

Attachment B
The Retiree Medical Plan

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ATTACHMENT B
TABLE OF CONTENTS

SECTION	TITLE	PAGE
1	ELIGIBLE RETIRED EMPLOYEES	214
2	ELIGIBLE DEPENDENTS OF RETIRED EMPLOYEES	214
	A. Special Provisions	215
	B. Incapacitated Children.....	215
3	HOW TO ENROLL	216
	A. Initial Enrollment	216
	B. Spouse Coverage	216
	C. Special Enrollment	216
	D. Transfer Between Plans.....	217
	E. Changes in Status	217
4	EFFECTIVE DATE OF COVERAGE	218
	A. Retired Employees	218
	B. Dependents	219
5	COMPANY & RETIRED EMPLOYEE CONTRIBUTIONS.....	219
6	TRADITIONAL MEDICAL PLAN	219
	A. Description	219
	B. Deductibles.....	219
	C. Copayments.....	220
	D. Plan Payment Levels.....	221
	E. Lifetime Maximum Benefit	224
	F. Medical Review Program	224
	G. Preventive Care	225
	H. Covered Medical Services and Supplies	226
	I. Special Conditions.....	231
	J. Prescription Drug Benefit.....	236
	K. Traditional Medical Plan Exclusions.....	238
	L. Right to Receive and Release Necessary Information	241
7	COORDINATION OF BENEFITS	242
	A. Order of Payment	242
	B. Payment Provisions	244
8	WHEN AN INJURY OR ILLNESS IS CAUSED BY THE NEGLIGENCE OF ANOTHER	244
9	DEFINITIONS.....	244
10	TERMINATION OF COVERAGE	250
	A. Retiree Coverage.....	250
	B. Dependent Coverage	251
	C. Continuation of Medical Coverage (COBRA)	251
	D. Conversion Privilege.....	251

1
2
3
4
5
6
7
8
9
10
11
12
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14
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Section 1. Eligible Retired Employees

To be eligible for the Retiree Medical Plan, the employee must retire from the service of the Company under the Company-sponsored retirement plan at age 55 or older with ten (10) or more years of vesting service under a Company-sponsored retirement plan.

If an employee becomes eligible for disability benefits under the Company-sponsored retirement plan, the employee also is eligible for the Retiree Medical Plan if he or she is at least age 50 and has ten (10) or more years of vesting service at retirement.

A retired employee who is at least age 55 and has ten (10) or more years of vesting service at retirement is eligible for the Retiree Medical Plan if he or she retires under the Company-sponsored retirement plan within the following time limits:

- Two (2) years following the start of an approved leave of absence, provided the approved leave of absence has not ended prior to the employee's retirement.
- Six (6) years following the employee's layoff.

A retired employee no longer is eligible for coverage under the Retiree Medical Plan after attaining age 65 or becoming eligible for Medicare.

Section 2. Eligible Dependents of Retired Employees

Dependents eligible for the Retiree Medical Plan are the retired employee's legal spouse and unmarried children (natural children, adopted children, children legally placed with the retired employee for adoption and stepchildren) who are under age 25, unmarried, and dependent on the retired employee for principal support, including children who are attending school.

A retired employee may request coverage for the following dependents:

1. A common law spouse if the relationship meets the common-law requirements for the state in which the retired employee entered into the common-law relationship. (A domestic partner is not considered an eligible spouse.)
2. Other children, as follows, who are under age 25, unmarried, and dependent on the retired employee for principal support, including children who are attending school:
 - a. Children who are related to the retired employee either directly or through marriage (e.g., grandchildren, nieces, nephews).
 - b. Children for whom the retired employee has legal custody or guardianship, or has a pending application for legal custody or guardianship and are living with the retired employee.

Annual certification of eligibility is required to continue coverage from age 19 through age 24.

In accordance with federal law, the Company also provides medical coverage to certain dependent children (called alternate recipients) if the Company is directed to

1 do so by a qualified medical child support order (QMCSO) issued by a court or state
2 agency of competent jurisdiction.

3 Documentation is required to request coverage for a child named in a QMCSO or for
4 a child for whom the retired employee has been given legal custody or guardianship.

5 **A. Special Provisions**

6 1. Dependents of a retired employee.
7 If the retired employee or the dependents are covered (or eligible for
8 benefits by reason of having been covered) under another *Company-*
9 *sponsored plan* providing hospital, medical or similar coverage, that
10 individual is not eligible for the Retiree Medical Plan; however, if a
11 dependent spouse is also a part-time Boeing employee, the spouse and
12 eligible children are considered eligible dependents if other Boeing
13 coverage is waived. A retired employee or eligible dependent is
14 considered eligible for the Retiree Medical Plan at the time such person is
15 no longer eligible for coverage under the plan of such person's spouse.

16 No person may be covered both as a retired employee and as a dependent
17 and no person will be considered as a dependent of more than one retired
18 or active employee.

19 2. Death of the retired employee.
20 Upon the death of the retired employee, the spouse and any other covered
21 dependents of the retired employee remain eligible for coverage under the
22 Retiree Medical Plan until the earliest date on which:

- 23 a. Such person attains 65 years of age.
24 b. Such person becomes eligible for Medicare.
25 c. The death of the spouse of the retired employee occurs.
26 d. For a spouse or dependent of a retired employee who is required to
27 make contributions, the end of the last month that contributions are
28 paid.

29 Surviving covered dependents under age 65 may be permitted to continue
30 their coverage as described above, in Section 10.C, or convert their
31 medical coverage as described in Section 10.D.

32 **B. Incapacitated Children**

33 A disabled child age 25 or older may continue to be eligible (or enrolled if the
34 employee is a newly eligible employee) if he or she is incapable of self-support
35 due to any mental or physical condition that began before age 25. The child
36 must be unmarried and dependent on the employee for principal support.
37 Coverage may continue under the Retiree Medical Plan for the duration of the
38 incapacity as long as the employee continues to be eligible under the Plan and
39 the child continues to meet these eligibility requirements.

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

1 **Section 3. How to Enroll**

2 **A. Initial Enrollment**

3 The retired employee and eligible dependents automatically will be enrolled at
4 the time the retired employee becomes eligible, provided the retired employee
5 pays any required contributions. The retired employee and dependents are
6 enrolled in the same plan as immediately before retirement, if available.

7 A retired employee who has been enrolled in a health maintenance organization
8 (HMO) or coordinated care plan may elect to change to the Traditional Medical
9 Plan by calling the Boeing Service Center within thirty-one (31) days of the
10 date the employee retires. The Company will supply enrollment instructions at
11 the time of retirement.

12 If a coordinated care plan or HMO plan does not offer the negotiated plan
13 design, the Company will substitute the closest available plan.

14 All family members, including the retired employee, must be enrolled in the
15 same medical plan.

16 **B. Spouse Coverage**

17 Each retired employee with a spouse must provide information regarding
18 coverage available through another employer to determine whether special
19 contributions are required to enroll the spouse. If the retired employee does not
20 authorize a required contribution, the spouse will not be enrolled for medical
21 coverage. The retired employee will not be able to enroll the spouse until the
22 date the spouse loses the option to be covered under the other employer-
23 sponsored medical plan.

24 The Company will require periodic verification of data.

25 **C. Special Enrollment**

26 If a retired employee declines enrollment for himself/herself or dependents in
27 the Retiree Medical Plan because of other employer-sponsored health care
28 coverage (such as through a spouse's employer), the retired employee may be
29 able to enroll himself/herself and eligible dependents in the Company-
30 sponsored Retiree Medical Plan at a later date as long as enrollment is within
31 sixty (60) days after other coverage ends.

32 If a retired employee declines enrollment for himself/herself or dependents
33 when first eligible and the retired employee's or dependent's other health care
34 coverage was through continuation coverage from a previous employer
35 (coverage mandated by the Consolidated Omnibus Budget Reconciliation Act
36 of 1985, or COBRA), the retired employee or dependent must exhaust his or
37 her COBRA coverage to be eligible for the special enrollment period.

38 If a retired employee's or dependent's other health care coverage was not
39 through COBRA, the coverage loss must be due to loss of eligibility for that
40 health care coverage (including from divorce, death, termination of
41 employment, or reduction in hours of employment) or termination of employer
42 contributions toward such coverage.

43 If a retired employee is *not* enrolled in the Company-sponsored Retiree
44 Medical Plan and has a new dependent as a result of an event such as marriage,

1 birth, adoption, or placement for adoption, the retired employee may enroll
2 himself or herself, his or her spouse, and any dependent children during the
3 year as long as enrollment is requested within sixty (60) days after the event by
4 contacting the Boeing Service Center.

5 If a retired employee *is* enrolled in the Retiree Medical Plan and has a new
6 dependent as a result of marriage, birth, adoption, or placement for adoption,
7 the retired employee may enroll the new dependent during the year as long as
8 enrollment is requested within one hundred twenty (120) days after the
9 qualified event. See “Changes in Status,” Section 3.E, for more information.

10 **D. Transfer Between Plans**

11 Transfer between plans is permitted only during authorized annual enrollment
12 periods or following a change of residence.

13 1. Annual enrollment period.

14 The Company establishes an annual enrollment period on or before July 1
15 each year when retired employees may change medical plans.

16 2. Change of residence.

17 A retired employee who moves out of an HMO or coordinated care plan
18 service area has sixty (60) days to select a medical plan available in the
19 new location by calling the Boeing Service Center.

20 It is the retired employee's responsibility to notify the Company of the
21 change in residence within the sixty (60)-day period.

22 **E. Changes in Status**

23 A retired employee will not be able to make dependent enrollment changes
24 until the next annual enrollment period unless the retired employee experiences
25 one of the qualified changes in status described in this Section. Any change in
26 enrollment must be consistent with the change in status. To be consistent, the
27 event must cause the retired employee or family member to gain or lose
28 eligibility for the Company-sponsored health care coverage or health care
29 coverage sponsored by a spouse's or dependent child's employer, and the
30 election change must be on account of and correspond with the gain or loss of
31 eligibility. Qualified changes in status include the following:

32 1. The retired employee marries, divorces, or becomes legally separated, or
33 the marriage is annulled.

34 2. The retired employee acquires a new, eligible dependent child, such as by
35 birth, adoption, or placement for adoption.

36 3. The retired employee's spouse or dependent child dies.

37 4. The retired employee, spouse, or dependent child starts or stops working.

