles and syringes when prescribed with insulin or other covered injectables.
- Legend drugs, including contraceptive medications, self-administered injectable drugs, and smoking cessation medications.

Refills can be obtained near the end of your supply, as authorized by your physician.



### What is a legend drug?

A legend drug is any drug that, according to Federal law, must be labeled “Caution: Federal law prohibits dispensing without a prescription.”

For information about drugs that are not covered, see “What the Boeing Medicare Supplement Plan Does Not Cover,” below.

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## What the Boeing Medicare Supplement Plan Does Not Cover

The following services and supplies are not covered under the Boeing Medicare Supplement Plan. Any charges for these services and supplies will be deducted from your expenses before **plan benefits** are determined.

### Medical Benefit Exclusions

The plan does not cover

- Acupuncture therapy, except when performed by a physician as a form of anesthesia in connection with surgery that is covered under this plan.
- Artificial insemination, in vitro fertilization, or embryo transfer procedures.
- Charges that exceed usual and customary amounts, as defined in Section 6.
- Completion of any insurance or claim forms.
- Custodial care.

- Elective services such as routine physical or eye examinations, except those covered by Medicare.
- Plastic surgery, reconstructive surgery, cosmetic surgery, or other services or supplies to improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extent needed to improve the function of a body part that is not a tooth or a structure that supports the teeth or is malformed as a result of a severe birth defect; this includes harelip or webbed fingers or toes or a direct result of disease or surgery performed to treat a disease or injury.
- Reversal of a sterilization procedure.
- Services or supplies for which no charge is made or for which no payment is required from you or any of your **dependents**.
- Services or supplies that are
  - Covered by or received from a Medicare Advantage Plan or a Medicare prescription drug plan.
  - Furnished, paid for, or otherwise provided for by reason of the past or present service of any person in the armed forces of a government, except as required by law.
  - In connection with occupational accidents or illnesses covered by a workers' compensation law.
  - Not medically necessary for treatment of an accidental injury or illness.
  - Not recognized by Medicare, except as specified under "Additional Covered Services and Supplies," earlier in this section.
  - Not recommended and approved by a physician or surgeon.
  - Paid or otherwise provided for under any law of a government unless the payments or benefits are provided by the government for its own civilian employees and their dependents, or as required by law.
  - Paid or payable by Medicare Part A, Part B, or Part D whether or not a claim is made to or a payment is made by Medicare.
  - Payable under the terms of any automobile medical, personal injury protection, automobile no-fault, automobile uninsured or underinsured motorist, or other contract of insurance providing benefits without a determination of liability for the injury; however, plan payments will be advanced upon request if the covered person agrees to reimburse the **service representative** when settlement is received.
  - Provided while the individual is not covered under this plan.
- Sex change surgery or any treatment of gender identity disorders.

## Prescription Drug Benefit Exclusions

The plan does not cover

- Administration or injection of any drug.
- Any medication to treat sexual dysfunction, obesity, or infertility unless the patient is being treated for a diagnosed medical condition and the prescription is preauthorized by the **service representative**.
- Any prescription filled in excess of the number prescribed by the physician.
- Any prescription for which the person is eligible to receive benefits under another employer's group benefit plan or a workers' compensation law or from any municipal, state, or Federal program, including Medicare Part D.
- Any refill after one year from the date of the prescription.
- Appetite suppressants or nutritional supplements.
- Appliances, devices, or other nondrug items, including but not limited to contraceptive devices, therapeutic devices, and artificial appliances; however, this does not apply to needles and syringes when prescribed along with insulin.
- Delivery or handling charges (except delivery by Aetna Home Delivery, the mail-order pharmacy service).
- Drugs dispensed during an inpatient admission by a hospital, skilled nursing facility, sanatorium, or other facility, unless covered as part of a hospital stay or administered by a physician as part of an office visit.
- Drugs that are not medically necessary for the treatment of an illness, injury, or other covered condition, including vitamins.
- Experimental or investigational drugs.

- Immunizing agents, including allergy serum.
  - Over-the-counter drugs that can be obtained without a prescription, except insulin.
  - Prescriptions purchased from a **nonparticipating pharmacy**.
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## How to Submit a Boeing Medicare Supplement Plan Claim

You must submit all medical expenses to Medicare before submitting them to the **service representative**. Your claim will not be processed by the service representative unless Medicare's Part A and Part B **explanation of benefits** accompanies it. Medicare typically will forward the claim to the service representative under the Medicare Direct program.

A claim must be filed for all services or supplies covered by this plan but not covered by Medicare Part A or Part B, such as prescription drugs and items listed in "Additional Covered Services and Supplies," earlier in this section. You may obtain a claim form by calling the Member Services number on your medical ID card (see Section 7, "Contacts").

Instructions for filing a claim are on the claim form. A claim form must be submitted for each covered person the first time a claim is made during a calendar year; subsequent medical bills for that person may be submitted without a claim form.

All bills must show the patient's name, the retiree's name and Social Security number or member ID number, the nature and date of each service, the condition being treated, and the charge. All claims for drugs and medicines not submitted through Medicare Direct or obtained under the mail-order pharmacy service should be submitted on a claim form showing the date of purchase, prescribing physician's name, prescription number, name of drug or medicine, and the price (including tax). You also must include the pharmacy receipt.

Claims for covered medical services and supplies should be submitted to the service representative within one year of the date the service or supply is received, or they may be denied.

For more information about submitting claims or appeals, see Section 3.

## How to Submit a Claim or File an Appeal

This section describes two types of claim review and appeal procedures:

1. Medical benefit claims and appeals for the medical plan described in this booklet.
2. Eligibility claims and appeals for the medical plan available to the groups listed in “Who Is Eligible,” in Section 1.

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## Medical Benefit Claims Process

The **service representative** is responsible for evaluating benefit claims in accordance with the terms of the Plan and using a reasonable claims procedure in accordance with Federal rules. The service representative has the right to obtain independent health care advice and to request additional information as necessary to decide your claims.

You will receive a written notice of the claim decision within the time limits described in this section. The time limits are based on Federal laws, the type of claim, and whether or not the service representative has all of the information needed to process the claim.

Your claim will fall into one of these four categories:

1. **Preservice claim:** a request for coverage of health care benefits for which the terms of this Plan require you to obtain prior approval before receiving treatment or services, such as benefits requiring preadmission review, preapproval, precertification, or predetermination.
2. **Concurrent care claim:** a request to continue coverage of services that the service representative approved previously as an ongoing course of treatment or to be provided for a certain time. Concurrent care claims are either urgent care claims or fall into one of the other claim categories: preservice or postservice.
3. **Postservice claim:** a request for coverage of health care benefits that is not a preservice, concurrent care, or urgent care claim. Generally, postservice claims are filed for payment or reimbursement of benefits for care that already has been received.
4. **Urgent care claim:** a request for a claim determination needed quickly due to medical exigencies. An urgent care claim is any claim for medical care or treatment with respect to which the application of the time period that otherwise applies to nonurgent claim determinations could seriously jeopardize the life, health, or ability of a patient to regain maximum function, or which—in the opinion of the attending physician—would subject the patient to severe pain that could not be managed adequately without the care or treatment that is the subject of the claim. In addition, if a physician with knowledge of the patient’s medical condition determines that a claim is an urgent care claim, the claim shall automatically be treated as an urgent care claim for the purposes of this provision.

## How to File a Claim for Benefits

Generally, whenever you receive services from a **provider** or **participating pharmacy**, that provider submits the claim on your behalf; you do not need to file a claim for yourself.

