COLLECTIVE BARGAINING AGREEMENT

Between

THE BOEING COMPANY

And

SOCIETY of PROFESIONAL ENGINEERING EMPLOYEES in AEROSPACE - WICHITA

(Wichita Engineering Unit)

Effective Date: December 5, 2008

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And

SOCIETY OF PROFESSIONAL ENGINEERING

EMPLOYEES IN AEROSPACE - WICHITA

THIS AGREEMENT is executed this 26th day of March, 2009, effective December 5, 2008 at Wichita, Kansas , by and between The Boeing Company (hereinafter referred to as the Company), and the Society of Professional Engineering Employees in Aerospace ("SPEEA" or the "Union"). The Union is the bargaining agent for the collective bargaining unit described in Article 1.

This agreement is a reflection of the parties' commitment to these shared values:

- To maintain a respectful, cooperative relationship.
- To work together to further the mutual success of both parties; positioning Boeing for continued competitive success in the marketplace while enabling SPEEA to best represent and serve its members.
- To resolve issues, to the greatest extent possible, through a collaborative process, marked by open communication and respect for each other's interests.

ARTICLE 1
RECOGNITION

Section 1.1 Recognition For the purposes of collective bargaining with respect to rates of pay and other conditions of employment, and in accordance with the certification of the National Labor Relations Board, the Company recognizes:

> The Society of Professional Engineering Employees in Aerospace (SPEEA) as the exclusive bargaining agent for all persons working in the Company's plants in Sedgwick County, Kansas, including persons who are on travel status from such plants, who are classified by the Company in one of the classifications listed in Article 11.

ARTICLE 2
RIGHTS OF MANAGEMENT

Section 2.1 Rights of Management.

2.1(a) The terms and conditions of this Agreement are minimum and the Company shall be free to grant more favorable terms and conditions and to pay salary rates higher than the salary ranges shown in Article 11 to any engineering employee.

2.1(b) The management of the Company and the direction of the workforce are vested exclusively in the Company subject to the terms of this Agreement. Without limitation, implied or otherwise, all matters not specifically and expressly covered or treated by the language of this Agreement may be administered for its duration by the Company in accordance with such policy or procedure as the Company from time-to-time may determine.

ARTICLE 3
GRIEVANCE AND ARBITRATION PROCEDURE

Section 3.1 Grievance and Arbitration Procedure. Grievances arising between the Company and its employees subject to this Agreement, or between the Company and the Union, with respect to the interpretation or application of any of the terms of this Agreement shall be settled according to the following procedure. Subject to the terms of this Article relating to cases of dismissal or suspension for just cause, or of involuntary resignation, only matters dealing with the interpretation or application of terms of this Agreement shall be subject to this grievance machinery.

Section 3.2 Employee Grievances.

3.2(a) Grievances on behalf of employees shall be handled as follows:

STEP 1. Oral Submission of Grievances to Supervisor. The employee and, at his/her option, a Union Representative shall contact the employee's supervisor and shall attempt to effect a settlement of the grievance. Such oral presentation shall be made within ten (10) workdays following the occurrence of the event giving rise to the grievance. The supervisor shall, within five (5) workdays thereafter, provide to the employee the answer to the grievance.

STEP 2. Oral Submission of Grievance to Designated Company Representative. If the decision of the supervisor does not settle the grievance, the Union Representative shall within five (5) workdays subsequent to the receipt of the supervisor's answer contact the Designated Company Representative for the purpose of arranging a meeting to discuss the grievance. The meeting will be held within five (5) workdays following such request and shall be attended by the Union Representative and the employee and appropriate Company

Representatives. The Company's answer to the grievance shall be made within ten (10) workdays following such meeting.

STEP 3. Written Submission of Grievance to Designated Company Representative. If no settlement is reached, the Union Representative may immediately thereafter reduce a statement of the grievance to writing, which shall contain the following:

(a) The detailed facts upon which the grievance is based.

(b) References to the section(s) of the Agreement alleged to have been violated. (This will not be applicable in cases of dismissal or suspension for just cause, or of involuntary resignation.)

(c) The remedy sought.

The Union Representative shall submit such written grievance to the designated Company Representative within five (5) workdays following receipt of the answer provided in Step 2 above. After such submission the designated Company Representative and the Union Representative may, within the next ten (10) workdays, meet and settle the grievance, and over their signatures indicate the disposition thereof. Otherwise, promptly after the expiration of such ten (10) day period they shall sign the grievance indicating that the grievance has been discussed and reconsidered by them and that no settlement has been reached, and the designated Company Representative will promptly thereafter confirm in writing to the Union Representative the denial of the grievance.

STEP 4. Arbitration. If no settlement is reached in Step 3 within the specified or agreed time limits, then either party may in writing, within ten (10) workdays thereafter, request that the matter be submitted to an arbiter for a prompt hearing as hereinafter provided in 3.4 through 3.6.

3.2(b) Layoff, Dismissal or Suspension. Employees shall not be discharged or suspended without just cause. An employee shall have the right to appeal a layoff, discharge, suspension, or involuntary resignation by filing a written grievance through the Union, beginning at Step 3, with the designated Company Representative, within ten (10) workdays after the date of such layoff, discharge, suspension, or involuntary resignation.

3.2(c) When the Union requests arbitration on behalf of bargaining unit employees who have been laid off, discharged, or suspended or who have involuntarily resigned, the Company and the Union will exercise reasonable efforts to have the arbitration hearing within ninety (90) days of the request for arbitration.

Section 3.3 Union Versus Company and Company Versus Union Grievances. Grievances which the Union may have against the Company or the Company may have against the Union, limited as aforesaid to matters dealing with the interpretation or application of terms of this Agreement shall be handled as follows:

3.3(a) Such grievances shall be submitted to the designated Company Representative or the Union Representative, as the case may be, within ten (10) workdays following the occurrence of the event giving rise to the grievance and shall contain the following:

(1) Statement of the grievance setting forth in detail facts upon which the grievance is based.