38 5. The retired employee, spouse, or dependent child has any other change in
39 employment status that affects eligibility for coverage such as changing
40 from full time to part time (or part time to full time), salaried to hourly (or
41 hourly to salaried), strike or lockout, or beginning or returning from a
42 leave of absence.

- 1 6. The retired employee, spouse, or dependent child experiences a significant
2 increase in the cost of employer-sponsored health care coverage or the
3 employer-sponsored health care coverage ends, including expiration of
4 COBRA coverage.
- 5 7. The retired employee, spouse, or dependent child experiences a significant
6 curtailment or cessation of employer-sponsored health care coverage.
- 7 8. The retired employee, spouse, or dependent child becomes eligible or
8 ineligible for Medicare or Medicaid.
- 9 9. The retired employee's dependent child becomes eligible for, or no longer
10 is eligible for, health care coverage due to age limits or a similar eligibility
11 requirement.
- 12 10. The retired employee, spouse, or dependent child makes an enrollment
13 change in his or her employer-sponsored health care coverage, either
14 because of a qualified change in status or an annual enrollment.
- 15 11. The retired employee, spouse, or dependent child changes place of
16 residence or work, affecting access to care within the current plan.

17 The retired employee also may change an election to comply with a qualified
18 medical child support order (QMCSO) to provide or cancel coverage for a child
19 resulting from a divorce, annulment or change in legal custody.

20 In most situations, the retired employee must request the dependent enrollment
21 change within sixty (60) days after the qualified event. A retired employee can
22 enroll a new dependent within one hundred twenty (120) days following the
23 retired employee's marriage or a dependent child's birth, adoption, or
24 placement for adoption. Enrollment may be requested by calling the Boeing
25 Service Center. To request enrollment for a new dependent more than sixty
26 (60) days but within one hundred twenty (120) days after marriage, birth,
27 adoption, or placement for adoption, the retired employee must call the Boeing
28 Service Center and speak with a customer service representative. The retired
29 employee must provide the Boeing Service Center with any required supporting
30 documentation within thirty-one (31) days of the date the dependent enrollment
31 change is requested or the coverage change request will be denied.

32 **Section 4, Effective Date of Coverage**

33 **A. Retired Employees**

34 For newly retired employees, the Plan becomes effective on the first day of the
35 month coinciding with the day such eligible employee retires, provided the
36 retired employee pays any required contributions.

37 Retired employees who are eligible for retiree medical coverage at the time
38 active employment with the Company ends may defer enrollment in the Retiree
39 Medical Plan until the date benefits begin under the Company-sponsored
40 retirement plan.

41 A retired employee is not eligible for retiree medical coverage after becoming
42 eligible for Medicare or attaining age 65.

1 **B. Dependents**

2 The retired employee's current eligible dependents are covered automatically
3 under the Plan on the same date the retired employee's coverage is effective,
4 provided proper application is made and the retired employee pays any required
5 contributions. Eligible dependents acquired after the retired employee's
6 coverage is effective become covered on the date of marriage, date of birth, or
7 date the child is legally placed with the retired employee for adoption, if
8 application is made within one hundred twenty (120) days and the retired
9 employee pays any required contributions. For other newly eligible dependents,
10 coverage is effective on the date dependency is established, if application is
11 made within sixty (60) days and the retired employee pays any required
12 contributions.

13 **Section 5. Company and Retired Employee Contributions**

14 Company and retired employee contributions for the Retiree Medical Plan are
15 described in Article 11—Group Benefits.

16 If contributions are required and coverage is elected, the retired employee may
17 authorize the monthly deduction of the applicable amount from his or her retirement
18 check from The Boeing Company Retirement Plan. Otherwise, the retired employee
19 may arrange to self-pay for coverage through the Boeing Service Center.

20 **Section 6. Traditional Medical Plan**

21 **A. Description**

22 The Traditional Medical Plan provides benefits for procedures, services and
23 supplies *medically necessary* for the diagnosis and/or therapeutic treatment of
24 nonoccupational accidental injuries or illnesses and treatment of certain listed
25 conditions.

26 Enhanced benefits are available to retired employees who receive care from
27 *network providers* as described in Section 6.D.2. Preventive care and
28 prescription drug benefits also are included in the Plan.

29 **B. Deductibles**

30 Deductibles are expenses for certain covered services and supplies that the
31 retired employee or family member must pay before benefits are payable.

32 1. Traditional Medical Plan

33 All covered expenses (except those for *network provider* outpatient visits
34 where the \$15 copayment applies, preventive care, prescription drugs, and
35 smoking cessation treatment) are subject to deductibles. Deductibles are
36 subtracted from the total of all other submitted expenses for covered
37 medical services and supplies before benefits are payable. Only expenses
38 covered by the Plan may be counted toward accumulation of deductibles.

39 a. Individual deductible.

40 Each year, a separate \$200 deductible applies to each covered person.

41 The deductible applies only once in any year even though the person
42 may have several different accidental injuries or illnesses.

1 b. Family deductible.
2 Each year, the Plan limits the deductible amounts applied to the
3 retired employee's family to \$600.
4 After the family deductible has been met, no further deductible is
5 applied during that year to the retired employee or to the family
6 members.

7 2. Preferred pharmacy card program.

8 a. Individual deductible.
9 Each year, a separate \$75 deductible applies to each covered person
10 for prescriptions obtained from the preferred pharmacy program.

11 The deductible applies only once in any year even though the person
12 may have several different prescriptions or refills. The deductible
13 does not apply to prescriptions or refills obtained from the *mail*
14 *service prescription drug program*.

15 b. Family deductible.
16 Each year, the Plan limits the preferred pharmacy card program
17 deductible amounts applied to the retired employee's family to \$225.

18 After the family deductible has been met, no further deductible is
19 applied during that year to the retired employee or to the family
20 members.

21 **C. Copayments**

22 1. Emergency room copayment.
23 A \$50 emergency room copayment applies to each *hospital* emergency
24 room visit. The emergency room copayment does not apply if the patient:

25 a. Is admitted to the *hospital* immediately following such treatment.

26 b. Is treated in the emergency room for twelve (12) or more hours.

27 c. Dies in the emergency room.

28 This emergency room copayment does not apply toward the individual
29 deductible, family deductible, or out-of-pocket expense limits listed in
30 Section 6.D.13.

31 2. Mail service prescription drug copayments.
32 A \$10 copayment applies to each covered generic prescription or refill
33 obtained from the mail service pharmacy. A \$30 copayment applies to
34 each covered brand-name formulary prescription or refill obtained from
35 the mail service pharmacy. A \$60 copayment applies to each covered
36 brand-name nonformulary prescription drug or refill obtained from the
37 mail service pharmacy.

38 3. Office visit copayment.
39 A \$15 copayment applies to each covered outpatient visit to a *network*
40 *physician* (except for preventive care, smoking cessation services, mental
41 health, and substance abuse).

1 **D. Plan Payment Levels**

2 Plan payment levels are subject to all provisions of this Traditional Medical
3 Plan, including medical review requirements, maximum benefits, coordination
4 of benefits, exclusions and definitions.

5 After satisfaction of the deductible and copayment requirements described in
6 Section 6.B and Section 6.C, the Plan pays for covered medical services and
7 supplies according to the following guidelines.

8 1. Network hospitals.

9 a. Prior to July 1, 2004, covered services are paid in full when received
10 from a *network hospital*.

11 b. Effective July 1, 2004, covered services are paid as follows:

12 1) Covered services are paid in full when received from a *network*
13 *hospital* that meets *patient safety standards*.

14 2) Covered services are paid at ninety-five (95) percent of the
15 *allowed charge* when received from a *network hospital* that does
16 not meet *patient safety standards*.

17 2. Other network providers.

18 Outpatient visits to a *network physician* are paid in full after a \$15
19 copayment.

20 Other covered services of *network providers* are paid at ninety-five (95)
21 percent of the *allowed charge*, except when provided for preventive care
22 (Section 6.D.12), smoking cessation (Section 6.D.11), or the treatment of
23 outpatient *mental illness* (Section 6.D.8) or temporomandibular joint
24 disease (TMJ) or myofascial pain dysfunction syndrome (MPDS) (Section
25 6.D.10).

26 3. Nonnetwork providers.

27 *Physicians, hospitals*, and other covered health care providers in a license
28 category eligible to participate in the *network* are paid as follows:

29 a. In a location where there are *network providers* qualified to provide
30 *medically necessary services*, covered services are paid at sixty (60)
31 percent of *usual and customary* charges except as specified in Section
32 6.D.7, Section 6.D.8 and Section 6.D.10.

33 b. In a location where there is no *network provider* qualified to provide
34 *medically necessary services*, covered services are paid according to
35 *network* provisions as described in Section 6.D.1 and Section 6.D.2,
36 based on *usual and customary* charges, except as specified in Section
37 6.D.10, Section 6.D.11, and Section 6.D.12.

38 c. Covered services in a hospital emergency room for medical
39 emergencies are paid according to *network* provisions.

40 Other covered health care providers, services and supplies furnished by
41 providers not in a license category eligible to participate in the *network* are
42 paid at eighty (80) percent of *usual and customary* charges except as
43 specified in Section 6.D.7, Section 6.D.8 and Section 6.D.10.

- 1 4. Alternatives to hospitalization.
2 Covered services and supplies provided by a *skilled nursing facility* or a
3 *hospice agency* are paid at one hundred (100) percent of *usual and*
4 *customary* charges.
- 5 5. Ambulance services.
6 Covered ambulance services are paid at ninety-five (95) percent of *usual*
7 *and customary* charges.
- 8 6. Prescription drugs.
9 a. Preferred pharmacy card program.
10 1) Covered generic prescription drugs are paid at ninety (90)
11 percent of *usual and customary* charges.
12 2) Covered brand-name formulary prescription drugs are paid at
13 eighty (80) percent of *usual and customary* charges.
14 3) Covered brand-name nonformulary prescription drugs are paid
15 at seventy (70) percent of *usual and customary* charges.
16 4) The covered person's out-of-pocket expense is limited to \$75 for
17 each prescription or refill after the deductible is satisfied.
- 18 b. *Mail service prescription drug program.*
19 1) Covered maintenance generic prescription drugs obtained from
20 the *network's mail service prescription drug program* are paid in
21 full after required copayments.
22 2) Covered maintenance brand-name formulary prescription drugs
23 obtained from the *network's mail service prescription drug*
24 *program* are paid in full after required copayments.
25 3) Covered maintenance brand-name nonformulary prescription
26 drugs obtained from the *network's mail service prescription*
27 *drug program* are paid in full after required copayments.
- 28 7. Treatment of *substance abuse*.
29 a. Covered services incurred in connection with the inpatient and
30 outpatient treatment of *substance abuse* are paid at ninety-five (95)
31 percent of *allowed charges* if treatment is coordinated through the
32 *network's referral service*.
33 b. Covered services for inpatient and outpatient treatment of *substance*
34 *abuse* are paid at a constant fifty (50) percent of *usual and customary*
35 charges if treatment is not coordinated through the *network's referral*
36 *service*.
37 c. Benefits are paid to a lifetime maximum of two courses of treatment.
38 Each course of treatment not coordinated through the *network's*
39 *referral service* is subject to a \$5,000 maximum.
- 40 8. Treatment of *mental illness*.