If you *do* need to file your own claim, which may be the case when you receive services not covered by Medicare or from a **nonparticipating pharmacy**, you must submit a written claim form to the appropriate **service representative**. You can obtain claim forms by calling the service representative or, in some cases, from the service representative’s web site.

You can ask your provider to submit the claim for you, but it is ultimately your responsibility to ensure that your claim for benefits is filed.

Claims must be filed within 12 months from the date you receive the **covered service**, treatment, or product to which the claim relates.



## How do I expedite an urgent care claim?

Because urgent care claims are time sensitive and important, you should call the service representative as soon as possible when you learn that you will need immediate care. If you (or your physician) provide all of the information needed to review your claim, the service representative will give you an answer within 72 hours.

## Time Limits for Decisions on Benefit Claims

The Federal Government sets time periods for reviewing and deciding health care claims. The **service representative** will notify you within the following time limits as to whether your claim is approved or denied, in whole or in part. If your claim is denied, you will have the opportunity to file an appeal within certain time limits also described here. If your claim is denied due to inaccurate or incomplete information, you can correct or submit additional information with your appeal.

Time Limits for Receiving Benefit Claim Decisions		
Type of claim	You will receive notification of the decision within . . .	But it may be extended for an additional . . .
Postservice care claim	30 days after your claim is received	15 days because of matters beyond the control of the service representative**
Preservice care claim*	15 days after your claim is received	15 days because of matters beyond the control of the service representative**
Concurrent urgent care claim	24 hours after your claim is received, provided that a request to extend an ongoing course of treatment is made at least 24 hours before the previous approval expires	Not applicable if you provide enough information†
Concurrent preservice or postservice care claim	Same as preservice or postservice claims, depending on medical circumstances	15 days because of matters beyond the control of the service representative**
Urgent care claim*	72 hours after your claim is received	Not applicable if you provide enough information†

\* If you or your authorized representative fails to follow the Plan's procedures for filing a preservice or urgent care claim, within 5 days (24 hours for an urgent care claim) the service representative will notify you or your authorized representative of the failure and explain the proper procedures.

\*\* If more information is required to review your claim, the service representative will notify you before the end of the initial review period (or within 5 days for a preservice claim) of the specific information needed and will allow you at least 45 days to provide that information. The review time periods for preservice and postservice claims will be suspended until the date that you respond to the request for more information.

† If more information is required to review your claim, the service representative will notify you within 24 hours of the specific information needed and will allow you at least 48 hours to provide that information. The review time periods for concurrent care and urgent care claims may be extended for as long as 48 hours from the earlier of (1) the date that the service representative receives the additional information or (2) the end of the time period that you were given to provide the additional information.

## If Your Benefit Claim Is Denied

If your medical benefit claim is denied, in whole or in part, the **service representative** will send you a notice that will include the following information:

- Specific reasons for the denial.
- Reference to the specific Plan provisions on which the claim determination was based.
- Description and explanation of any additional information that is needed to process your claim.
- Description of the Plan's appeal procedures and the applicable time limits, as well as your right to bring legal action if your claim is denied on appeal.
- Statement that you can request, free of charge, copies of documentation related to the decision.
- Description of any rule, protocol, or other criterion that was relied on in determining your claim, and your right to obtain a copy, free of charge, upon request.

- Statement that you can request, free of charge, an explanation of the scientific or clinical judgment that was used if your claim was denied based on a medical necessity, an experimental treatment, or another similar exclusion or limitation.
- For an urgent care claim, a description of the expedited review process applicable to such claims.



### How can I avoid claim delays?

In many cases, your physician or other health care provider will send a bill directly to the service representative. If you are required to submit a claim, use the following tips to prevent delays and other claim-filing problems:

- Provide all information that is requested on the form, including your full name, address, and Social Security or member ID number; the patient's name and birth date; the date of the service; the diagnosis; and the types of services received.
- Always attach an itemized bill that includes the provider's name, address, and tax ID number. A notice from the provider that payment is overdue generally does not provide enough information for determining benefits and payments.
- If you are asked to provide more information, be sure to include the patient's full name and your full name and Social Security or member ID number.
- If you or a covered dependent is eligible for coverage under another employer's group benefit plan, you should submit the claim first to the plan that provides primary coverage (as determined under the coordination of benefit provisions). When that plan sends you a written Explanation of Benefits form, send a copy of the explanation, the appropriate claim form, and an itemized bill to the second plan. If you are not sure which plan provides primary coverage, submit a claim to both plans at the same time.

### How to Appeal if Your Benefit Claim Is Denied

If your benefit claim is denied, in whole or in part, you may be able to resolve the denied claim through an informal review process. Simply call the **service representative** and discuss the situation.

If the claim is not resolved with a telephone call, you have the right to file a formal (written) appeal with the service representative. You must file your appeal within 180 days of the date that you are notified of the denial. To file your appeal, you must

- State, in writing, why you believe the claim should have been approved.
- Submit any information and documents you think are appropriate, including any additional information not submitted with your initial claim.
- Send the appeal and any supporting documentation to the service representative at the appropriate claim-filing address.

You may request, free of charge, copies of all documents, records, and other information relevant to your claim for benefits.

The service representative will review your appeal and make a decision. The review will be conducted by a person who did not make the decision on your initial claim and is not the subordinate of that person. The review will include all information you submit and will not give deference to the initial claim decision. If deciding the appeal involves medical judgment, such as determining medical necessity or if treatment was experimental, a qualified health care professional will be consulted. That health care professional will not be one who was consulted in determining your initial claim and will not be a subordinate of such person. In reviewing your appeal, the service representative will use its discretion in interpreting the terms of the Plan and will apply them accordingly.

The decisions of the service representative are final and binding. Benefits will be paid under the Plan only if the Employee Benefit Plans Committee (the "Committee") decides in its discretion that you have met the eligibility and participation requirements and the service representative has determined that you are entitled to the benefits.



## How can I expedite an appeal for urgent care?

You can make an appeal for urgent care by calling the service representative. (All other appeals must be made to the service representative in writing.)

### Time Limits for Decisions on Benefit Appeals

The Federal Government provides time limits for reviewing and deciding health care benefit appeals. If the **service representative** denies your appeal, in whole or in part, you will be notified as follows:

Time Limits for Receiving Benefit Appeal Decisions	
You will receive notification of the decision on your . . .	Within . . .
Postservice care appeal	30 days for each of two levels of appeal
Preservice care appeal	15 days for each of two levels of appeal
Concurrent care appeal	Same as preservice, postservice, or urgent care appeals, depending on medical circumstances
Urgent care appeal	72 hours* after your appeal is received

\* For an urgent care appeal, you can submit information by any timely method, including fax, telephone, other electronic means, or orally.

### If Your Benefit Appeal Is Denied

If your benefit appeal is denied, in whole or in part, the **service representative** will send you a notice that will include the following information:

- Specific reasons for the denial.
- Reference to the specific Plan provisions on which the claim determination was based.
- Statement of your right to obtain, free of charge, copies of documentation related to the decision.
- Summary of your right to additional appeals or legal action.
- Statement that you can request, free of charge, identification of medical or vocational experts whose advice was obtained by the service representative.
- Description of any rule, protocol, or other criterion that was relied on in determining your appeal, and your right to obtain a copy, free of charge, upon request.
- Statement that you can request, free of charge, an explanation of the scientific or clinical judgment that was used if your appeal was denied based on a medical necessity, an experimental treatment, or another similar exclusion or limitation.

### Whom to Contact for Benefit Claim and Appeal Procedures

You can obtain a copy of the benefit claim review and appeal procedures by calling the **service representative**.