(2) The section(s) of the Agreement alleged to have been violated.

(3) The remedy sought.

3.3(b) The grievance shall be signed by the Union Representative or the designated Company Representative, as the case may be. If no settlement is reached within ten (10) workdays from the submission of the grievance to the designated Company Representative or the Union Representative, as the case may be, both shall sign the grievance and indicate it has been discussed and considered by them and that no settlement has been reached, and the party responding to the grievance will promptly confirm in writing to the other party the denial of the grievance. Within ten (10) workdays thereafter either party may in writing request that the matter be submitted to an arbiter for a prompt hearing as hereinafter provided in 3.4 through 3.6.

3.3(c) No matter shall be considered as a grievance under this 3.3 unless it is presented to the designated persons within ten (10) workdays after occurrence of the last event on which the grievance is based.

Section 3.4 Selection of Arbiter - By Agreement. In regard to each case that reaches arbitration, the parties will attempt to agree on an arbiter to hear and decide the particular case. If the parties are unable to agree to an arbiter within ten (10) workdays after submission of the written request for arbitration, the provisions of 3.5 (Selection of Arbiter - Federal Mediation and Conciliation Service) shall apply to the selection of an arbiter.

Section 3.5 Selection of Arbiter - Federal Mediation and Conciliation Service. In the event an arbiter is not agreed upon as provided in 3.4, the parties shall jointly request the Federal Mediation and Conciliation Service to submit a panel of seven (7) arbiters. Such request shall state the general nature of the case and ask that the nominees be qualified to handle the type of case involved. When notification of the names of the panel of seven (7) arbiters is received, the parties in turn shall have the right to strike a name from the panel until only one (1) name remains. The remaining person shall be the arbiter. The right to strike the first name from the panel shall be determined by lot.

In the event either party is dissatisfied with the credentials of each of the arbiters whose names are contained on the first panel offered by the Federal Mediation and Conciliation Service, such party can summarily reject that panel and insist on a second panel. Selection must be made from the second panel.

Section 3.6 Arbitration - Rules of Procedure. Arbitration proceedings shall be in accordance with the following:

3.6(a) The arbiter shall hear and accept pertinent evidence submitted by both parties and shall be empowered to request such data as the arbiter deems pertinent to the grievance and shall render a decision in writing to both parties within sixty (60) days (unless mutually extended) of the completion of the hearing.

3.6(b) The arbiter shall be authorized to rule and issue a decision in writing on the issue presented for arbitration which decision shall be final and binding on both parties.

3.6(c) The arbiter shall rule only on the basis of information presented in the hearing and shall refuse to receive any information after the hearing except when there is mutual agreement, in the presence of both parties.

3.6(d) Each party to the proceedings may call such witnesses as may be necessary in the order in which their testimony is to be heard. Such testimony shall be limited to the matters set forth in the written statement of grievance. The arguments of the parties may be supported by oral comment and rebuttal. Either or both parties may submit written briefs within a time period mutually agreed upon. Such arguments of the parties, whether oral or written, shall be confined to and directed at the matters set forth in the grievance.

3.6(e) Each party shall pay any compensation and expenses relating to its own witnesses or representatives.

3.6(f) The Company and the Union shall, by mutual consent, fix the amount of compensation to be paid for the services of the arbiter. The Union or the Company, whichever is ruled against by the arbiter, shall pay the compensation of the arbiter including necessary expenses.

3.6(g) The total cost of the stenographic record, if requested, will be paid by the party requesting it. If the other party also requests a copy, that party will pay one-half of the stenographic costs.

Section 3.7 Binding Effect of Award. All decisions arrived at under the provisions of this Article 3, by the representatives of the Company and the Union, or the arbiter, shall be final and binding upon both parties, provided, however, in arriving at such decisions neither of the parties nor the arbiter shall have the authority to alter this Agreement in whole or in part.

Section 3.8 Time Limitation as to Back Pay. Grievance claims regarding retroactive compensation shall be limited to thirty (30) calendar days prior to the written submission of the grievance to Company representatives, provided, however, that this thirty (30) day limitation may be waived by mutual consent of the parties.

Section 3.9 Extension of Time Limits by Agreement. The time limits set forth in this Article are recognized by the parties as being necessary for prompt resolution of grievances. Reasonable extensions of these times may be arranged by mutual written agreement. If a decision is not rendered by the Company within the time limits established for Step 1, Section 3.2, the Union may thereupon advance the grievance to the next step. Grievances not presented, or presented and not pursued, within the specified or mutually extended time limits will be considered waived.

Section 3.10 Conferences During Working Hours. All conferences resulting from the application of provisions of this Article shall be held during working hours.

Section 3.11 Signing Grievance Does Not Concede Arbitrable Issue. The signing of any grievance by any employee or representative of either the Company or the Union shall not be construed by either party as a concession or agreement that the grievance constitutes an arbitrable issue or is properly subject to the grievance machinery under the terms of this Article.

Section 3.12 Jurisdictional Disputes. Any dispute where the Union contends either (1) that work performed by represented employees not within the unit described in Article 1 should be performed by employees within the unit, or (2) that represented employees not within the unit described in Article 1 should be included within the unit, shall not be subject to the grievance and arbitration provisions of Article 3. This section 3.12 shall not apply to such disputes where the Union obtains the written consent of all other interested bargaining representatives to participate in and be bound by the decision of an arbitrator or panel of arbitrators.

ARTICLE 4
PERFORMANCE MANAGEMENT

Section 4.1 Performance Management Process.

The Union and the Company agree that many factors contribute to performance. The Performance Management Process provides a method for employees and management to determine individual performance goals, assess performance against those goals and establish developmental plans to address performance needs or gain additional knowledge, skills and abilities as necessary.