- 1 a. Covered services for inpatient treatment of *mental illness* are paid at
2 ninety-five (95) percent of *allowed charges* if coordinated through
3 the *network's referral service*.
- 4 b. Covered services for outpatient treatment of *mental illness* are paid at
5 a constant eighty (80) percent of *allowed charges* if coordinated
6 through the *network's referral service*.
- 7 c. Covered services for treatment of *mental illness* not coordinated
8 through the *network's referral service* are paid at a constant fifty (50)
9 percent of *usual and customary* charges to a maximum of twenty (20)
10 inpatient days and twenty (20) outpatient visits each year if the
11 services are certified as covered by the *network's referral service*.
- 12 9. *Neurodevelopmental therapy*.
13 Covered services for *neurodevelopmental therapy* for children age six or
14 younger are paid at *network* and nonnetwork levels to a maximum of
15 \$1,000 each benefit year.
- 16 10. Treatment of temporomandibular joint disease (TMJ) and myofascial pain
17 dysfunction syndrome (MPDS).
18 Covered services for treatment of TMJ and MPDS are paid at a constant
19 fifty (50) percent of *usual and customary* charges to a \$3,500 lifetime
20 maximum.
- 21 11. Smoking cessation treatment.
22 Covered services and supplies are paid at one hundred (100) percent of
23 *usual and customary* charges to a \$500 lifetime maximum.
- 24 12. Preventive care.
25 a. Covered services of network providers are paid in full; covered
26 routine physical examinations for retired employees and spouses are
27 paid up to \$200 per examination, including related laboratory and X-
28 ray charges.
- 29 b. No coverage is provided for services obtained in a *network* service
30 area from nonnetwork providers.
- 31 13. Out-of-pocket expense limits.
32 a. Individual out-of-pocket expense limits.
33 When a covered person's out-of-pocket expenses reach \$2,000 in any
34 year, any further benefits that would have been paid at sixty (60),
35 eighty (80) or ninety-five (95) percent (except prescription drugs)
36 will be paid at one hundred (100) percent of *usual and customary*
37 charges for the remainder of that year to the maximum benefit
38 amounts.
- 39 b. Family out-of-pocket expense limits.
40 When two or more family members satisfy their deductibles and have
41 combined out-of-pocket expenses of \$4,000 (but not more than
42 \$2,000 for any one individual), any further benefits that would have
43 been paid at sixty (60), eighty (80) or ninety-five (95) percent (except

- 1 prescription drugs) will be paid at one hundred (100) percent of *usual*
2 *and customary* charges for the remainder of the year to maximum
3 benefit amounts.
- 4 c. The following expenses do not count toward the individual or family
5 out-of-pocket expense limits:
- 6 1) Yearly deductibles.
7 2) *Hospital* emergency room copayment.
8 3) Office visit copayment.
9 4) Difference between *usual and customary* charges and the
10 provider's actual charge.
11 5) Any balance remaining after a benefit maximum has been
12 reached.
13 6) Covered medical services paid at one hundred (100) percent of
14 *usual and customary* charges or in full.
15 7) Covered medical services for treatment of *mental illness*,
16 smoking cessation, *substance abuse*, TMJ/MPDS, or
17 prescription drugs.
18 8) Benefits paid at a reduced amount or denied when the patient
19 fails to follow medical review program procedures and
20 requirements.

21 **E. Lifetime Maximum Benefit**

22 The lifetime maximum benefit for all covered medical services (including
23 prescription drugs) is \$1,500,000, subject to all other Traditional Medical Plan
24 provisions. This maximum applies separately to each covered family member.
25 Benefits paid and applied to reduce the maximum benefit, while covered under
26 a *Company-sponsored plan* for active or retired personnel and not reinstated
27 under a prior Agreement, are not reinstated by this Agreement and serve to
28 reduce the maximum benefits available hereunder.

29 **F. Medical Review Program**

30 The Traditional Medical Plan has a medical review program to encourage
31 appropriate utilization of health care services. The program includes
32 *precertification* requirements, voluntary second surgical opinion provisions, a
33 *referral service* for *mental illness* and *substance abuse* treatment and individual
34 case management.

35 1. *Precertification* requirements.

36 The retired employee is responsible for obtaining *precertification* for all
37 nonemergency *hospital* admissions (except admissions for childbirth
38 during the first forty-eight (48) hours following a normal delivery or
39 ninety-six (96) hours following a cesarean section), *skilled nursing facility*
40 admissions and services for home health care and hospice care. Treatment
41 of *substance abuse* and *mental illness* must be *precertified* through the
42 *referral service*.

- 1 a. If the medical review program is not contacted, but retrospective
2 review shows that the *hospital* or *skilled nursing facility* admission,
3 home health care, or hospice care was *medically necessary*, regular
4 Plan benefits are reduced to fifty (50) percent of *usual and customary*
5 charges to a maximum retired employee expense of \$1,000.
- 6 1) This \$1,000 expense does not apply toward the yearly deductible
7 and/or out-of-pocket expense limits.
- 8 2) Benefits denied under other Plan exclusions do not count toward
9 this \$1,000 expense.
- 10 b. No benefits are provided for any services or supplies that are not
11 *medically necessary*.
- 12 2. Voluntary second surgical opinion provisions.
13 The Plan provides benefits for second surgical opinions the same as for
14 other covered services provided by *network* and nonnetwork providers.
- 15 3. *Referral service*.
16 Retired employees and eligible dependents may use a *referral service* for
17 treatment of *mental illness* and *substance abuse*. The *referral service*
18 refers the patient to a *referral service provider* and precertifies initial
19 treatment; ongoing treatment is precertified on a regular basis. Individuals
20 who do not use the *referral service* receive reduced benefits.
- 21 4. Individual case management.
22 In the event of a severe or long-term illness or injury, the service
23 representative will assist the patient's *network provider* in identifying
24 treatment alternatives that offer cost-effective care and enhancements to
25 the patient's quality of life.

26 **G. Preventive Care**

- 27 1. Benefits are provided for a routine physical examination for retired
28 employees and spouses as follows:
- 29 a. One (1) examination every year for retired employees and spouses
30 age 35 and above.
- 31 b. One (1) examination every three (3) years for covered spouses under
32 age 35.
- 33 2. Benefits are provided for the following routine screening examinations:
34 Mammograms, Pap smears and prostate examinations (including the office
35 visit) as recommended by the patient's *physician*.
- 36 3. The Plan covers up to eight (8) routine physical examinations for well-
37 baby care during the child's first twenty-four (24) months.
- 38 4. For children age two through age five, the Plan covers one (1) routine
39 physical examination each year.
- 40 5. The Plan covers routine childhood immunizations recommended by the
41 child's physician according to American Academy of Pediatrics
42 guidelines.

1 **H. Covered Medical Services and Supplies**

2 The Traditional Medical Plan provides benefits for the following procedures,
3 services and supplies *medically necessary* for the diagnosis and/or therapeutic
4 treatment of nonoccupational accidental injuries or illnesses and treatment of
5 certain listed conditions. Benefits for special conditions are specified in
6 Section 6.I.

- 7 1. The services of a *physician*, including:
- 8 a. A voluntary second (or third) surgical opinion obtained from one (1)
9 or two (2) other specialists.
 - 10 b. An eye examination including refraction performed in conjunction
11 with a medical condition such as diabetes, glaucoma and cataracts.
 - 12 c. Injectable legend drugs administered in a *physician's* office for
13 covered conditions; medical devices (including contraceptive
14 injections, devices and implants) dispensed by a *physician*.
15 Preventive injections or immunizations are not covered except as
16 described in Section 6.G. Antigen, allergy serum and insulin are not
17 considered a *physician's* service. Antigen, allergy serum and insulin
18 are covered under the preferred pharmacy card program; insulin also
19 is covered under the *mail service prescription drug program*.
- 20 2. Services of other health care professionals.
- 21 a. Diagnostic X-ray and laboratory examinations, including
22 examinations incurred in connection with a second (or third) surgical
23 opinion.
 - 24 b. Intermittent visits of a registered nurse (R.N.), other than a nurse who
25 ordinarily lives in the retired employee's home or who is a family
26 member of the retired employee or spouse, if skilled care in place of
27 hospitalization is not available through an alternative provider at a
28 lesser cost.
 - 29 c. The services of a *physician's assistant* for services that would have
30 been covered if performed by a *physician* licensed as a doctor of
31 medicine (M.D.).
 - 32 d. The services of a *physical therapist* for physical therapy (but not
33 other types of therapy), the services of an *occupational therapist* for
34 occupational therapy and the services of a *speech therapist* for speech
35 therapy, when specifically prescribed by a *physician* as to type and
36 duration. Services must be performed under the *physician's*
37 supervision while the patient remains under the attending *physician's*
38 care, and only to the extent that the therapy will significantly restore
39 bodily functions. The *physician* must reevaluate the therapy at least
40 every three (3) months and certify that continuing therapy is required.
41 All therapy beyond three (3) months must be approved by the service
42 representative. Benefit determination is based on the attending
43 *physician's* evaluation of the therapy as well as the therapist's
44 progress reports. The information from the *physician* and therapist is