### Eligibility Claims Process

Call the Boeing Pension Service Center through Boeing TotalAccess if

- You have questions about eligibility.
- You believe that you or an **eligible dependent** has been improperly denied
  - Participation in a health care plan.
  - The opportunity to make an election as a result of a status change.

See Section 7 for the telephone number.

## How to File a Claim for Eligibility

You may be able to resolve questions about eligibility for health **plan benefits** by calling the Boeing Pension Service Center through Boeing TotalAccess. If your question or request is not resolved by telephone (an informal review process), you may file a formal (written) eligibility claim. To do so, call the Boeing Pension Service Center through Boeing TotalAccess and request a claim initiation form.

You can submit urgent care claims for eligibility by calling the Boeing Pension Service Center through Boeing TotalAccess. You may be required to provide information from your **provider** to substantiate your urgent eligibility claim.

Eligibility claims must be filed within 12 months from the date your eligibility claim is denied. Any claims submitted after that time will be denied.

### Time Limits for Decisions on Eligibility Claims

The Boeing Pension Service Center will review your eligibility claim and notify you of its decision within the following time frames:

Time Limits for Receiving Eligibility Claim Decisions		
If your claim for eligibility involves . . .	You will receive notification of the decision within . . .	But it may be extended for an additional . . .
A preservice care claim*	15 days after your claim is received	15 days because of matters beyond the control of the Boeing Pension Service Center**
A concurrent urgent care claim	24 hours after your claim is received, provided that a request to extend an ongoing course of treatment is made at least 24 hours before the previous approval expires	Not applicable if you provide enough information†
A concurrent preservice or postservice care claim	Same as preservice or postservice claims, depending on medical circumstances	15 days because of matters beyond the control of the Boeing Pension Service Center**
An urgent care claim*	72 hours after your claim is received	Not applicable if you provide enough information†
Another claim, including a postservice claim or eligibility claim that does not involve medical services	30 days after your claim is received	15 days because of matters beyond the control of the Boeing Pension Service Center**

\* If you or your authorized representative fails to follow the Plan's procedures for filing a preservice or urgent care eligibility claim, within 5 days (24 hours for an urgent care claim) the Boeing Pension Service Center will notify you or your authorized representative of the failure and explain the proper procedures.

\*\* If more information is required to review your claim, the Boeing Pension Service Center will notify you before the end of the initial review period (or within 5 days for a preservice claim) of the specific information needed and will allow you at least 45 days to provide that information. The review time periods for preservice and postservice claims will be suspended until the date that you respond to the request for more information.

† If more information is required to review your claim, the Boeing Pension Service Center will notify you within 24 hours of the specific information needed and will allow you at least 48 hours to provide that information. The review time periods for concurrent care and urgent care claims may be extended for as long as 48 hours from the earlier of (1) the date that the Boeing Pension Service Center receives the additional information or (2) the end of the time period that you were given to provide the additional information.

## If Your Eligibility Claim Is Denied

If your eligibility claim is denied, the Boeing Pension Service Center will send you a notice that will include the following information:

- Specific reasons for the denial.
- Reference to the specific Plan provisions on which the claim determination was based.

- Description and explanation of any additional information that is needed to process your claim.
- Description of the Plan’s appeal procedures and the applicable time limits, as well as your right to bring legal action if your claim is denied on appeal.
- Statement that you can request, free of charge, copies of documentation related to the decision.
- Description of any rule, protocol, or other criterion that was relied on in determining your claim, and your right to obtain a copy, free of charge, upon request.
- For an eligibility claim involving urgent care, a description of the expedited review process applicable to such claims.

## How to Appeal if Your Eligibility Claim Is Denied

If your eligibility claim is denied, you (or your legal representative) may file an appeal with the Committee or its delegate.

You must file your appeal within 180 days of the date that you are notified of the denial. To file your appeal, you must

- State, in writing, why you believe the claim should have been approved.
- Submit any information and documents you think are appropriate.
- Send the appeal and any supporting documentation to the Committee:

**Address:** Employee Benefit Plans Committee  
The Boeing Company  
100 North Riverside  
MC 5002-8421  
Chicago, IL 60606-1596

**Fax:** 312-544-2077

**Telephone  
(for urgent appeals):** 312-544-2799

You may request, free of charge, copies of all documents, records, and other information relevant to your claim for eligibility.

The Committee may require you to provide information from your **provider** to substantiate your urgent appeal. The Committee has the exclusive right to interpret and apply the terms of the Plan and to exercise its discretion to determine all questions that arise under the Plan. The Committee will review all information you submit and will not give deference to the initial eligibility claim decision.

The decisions of the Committee are final and binding. Benefits will be paid under the Plan only if the Committee decides in its discretion that you have met the eligibility and participation requirements and the **service representative** has determined that you are entitled to the benefits.

## Time Limits for Decisions on Eligibility Appeals

The Federal Government provides time limits for reviewing and deciding health care appeals. If the Committee denies your appeal, in whole or in part, you will be notified as follows:

Time Limits for Receiving Eligibility Appeal Decisions	
You will receive notification of the decision on your . . .	Within . . .
Preservice care appeal	30 days after receipt of your appeal
Concurrent care appeal	Same as preservice, postservice, or urgent care appeals, depending on medical circumstances
Urgent care appeal	72 hours* after receipt of your appeal
Other appeal, including a postservice appeal or eligibility appeal that does not involve medical services	60 days after receipt of your appeal

\* For an urgent care appeal, you can submit information by any timely method, including fax, telephone, other electronic means, or orally.

## If Your Eligibility Appeal Is Denied

If your eligibility appeal is denied, in whole or in part, the Committee will send you a notice that will include the following information:

- Specific reasons for the denial.
- Reference to the specific Plan provisions on which the appeal determination was based.
- Summary of your right to bring legal action.
- Statement of your right to obtain, free of charge, copies of documentation related to the decision.
- Statement that you may request, free of charge, identification of medical or vocational experts whose advice was obtained by the Committee.
- Description of any rule, protocol, or other criterion that was relied on in determining your appeal, and your right to obtain a copy, free of charge, upon request.

### Whom to Contact for Eligibility Claim and Appeal Procedures

You can obtain a copy of the eligibility claim review and appeal procedures by calling the Boeing Pension Service Center through Boeing TotalAccess.

## What You Can Do if Your Appeal Is Denied

If the **service representative** or the Committee denies your appeal, you may bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA). However, except as otherwise provided in an insured contract, you must bring any legal action within 180 days of the

- Decision on appeal of your claim for benefits or eligibility, or
- Expiration of time to take an appeal if no appeal is taken.

A post-denial review of your appeal will not extend the time period for commencing legal action.

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## How Claims Are Paid When You Have Duplicate Coverage

Plans that offer medical benefits follow certain rules when there is duplicate coverage. For example, if both you and your spouse are working, you or your family members might have duplicate coverage. That is, one or more of you might be enrolled in more than one group health care plan. Other coverage includes, whether insured or uninsured, another employer's group benefit plan, another arrangement of individuals in a group, Medicare (to the extent allowed by law), individual insurance or health coverage, and insurance that pays without consideration of fault.

If you or your **covered dependents** have duplicate medical coverage, the two plans must coordinate their benefits to determine which plan will be responsible for paying which part of the bill. In this coordination of benefits, one insurer will be considered primary (the plan that considers the charges first) and the other will be considered secondary (the plan that considers the charges second). When you file a claim, it is your responsibility to know which plan is primary and which plan is secondary for you and your covered dependents.

**When the Boeing Medicare Supplement Plan is primary**, this plan will pay its benefits first and without regard to any benefits that may be payable under the secondary plan.