4.1(a) Each employee, including new hires and his or her supervisor will participate in periodic Performance Management discussions, which may be initiated by either party. Discussions should promote a mutual understanding of all factors that contribute to or are affected by performance, such as:

- Job assignment, responsibilities, and expectations;
- The effect of performance on salary reviews;
- The effect of performance, knowledge, skills, abilities, and targeted job family attributes on retention ratings;
- Education and/or significant experience gained by the employee and related to his or her career progress within the Company;
- Other assignments, skills, or classifications that the employee may be qualified to perform.

For newly hired employees, Performance Management discussions should be initiated as soon as possible and occur as frequently as necessary to ensure early alignment with organizational goals and objectives and performance expectations, encourage job progress and growth, and ensure a smooth transition into the workforce.

Managers with employees on a cross training, rotational or other temporary assignment shall contact appropriate managers to solicit input.

4.1(b) The Performance Management Process consists of four activities: setting goals, coaching and feedback, assessing performance and employee development.

4.1(b)(1) "Goal setting" consists of documenting job responsibilities and establishing individual performance goals and objectives, based on previously communicated organizational business goals and objectives. Goals should also show alignment with the expectations for the employee's Job Family (JF) and Skills Management Code (SMC) appropriate to their current or higher level.

4.1(b)(2) "Coaching and feedback" consists of the following:

- Ongoing discussions that provide valid, constructive, performance-based feedback related to goal attainment,
- Frequent and focused coaching interactions between employees and supervisors,
- Encouraging further development of those employees who meet or exceed expectations, and
- Helping those who are falling short to identify and overcome impediments to their success.

4.1(b)(3) "Performance assessment" consists of an ongoing communication and assessment of previously defined job responsibilities, and performance goals, and objectives. Assessment results from each review shall be recorded in the Company Performance Management record system. Employees and Management will work together to continuously update their plan as goals and/or objectives change between scheduled reviews.

4.1(b)(4) "Employee development" is a discussion and coaching process to help employees and managers work together to enhance employee's knowledge, skills, and abilities to meet current and future business needs. Additionally, it provides a mechanism to support the development of skills and abilities so that each employee has the opportunity to develop professionally and personally.

4.1(c) Each employee will have at least one (1) interim review for coaching and feedback and one (1) performance assessment review during each twelve (12) month period. Employee and supervisor are encouraged to conduct additional interim reviews as often as appropriate.

4.1(d) In the final assessment review meeting, overall performance is assessed, summarized, and documented. This meeting will include a discussion

regarding the assessment's relationship to the salary review and retention index review processes.

4.1(e) Performance Management sessions (goal setting and assessment reviews) shall be scheduled to maximize their utility in salary and retention exercises.

Section 4.2 Performance Management Form. SPEEA-represented employees shall utilize the standard Company Performance Management process.

Section 4.3 Process Revision. The Performance Management process, utilization, and changes will be reviewed jointly in each year of this Agreement through the Joint Oversight Committee in accordance with LOU 8.

ARTICLE 5
VACATION PLAN

Section 5.1 General. Reasonable time away from the job is conducive to good health and well being and is considered in the best interest of the employee and the Company. Each employee should have the opportunity to schedule and take vacation each year and thereby use their vacation credits, allowing adequate staffing for Company operations.

Section 5.2 Accumulation of Vacation.

5.2(a) Vacation credits are accrued daily and awarded weekly, with credits increasing on the basis of established increments as follows:

Company Service	Annual Vacation
1 thru 4 years	80 hours
5 thru 9 years	96 hours
10 and 11 years	120 hours
12 and 13 years	128 hours
14 and 15 years	136 hours
16 and 17 years	144 hours
18 years or more	160 hours

Company service date will be used to determine the credits to be awarded. Vacation credits may accumulate to a maximum of two (2) years of credit (as determined from above schedule). No additional vacation credits will be accrued until the number of credits in the account drops below the two (2) year maximum. Deviations to the two (2) year maximum accrual must be approved by Corporate compensation and benefits.

Vacation credits will not be accrued in excess of ninety (90) calendar days on a leave of absence.

5.2(b) Part-time employees are awarded vacation credits in accordance with the above schedule on a pro-rata basis. Vacation credits will be prorated based on hours paid (excluding overtime and short-term disability leave payments).

5.2(c) Vacation accounts will be maintained to the nearest tenth of an hour unit.

Section 5.3 Use of Vacation Credits.

5.3(a) Subject to management approval based on Company work schedule requirements, previously awarded vacation credits may be used by the employee without limit. Management will encourage employee use of vacation for time off within the period credits are available. Use of vacation at times convenient to the employee will be arranged to the extent permitted by Company work schedule requirements.

5.3(b) Vacations are to be taken as time off and there will be no pay in lieu of time off.

5.3(c) Effective June 1, 2009 and subject to 5.3(d), vacation credits may be used in partial day increments of 4 hours or more, up to the scheduled hours in the employee's normal workday. Employees may use personal time off (PTO) with pay for incidental absences that can't normally be scheduled outside the employees ETS baseline work schedule, subject to management approval.

5.3(d) Part-time employees normally will use vacation credits in amounts comparable to their part-time work schedules. However, subject to the scheduling requirements of his or her organization, a part-time employee may request and receive vacation in eight (8) hour increments.

5.3(e) Holidays occurring while an employee is on vacation are not deducted from vacation credits.

5.3(f) Payment for vacations will be made at the employee's base rate in effect at the time vacation is taken plus, if applicable, any supplement to the base rate approved by the Company for inclusion in vacation pay.

5.3(g) An employee on leave of absence is eligible to use vacation credits.

Section 5.4 Vacation Pre Load. Employees hired or rehired into the Company following the date of ratification of this agreement will have their vacation account credited with one half their annual vacation accrual. Those hours may be used subject to 5.3(a). Normal vacation accrual will commence after six months of employment.

Section 5.5 Vacation Payment on Termination. An employee who terminates for any reason will be paid for all unused credits in his or her vacation account and all accrued vacation through the last day worked.