- 1 then reviewed against established medical criteria to determine
2 medical necessity.
- 3 No benefits are payable for therapy given at the therapist's discretion,
4 elected by the covered person, for any treatment for delayed
5 development or therapy that is solely for the purpose of slowing body
6 degeneration rather than restoring functional improvement, custodial
7 maintenance, self-help, recreational or educational therapy.
- 8 Benefits also are provided for *neurodevelopmental therapy* by a
9 licensed and certified therapist for children age six and younger, to a
10 maximum benefit of \$1,000 each benefit year, including in-home
11 therapy if homebound.
- 12 e. The services of a *dentist* as specified in Section 6.I.6 and Section
13 6.I.10.
- 14 f. The services of an authorized Christian Science practitioner
15 necessary for the healing treatment of a nonoccupational physical or
16 mental condition.
- 17 g. Acupuncture services for a covered illness or in place of covered
18 anesthesia when provided by a licensed acupuncturist (L.A.C.), or a
19 doctor of medicine (M.D.), or a doctor of osteopathy (D.O.).
- 20 h. Spinal and extremity manipulations by an approved provider, such as
21 a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), or a
22 chiropractic doctor (D.C.), for up to twenty-six (26) spinal and
23 extremity manipulations performed by hand each year. Related
24 services, such as an initial examination and initial X-rays, also are
25 covered.
- 26 3. Medical equipment, services, and supplies.
- 27 a. Professional ambulance service when used to transport the patient
28 from the place of injury, accident or illness to the first *hospital* where
29 treatment is given. These services also are covered when the
30 *physician* requires an ambulance to transport the patient to a *hospital*
31 in the patient's area of residence to protect the patient's health or life.
32 Air ambulance transportation is covered when *medically necessary*.
33 Ambulance service from one *hospital* to another, including return, is
34 covered only if the facility is the nearest one with appropriate
35 regional specialized treatment facilities, equipment or staff
36 *physicians*. Ambulance transportation from or to the patient's home
37 is covered when *medically necessary*. No other expenses in
38 connection with travel are covered.
- 39 b. The cost and installation of a hearing aid or aids purchased under a
40 *physician's* or certified audiologist's written recommendation to a
41 \$600 benefit payable for each hearing aid. This benefit is limited to
42 one (1) per ear every three (3) consecutive years, including any
43 period covered under a *Company-sponsored plan*. The Plan also

- 1 covers the overhaul of a hearing aid in place of a new hearing aid
2 after three (3) years.
- 3 No benefits are payable for:
- 4 1) Hearing or audiometric examinations. (When disease is present,
5 such expenses may be covered under other portions of the
6 Traditional Medical Plan.)
 - 7 2) Hearing aids ordered either before the person became eligible or
8 after coverage ends.
 - 9 3) Hearing aids ordered before coverage ends but delivered more
10 than sixty (60) days after coverage ends.
 - 11 4) Charges for hearing aids that do not meet professionally
12 accepted standards of practice or for *experimental or*
13 *investigational services or supplies.*
 - 14 5) Replacement of hearing aids that are lost, broken or stolen
15 unless replacement is within the frequency limit of one (1)
16 hearing aid per ear every three (3) consecutive years.
 - 17 6) Replacement parts for hearing aid repairs, unless part of an
18 overhaul after three (3) years.
 - 19 7) Replacement batteries.
 - 20 8) Charges for eyeglass-type hearing aids above the covered
21 expense for one (1) hearing aid.
- 22 c. Hemodialysis in the patient's home when the treatment is repetitive
23 and for chronic, irreversible kidney disease. Covered services and
24 supplies include the rental, lease, or (under certain conditions)
25 purchase of major hemodialysis equipment and specific supplies and
26 certain training necessary to operate the dialyzer. Purchase of
27 specific supplies is contingent on the supplies having no real utility to
28 the patient in the absence of the disease and having no value to other
29 household members. Coverage of the purchase of equipment is
30 subject to specific conditions, including an amortization period,
31 decided by the service representative.
- 32 d. Rental (or purchase if approved by the service representative) of
33 durable medical or surgical equipment used exclusively for the
34 patient's therapeutic treatment.
- 35 e. Orthopedic appliances and braces, including repair and replacement
36 necessary as a result of normal usage or change in condition.
- 37 f. Oxygen and anesthesia.
- 38 g. Artificial limbs, artificial eyes and other prostheses. This benefit
39 includes repair and replacement necessary as a result of normal usage
40 or change in condition.
- 41 h. Radiation therapy (including X-ray therapy) and chemotherapy.

1 i. Smoking cessation services, including the services of a *physician* or
2 other health care professional who is practicing within the scope of
3 his or her license, or an approved smoking cessation provider. To
4 receive benefits for smoking cessation treatment, the patient must
5 complete the full course of treatment. No smoking cessation benefits
6 will be provided for inpatient services; vitamins, minerals, or other
7 supplements; acupuncture; over-the-counter drugs or provider
8 prescribed prescription drugs to ease nicotine withdrawal; books;
9 tapes; or hypnotherapy (unless performed by an approved provider).
10 Prescription drugs prescribed by an approved provider to ease
11 nicotine withdrawal are covered under the prescription drug benefit.

12 4. *Hospital* room, board, services and supplies, including a *medically*
13 *necessary* private room. If a private room is used when one is not
14 *medically necessary*, any excess of daily board and room charges over the
15 *hospital's* average semiprivate room charge is not covered. If the *hospital*
16 does not have semiprivate accommodations, the semiprivate charge for
17 similar facilities in the area is considered in determining the rate.

18 *Hospital* benefits are subject to the medical review program for medical
19 necessity, appropriateness, level of care and setting.

20 5. *Hospital* alternatives.

21 a. Home health care visits and supplies provided to patients in their
22 home by a *home health care agency* instead of confinement in a
23 *hospital* or *skilled nursing facility*.

24 Benefits are subject to the medical review program.

25 1) To be eligible for benefits:
26 a) Home health care visits and supplies must be for the
27 *medically necessary* treatment of a covered illness or
28 injury.

29 b) A *physician* must establish a written *home health care*
30 *treatment plan*.

31 c) The patient must be homebound, which means leaving
32 home involves a considerable, taxing effort and the patient
33 is unable to use public transportation without assistance.

34 2) Covered benefits for home health care visits and supplies must
35 be provided by and billed by the *home health care agency* and
36 are limited to:

37 a) *Physician* services.

38 b) Nursing visits by a registered nurse (R.N.) or licensed
39 practical nurse (L.P.N.).

40 c) Physical therapy visits by a *physical therapist*.

41 d) Speech therapy visits by a *speech therapist*.

- 1 e) Occupational therapy visits by an *occupational therapist*.
- 2 f) Medical social visits by a person with a master's degree in
3 social work (M.S.W.).
- 4 g) *Home health aide* visits.
- 5 h) Respiratory therapy visits by an inhalation therapist
6 certified by the National Board of Respiratory Therapists.
- 7 i) Medical supplies dispensed by the *home health care agency*
8 that would have been provided on an inpatient basis.
- 9 j) Nutritional supplements such as diet substitutes
10 administered intravenously or through hyperalimentation.
- 11 k) Nutritional guidance by a registered dietician.
- 12 l) Services and supplies for infusion therapy. (Patients do not
13 need to meet the treatment plan and homebound
14 requirements.)
- 15 3) See Section 6.K for listed home health care exclusions.
- 16 b. Visits and supplies of a *hospice agency* when provided in place of
17 confinement in a *hospital* or *skilled nursing facility*.
- 18 Benefits are subject to the medical review program.
- 19 1) To be eligible for benefits:
- 20 a) Hospice care visits and supplies must be for the *medically*
21 *necessary* treatment or palliative care of terminally ill
22 patients with a life expectancy of six (6) months or less.
- 23 b) The *physician* must establish a written *hospice care*
24 *treatment plan*.
- 25 2) Hospice visits and supplies in the patient's home must be
26 provided by and billed by the *hospice agency* and are limited to
27 the same items as listed under Section 6.H.5.a. In addition,
28 benefits are provided for respite care for a minimum of two (2)
29 hours per day (continuous patient care to provide temporary
30 relief to family members or friends).
- 31 3) Expenses for inpatient hospice confinement are covered to the
32 same extent as if incurred in a *hospital*.
- 33 4) Limits.
- 34 a) Respite care of two (2) or more hours per day when no
35 skilled care is required is limited to a combined total of one
36 hundred twenty (120) hours in each three (3)-month period.
- 37 b) Expenses for hospice care that qualify under this benefit
38 and under any other benefit of this Plan are covered only

1 under the benefit the service representative determines as
2 the most appropriate.

3 Patients who exhaust the above limits may apply to the service
4 representative for an extension of benefits, which will be
5 approved by the service representative if the treatment is
6 *medically necessary*.

7 5) See Section 6.K for listed hospice care exclusions.

8 c. *Skilled nursing facility* room, board, services and supplies when
9 provided in place of *medically necessary* hospitalization, limited to
10 the facility's average semiprivate room charge. If the *skilled nursing*
11 *facility* does not have semiprivate accommodations, the semiprivate
12 charge for similar facilities in the area is considered in determining
13 the rate.

14 Benefits are subject to the medical review program for medical
15 necessity, appropriateness, level of care and setting.

16 Patients who exhaust the above limits may apply to the service
17 representative for an extension of benefits, which will be approved if
18 the treatment is *medically necessary*.

19 d. Expenses incurred for room and board while in a *Christian Science*
20 *sanatorium* also are covered if the patient is admitted for healing (not
21 rest or study) and is under the care of an authorized Christian Science
22 practitioner. If a private room is used, any excess of daily room and
23 board charges over the facility's average semiprivate room charge is
24 not covered. If the facility does not have semiprivate
25 accommodations, the semiprivate charge for other *Christian Science*
26 *sanatoriums* will be considered in determining the rate.

27 e. Services of an approved free-standing surgical center or hospital-
28 based emergency facility if such services would be covered if
29 received in a *hospital*.

30 6. If the patient accepts a referral from the service representative to a *network*
31 *provider* designated as a "center of excellence," reasonable travel and
32 lodging expenses for the patient and the patient's family will be covered
33 when the patient is required by the service representative to travel more
34 than one hundred fifty (150) miles from his or her place of residence for
35 an approved service. Benefits for travel expenses will be paid in full to a
36 maximum of \$2,500 per episode requiring travel and must be approved in
37 advance by the service representative.

38 **I. Special Conditions**

39 Covered medical services and supplies described in Section 6.H also are
40 provided for the following special conditions.