**When the Boeing Medicare Supplement Plan is secondary**, this plan will pay the difference between the benefits paid by the primary plan and what this plan would have paid had it been primary.

## Determine Whether the Plan Is Primary or Secondary

When determining whether this health care plan is primary or secondary, this plan applies the following rules. A plan is considered primary when

- It has no order of benefit determination rules.
- It has benefit determination rules that differ from coordination of benefit rules under state regulations or, if not insured, that differ from these rules.
- All plans that cover an individual use the same coordination of benefit rules, and under those rules, the plan is primary.

If the aforementioned rules do not determine which group plan is considered primary, this plan applies the following coordination of benefit rules:

1. A plan that covers a person as an employee, retired employee, member, or subscriber pays before a plan that covers the person as a dependent.
2. A plan that covers a person as an active employee or dependent of an active employee is primary. The plan that covers a person as a retired, laid-off, or other inactive employee or as a dependent of a retired, laid-off, or other inactive employee is secondary.
3. If a dependent child is covered under both parents' group plans, the child's primary coverage is provided through the plan of the parent whose birthday comes first in the calendar year, with secondary coverage provided through the plan of the parent whose birthday comes later in the calendar year.
4. If a dependent child's parents are divorced or separated and a court decree establishes financial responsibility for the health care coverage of the child, the plan of the parent with such financial responsibility is the primary plan of coverage. If the divorce decree is silent on the issue of coverage, the following guidelines are used:
  - a. The plan of the parent with custody pays benefits first.
  - b. The plan of the spouse of the parent with custody pays second.
  - c. The plan of the parent without custody pays third.
  - d. The plan of the spouse of the parent without custody pays fourth.
5. If none of the aforementioned rules establishes which group plan should pay first, then the plan that has covered the person for the longest period is considered the primary plan of coverage.
6. Continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (**COBRA**), always is secondary to other coverage, except as required by law.
7. If you or an **eligible dependent** is confined to a hospital when first becoming covered under this plan, this plan is secondary to any plan (including a Company-sponsored health care plan) already covering you or your dependent for the eligible expenses related to that hospital admission. If you or your dependent does not have other coverage for hospital and related expenses, this plan is primary.

### **If You Are Covered by Two Boeing-Sponsored Plans**

Benefits under a Company-sponsored medical plan are not coordinated with benefits paid under any other group plan offered by the Company, except as described below. You can receive benefits from only one Company-sponsored medical plan.

### **If You Are Covered by Medicare and This Plan**

Federal rules govern coordination of benefits with Medicare. In most cases, Medicare is secondary to a plan that covers a person as an active employee or **dependent** of an active employee. Medicare is primary in most other circumstances.

Treatment of end-stage renal disease is covered by the Boeing Medicare Supplement Plan for the first 30 months following Medicare entitlement due to end-stage renal disease, and Medicare provides secondary coverage. After this 30-month period, Medicare provides primary coverage, and the Boeing Medicare Supplement Plan provides secondary coverage.

### **Claim Administration**

The **service representative** has the right to obtain and release any information or recover any payment it considers necessary to administer these provisions.

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## When an Injury or Illness Is Caused by the Negligence of Another

In some situations, you or a **covered dependent** may be eligible to receive, as a result of an accident or illness, health care or disability benefits from an automobile insurance policy, homeowner's insurance policy or other type of insurance policy, or from a responsible third party. In these cases, this plan will pay benefits if the covered person agrees to cooperate with the **service representative** in administering the plan's subrogation rights.

If a person covered by this plan is injured by another party who is legally liable for the medical or dental bills or disability income, he or she may request this plan to pay its regular benefit on his or her behalf. In exchange, the covered person agrees to

- Complete a claim and submit all bills related to the injury or illness to the responsible party or insurer.
- Complete and submit all of the necessary information requested by the service representative.
- Reimburse the plan if he or she recovers payment from the responsible party or any other source.
- Cooperate with the service representative's efforts to recover from the third party any amounts this plan pays in benefits related to the injury or illness, including any lawsuit brought against the responsible party or insurer.

This provision applies whenever you or a covered dependent is entitled to or receives benefits under this plan and is also entitled to or receives compensation or any other funds from another party in connection with that same disability or medical condition, whether by insurance, litigation, settlement, or otherwise. The plan is entitled to such funds to the extent of **plan benefits** paid to or on behalf of the individual, whether or not the individual has been "made whole," and without regard to any common fund doctrine. This plan may recover such funds by constructive trust, equitable lien, right of subrogation, reimbursement, or any other equitable or legal remedy.

If an individual fails, refuses, or neglects to reimburse the plan or otherwise comply with the requirements of this provision, or if payments are made under the plan based on fraudulent information or otherwise in excess of the amount necessary to satisfy the provisions of the plan, then, in addition to all other remedies and rights of recovery that the plan may have, the plan has the right to terminate or suspend benefit payments and/or recover the reimbursement due to the plan by withholding, offsetting, and recovering such amount out of any future plan benefits or amounts otherwise due from the plan to or with respect to such individual. The plan also has the right in any proceeding at law or equity to assert a constructive trust, equitable lien, or any other equitable or legal remedy or recovery, against any and all persons who have assets that the plan can claim rights to. The plan has the right of first recovery from any judgment, settlement or other payment, regardless of whether the individual has been "made whole," and without regard to any common fund doctrine.



## How Coverage Can End

If you are eligible for retiree medical coverage through The Boeing Company and terminate your employment, your active coverage will continue until the end of the month after the month you terminate. Once you and your **eligible dependents** enroll, retiree medical coverage stays in effect until

- You cancel coverage.
- You lose eligibility for coverage.
- You fail to make timely payments of required premium contributions.
- The Company ends this Plan or changes the Plan provisions so you are no longer eligible.

The Company fully intends to continue the Plan. However, the Company reserves the right to terminate, suspend, or modify any benefits described in this booklet, in whole or in part, at any time, and for any reason for employees, former employees, retirees, and their dependents.

If retiree medical coverage ends, you or your **covered dependents** may be able to continue retiree medical coverage under this plan through the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA).

For coverage continuation options, see “Continue Coverage Through COBRA,” in this section.

## How You and Your Dependents Can Lose Eligibility for Coverage

Your retiree medical coverage will end if you become ineligible for participation in the plan for one of the following reasons:

- You die.
- The Company ends this Plan.
- You fail to make timely payments of your required contribution.
- You cancel coverage.
- You incur a claim that exceeds the plan’s lifetime maximum benefit.

Your spouse will become ineligible for coverage if

- You become ineligible for coverage, as described above, except if you die.
- You divorce, you legally separate, or your marriage is annulled.
- Your spouse enrolls in any Company-sponsored medical plan (including this one) as an employee or retiree.
- Your spouse otherwise no longer meets the eligibility requirements described in Section 1.

Your child will become ineligible for coverage if

- You become ineligible for coverage, as described above, except if you die.
- Your child becomes an employee covered by this or any other Company-sponsored medical plan.
- Your child otherwise no longer meets the eligibility requirements described in Section 1.

## When Coverage Ends

Generally, coverage ends on the last day of the month in which you and/or your **dependents** become ineligible for coverage. However, if you (or your **covered dependent**) are in a hospital when retiree medical coverage would otherwise end, coverage will continue for you (or your hospitalized dependent) for the duration of the hospitalization or 31 days, whichever is shorter.

If you or your dependents incur a claim that exceeds the plan’s lifetime maximum benefit, your coverage ends on the day the medical service is rendered or supply is purchased, resulting in a claim that exceeds the plan’s overall lifetime maximum benefit.