Section 5.6 Vacation Credits When Payroll Is Changed. In all cases involving the transfer of an employee from one payroll to another, the provisions of the Company's procedures pertaining to vacations, as may be revised from time-to-time by the Company, shall be applicable.

ARTICLE 6

SICK LEAVE, BEREAVEMENT LEAVE &FINANCIAL SECURITY PLAN

6.1 Purpose and Benefit of Sick Leave Hours.

Generally, sick leave is provided to help prevent a loss of wages when absent from work for one or more of the following reasons:

- Illness of employee, including physical incapacity of a female employee due to her pregnancy.
- Illness or injury in the family (requiring the employee's presence)
- Death in the family (includes domestic partner) to attend the funeral or deal with matters related to the death. Management may grant up to 3 days of personal time off with pay (PTO), pursuant to the Company guidelines, should the employee's various sick leave accounts and vacation balance be depleted.
- Medical or dental appointment which can be scheduled only during the working hours.
- Birth and care of a child of the employee.
- Placement of a child with the employee for adoption or foster care.

6.2 Definitions and Sick Leave Accrual Rates.

- **Sick leave eligibility/anniversary date** - date on which an employee begins to accrue sick leave hours each year. This is the anniversary of the employee's last start date.
- **Current sick leave account** – an account in which current year awarded sick leave hours are accumulated, maintained and used.
- **Unused sick leave account** – an account in which sick leave earned but not used from previous years is accumulated and is maintained for use as needed. These hours accumulate from year to year without limit to the total number of accumulated hours.

6.3 Award, Accumulation and Maintenance of Sick Leave Hours

- **Award** – after completing one full month of continuous Company service, employees are awarded eight hours each consecutive month, up to a maximum of 80 hours per sick leave eligibility year. These hours are available for use in the current sick leave account.

    - When the continuity of employment is broken other than by layoff or termination to enter military service, an employee must begin with the date of reemployment to accumulate one (1) month continuous active service with the Company before being eligible for sick leave.

- For part-time employees, sick leave credits will be accumulated in the proportion that the hours worked bear to full-time hours, rounded to the nearest one-tenth hour unit.

- **Accumulation** – upon reaching the annual sick leave eligibility date, one half of the remaining hours in the current sick leave account will be moved to the unused sick leave account and maintained there while the other half of the current year account is forfeited.

- **Maintenance of Current Sick Leave** A**ccount** – when this account is zeroed out upon reaching the employee's eligibility/anniversary date, a new sick leave award period begins.

- **Maintenance of Unused Sick Leave Account** – when half of the current sick leave balance is transferred to this account, the new balance will immediately reflect the addition of these hours to the previous balance. There is no maximum balance limit for this account.

Other Provisions

- In all cases involving the transfer of an employee from one payroll to another, the provisions of the Company's procedures pertaining to sick leave, as may be revised from time to time by the Company, shall be applicable.

- No sick leave credit will be accumulated during periods on layoff or for absences in excess of the first ninety (90) calendar days on a leave of absence. Such absence from the active payroll will reduce the monthly sick leave award, if applicable, in the proportion of $1/30^{th}$ of eight (8) hours for each calendar day of absence during the month, or a comparable proportionate reduction if a part-time employee, rounded to the nearest tenth of an hour.

- Eligibility dates and accumulated sick leave credits established prior to this Agreement will not be changed as a result of this Agreement.

6.4 Use of Sick Leave Hours

When using sick leave hours, the various sick leave accounts will be charged in the following order:

1. Current sick leave account
2. Unused sick leave account
3. Any accrual under a collective bargaining agreement that provides for usage upon leaving the unit
4. Financial Security Plan (at the employee's option)

Full Time Exempt

- If the employee is absent for a full day, employees must use hours equal to scheduled workday hours as reflected in the ETS baseline work schedule.

- Effective June 1, 2009, if the employee is absent for less than a full day, Sick Leave credits may be used in partial day increments of 2 hours or more, up to the remaining hours in the employees scheduled workday. Employees may use personal time off (PTO) with pay for incidental medical absences that can't normally be scheduled outside the employee's ETS baseline work schedule.

Part-time

- Employees shall use sick leave hours equal to scheduled workday hours or may request and use sick leave hours in eight (8) hour increments. ETS will allow partial day increments for part-time employees.

6.5 Financial Security Plan (FSP)

6.5(a) Continuation of Plan. Subject to the continuing approval of the Commissioner of Internal Revenue and of other cognizant governmental authorities, as more particularly hereinafter specified, a Financial Security Plan (the "Plan") in the form as now in effect as to the employees within the units to which this Agreement relates shall continue to be effective while this Agreement is in effect as to such employees in accordance with and subject to the terms, conditions and limitations of the Plan. No new contributions will be made to the Financial Security Plan with respect to Members after December 22, 2005. All other features of the Plan shall remain in place including, but not limited to, the ability to direct investments and the rules regarding distributions.

6.5(b) Approval of Plan. Approval of the Plan by the Commissioner of Internal Revenue as referred to in 6.1(a) means a continuing approval sufficient to establish that the Plan and related trust(s) are at all times qualified and exempt from income tax under Section 401(a) and other applicable provisions of the Internal Revenue Code of 1986.

6.5(c) Accrued Benefit. An employee who has an accrued benefit under the Financial Security Plan shall retain such accrued benefit under the Plan subject to the current provisions of the Plan.

Section 6.6 Unreserved Sick Leave Credits. Upon retirement under the Company's retirement plan or upon layoff or death while retirement eligible, employees will receive payment for 50 percent of their unreserved sick leave credits remaining on the date of retirement, layoff, or death. Such credits will be paid at the employee's then-current base rate, subject to a maximum rate that is established from time-to-time by the Company for all salaried employees.