41 1. Congenital abnormalities and hereditary complications.
42 Benefits are provided for *medically necessary* services and supplies
43 required for the treatment of congenital abnormalities and hereditary

- 1 complications. This coverage applies to newborn children as well as to all
2 other persons covered under the Plan.
- 3 2. Cosmetic surgery.
4 Benefits are provided for cosmetic surgery only if the surgery is for
5 prompt repair of an accidental injury.
- 6 3. Erectile dysfunction.
7 Benefits are provided for the treatment of organic erectile dysfunction
8 when the patient has a history of one or more of the following:
- 9 a. Peripheral vascular disease or local penile vascular abnormalities.
10 b. Peripheral neuropathy or autonomic insufficiency.
11 c. Prostate cancer.
12 d. Spinal cord disease or injury.
13 e. Major pelvic surgery.
14 f. Insulin-dependent diabetes.
15 g. Severe Peyronie's disease.
- 16 Covered therapy includes vacuum erection device, injection therapy,
17 penile prosthesis, urethral pellets, and prescription medications.
- 18 The Plan does not cover treatment for nonorganic impotence such as
19 psychosexual dysfunction.
- 20 4. Infertility.
21 Benefits are provided for the following services in connection with the
22 diagnosis and treatment of infertility:
- 23 a. Diagnostic tests necessary to determine the cause of infertility.
24 b. Surgical correction of a condition causing or contributing to
25 infertility.
26 c. Conventional medical treatment (such as office visits, laboratory
27 services and prescription medications) of the infertility.
- 28 The Plan does not cover the infertility services and supplies listed under
29 "Traditional Medical Plan Exclusions" in Section 6.K.
- 30 5. *Mental illness* and *substance abuse* treatment.
- 31 a. *Mental illness*.
32 Benefits are provided for the services of the following providers in
33 connection with the inpatient and outpatient treatment of *mental*
34 *illness*:
- 35 1) Any provider contracted with the *referral service*.
36 2) Licensed psychiatric doctor (M.D.).
37 3) Licensed clinical psychologist.

- 1 4) Licensed psychiatric nurse (R.N.).
- 2 5) Professional at master's level or above who is licensed in the
- 3 area where the services are performed.
- 4 6) Licensed hospital or treatment facility.

5 Treatment of a *mental illness* includes only treatment of a mental
6 disorder or condition not related to, accompanying or resulting from
7 *substance abuse*. Treatment of any such related, accompanying or
8 resulting disorder or condition is considered to be treatment of the
9 *substance abuse*.

10 b. *Substance abuse*.
11 Expenses incurred at a *substance abuse* treatment facility or a
12 *hospital*, including *physician's* charges and charges for prescription
13 drugs, are covered only to the extent they are in connection with the
14 effective treatment of *substance abuse*. The benefit at a *substance*
15 *abuse* treatment facility is limited to intensive inpatient treatment and
16 outpatient *substance abuse* counseling as prescribed by a *physician*.

17 No benefits are provided for recovery houses that provide an alcohol-
18 or drug-free residential setting; alcohol or drug information and
19 *referral services*; schools; emergency service patrols; or
20 detoxification, except when immediately followed by a rehabilitative
21 program.

22 The patient must complete the course of treatment to be eligible for
23 *substance abuse* benefits.

24 6. Oral surgery.

25 a. Benefits are provided for services in connection with the prompt
26 repair of natural teeth or other body tissue performed by a *physician*
27 or *dentist* and required as a result of a nonoccupational injury,
28 provided that:

- 29 1) The damaged, lost or moved teeth were free from decay or in
30 good repair and firmly attached to the jaw bone at the time of
31 the injury, and
- 32 2) If crowns (caps), dentures (false teeth), bridgework (fixed or
33 removable), or in-mouth appliances are installed due to such
34 injury, only charges for the first denture or bridgework to
35 replace lost teeth, the first crown needed to repair each damaged
36 tooth and an in-mouth appliance used in the first course of
37 orthodontic therapy after the injury are included.

38 Charges to remove, repair, replace, restore or reposition teeth lost or
39 damaged while biting or chewing are not covered.

40 b. Benefits are provided for *medically necessary* services in connection
41 with oral surgery performed by a *physician* or *dentist* for a medical
42 condition that does not relate to the correction of the gum, teeth or

- 1 mouth tissues for dental purposes. These services include, but are not
2 restricted to:
- 3 1) Removal of tumors and cysts of the jaw, cheeks, lips, tongue,
4 and roof and floor of the mouth.
 - 5 2) Surgical procedures required to correct accidental injuries of the
6 jaw, cheeks, lips, tongue, and roof and floor of the mouth.
 - 7 3) Removal of exostoses of the jaw and hard palate.
 - 8 4) Treatment for fractures of the facial bones (maxilla or
9 mandible).
 - 10 5) Incision and drainage of cellulitis.
 - 11 6) Incision of accessory sinuses, salivary glands or ducts.
- 12 c. Benefits are provided for *physician* or *dentist* services in connection
13 with the correction of developmental abnormalities of the jaw or
14 malocclusion of the jaw by osteotomy (the surgical cutting of bone or
15 bony tissue) with or without bone grafting.
- 16 d. The surgical placement of endosseous implants is covered if there is a
17 reasonable expectation of success for a minimum of five (5) years.
- 18 e. *Hospital* services and benefits for general anesthesia are provided in
19 connection with other dental or oral surgery when *medically*
20 *necessary*.
- 21 The preceding listed services incurred in connection with dental work or
22 oral surgery do not apply to any services in connection with the diagnosis
23 and treatment of temporomandibular joint disease (TMJ) or myofascial
24 pain dysfunction syndrome (MPDS). See Section 6.I.10.
- 25 7. Pregnancy.
- 26 Benefits are provided for pregnancy the same as any other condition for
27 covered retired employees or covered dependents, provided that expenses
28 are incurred while this coverage is in force.
- 29 Pregnancy includes normal delivery, cesarean section, spontaneous
30 abortion (miscarriage), legal abortion and complications of pregnancy.
- 31 Following childbirth, mothers and newborns may stay in the hospital for
32 forty-eight (48) hours following a normal delivery or for ninety-six (96)
33 hours following a cesarean section, unless a shorter stay is authorized by
34 the attending health care provider in consultation with the mother.
35 Preadmission review is not required for these lengths of stay. Any length
36 of stay beyond forty-eight (48) hours or ninety-six (96) hours must be
37 approved through the medical review program.
- 38 Benefits are provided for a *birthing center* only to the extent that such
39 services would have been covered in a *hospital*.
- 40 A newborn child is eligible from the date of birth if the child qualifies as a
41 dependent of the retired employee and is enrolled within one hundred

1 twenty (120) days. The following services and supplies are covered for a
2 newborn child enrolled in the Plan, subject to the payment provisions of
3 Section 6.B, Section 6.C, Section 6.D and Section 6.E.

4 a. Routine *hospital* services and supplies and *physician* services during
5 the first forty-eight (48) hours following a normal delivery or ninety-
6 six (96) hours following a cesarean section.

7 b. *Medically necessary hospital* and *physician* services and supplies.

8 8. Reconstructive breast surgery.

9 Benefits are provided for breast reconstruction in connection with the
10 mastectomy in a manner determined in consultation with the patient and
11 attending *physician*. Covered services include the following:

12 a. All stages of reconstruction of the breast on which the mastectomy
13 was performed.

14 b. Surgery and reconstruction of the other breast to produce a
15 symmetrical appearance.

16 c. Prosthesis and treatment of physical complications of all stages of
17 mastectomy, including lymphedema.

18 9. Sterilization (vasectomy and tubal ligation).

19 Benefits are provided for a vasectomy or tubal ligation, but not a reversal.

20 10. Temporomandibular joint disease (TMJ) and myofascial pain dysfunction
21 syndrome (MPDS).

22 a. The following surgical or nonsurgical treatment of TMJ or MPDS by
23 a *physician* or a *dentist* is included as covered medical services and
24 supplies:

25 1) Initial diagnostic examinations and X-rays.

26 2) Follow-up office visits.

27 3) Surgical procedures and related hospitalization.

28 4) Appliances (i.e., nightguards, bite plates, orthopedic
29 repositioning or mandibular orthopedic devices).

30 5) Appliance management, kinesitherapy, physical therapy,
31 biofeedback therapy, joint manipulation, prescription drugs,
32 injections of muscle relaxants and therapeutic drugs or agents.

33 b. The following expenses are not covered:

34 1) Restorative techniques to build occlusion unless the tooth is
35 diseased or accidentally damaged.

36 2) Nonsurgical orthodontic treatment, except as provided above.

37 3) Banding treatment.

1 11. Transplant benefits.

2 Benefits are provided for *medically necessary* services relating to a
3 covered transplant. Transplants that are part of an approved clinical trial
4 also may be covered.

5 a. If the patient covered by this Plan is the recipient of a human organ or
6 tissue transplant covered by this Plan, donor organ procurement costs
7 are covered to a maximum benefit of \$30,000 per transplant, to a
8 lifetime maximum benefit of \$60,000. Benefits are limited to
9 selection, removal of the organ, storage, transportation of the surgical
10 harvesting team and the organ, and other *medically necessary*
11 procurement costs. Donor expenses that are covered under this Plan
12 are applied against the Plan lifetime maximum benefit for the
13 recipient covered under this Plan.

14 b. No benefits are provided for the following:

- 15 1) Nonhuman, artificial or mechanical organ transplants.
16 2) *Experimental or investigational services or supplies* unless they
17 are part of an approved clinical trial.
18 3) Services and supplies for the donor when donor benefits are
19 available through other group coverage.
20 4) Expenses for that portion of treatment funded by government or
21 private entities as part of an approved clinical trial.
22 5) Expenses when the recipient is not covered under this Plan.
23 6) Lodging, food or transportation costs, unless otherwise
24 specifically provided under this Plan.
25 7) Donor and procurement services and costs incurred outside the
26 United States, unless specifically approved by the service
27 representative.
28 8) Living (noncadaver) donor transplants (except kidney, liver,
29 lobar lung and bone marrow or stem cell transplants for covered
30 conditions) including selective islet cell transplants of the
31 pancreas.

32 **J. Prescription Drug Benefit**

33 Benefits are subject to all Traditional Medical Plan provisions, including
34 exclusions.

35 1. Preferred pharmacy card program.

36 a. Description of benefit.

37 Retired employees and dependents may obtain covered prescription
38 drugs through the preferred pharmacy card program or through any
39 licensed pharmacist. A formulary applies.

40 b. Covered prescription drug expenses.