**Note:** When you reach age 65 or otherwise become eligible for Medicare, your **eligible dependents** may continue coverage in a Company-sponsored retiree medical plan designed for **participants** without Medicare coverage if

- You enroll in the Boeing Medicare Supplement Plan.
- Your dependents are not age 65 or otherwise eligible for Medicare.

When your eligible dependents reach age 65 or otherwise become eligible for Medicare, they may continue coverage under the Boeing Medicare Supplement Plan if you are enrolled in this plan.

Contact the Boeing Service Center through Boeing TotalAccess for details.

You and your dependents may be able to continue coverage through **COBRA** in certain circumstances. You and your dependents cannot continue coverage through COBRA if

- The Company ends all of its retiree medical plans, or
- You or your dependents reach the lifetime maximum benefit provided by a medical plan and are not eligible to enroll in another Company plan in your area.

For coverage continuation options, see “Continue Coverage Through COBRA,” in this section.



### **Will I receive evidence of my Boeing coverage?**

Yes. When retiree medical coverage ends, you automatically will receive a certificate of coverage as evidence of insurance, describing your retiree medical coverage and the time period of your enrollment. You may present this certificate of coverage to a new medical plan to reduce or eliminate any preexisting condition waiting period.

If the coverage periods for your covered dependents are different from yours, their coverage dates will be noted separately on the certificate. You may request a duplicate copy of your certificate within 24 months after your coverage ends by calling the Boeing Service Center through Boeing TotalAccess.



### **Can I continue coverage for a disabled child age 25 or older?**

If your child is disabled and will lose coverage when he or she turns 25, you may continue coverage for that child if he or she meets the eligibility conditions described in Section 1 and you continue to be enrolled in the plan. You must notify the Boeing Service Center within 31 days of the child’s 25th birthday and provide proof that the child is incapable of self-support because of the disability.

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## **What Happens if You Die**

Your **eligible dependents** may continue coverage if, when you die, your dependents are covered under this plan. This continued coverage for your eligible dependent children applies even if your spouse is not enrolled in the plan.

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## **Continue Coverage Through COBRA**

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), is a Federal law that entitles you and your **covered dependents** to continue retiree medical coverage for a period of time after it would otherwise end.

Anyone who continues coverage under COBRA is covered by the medical plan just as before coverage was lost. There is no effect on the amounts still due to meet the **annual deductible** or on any **plan benefits** paid to date, and the accrual of charges toward the annual out-of-pocket maximum for the plan continues as before. The only difference is that you and/or your covered dependent may be required to pay the full cost of coverage plus two percent for administration costs.

COBRA coverage becomes available when a qualifying COBRA event occurs. If you or your covered dependents decline this coverage when you first are eligible, you may not enroll at a later date.

The Boeing Service Center administers COBRA coverage.

## Who Is Eligible for COBRA Coverage

You, your spouse, and your **covered dependent** children may be eligible to enroll for **COBRA** coverage. The circumstances that cause your loss of coverage determine your eligibility for COBRA. These circumstances are outlined here.

### Your Right to COBRA Coverage

You have a right to elect **COBRA** coverage if you are covered by a Company-sponsored retiree medical plan and you lose coverage because the Company commences a bankruptcy proceeding. This is the only circumstance under which a retired employee can become eligible for COBRA coverage.

**Note:** The administrative rules described in this section for electing, paying for, and changing **dependent** COBRA coverage also apply to retired employee COBRA coverage in the event of Company bankruptcy.

### Your Spouse's Right to COBRA Coverage

Your covered spouse has a right to elect **COBRA** coverage if he or she is covered by a Company-sponsored retiree medical plan and loses coverage because of

- Your death.
- Your divorce or legal separation from you.
- The Company commencing a bankruptcy proceeding.

### Your Child's Right to COBRA Coverage

Your **covered dependent** child has a right to elect **COBRA** coverage if he or she is covered by a Company-sponsored retiree medical plan and loses coverage because of

- Your death.
- Your divorce or legal separation.
- His or her loss of eligibility for coverage. (See "Who Is Eligible," in Section 1.)
- The Company commencing a bankruptcy proceeding.



#### Are the medical benefits under COBRA coverage different from benefits under retiree coverage?

No. COBRA coverage will be identical to the coverage provided to similarly situated retired employees or dependents. However, costs may differ, as described later in this section.

## How to Enroll for COBRA Coverage

You are responsible for

- Notifying the Boeing Service Center when your **dependent's** eligibility ends.
- Notifying the Boeing Service Center if you or your dependents become covered by another medical plan or Medicare.
- Enrolling for **COBRA** coverage.
- Paying any required contributions in a timely manner.
- Notifying the Boeing Service Center if your or your dependent's address changes.

The Company and the Boeing Service Center also have certain responsibilities to explain your COBRA rights and how to request coverage. These responsibilities are explained here.

If your coverage ends because of your death, the Company will notify the Boeing Service Center within 30 days from the date your coverage ends.

### Notify the Boeing Service Center When Coverage Ends

You or your **covered dependents** must notify the Boeing Service Center, in writing or by telephone, if your covered dependent loses coverage because of divorce or legal separation or if your child loses eligibility for coverage.

You must notify the Boeing Service Center of your dependent's loss of coverage within 60 days from the end of the month in which the loss of eligibility occurs. Otherwise, the right to enroll in **COBRA** coverage will be forfeited.

### Watch Your Mail for COBRA Election Forms

The Boeing Service Center will send you a notice of **COBRA** rights and enrollment materials within 14 days of the date it is notified that coverage will end or has ended.

### Elect COBRA Coverage

Any **dependent** who has lost coverage has an independent right to elect **COBRA** coverage. For example, your spouse may elect COBRA coverage, but decline COBRA coverage for your dependent children.

Your **covered dependent** must enroll by calling the Boeing Service Center or through the Your Benefits Resources web site within 60 days after either (1) the date your coverage ends or (2) the date you receive the notice, whichever is later. If your dependents do not enroll within this 60 days, they will forfeit their right to COBRA coverage.

During the 60-day election period, your dependent may change his or her mind about enrolling for coverage. That is, he or she may decline enrollment and then decide to elect COBRA coverage within the same 60-day period. Your dependent may do this as long as he or she contacts the Boeing Service Center and elects COBRA coverage before the end of the 60 days.

If your dependent declines COBRA enrollment, then changes his or her mind and elects COBRA coverage before the end of the 60-day enrollment period, your dependent's COBRA coverage will start the day he or she contacts the Boeing Service Center and enrolls in COBRA. The coverage period will be measured from the date of the qualifying event. For example, assume your dependent becomes eligible for COBRA on December 31 and declines COBRA enrollment on January 15. Then, on February 20, he or she enrolls in COBRA. In this case, COBRA coverage will be effective February 20, but your dependent's COBRA coverage period will be measured from December 31, the date of the COBRA qualifying event.

If the Boeing Service Center determines that your dependents are not eligible for COBRA coverage, they will receive a notice stating the reasons for ineligibility.

### Pay for COBRA Coverage

The Boeing Service Center will notify your **dependents** of the amount they must pay for **COBRA** coverage.

If the cost of coverage changes for similarly situated retired employees or dependents, the cost of COBRA coverage also will change.

Your dependents have an initial 45-day grace period from the date of their election to pay the first premium. They also must pay for any months of continued retiree medical coverage since the date their retiree medical coverage ended. After the first payment, COBRA coverage payments are due by the first of each month. (There is a 31-day grace period, beginning on the first day of the month, in which to make each payment. Payments must be postmarked within the 31-day grace period.)

If only a partial payment is submitted (but not significantly less than the full amount), the Boeing Service Center will bill your dependents for the remaining amount and allow 31 days to pay it.