ARTICLE 7
HOLIDAYS

Section 7.1 Dates on Which Observed. The following holidays will be observed by the Company during the term of this Agreement:

HOLIDAYS	2008 DAY	DATE OF OBSERVATION
Winter Break	Wednesday	December 24, 2008
Winter Break	Thursday	December 25, 2008
Winter Break	Friday	December 26, 2008
Winter Break	Monday	December 29, 2008
Winter Break	Tuesday	December 30, 2008
Winter Break	Wednesday	December 31, 2008

HOLIDAYS	2009 DAY	DATE OF OBSERVATION
New Year's Day	Thursday	January 1, 2009
Memorial Day	Monday	May 25, 2009
Independence Day	Friday	July 3, 2009
Labor Day	Monday	September 7, 2009
Thanksgiving Day	Thursday	November 26, 2009
Day following Thanksgiving	Friday	November 27, 2009
Winter Break	Thursday	December 24, 2009
Winter Break	Friday	December 25, 2009
Winter Break	Monday	December 28, 2009
Winter Break	Tuesday	December 29, 2009
Winter Break	Wednesday	December 30, 2009
Winter Break	Thursday	December 31, 2009

HOLIDAYS	2010 DAY	DATE OF OBSERVATION
New Year's Day	Friday	January 1, 2010
Memorial Day	Monday	May 31, 2010
Independence Day	Monday	July 5, 2010
Labor Day	Monday	September 6, 2010
Thanksgiving Day	Thursday	November 25, 2010
Day following Thanksgiving	Friday	November 26, 2010
Winter Break	Friday	December 24, 2010
Winter Break	Monday	December 27, 2010
Winter Break	Tuesday	December 28, 2010
Winter Break	Wednesday	December 29, 2010
Winter Break	Thursday	December 30, 2010
Winter Break	Friday	December 31, 2010

HOLIDAYS	2011 DAY	DATE OF OBSERVATION
New Year's Day	Monday	January 3, 2011
Memorial Day	Monday	May 30, 2011
Independence Day	Monday	July 4, 2011
Labor Day	Monday	September 5, 2011
Thanksgiving Day	Thursday	November 24, 2011
Day following Thanksgiving	Friday	November 25, 2011

For the period following Friday, November 25, 2011, through the remaining effective period of this Agreement, the holidays to be observed under the terms of this Article shall be those holidays scheduled and observed by the Company.

Section 7.2 Holiday Practices. Practices relating to the observance of the holidays referred to above will be administered in accordance with the established procedures of the Company. This includes the flexible redistribution of hours from one day to another within an eighty (80) hour pay period with management approval for those on other than a five-day, eight hour schedule, as permitted by Company policy. An employee on leave of absence on the day of the holiday is eligible for holiday pay if he or she meets the criteria outlined in Company policy.

Section 7.3 Employees Prevented from Working Because of Local Holidays.
Employees assigned to a non-Company facility who are prevented from working their assigned work period because a holiday not listed in this Article is recognized at the facility shall be paid for such assigned work period, unless the Company, at its option and if the employees volunteer, modifies the work schedule for the week in which the holiday falls so that the employees are able to work a full work week. In all cases, hours worked on scheduled days of rest will be treated as scheduled overtime under 11.3(b).

ARTICLE 8
WORKFORCE ADMINISTRATION

Section 8.1 Employees to Whom this Article is Applicable.

8.1(a) This Article applies and refers to employees within the collective bargaining unit described in Article 1.

8.1(b) The terms "employee" or "employees" wherever used in this Article will be subject to the foregoing limitations.

Section 8.2 Objective

The general objective of the procedure stated in this Article is to provide for the accomplishment of workforce reductions for business reasons, to the end that insofar as practicable the reductions will be made equitably, expeditiously and economically, and at the same time will result in retention on the payroll of those employees regarded by Management as comprising the workforce that is best able to maintain or improve the efficiency of the Company, further its progress and success and contribute to the successful accomplishment of the Company's current and future business. The location, occurrence and existence of any condition necessitating a workforce reduction, and the number of employees involved, will be determined exclusively by the Company. Following such determination, the Company will notify the Union of the location and the estimated size and job family and skills management code(s) involved in the anticipated workforce reduction at least one day prior to employee notification. Wherever practicable, affected employees will be given two (2) weeks notice prior to layoff and will receive consideration for open positions in accordance with 8.7(c).

8.2(a) It is recognized by both parties that due to schedule requirements, the varying kinds of work performed, the geographical location of the work, and other relevant factors, it is necessary at times to work certain skills management coded employees overtime while at the same time workforce reductions involving the same skills management codes will be going on. Management will review the use of overtime in any skills management code in which layoffs are contemplated with the intent of minimizing the use of such overtime. Management, at its sole discretion, will determine the level of overtime to be worked.

Section 8.3 Terminology for Use in Procedure

8.3(a) "**Job Classification"** refers to the Occupation Code, Job Family, Level, and Skills Management Code as provided and further defined in Article 22. Job classification is intended to define an employee's current assignment and not necessarily the employee's highest skill.

8.3(b) "Skills Management Code" is referred throughout this Article and balance of this Agreement as "SMC". SMCs identify unique knowledge, skills, abilities, and other

attributes within a particular job family. Employees may request assignment of a secondary SMC from the Company's job classification system.

8.3(c) "Major Organization" as used in this Article will mean a Major Organizational element of the Company reporting to the Chief Executive Officer of the Company or identified as such by the Chief Executive Officer. The Company shall provide to the Union an updated list of Major Organizations and advise the Union of changes made thereto.

Section 8.4 Retention Indexing / Ratings

Management periodically will make a comparative rating of each employee. The individual rating will be referred to as a "retention rating," and the process of applying these ratings and compiling them in order of rating as "retention indexing." Similar usage of these terms is made herein.

8.4(a) Frequency. The periodic retention indexing will occur not sooner than four (4) months nor longer than eighteen (18) months from the prior periodic retention indexing. The Company will complete retention reviews as near as practicable to completion of the final review phase of the Performance Management process.