1 The Plan covers the following *medically necessary* prescription drug
2 expenses:

- 3 1) Legend drugs, which must be dispensed under federal or state
4 law through the written prescription of a *physician* or *dentist*.
- 5 2) Injectable insulin (including needles, syringes, chem strips,
6 chem pads and lancets when prescribed along with insulin)
7 when ordered in writing by the patient's *physician*.
- 8 3) Antigen or allergy serum prescribed by a *physician* in writing.

9 The Plan also covers prescribed legend drugs for contraception and
10 smoking cessation.

- 11 c. Maximum medication covered.
12 The program covers a supply of medication which, when taken
13 according to the *physician's* written order, does not exceed a thirty-
14 four (34)-day supply.

15 However, any drug labeled "Caution—Limited by Federal Law to
16 Investigational Use" or any experimental drug, even though a charge is
17 made to the patient, is not a covered prescription drug expense.

18 2. *Mail service prescription drug program.*

- 19 a. Description of benefit.
20 Retired employees and eligible dependents may use the *mail service*
21 *prescription drug program* to obtain covered maintenance
22 prescription drugs. Maintenance prescription drugs are prescription
23 drugs taken on an ongoing basis to control chronic medical
24 conditions. A formulary applies.

25 Unless the *physician* indicates otherwise, a generic equivalent of the
26 prescribed drug will be dispensed when available and permissible
27 under the law.

- 28 b. Covered prescription drug expenses.
29 The Plan covers the following *medically necessary* prescription drug
30 expenses:

- 31 1) Legend drugs, which must be dispensed under federal or state
32 law through the written prescription of a *physician* or *dentist*.
- 33 2) Injectable insulin (including needles, syringes, chem strips,
34 chem pads and lancets when prescribed along with insulin)
35 when ordered in writing by the patient's *physician*.

36 The Plan also covers prescribed legend drugs for contraception and
37 smoking cessation.

- 38 c. Maximum medication covered.
39 The program covers a supply of medication which, when taken
40 according to the *physician's* written order, does not exceed a ninety
41 (90)-day supply per prescription or refill. Authorized refills are

1 covered only after the initial substance has been used. Certain
2 controlled substances are subject to quantity limitations.

3 3. Exclusions.

4 No benefits are payable under the preferred pharmacy card program and
5 the *mail service* prescription drug programs for the following:

6 a. Appliances, devices, or other nondrug items, including but not
7 limited to therapeutic devices or artificial appliances. However, this
8 does not apply to needles, syringes, or other diabetic supplies when
9 prescribed along with insulin.

10 b. Any charges for the administration or injection of any drug.

11 c. Any prescription for which the person is eligible to receive benefits
12 under another employer's group benefit plan or a workers'
13 compensation law or from any municipality, state, or federal
14 program.

15 d. Any prescription filled in excess of the number prescribed by the
16 physician or any refill after one (1) year from the date of the
17 *physician's* order.

18 e. Immunizing agents, except that allergy serum (antigen) is covered
19 under the preferred pharmacy card program with a *physician's*
20 written prescription.

21 f. All medications to treat sexual dysfunction, unless the patient is
22 being treated for a diagnosed medical condition.

23 g. Obesity drugs.

24 h. Drugs dispensed during an inpatient admission by a *hospital, skilled*
25 *nursing facility*, sanatorium, or other facility.

26 i. Experimental drugs or drugs used for investigational purposes.

27 j. Drugs that are not *medically necessary* for the treatment of an illness,
28 injury, or other covered condition, including vitamins, except as
29 specifically provided by the Plan.

30 k. Infusion therapy drugs except as described in the home health care
31 benefit.

32 l. Delivery or handling charges.

33 m. Any service or supply otherwise excluded by the Plan.

34 **K. Traditional Medical Plan Exclusions**

35 These charges are deducted from the eligible person's expenses before the
36 benefits of this Plan are determined. The Plan does not pay for charges for or
37 related to:

38 1. Any accident or illness covered by a workers' compensation law.

- 1 2. Services or supplies not recommended and approved by a *physician* or
2 other covered health care professional or provided before the person
3 becomes covered under this Plan.
- 4 3. Services or supplies that the Plan's service representative determines are
5 not *medically necessary* for treatment of an accidental injury, illness, or
6 other condition covered under the Plan. This includes routine physical
7 examinations, immunizations or other preventive services and supplies,
8 except as specifically provided by the Plan.
- 9 Inpatient *hospital* care (including *physician* visits while hospitalized) is
10 not considered *medically necessary* when the care can be provided safely
11 in an outpatient setting, such as a *hospital* outpatient department,
12 *physician's* office or an ambulatory surgical facility, without adversely
13 affecting the patient's physical condition.
- 14 Examples of care that generally should be provided in an outpatient setting
15 include observation and/or diagnostic studies, surgery that can be
16 performed on a same-day basis, and psychiatric care primarily aimed at
17 controlling or changing the patient's environment.
- 18 4. Amounts exceeding *usual and customary* charges.
- 19 5. *Skilled nursing facility* services when the services usually are not provided
20 by such facilities or when the services are not expected to lessen the
21 disability and enable the person to live outside the facility. However,
22 *skilled nursing facility* services are covered for the terminal patient when
23 the illness has reached a point of predictable end.
- 24 6. Services or supplies related to cosmetic surgery, except as specifically
25 provided.
- 26 7. Services or supplies related to obesity, unless approved in advance by the
27 service representative according to written guidelines. Retired employees
28 may request a copy of the guidelines by calling the service representative.
- 29 8. Any treatment or services required in connection with a sex
30 transformation.
- 31 9. Services or supplies to the extent they are covered under any *Company-*
32 *sponsored plan* that has been discontinued.
- 33 10. Services or supplies to the extent they are covered under any federal, state
34 or other government plan, except where required by law.
- 35 11. Confinement or surgical, medical or other treatment, services or supplies
36 received in or from a U.S. Government *hospital*, except as required by
37 law.
- 38 12. Services or supplies for which no charge is made or charges the retired
39 employee or dependent is not required to pay.
- 40 13. Dyslexia, visual analysis therapy or training related to muscular imbalance
41 of the eye or for orthoptics. However, coverage is provided for up to six
42 (6) months when necessary to correct muscle imbalance (strabismus,

- 1 esotropia or exotropia) if treatment begins before the person's 12th
2 birthday.
- 3 14. Completion of claim forms or reports.
- 4 15. Full body computerized axial tomography (CAT) scans other than at a
5 *hospital* or an institution having an agreement with a *hospital* to supply
6 these services. However, expenses are covered under other circumstances
7 if the equipment is required and certified by the *physician* for immediate
8 use to diagnose a potentially life-threatening condition or if the services
9 are provided at a *physician's* office, clinic or other institution approved by
10 the Company for other than emergency use.
- 11 16. Benefits payable under any automobile medical, personal injury protection
12 (PIP), automobile no-fault, automobile uninsured or underinsured
13 motorist, homeowner's or commercial premises medical coverage when
14 such contract or insurance is issued to or provides benefits available to the
15 patient. Any benefits paid by this Plan before benefits are paid under one
16 of these other types of contracts or insurance are provided to assist the
17 patient and do not indicate the service representative is acting as a
18 volunteer or waiving any right to reimbursement or subrogation.
- 19 17. *Experimental or investigational services or supplies*, or related
20 complications.
- 21 18. Services or supplies related to treatment of *mental illness*, including eating
22 disorders, or *substance abuse*, except as specifically provided.
- 23 19. Services or supplies related to treatment of TMJ and MPDS, except as
24 specifically provided.
- 25 20. Smoking cessation treatment, except as specifically provided.
- 26 21. Radial keratotomy or other eye surgery to correct refractive errors, except
27 when preoperative visual acuity is 20/50 or less with a lens.
- 28 22. Reversal of a sterilization procedure.
- 29 23. Infertility services or supplies, including but not limited to in vitro
30 fertilization; artificial insemination; embryo transfer; gamete intrafallopian
31 transfer (GIFT); microinjections; zona drilling; sperm preparation; sperm
32 separation; fertility drugs (including but not limited to Clomid, Pergonal,
33 Serophene or HCG) when associated with any artificial means of
34 conception; consecutive follicular ultrasounds, cycle therapy, or
35 corresponding lab tests when associated with any artificial means of
36 conception; any tests, visits, consultations, or treatment related to, or
37 resulting in, one of the preceding listed noncovered services.
- 38 24. *Custodial care*.
- 39 25. Services or supplies required by law to be provided by any school system.
- 40 26. Education, special education or job training, whether or not provided by a
41 facility that also provides medical or psychiatric care.

- 1 27. Marriage counseling, family counseling, child counseling, career
2 counseling, social adjustment counseling, pastoral counseling or financial
3 counseling.
- 4 28. Intentionally self-inflicted injury, unless under treatment for a mental
5 illness.
- 6 29. Missed appointments.
- 7 30. Equipment or supplies that are not solely related to the medical care of a
8 diagnosed illness or injury. Examples include, but are not limited to, any
9 luxury or convenience item or supply, general exercise equipment,
10 modification to home (e.g., wheelchair ramps, support railings) or
11 automobile or van (e.g., ramps, lifts), environmental control devices (e.g.,
12 air conditioners, purifiers, humidifiers), swimming pool, spa, or whirlpool,
13 Craftmatic or similar bed, orthopedic chair, special car seat, or any
14 personal hygiene item.
- 15 31. The following home health care and hospice services:
- 16 a. Homemaker or housekeeping services.
- 17 b. Services provided by volunteers, household members, family, or
18 friends.
- 19 c. Unnecessary or inappropriate services, food, clothing, housing, or
20 transportation.
- 21 d. Social services.
- 22 e. Psychiatric care.
- 23 f. Maintenance or *custodial care*.
- 24 g. Supplies or services not included in the written *home health or*
25 *hospice care treatment plan* or not otherwise covered.
- 26 h. Hospice services to other family members, including bereavement
27 counseling.
- 28 i. Hospice services of financial, legal or spiritual counselors.

29 **L. Right to Receive and Release Necessary Information**

30 As a condition of receiving benefits under this Plan, the patient agrees to
31 authorize:

- 32 1. Any *physician, hospital*, or other provider or party having knowledge to
33 disclose to the service representative any medical information requested to
34 administer this Plan.
- 35 2. The service representative to:
- 36 a. Examine medical records at the offices of any *physician, hospital* or
37 other provider to verify services or supplies.