It is important to make timely payments for COBRA coverage. If a payment is not made as described above, coverage will end automatically on the last day of the month for which coverage was paid. Coverage cannot be reinstated if it has been terminated because timely payments were not made.

## When COBRA Coverage Begins

Generally, **COBRA** coverage begins when retiree medical coverage ends.

### When COBRA Coverage Can Be Changed

As **COBRA** participants, your **dependents** who are over age 65 have the same opportunity as a retired employee to enroll **eligible dependents** under special enrollment and status change rules. (For example, add a new dependent acquired through marriage, birth, or adoption.)

For more information, see “Special Enrollment Events” and “Status Changes,” in Section 1.



#### Can my dependents add a new dependent to their COBRA coverage?

Your dependents may add a new spouse or a child born or placed for adoption while they are covered through COBRA. A dependent added to COBRA coverage only will have the rights to your dependents' then-current COBRA coverage period; the new dependent will not be able to extend coverage if a second qualifying event occurs. However, if the new dependent is your child, that child will have all of the COBRA rights as if he or she had been a covered dependent under your retiree medical coverage.

## How Long COBRA Coverage Can Continue and How Much It Costs

Generally, **COBRA** coverage for your **dependents** may last for up to 36 months, depending on the event that caused you or your dependent to lose coverage. These COBRA coverage periods and the events that determine them are shown here.

If your dependents are covered by a fully insured health plan, they may be eligible for additional continuation of coverage under their state's insurance regulations beyond the Federal COBRA continuation requirements. Contact the retiree medical plan directly to determine what options are available after Federal COBRA coverage ends.

If the cost of coverage changes for similarly situated retired employees or dependents, the cost of COBRA coverage will change.

COBRA Coverage Periods and Qualifying Events		
Qualifying Event	Qualified Beneficiaries	Maximum Length of COBRA Coverage and Cost of COBRA Coverage
You are covered by a Company-sponsored retiree medical plan and you lose coverage because the Company commences a bankruptcy proceeding	<ul style="list-style-type: none"><li>You</li><li>Your spouse</li><li>Your dependent child</li></ul>	Coverage continues at 102% for the remainder of the retired employee's life; then eligible surviving dependents may continue coverage for 36 months at 102%
You die	<ul style="list-style-type: none"><li>Your spouse</li><li>Your dependent child</li></ul>	36 months at 102%
Divorce or legal separation	<ul style="list-style-type: none"><li>Your spouse</li><li>Your dependent child</li></ul>	36 months at 102%
A dependent child loses eligibility	<ul style="list-style-type: none"><li>Your dependent child</li></ul>	36 months at 102%

## When COBRA Coverage Ends

Generally, **COBRA** coverage ends on the earliest date in which any of the following events occurs:

- The 36-month COBRA period expires.
- The Company no longer provides group health coverage to retired employees.
- The COBRA coverage premium is not paid within 31 days of the due date (except during the initial 45-day grace period).
- Your **dependents** become covered, after electing COBRA coverage, under another group health plan that contains no applicable exclusion or preexisting condition limit.
- Your dependent becomes covered by Medicare (under Part A or Part B, with or without Part D), or a Medicare Advantage plan after the date COBRA coverage is elected.
- The last day of the month in which your dependent who is not a qualified beneficiary ceases to be an **eligible dependent** as defined by the plan.

Once COBRA coverage ends, it cannot be reinstated.

**Note:** If the Company ends all its retiree medical plans or you or your dependents reach the lifetime maximum benefit provided by a medical plan and are not eligible to enroll in another Company plan in your area, COBRA continuation coverage will not be available.



### What events must be reported?

You or your dependent must call the Boeing Service Center through Boeing TotalAccess when your COBRA-covered dependent becomes covered under another group health plan or Medicare, or when your dependent who is not a qualified beneficiary no longer meets the plan's eligibility requirements.

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## Convert Your Coverage to an Individual Policy

If retiree medical or **COBRA** coverage ends, you or your **covered dependents** may convert coverage to an individual group medical conversion policy offered by the **service representative** for your medical plan, if available. Individual policy benefits will not be the same as under this plan, however, so be sure to read the application materials carefully.

To convert to an individual policy, complete a conversion application and submit it to the service representative by the later of the following:

- 31 days after your Company-sponsored coverage ends.
- 31 days after the date the Boeing Service Center provides written notice of your conversion rights if notice is sent within 90 days of the date your Company-sponsored coverage ends.

You will be billed for the applicable rate, which generally is higher than the group rate. Conversion applications are available from the service representative.

No evidence of insurability will be required.

Your covered dependents may be able to convert COBRA coverage at the end of the 36-month COBRA coverage period.

## Your Rights and Responsibilities

### What Rights You Have Under Federal Law

The Employee Retirement Income Security Act of 1974, as amended (ERISA), provides you with certain rights and protections. These rights are explained here.

#### Receive Information About Your Plan and Benefits

You have the right to

- Examine, without charge, at the Plan Administrator's office and other specified locations, such as work sites 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 Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of documents governing Plan operation, including insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and updated summary plan descriptions by writing to the Plan Administrator. The Plan Administrator may charge you a reasonable fee for copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each **participant** with a copy of this summary annual report.

#### Continue Group Health Plan Coverage

You have the right to continue health care coverage for yourself, your spouse, or your **dependents** under the Plan if you lose coverage because of a qualifying event. You or your dependents may have to pay for such coverage. This summary plan description and documents that govern the Plan explain the rules for **COBRA** continuation coverage rights.

#### Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan **participants**, **ERISA** imposes duties on the people who are responsible for operating the Plan (known as fiduciaries).

The fiduciaries have a duty to operate the Plan 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 **Plan benefit** or exercising your rights under **ERISA**.

#### Enforce Your Rights

If your eligibility or a **Plan benefit** claim is denied or ignored, in whole or in part, you have the right to

- Know why this was done.
- Obtain copies of documents relating to the decision without charge.
- Appeal any denial—all within certain time schedules. (See Section 3, "Claims and Appeals.")

You can take steps to enforce your rights under **ERISA**. For instance

- If you request a copy of Plan documents or the latest annual report and you do not receive it within 30 days, you may file suit in 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 them, unless the materials were not sent because of reasons beyond the Plan Administrator's control.
- If your eligibility or Plan benefit claim is denied or ignored, in whole or in part, you may file suit in state or Federal court after you exhaust your appeal rights.

- In addition, if you disagree with the Plan’s decision or lack of decision concerning the qualified status of a medical child support order, you may file suit in Federal court.
- If Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the Department of Labor or you may file suit in 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.

## Receive Assistance With Your Questions

If you have any questions about

- Your Plan, contact the Plan Administrator.
- This statement or your rights under **ERISA**, or if you need assistance obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (see your telephone directory for the number), or write to

Division of Technical Assistance and Inquiries  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue NW  
Washington, DC 20210

You also can obtain certain publications about your rights and responsibilities under ERISA from the Employee Benefits Security Administration on the World Wide Web (<http://askebsa.dol.gov/>) or by calling the hot line at 1-866-444-EBSA (1-866-444-3272).

## Your Responsibilities Under the Plan

As a **participant** in the Plan, you must

- Submit any claim for **Plan benefits** in accordance with Plan rules.
- Inform the Boeing Service Center through Boeing TotalAccess of any change in
  - Your marital status.
  - The status of your eligible children, as defined by Plan rules.
  - Your address or the address of your **eligible dependents**.
- Provide any information or documentation requested by the Boeing Service Center, health plan **service representative**, or Plan Administrator.
- Abide by Plan rules.