8.4(b) Retention Group Make-up / Review Process. Management will assign a retention rating by SMC to each employee to whom this Article applies, with the basic objective of identifying those employees who in the opinion of Management, are best able to maintain or improve the efficiency of the Company, further its progress and success and contribute to the successful accomplishment of the Company's current and future business as identified in the employee's Performance Management Plan. Consistent with this objective, Management will consider each employee's length of Company service, competence, diligence and demonstrated usable capabilities based upon the employee's current performance and a review of the employee's previous performance. Length of Company service will be a positive factor to the extent that the experience so gained continues to be reflected in increased capability. Employees on part-time work schedules as defined in Article 11 will be retention indexed with employees on full-time work schedules. It is recognized that any practicable process of retention indexing cannot be completely free of error as to method used or as to resulting ratings, taking into account the large numbers of employees, skills, organizations and requirements involved; the fact that numerous Management representatives necessarily must participate in the process; and the additional facts that professional employees are involved and many of the factors that must be dealt with in the process are intangible in nature. The Company will determine the retention rating of each employee, the time at which such ratings will be assigned, the members of Management who will determine ratings or participate in the process, the groupings to be utilized and the other mechanics and details of such process. The Company will instruct and periodically will reinstruct members of Management participating in the process to assign retention ratings with the greatest possible care and objectivity. Such instructions will stress that retention review

is to be accomplished without regard to potential adjustments for Company service as provided in 8.4(e).

8.4(c) Distribution. Retention indexing will result in each employee being rated in one of four (4) categories, hereinafter referred to as R1, R2, R3, and R4. Each periodic retention indexing will be in accordance with a forced distribution of employees so that, at the time of the periodic retention indexing, 23% to 27% of the employees within each job family and skills management code will be rated in each of the first three indexes with the remaining employees rated in the Fourth index. In instances where it is mathematically impossible to accomplish this 23% to 27% distribution within each job family and skills management code, the distribution will conform as nearly as is mathematically feasible with this 23% to 27% distribution requirement. Since personnel transactions subsequent to each periodic retention indexing will occur, it is not necessary to maintain this distribution during intervals between periodic retention indexings. Assignment of retention ratings between periodic reviews will be handled in accordance with 8.4(h) and such ratings will be reaffirmed or superseded by ratings assigned during the next periodic indexing

8.4(d) Designated Employees. Designated employees will be identified as part of the retention indexing process and advised in writing via the retention rating notification per 8.4(f) that, in the event of layoff during the period of time between retention indexes, they will have no first consideration recall rights.

- Designated employees must have an assigned lowest retention rating.
- Designated employees will be identified by skill teams.
- Designated employees who have one (1) full year of service and who elect to receive income continuation benefits under 21.3(a)(1) will nevertheless be ineligible for first consideration recall rights.

Employees who have been so designated will be provided with an Employee Improvement Action Plan which will identify the specific conditions leading to the designation and improvements necessary to avoid such designations in the future. Management and the employee will have on-going discussions about the employee's progress in achieving the objectives outlined in the action plan. The Company will promptly notify the Union of the identities of designated employees. The identification of designated employees shall not be subject to Article 3; however, designated employees may appeal the designation regardless of their previous retention index rating in accordance with 8.4(g).

Designations will remain in effect until the next scheduled retention index review exercise or until successful completion of improvements identified in the Employee Improvement Action Plan.

8.4(e) Adjustments for Company Service. As a part of each periodic retention index review and immediately following completion of the distribution procedure set forth in 8.4(c), adjusted retention ratings will be assigned in compliance with the following:

Employees with twenty (20) or more but less than thirty (30) years of Company service whose assigned retention rating is R4 will be adjusted to a R3 retention rating. Employees with thirty (30) or more years of Company service who are rated R3 or R4 will be adjusted to a R2 retention rating. Such adjustments will be reflected in the written notification to each employee described in 8.4(f). (Employees who reach the aforementioned Company service dates between periodic retention index reviews will receive an adjusted retention rating accordingly.)

Employees may elect to temporarily waive any service adjustment by sending a digitally signed email within 14 days of receiving their retention notice to their Skill Captain stating their desire to waive their adjusted rating. The waiver of the service adjustment will remain in place until the next periodic retention index review.

Employees designated pursuant to the process described in 8.4(d) will not be eligible for service adjustments. Such employees may appeal their designation using the process described in 8.4(g).

8.4(f) Employee Notification. Management will provide each employee with written notification of his or her new periodic retention rating not later than the effective date of the new periodic retention indexing, except where such a schedule is made impractical due to the unavailability of the employee or the supervisor occasioned by vacations, travel assignments, etc. In addition, management will offer to discuss the new retention index with employees. The written notification will contain that employee's:

8.4(f)(1) The employee's job classification and SMC

8.4(f)(2) The employee's assigned retention rating and adjusted rating, if any, under 8.4(e),

8.4(f)(3) The effective date of the retention rating,

8.4(f)(4) The number of employees in each of the four (4) retention rating categories as adjusted under 8.4(e) within the employee's Retention Index Group as defined in 8.4(b).

8.4(f)(5) The Assessment Criteria used for the employee's job classification and SMC.

8.4(f)(6) The name of the member of management who chaired the review **(**Skill Captain)

8.4(f)(7) The notice to an employee who is identified by their skill team as designated per 8.4(d)shall include the following statement: **Designated**: In the event of layoff during the period of being designated you will have no first consideration recall rights.

8.4(g) Retention Rating Appeals. An employee who feels the assigned retention rating is inappropriate may at any time discuss the matter with his or her immediate supervisor. If within thirty (30) calendar days following notification of the assigned retention rating, the employee elects to appeal the rating, and discussion with the immediate supervisor has not resolved the employee's concern, certain ratings may be appealed for further review as provided below:

8.4(g)(1) Only those assigned retention ratings may be appealed where the assigned rating represents a two (2) or three (3) position drop from the previous rating, or a one (1) position drop in two consecutive ratings, and it is substantiated that the drop is not due to the effect of workforce reduction and/or consolidation of retention indexing groups.