- 1 b. Release to or obtain from any other insurer, organization or person
2 any information necessary to administer the coordination of benefits
3 provisions.
 - 4 c. Exercise the subrogation rights described in Section 8 releasing any
5 information about the accident, injuries and benefits or services
6 received to any person who may be liable to the patient, to that
7 person's insurer or to the service representative.
 - 8 d. Examine employment and payroll records of the patient to verify Plan
9 eligibility and enrollment.
- 10 3. The service representative will keep this information confidential
11 whenever possible, but under certain circumstances it may be disclosed to
12 other parties, such as:
- 13 a. To a law enforcement or other governmental authority in case of
14 fraud or illegal activity.
 - 15 b. In response to a subpoena or judicial order.
 - 16 c. To a medical person or institution to verify coverage or to conduct an
17 audit.
 - 18 d. To a professional review organization to review the service or
19 conduct of a medical person or institution.
- 20 4. The patient waives any claim of privilege or confidentiality in any action
21 by or against the service representative or the party furnishing the
22 information.

23 **Section 7. Coordination of Benefits**

24 If a retired employee or dependent has other health care coverage in addition to
25 being covered under this Plan, the following rules govern coordination of benefits
26 with the other coverage. Other coverage includes, whether insured or uninsured,
27 another employer's group benefit plan, other arrangement of individuals in a group,
28 Medicare (to the extent allowed by law), individual insurance or health coverage and
29 insurance that pays without consideration of fault.

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

32 The exclusion of government benefits and services is described in "Traditional
33 Medical Plan Exclusions" in Section 6.K.

34 **A. Order of Payment**

35 The primary plan pays its benefits first and pays its benefits without regard to
36 benefits that may be payable under other plans. When another plan is the
37 primary plan for health care coverage, the secondary plan pays the difference
38 between the benefits paid by the primary plan and what would have been paid
39 had the secondary plan been primary.

- 40 1. A plan is considered primary if:
 - 41 a. It has no order of benefit determination rules.

- 1 b. It has benefit determination rules that differ from coordination of
2 benefit rules under state regulations or, if not insured, that differ from
3 these rules.
- 4 c. All plans that cover an individual use the same coordination of
5 benefit rules, and under those rules, the plan is primary.
- 6 2. If the aforementioned rules do not determine which group plan is
7 considered primary, this plan applies the following coordination of benefit
8 rules:
- 9 a. A plan that covers a person as an employee, retiree, member, or
10 subscriber pays before a plan that covers the person as a dependent.
- 11 b. A plan that covers a person as an active employee or dependent of an
12 active employee is primary. The plan that covers a person as a
13 retired, laid-off, or other inactive employee or as a dependent of a
14 retired, laid-off, or other inactive employee is secondary.
- 15 c. If a dependent child is covered under both parents' group plans, the
16 child's primary coverage is provided through the plan of the parent
17 whose birthday comes first in the calendar year, with secondary
18 coverage provided through the plan of the parent whose birthday
19 comes later in the calendar year.
- 20 d. If a dependent child's parents are divorced or separated and a court
21 decree establishes financial responsibility for the health care coverage
22 of the child, the plan of the parent with such financial responsibility
23 is the primary plan of coverage. If the divorce decree is silent on the
24 issue of coverage, the following guidelines are used:
- 25 1) The plan of the parent with custody pays benefits first.
- 26 2) The plan of the spouse of the parent with custody pays second.
- 27 3) The plan of the parent without custody pays third.
- 28 4) The plan of the spouse of the parent without custody pays
29 fourth.
- 30 e. If none of the aforementioned rules establishes which group plan
31 should pay first, then the plan that has covered the person for the
32 longest period is considered the primary plan of coverage.
- 33 f. Continuation coverage under the Consolidated Omnibus Budget
34 Reconciliation Act of 1985 (COBRA) always is secondary to other
35 coverage, except as required by law.
- 36 g. If the retired employee or dependent is confined to a hospital when
37 first becoming covered under this plan, this plan is secondary to any
38 plan already covering the retired employee or dependent for the
39 eligible expenses related to that hospital admission. If the retired
40 employee or dependent does not have other coverage for hospital and
41 related expenses, this plan is primary.

1 Benefits under a Company-sponsored health care plan are not coordinated
2 with benefits paid under any other group plan offered by the Company. A
3 retired employee can receive benefits from only one Company-sponsored
4 health care plan. However, when dental services performed by a licensed
5 *dentist* also are covered under the medical plan, the dental plan pays its
6 benefits first and the medical plan is secondary.

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

11 **B. Payment Provisions**

12 The primary plan pays benefits without regard to any other plan. When the
13 Traditional Medical Plan is secondary, it adjusts benefits so that the total
14 payable under both plans for expenses covered under the Traditional Medical
15 Plan is not more than would be payable under the Traditional Medical Plan.
16 Neither plan pays more than it would without coordination of benefits.

17 Plan means any plan providing medical, dental, vision care, hearing aid benefits
18 or treatment under individual insurance, group insurance or any other coverage
19 for individuals in a group, whether on an insured or uninsured basis.

20 Treatment of end-stage renal disease is covered by the Traditional Medical Plan
21 for the first thirty (30) months following Medicare entitlement due to end-stage
22 renal disease, and Medicare provides secondary coverage. After this thirty (30)
23 -month period, Medicare provides primary coverage and the Traditional
24 Medical Plan provides secondary coverage.

25 **Section 8. When an Injury or Illness Is Caused by the Negligence of Another**

26 If a third party is legally liable for an injury or illness to a person covered under this
27 Plan, regular plan benefits will be paid if the injured person agrees to cooperate with
28 the service representative in administering the Plan's subrogation rights. This
29 includes providing all the necessary and requested information and submitting bills
30 related to the injury or illness to any applicable insurer. The injured person must also
31 agree to reimburse the Plan if he or she recovers payment from the liable party or
32 any other source. A third party includes any party possibly responsible for causing
33 or compensating the injury or illness of a person covered under this Plan, or the
34 covered person's automobile, homeowner's, or other insurance coverage.

35 **Section 9. Definitions**

36 The following definitions apply to italicized terms in this document.

- 37 1. ***Allowed charge*** means the amount that would have been paid for like
38 services or supplies to a *network provider* who has a participating
39 agreement with the service representative.
- 40 2. ***Birthing center*** means a facility for normal delivery operating under the
41 direction and control of the licensing or regulatory agency in its location.
- 42 3. ***Chiropractor*** means a person duly licensed in the area where his or her
43 services are performed and practicing within the scope of that license.

- 1 4. **Christian Science sanatorium** means a facility that, at the time of the
2 healing treatment, is operated (or listed) and certified by the First Church
3 of Christ, Scientist, in Boston, Massachusetts.
- 4 5. **Company-sponsored plan** means a group health care plan approved by
5 Boeing or one of its subsidiaries or affiliates for its retired employees and
6 dependents. This includes the Traditional Medical Plan, coordinated care
7 plans and health maintenance organizations.
- 8 6. **Custodial care** means care that does not require the continuing services of
9 skilled medical or health professionals and is primarily to assist patients in
10 activities of daily living, including institutional care primarily to support
11 self-care and provide room and board. *Custodial care* includes, but is not
12 limited to, help in walking, getting into and out of bed, bathing, dressing,
13 feeding and preparation of special diets, and supervision of medications
14 that are ordinarily self-administered.
- 15 7. **Dentist** means a legally qualified *dentist* practicing within the scope of his
16 or her license.
- 17 8. **Experimental or investigational service or supply** means:
- 18 a. A service or supply that meets at least one of the following criteria:
- 19 1) It requires approval by the Food and Drug Administration or
20 other government agency, which approval has not been granted
21 when the service or supply is ordered.
- 22 2) It has been classified by the national Blue Cross and Blue Shield
23 Association as experimental or investigational.
- 24 3) It is under clinical investigation by health professionals.
- 25 4) It is not generally recognized by the medical profession as tested
26 and accepted medical practice.
- 27 b. However, a service or supply will not be considered experimental or
28 investigational if it is part of an approved clinical trial. An approved
29 clinical trial is one that meets each of the criteria in either Category 1
30 or 2 below.
- 31 1) Category 1
- 32 a) The trial has been approved by the National Institutes of
33 Health, the Food and Drug Administration, the Department
34 of Veterans Affairs, or a research center approved by the
35 Plan's service representative.
- 36 b) The trial has been reviewed and approved by a qualified
37 institutional review board.
- 38 c) The facility and personnel have sufficient experience and
39 training to provide the treatment or use the supplies.

- 1
- 2) Category 2
- 2 a) The trial is to treat a condition that is too rare to qualify for
3 approval under Category 1.
- 4 b) The trial has been reviewed and approved by a qualified
5 institutional review board.
- 6 c) The facility and personnel have sufficient experience and
7 training to provide the treatment or use the supplies.
- 8 d) The available clinical or preclinical data provide reasonable
9 expectation that the trial treatment will be at least as
10 effective as noninvestigational therapy.
- 11 e) There is no therapy clearly superior to the trial treatment.
- 12 9. **Home health aide** means an individual employed by a *home health care*
13 *agency* or a *hospice agency* who provides, under the supervision of a
14 registered nurse or *physical or speech therapist*, part-time or intermittent
15 personal care, ambulation and exercise, household services essential to
16 health care at home, and assistance with medications ordinarily self-
17 administered; reports on changes in patients' conditions and completes
18 appropriate records.
- 19 10. **Home health care agency** means a public or private organization that
20 administers and provides home health care, and is either Medicare
21 certified or operating under the direction and control of the licensing or
22 regulatory agency in its location.
- 23 11. **Home health (or hospice) care treatment plan** means a written program
24 for continued care and treatment by the patient's attending *physician*. This
25 plan must be reviewed and the continued need for care must be certified
26 by a *physician* at least every two (2) months.
- 27 12. **Hospice agency** means a public or private organization that administers
28 and provides hospice care, and is either Medicare certified or operating
29 under the direction and control of the licensing or regulatory agency in its
30 location.
- 31 13. **Hospital** means an accredited institution licensed by the Joint Commission
32 on Accreditation of Healthcare Organizations (JCAHO) as a general
33 hospital.
- 34 14. **Mail service prescription drug program** means a mail service prescription
35 company approved by the service representative to provide services under
36 an arrangement with the service representative.
- 37 15. **Medically necessary procedure, service or supply** means one that, in the
38 reasonable opinion of the service representative, meets the following
39 criteria:
- 40 a. It is required to diagnose or treat the patient's condition, and the
41 condition could not have been diagnosed or treated without it.