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## How the Plan Is Administered

The Boeing Company Board of Directors has designated the Employee Benefit Plans Committee (the “Committee”) to be the Plan Administrator. This Committee is composed of Company employees who are appointed to their positions by the Board of Directors.

## Plan Administrator’s Rights

Notwithstanding any other provision in the Plan, and to the full extent permitted under **ERISA** and the Internal Revenue Code, the Plan Administrator has the exclusive right, power, and authority, in its sole and absolute discretion, to

- Administer, apply, construe, and interpret the Plan and all related Plan documents.
- Decide all matters and questions arising in connection with entitlement to benefits and the nature, type, form, amount, and duration of benefits.
- Amend the Plan.
- Establish rules and procedures to be followed by **participants** and beneficiaries in filing applications for benefits and in other matters required to administer the Plan.
- Prescribe forms for filing benefit claims and for annual and other enrollment materials.

- Receive all applications for benefits and make all determinations of fact necessary to establish the right of the applicant to benefits under the provisions of the Plan, including the amount of such benefits.
- Appoint accountants, attorneys, actuaries, consultants, and other persons (who may be employees of the Company) for advice, counsel, and reports to make determinations of benefits or eligibility.
- Delegate its administrative duties and responsibilities to persons or entities of its choice such as the Boeing Service Center, the **service representatives**, and employees of the Company.

All decisions that the Plan Administrator (or any duly authorized designees) makes with respect to any matter arising under the Plan and any other Plan documents are final and binding. If any part of this Plan is held to be invalid, the remaining provisions will continue in force.

## Company's Right to Amend, Modify, and Terminate the Plan

Although the Company currently intends to continue the Plan, the Company reserves the right to change, modify, amend, or terminate the Plan at any time and for any reason for employees, former employees, retirees, and their **dependents**. If the Plan is terminated and any Plan assets remain, they will be used to pay **Plan benefits** and administrative expenses.

Any Plan assets that remain after all Plan obligations are met will revert to the Company to the extent permitted under the applicable insurance contract or trust agreement. If the insurance contract or trust agreement provides that Plan assets may not revert to the Company, remaining assets will be used to pay other benefits as permitted under applicable law.

## Who Pays for This Plan

Retired employee contributions primarily pay the cost of coverage under this Plan. The cost of coverage is published annually, before the new plan year. Retired employee contributions are fixed for each benefit year. You may obtain current contribution information by visiting the Your Benefits Resources web site or calling the Boeing Service Center through Boeing TotalAccess.

The Company pays the full cost of the Plan in excess of retired employee contributions, including any costs that are higher or lower than expected. Any claims experience dividends, refunds, or other adjustments in premiums, fees, or other Plan costs related to benefits provided under the Plan will be used to reduce the amount of Company contributions.

## How the VEBA Trust Fund Works

The Company has established a Voluntary Employees' Beneficiary Association (VEBA) trust for The Boeing Company Retiree Health and Welfare Benefit Plan (Plan 502). The VEBA trust is a tax-exempt trust that was established solely to provide benefits to Plan **participants** as allowed under Federal law. All or part of your health care benefits may be provided through this trust.

The VEBA trust holds Plan contributions, funds medical benefits, and pays administrative expenses authorized by the Plan Administrator. Assets that are held in the VEBA trust are considered Plan assets and are protected under **ERISA**.

The Company may establish a minimum contribution to be made under the Plan for each year. There is no assurance the Company will establish an annual minimum contribution. This minimum contribution will be used to provide benefits and pay covered expenses under the Plan and trust. The Company will notify participants each year that the Company commits to make a minimum contribution.

Necessary and proper covered expenses for Plan administration will be paid from VEBA trust assets, except for covered expenses that the Company is required by law or chooses to pay.

## How Benefits Are Paid

The **service representative** administers benefit payments in accordance with the provisions of the applicable administrative agreements and insurance contracts.

If a benefit is payable to a person who is legally disabled, incapacitated, or otherwise unable to manage his or her affairs, the Plan Administrator, at its discretion, may direct payment of that benefit to another person, including a guardian or legal representative of that person. If a payment is made under these circumstances, the Committee and the Plan will have no further liability for that claim.

## Right to Recover Overpayments

If an incorrect amount is paid to you or on your behalf, any remaining payments may be adjusted, including withholding funds from future reimbursements, to correct the error. The Plan Administrator, Boeing Service Center, and **service representative** also may take other action that they determine is necessary or appropriate to correct any such error.

Any retired employee who knowingly, and with intent to defraud or deceive, gives false, incomplete, or misleading information during enrollment, when filing a claim, or in any other respect under this Plan may be subject to discipline, up to and including disenrollment from the plan. The Plan reserves the right to recover from retired employees any overpayment of claims or costs of coverage.

## Plan Information

<b>Plan Document</b>	The Boeing Company Master Welfare Plan
<b>Plan Name and Number</b>	The Boeing Company Retiree Health and Welfare Benefit Plan (Plan 502)
<b>Plan Sponsor</b>	The Boeing Company 100 North Riverside MC 5002-8421 Chicago, IL 60606-1596
<b>Employer Identification Number</b>	91-0425694
<b>Plan Year</b>	Calendar-year basis (January 1 through December 31)
<b>Plan Administrator</b>	Employee Benefit Plans Committee 100 North Riverside MC 5002-8421 Chicago, IL 60606-1596 312-544-2297
<b>Agent for Service of Legal Process</b>	Employee Benefit Plans Committee The Boeing Company c/o United States Corporation Company of Illinois 33 North La Salle Street Chicago, IL 60602 Legal process also may be served on the Plan Trustee or Plan Administrator
<b>Type of Plan</b>	Health and welfare benefit plan that provides medical benefits
<b>Type of Administration</b>	This Plan is administered according to the terms of the applicable administrative agreements and insurance contracts with the service representatives for each benefit coverage
<b>Contributions</b>	Employer and retired employee contributions
<b>Collective Bargaining Agreement</b>	The Plan is maintained pursuant to a provision in collective bargaining agreements that provides that a Medicare supplement plan will be available; a copy of such agreement or agreements may be obtained by participants and beneficiaries upon written request to the Plan Administrator and is available for examination by participants and beneficiaries
<b>Contributions</b>	Employer and retired employee contributions, as applicable, based on the collective bargaining agreements
<b>Funding</b>	The Boeing Company VEBA Master Trust
<b>Plan Trustee</b>	JPMorgan Chase Bank c/o Global Investor Services 3 MetroTech Center, Fifth Floor Brooklyn, NY 11245 718-242-1857
<b>Claim Administrators</b>	Various health insurance issuers (called service representatives); see Section 7

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## Other Groups That the Plan Covers

The Boeing Company Retiree Health and Welfare Benefit Plan (Plan 502) includes other medical benefit plans. Those plans provide benefits—which differ from those described in this booklet—for the following employee groups:

### **Certain nonunion retired employees of the Company**

Boeing North America, Inc.  
Jeppesen Sanderson, Inc.  
Jeppesen DataPlan, Inc.  
Boeing Satellite Systems, Inc.  
Spectrolab, Inc.  
The Boeing Company

### **Eligible retired employees of the Company who are represented by**

International Association of Fire-Fighters

Local No. I-17  
Local No. I-66 (Kansas, Washington)

International Association of Machinists and Aerospace Workers, AFL-CIO

Aerospace Industrial District Lodge No. 751  
District Lodge No. 24  
District Lodge No. 70  
District Lodge No. 86  
Space and Rocket City Lodge No. 2766

International Brotherhood of Electrical Workers, AFL-CIO

Local No. 271

International Union of Operating Engineers

Local No. 286  
Local No. 286W

International Union, Security, Police and Fire Professionals of America and Certain Affiliated Amalgamated Locals

Local No. 2  
Local No. 5  
Local No. 255  
Local No. 507

International Union, United Automobile, Aerospace and Agricultural Implement Workers of America

Local No. 1069

The employee groups participating in Plan 502 change from time to time. You may obtain an updated list by contacting the Plan Administrator.