8.4(g)(2) The employee so affected will address his or her concerns in writing to the Union setting forth the basis for such appeal.

8.4(g)(3) If the Union believes the employee's appeal warrants further review, the Union will notify the Enterprise Senior Workforce Manager or designee within ten (10) workdays of receipt of the employee's appeal.

8.4(g)(4) Within ten (10) workdays following such notice, a Workforce Representative, an Employee Relations Representative, and a Union Representative will meet to hear the appeal. The employee, immediate supervisor, and/or Skill Captain shall be invited to provide pertinent information at this meeting.

8.4(g)(5) The Workforce Representative, Employee Relations Representative, and Union Representative will resolve the appeal at the meeting or within five (5) workdays thereafter. In the event the Union considers the decision to be inappropriate to the facts of the case, the Union may advance its appeal to the Enterprise Senior Workforce Manager. Such resolution by the Enterprise Senior Workforce Manager will be final and binding and will conclude the appeal process.

8.4(h) Out of Sequence. An employee hired into the unit who has less than two (2) years of directly applicable work experience will be assigned a job family and skills management code. Such employees will not be included in or subject to the retention index review and will not be assigned a retention rating until (1) management is able to evaluate the employee’s capability and elects to assign the employee a retention rating; or (2) a period of twelve (12) months from the employee’s date of hire into the unit; or (3) a

surplus condition occurs in the assigned job family and skills management code, whichever occurs first.

8.4(h)1 An employee who returns to active employment from layoff or leave of absence status will retain the job family and skills management code and retention rating held at time of layoff until such time as Management is able to evaluate the employee's capability and elects to assign the employee a new retention rating.

8.4(h)2 Employees entering the unit to which this Article applies, other than as described in 8.4(h) and 8.4(h)1 and those employees whose job family and skills management codes are changed, will receive new retention ratings within the six (6) month period following the date of such entrance or change. Prior to receiving the new ratings, employees whose job family and skills management codes were changed will be regarded as having the retention ratings held immediately prior to the job family and skills management code change or entrance to the unit.

Section 8.5 Redeployment Procedure

8.5(a) When a workforce reduction is determined by Management to be necessary within one or more job family and skills management codes in a Major Organization, Management will designate for layoff the required number of employees in the Major Organization within such job family and skills management codes with R4 retention ratings. Exceptions to the designation for layoff of R4 rated employees may be made by the Company, where it desires to retain certain R4 rated employees in such job family and skills management codes in the Major Organization, as long as the number of R4 rated employees so retained in each affected job family and skills management code in the Major Organization does not exceed 10% or one employee, whichever is greater, of the number of employees rated R4 within the job family and skills management code at the most recent periodic indexing. If the remaining R4 rated employees in any such job family and skills management code are less than the number required to be designated for layoff in that job family and skills management code, the procedures in 8.5(b) will be applied, subject to the exceptions stated herein.

8.5(b) If, after application of the procedures and exceptions stated in 8.5(a), a necessity for workforce reduction continues to exist in any such job family and skills management codes in the Major Organization, Management will designate for layoff the required number of employees in the Major Organization within such job family and skills management codes with R3 retention ratings. Exceptions to the designation for layoff of R3 rated employees may be made by the Company, where it desires to retain certain R3 rated employees in such job family and skills management codes in the Major Organization, as long as the number of R3 rated employees so retained in each affected job family and skills management code in the Major Organization does not exceed 10% or one employee, whichever is greater, of the number of employees rated R3 in the Major Organization within the job family and skills management code at the most recent periodic indexing. If the remaining R3 rated employees in any such job family and skills management code are less than the number required to be designated for layoff in that job

family and skills management code, the procedures in 8.5(c) will be applied, subject to the exceptions stated therein.

8.5(c) If, after application of the procedures and exceptions stated in 8.5(b), a necessity for workforce reduction continues to exist in any such job family and skills management codes in the Major Organization, the reduction will be accomplished by transferring a sufficient number of the remaining employees in the Major Organization within such job family and skills management codes to another Major Organization within the same labor market area displacing R4 rated employees in such job family and skills management codes in the latter Major Organization who will be designated for layoff; and then, to the extent necessary, R3 rated employees in such job family and skills management codes in the latter Major Organization will be displaced and designated for layoff. The latter Major Organization will have the right to retain in each affected job family and skills management code not to exceed 20% of its R4 rated employees in each such job family and skills management code and not to exceed 40% of its R3 rated employees in each such job family and skills management code. To determine the number of employees that may be retained by the latter Major Organization, these percentages are to be applied respectively to the number of R4 rated employees and R3 rated employees that were within the particular job family and skills management code in the latter Major Organization at the most recent periodic indexing.

8.5(d) If, after application of the procedures and exceptions stated in 8.5(a), 8.5(b) and 8.5(c) if applicable, a necessity for workforce reduction continues to exist in any of the job family and skills management codes in the Major Organization where the reduction originated, a sufficient number of R2 rated employees in such Major Organization within such job family and skills management codes will be designated for layoff to reduce to the extent possible or eliminate the condition. Exceptions to the designation of R2 rated employees for layoff may be made by the Company where it desires to retain certain R2 rated employees in such job family and skills management codes in the Major Organization, as long as the number of R2 rated employees so retained in each affected job family and skills management code in the Major Organization does not exceed 10% or one (1) employee, whichever is greater, of the number of employees rated R2 rated in the Major Organization within the job family and skills management code at the most recent periodic indexing.