- 1 b. It is consistent with the symptom or diagnosis and treatment of the
2 condition.
- 3 c. It is the most appropriate service or supply essential to the patient's
4 needs.
- 5 d. It is appropriate as good medical practice.
- 6 e. It is professionally and broadly accepted as the usual, customary and
7 effective means of diagnosing or treating the illness, injury, or
8 condition.
- 9 f. When applied to an inpatient, it cannot safely be provided to the
10 patient as an outpatient.
- 11 The fact that a procedure, service or supply is furnished, prescribed,
12 recommended or approved by a *physician* does not, of itself, make it
13 *medically necessary*. A service or supply may be *medically necessary* in
14 part only.
- 15 16. **Mental illness** means a disorder (including an eating disorder) that
16 exhibits symptomology, etiology and features congruent with a *Diagnostic*
17 *and Statistic Manual of Mental Disorders IV* diagnosis of mental disorder.
- 18 17. **Network** means a group of health care providers approved by the service
19 representative as meeting criteria for efficient care delivery and
20 performing services under a contract with the service representative.
- 21 The service representative may designate certain health care providers and
22 facilities as *network providers* for specific medical services through a
23 “centers of excellence” program.
- 24 18. **Network provider** means a provider who is a member of a *network*.
- 25 19. **Neurodevelopmental therapy** means physical, occupational and speech
26 therapy for treatment of neurodevelopmental delay. Neurodevelopmental
27 delay means lack of development of motor or speech function not due to
28 injury or trauma.
- 29 20. **Participating pharmacy** means a pharmacy that has an agreement with the
30 service representative to accept payments in excess of the prescription
31 drug deductible as payment in full for covered prescription costs.
- 32 21. **Patient safety standards** means established criteria for patient safety
33 related to hospital services. A hospital meets *patient safety standards* if it
34 meets established criteria such as those listed below. The hospital must
35 publicly certify that it meets all criteria and the statements pertaining to
36 the standards are accurate and reflect normal operating procedures at the
37 hospital. The criteria include:
- 38 a. Computerized physician order entry: The hospital requires physicians
39 to enter all medication orders via computer linked to prescribing
40 error-prevention software that helps eliminate confusion over paper
41 prescription orders and alerts providers to negative drug interactions
42 or other possible problems.

- 1 b. Intensive care unit staffing: The hospital, which operates an adult
2 general medical/surgical ICU, assures that all ICU patients are
3 managed or co-managed by physicians certified (or eligible for
4 certification) in critical care medicine during daytime hours, and
5 intensivists are on call and available twenty-four (24) hours a day.
- 6 c. Evidence-based hospital referrals: The hospital meets experience
7 criteria for performance of specific, listed complex procedures.
- 8 22. **Physical therapist or occupational therapist or speech therapist** means a
9 qualified physical, occupational or speech therapist licensed in the
10 jurisdiction where his or her services are rendered and practicing within
11 the scope of that license. In locations without licensing requirements, the
12 physical therapist must be certified by the American Physical Therapy
13 Association, the occupational therapist must be certified by the American
14 Occupational Therapy Association and the speech therapist must be
15 certified by the American Speech and Hearing Association.
- 16 23. **Physician** means only a physician who is licensed to prescribe and
17 administer all drugs or to perform surgery. Physician also means the
18 following health care professionals if they are licensed in the jurisdiction
19 where they render services and are practicing within the scope of that
20 license:
- 21 a. Podiatrist.
22 b. Psychologist.
23 c. Optometrist.
24 d. *Chiropractor*.
25 e. Registered nurse (if services would normally have been performed by
26 a physician).
- 27 If a health care professional lawfully performs a service covered by this
28 Plan when performed by a physician and if applicable law requires
29 recognition of this health care professional under this Plan, the term
30 physician will include the professional only to the extent required by law.
- 31 24. **Physician's assistant** means a person duly licensed in the area where his
32 or her services are performed and practicing within the scope of such
33 license.
- 34 25. **Plan administrator** means the Boeing Employee Benefit Plans
35 Committee.
- 36 26. **Precertification** means prospective review and evaluation of proposed
37 elective *hospital, substance abuse treatment facility* and *skilled nursing*
38 *facility* admissions as well as home health and hospice care by qualified
39 health care professionals. This evaluation, which uses accepted medical
40 criteria to determine medical necessity and whether treatment could be
41 given in a less intense or more appropriate setting, may include:

- 1 a. Patient safety review: Referrals to hospitals which meet *patient*
2 *safety standards*, including, for specific, listed complex procedures,
3 hospitals that meet experience, volume and outcomes criteria.
- 4 b. Length of stay review: A process that begins during precertification
5 review in which medical professionals indicate the number of
6 inpatient days medically appropriate for the proposed admission or
7 certify medical necessity of the intensity or type of services received
8 for home health or hospice care. Follow-up reassessments and
9 extensions are made as medically warranted.
- 10 c. Concurrent review: Ongoing review while the patient is undergoing
11 treatment in the *hospital* or receiving care from a *home health care*
12 *agency* or *hospice agency*.
- 13 d. Discharge planning: Discharge planning is designed to identify
14 patients who could be discharged early if appropriate arrangements
15 are made for covered alternative care.
- 16 e. Retrospective review: Retrospective review includes all the steps of
17 precertification review, but after services are rendered. Retrospective
18 review occurs when the medical review program (or *referral service*
19 for the treatment of *substance abuse* and *mental illness*) is not
20 contacted before treatment.

21 The role of the reviewing organization is to advise on medical
22 appropriateness. The patient and *physician* decide on the treatment
23 actually performed. Medical review affects payments under the
24 Traditional Medical Plan as specified in Section 6.F.

25 27. **Referral service** means an organization that manages treatment of
26 *substance abuse* and *mental illness* by contracting with providers of this
27 treatment. The organization is responsible for:

- 28 a. Assessment of the patient's condition (including crisis intervention).
29 b. Referrals to *referral service providers*.
30 c. *Precertification* review of treatment for *substance abuse*, *mental*
31 *illness* and eating disorders.
32 d. Initial and ongoing review of provider treatment plans to assure
33 services are *medically necessary* and given in the appropriate setting.

34 The *referral service* is considered the service representative for
35 determining medical necessity of *substance abuse* and *mental illness*.

36 28. **Referral service provider** means a provider performing services under a
37 contract with the *referral service* or a provider meeting *referral service*
38 criteria for care to a designated patient.

39 29. **Skilled nursing facility** means an institution approved as such by
40 Medicare.

- 1 30. **Substance abuse** means alcohol or drug dependence as classified in
2 categories 303.0 to 304.9 of the most current edition of the “*International*
3 *Classification of Diseases, 9th Revision, Clinical Modification.*”
- 4 31. **Substance abuse (alcoholism and/or drug abuse) treatment facility**
5 means an institution providing treatment for chronic alcoholism and/or
6 drug abuse and operating under the direction and control of the licensing
7 or regulatory agency in its location.
- 8 32. **Totally disabled** means that the patient is prevented, solely because of an
9 illness or accidental injury, from working in his or her occupation or, if
10 not previously employed, is unable to perform most of the normal
11 activities of a person of like age and gender in good health.
- 12 33. **Usual and customary** (Traditional Medical Plan), as determined by the
13 service representative, is the lowest of these amounts:
- 14 a. The provider's actual charge to the patient after any discounts or other
15 reductions.
- 16 b. The charge most frequently made by the provider to all other patients
17 for comparable services or supplies.
- 18 c. The charge most frequently made by providers with similar
19 professional qualifications for comparable services or supplies in the
20 same geographic area.
- 21 d. In the service area of a *network*, the amount that would have been
22 paid for like services or supplies to a provider who has a participating
23 agreement with the service representative.
- 24 The usual and customary charge for an unusual or complicated service
25 will be evaluated by considering charges to treat illnesses or injuries of a
26 comparable nature or complexity.
- 27 34. **Usual and customary** (preferred pharmacy card program) means the lesser
28 of:
- 29 a. The pharmacy's retail charge, including state sales tax if applicable,
30 or
- 31 b. Amounts payable under the prescription drug card program to
32 *participating pharmacies* in that state.

33 **Section 10. Termination of Coverage**

34 **A. Retiree Coverage**

35 Medical coverage for the retired employee terminates on whichever of the
36 following dates occurs first:

- 37 1. Such person attains 65 years of age.
- 38 2. Such person becomes eligible for Medicare.
- 39 3. The end of the last month that any required contributions are paid.

- 1 **B. Dependent Coverage**
2 Coverage for the eligible dependents of the retired employee terminates on
3 whichever of the following dates occurs first:
- 4 1. Such person is no longer an eligible dependent.
 - 5 2. Such person attains 65 years of age.
 - 6 3. Such person becomes eligible for Medicare.
 - 7 4. The death of the surviving spouse of the retired employee.
 - 8 5. The death of the retired employee, if there is no surviving spouse.
 - 9 6. The end of the last month that any required contributions are paid.
- 10 The surviving covered dependents under the age of 65 may be permitted to
11 convert their medical coverage as described in Section 10.D.
- 12 **C. Continuation of Medical Coverage (COBRA)**
13 If medical coverage for the retired employee's dependents otherwise would
14 terminate due to one of the following reasons, these benefits may continue for
15 specified periods under Public Law 99-272, Title X, as amended, if the
16 individual makes a timely request to the Company and pays the required
17 contribution.
- 18 1. The retired employee's death.
 - 19 2. The retired employee's divorce.
 - 20 3. The retired employee becomes entitled to Medicare.
 - 21 4. A dependent child ceases to be a dependent as defined under this Plan. (A
22 child eligible to be continued under the Plan's incapacitated child
23 provision will still be considered to have dependent status.)
- 24 **D. Conversion Privilege**
25 If medical coverage terminates for reasons other than voluntary cancellation of
26 coverage by the individual or by becoming eligible for another *Company-*
27 *sponsored plan*, that individual may apply for an individual policy of insurance
28 of a kind then being issued by the service representative for group conversion
29 purposes. Evidence of good health will not be required, provided written
30 application is made and the first retiree premium is paid within thirty-one (31)
31 days following the end of the month in which medical coverage terminates.
32 The individual's policy will be issued at the service representative's customary
33 rate applicable to the age of the individual and to the form and amount of
34 insurance provided under the converted policy.