## **annual deductible**

The amount of money that you pay for covered services and supplies before your plan begins to pay for covered expenses. The annual deductible does not apply to some services and supplies, as described in the applicable section.

## **assignment**

If a physician accepts Medicare assignment, Medicare pays the physician directly, and the physician agrees not to charge more than Medicare's approved amount.

If a physician participates in Medicare but does not accept Medicare assignment, the physician will send a bill to Medicare but will not accept payment directly from Medicare. Medicare will send its benefit payment to you.

## **benefit year**

The 12-month period used to calculate the annual deductible, annual out-of-pocket maximum, and other benefit limits for the Boeing Medicare Supplement Plan. The benefit year for this health care plan is January 1 through December 31.

## **COBRA**

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

## **coinsurance**

The percentage of the covered charge that you are required to pay toward your benefits.

## **Company-sponsored plan**

A group health care plan provided by the Company (or a subsidiary or affiliate) for retired employees and dependents. This includes the Boeing Medicare Supplement Plan described in this booklet. (To find out whether a particular plan is sponsored by the Company, contact the Boeing Service Center through Boeing TotalAccess.)

## **copayment**

A fixed dollar amount that you pay toward the cost of a particular covered service such as mail-order prescription drugs. You generally pay the copayment at the time the service is received.

## **covered charge**

The provider's charge for a covered service or supply, up to the service representative's maximum allowance or Medicare's limits and allowances.

## **covered dependent**

Your spouse or child who has met the eligibility conditions for the plan and who is currently enrolled in the plan.

## **covered service**

Any medically necessary treatment, procedure, or supply that the plan will accept for payment under the terms of the plan, subject to any deductible, coinsurance, copayment, or payment limitation of the plan.

## **dependent**

See *eligible dependent* and *covered dependent*.

## **eligible dependent**

Your spouse or child who has met the eligibility conditions for enrollment in this plan, as described in Section 1.

**eligible retired employee**

A retired employee who qualifies for benefits under the plan by meeting the conditions described in Section 1.

**ERISA**

The Employee Retirement Income Security Act of 1974, as amended.

**explanation of benefits**

A statement from a health care service representative that lists which services and supplies the plan covered, how much it paid toward those services and supplies, and any amount for which you may be responsible. This statement also provides notice when a benefit is denied and when additional information is needed to process a claim.

**limiting charge**

The highest amount you can be charged for a covered service by a provider who does not accept assignment of Medicare benefits. The limiting charge is 15 percent over Medicare's approved amount. The limiting charge applies only to certain services and not to supplies or equipment.

**nonparticipating pharmacy**

A retail pharmacy that does not have a contract with the service representative to provide prescription drugs at discounted prices. The Boeing Medicare Supplement Plan does not cover prescription drugs purchased at a nonparticipating pharmacy.

**participant**

Any retired employee or eligible dependent who has fulfilled the requirements for participation described in Section 1, who continues to fulfill these eligibility requirements, and who has not terminated participation in the plan.

**participating pharmacy**

A retail pharmacy that participates in the service representative's network of pharmacies to provide prescription drugs at negotiated, discounted prices.

**plan benefit**

The portion of the covered charge that the plan pays.

**principal support**

Refers to you and/or your current or former spouse providing more than half the financial support for your child. (In determining this, you can exclude any scholarships for study at a regular educational institution unless the child is not your natural child, adopted child, or stepchild.) In most cases, if you claim the child as a dependent on your annual Federal taxes, then you provide principal support for the purposes of eligibility for this plan.

If you have never been married to the other parent of your child, then you must provide more than half the support for your child, regardless of the other parent's support. If you are divorced from the other parent of your child, special rules apply; contact your tax adviser. You also may want to review Internal Revenue Service Publication 502, *Medical and Dental Expenses*.

**provider**

A general term for a physician, hospital, health care facility, or other medical professional or specialist that delivers health care treatment and/or services within the scope of his or her license.

**service representative**

An agent that the Company has contracted with to make benefit determinations and administer benefit payments under the plan described in this booklet. See Section 7 for the service representative. The Company may change a service representative at any time.

### **usual and customary charge**

The maximum charge for a covered service or supply the service representative will consider for reimbursement from a provider. The service representative may refer to this as the “maximum reimbursable charge,” “maximum allowable charge,” “reasonable and customary charge,” “allowed amount,” or a similar term.

The usual and customary charge is the least of

- The provider’s actual charge for the service or supply,
- The provider’s normal charge for a similar service or supply, or
- A predetermined percentile (negotiated between each carrier and plan sponsor) of charges made by providers of a comparable service or supply in the geographic area where it is received.

To determine if a charge exceeds the usual and customary charge for medical services or supplies in situations involving unusual or complicated services or supplies, the nature and severity of the injury or sickness may be considered.

The service representative uses a database of provider charges to determine the usual and customary charge in an area. Information about the database and percentile used to determine the usual and customary charge can be obtained by contacting the service representative.

You pay any charges above the usual and customary amount.



Where to Get More Information		
If you have questions about . . .	Contact . . .	At . . .
<b>Eligibility and enrollment</b> <ul style="list-style-type: none"> <li>• Cost of coverage</li> <li>• Enrollment</li> </ul>	<b>Boeing Service Center for Health and Insurance Plans</b>	<p>Web site: Your Benefits Resources, through Boeing TotalAccess on the World Wide Web: <i>www.boeing.com/express</i></p> <p>Telephone: through Boeing TotalAccess</p> <ul style="list-style-type: none"> <li>• General: 1-866-473-2016</li> <li>• TTY/TDD: 1-800-755-6363</li> <li>• Boeing TotalAccess hours of service                             <ul style="list-style-type: none"> <li>– Automated telephone system: Self-service applications are available 24 hours a day, 7 days a week</li> <li>– Representatives available Monday through Friday from 7 a.m. to 8 p.m. Central time</li> </ul> </li> </ul> <p>You must have your BEMS ID number (or Social Security number) and Boeing TotalAccess password to use Boeing TotalAccess on the World Wide Web or by telephone</p> <p>Mailing address: 100 Half Day Road P.O. Box 1466 Lincolnshire, IL 60069-1466</p>
<b>COBRA information</b> <ul style="list-style-type: none"> <li>• Notification of COBRA event</li> <li>• Enrollment in COBRA coverage</li> <li>• COBRA payments</li> </ul>	<b>Boeing Service Center for Health and Insurance Plans</b>	<p>Same as for eligibility and enrollment, above</p>
<b>Eligibility claim requests</b>	<b>Boeing Pension Service Center</b>	<p>Mailing address: P.O. Box 7833 Ocala, FL 34478-7833</p>
<b>Boeing Medicare Supplement Plan</b> <ul style="list-style-type: none"> <li>• Medical coverage (including prescription drug coverage)</li> <li>• Pretreatment review</li> <li>• Medical claims</li> <li>• Member services</li> <li>• Medical cards and replacement cards</li> </ul>	<b>Aetna, Inc.</b>	<p>Telephone:</p> <ul style="list-style-type: none"> <li>• Through Boeing TotalAccess (above), or</li> <li>• Direct: 1-800-221-7371</li> </ul> <p>Mailing address: Aetna Insurance P.O. Box 14089 Lexington, KY 40512-4089</p> <p>Web site: <i>www.aetna.com</i></p>