8.5(e) Further rounding under 8.5(a), 8.5(b), and 8.5(d) is permitted within the following parameters:

> **8.5(e)(1)** One (1) employee may be subject to the 10% exception if there are one (1) to fourteen (14) employees in the retention index group;
>
> **8.5(e)(2)** Two (2) employees may be subject to the 10% exception if there are fifteen (15) to twenty-four (24) employees in the retention index group;
>
> **8.5(e)(3)** Three (3) employees may be subject to the 10% exception if there are twenty-five (25) to thirty-four (34) employees in the retention index group;

8.5(e)(4) Higher numbered retention index groups may be rounded similarly.

8.5(f) If, after application of the procedures and exceptions stated in 8.5(a), 8.5(b), 8.5(c) if applicable, and 8.5(d), a necessity for workforce reduction continues to exist in any of the job family and skills management codes in the Major Organization where the reduction originated, the Company will have the right to select, designate and lay off any of the remaining employees in the affected job family and skills management codes within the collective bargaining unit irrespective of their retention index, Major Organization, or any other factor.

8.5(g) The Company may lay off employees from the unit without regard to the provisions of this procedure provided the number of such layoffs per month does not exceed .25% (one quarter of one percent) of the total number of employees employed in the collective bargaining unit on the first day of that month.

8.5(h) Nothing in this Article is intended to preclude Management from using other actions, such as employee transfers, reclassifications, reassignments or combinations thereof which are not inconsistent with the terms and conditions governing such actions as may be set forth in this Agreement, in order to avoid or reduce the necessity to initiate or carry out workforce reductions.

8.5(i) Employees designated by the Company for special training in programs approved by the Company will be assigned a unique skills management code UNAX.

8.5(j) The provisions of 8.5 will not apply to employees placed on travel status by the Company, and such employees will not be laid off while on such status.

8.5(k) Exceptions to Foregoing Procedures. In instances where, in the opinion of Management, the foregoing procedures contained in this Article do not achieve the Company objectives stated in 8.2, exceptions thereto, without any limitation as to number, may be made when approved by the Chief Executive Officer of the Company, or designated representative. It will be the responsibility of any supervisor who recommends such an exception to prepare and transmit through the line organization to the Vice President of Engineering or equivalent level of management and then the Office of the Chief Executive Officer of the Company, or designated representative, a detailed report of the proposed exception or exceptions and the reasons therefore. An explanation will be provided to the Union.

Section 8.6 Layoff Status and Return to Active Employment.

8.6(a) Maintenance of Layoff Status.

8.6(a)(1) Each employee laid off under the provisions of this Article will remain on layoff status for a total period of three (3) years from the date the layoff was effective, subject to 8.6(a)(2).

8.6(a)(2) The Company will maintain a list of the names of all laid-off employees except those determined ineligible under 8.6(b)(3), those who have received layoff benefits as a lump sum under 21.3(a), and those identified under 8.4(d).

8.6(a)(3) An employee shall remain on layoff status in accordance with 8.6(a)(1), provided he or she does not:

> **8.6(a)(3)a** Reject consideration for employment, for example, fail to respond to a Company contact, letter of interest, request to update Conflict of Interest status, or a formal offer from the Company of a job within ten (10) workdays after such contact by the Company or by such later date as may be stipulated by the Company, or the Company was unable to contact the laid off employee due to non-existent or inaccurate contact information on record in TotalAccess and the Company's Employment Staffing System, or
>
> **8.6(a)(3)b** Refuse a formal offer from the Company for a fulltime job in the same labor market area from which laid off, for which the salary offered is equal to or greater than the employee's salary at the time of layoff plus any contractual minimum wage increases that were applied during the time period between layoff and recall, or
>
> **8.6(a)(3)c** Fail to report to work within ten (10) workdays following acceptance of a formal Company offer or on such date as may be stipulated in the Company offer, or
>
> **8.6(a)(3)d** Elect retirement under the Company Retirement Plan thereby removing himself or herself permanently from layoff status.

8.6(a)(4) Employees removed from layoff status for any reason other than retirement or expiration of the three (3) year period following layoff will be notified in writing of such removal, and the reasons therefore, by the Company.

8.6(a)(5) Laid-off employees who are prevented from meeting the conditions described in 8.6(a)(3)a, 8.6(a)(3)b, 8.6(a)(3)c or 8.6(a)(2) solely due to medical disability, verified to the Company's satisfaction by their personal physician, shall upon request be granted a waiver for the missed requirement(s).

8.6(a)(6) If any employee on layoff status disputes his or her recall status as reflected in Company records, Company records shall prevail unless employee can produce proof of registration pursuant to 8.6(b)(4).

8.6(b) Return to Active Employment.

8.6(b)(1) It is a mutual objective of the Company and the Union that laid-off employees, who have not been determined ineligible under 8.6(b)(3), 21.3(a), or 8.4(d) be recalled to active employment, and a mutual desire that such recall into the Major Organization from which the employee was laid off be offered in approximate reverse order of layoff with the objective of matching laid off employee skills to job requirements as defined in 8.6(b)(1)c. An explanation of the exceptions to the approximate reverse order of recall will be provided to the Union. Accordingly, laid off employees on file for recall pursuant to 8.6(b)(4) will be offered return to active employment within the applicable job family and skills management code, in approximate reverse order of lay-off, prior to workforce additions from sources external to the Company, subject to the following limitations:

8.6(b)(1)a Eligible laid off employees must set up and maintain a profile in the Company's Employment Staffing System.

8.6(b)(1)b Nothing in 8.6 will preclude the Company from hiring from sources outside the Company when projected requirements exceed the number of laid off employees in applicable job family and skills management codes on file pursuant to 8.6(b)(4) who are eligible for an offer of recall. In such instances, qualified laid off employees with priority recall consideration within the applicable job family and skills management code shall be extended a job offer.

8.6(b)(1)c In making recall and hiring decisions, the Company will review the specific qualifications of individuals on the basis of product familiarity, specialized experience or education, customer requirements and the need to achieve the most efficient and accurate match of individual capabilities to job requirements. Consequently, not all Company decisions relating to recall and hiring can promote the mutual objective and desire stated above. Such decisions will not be subject to Article 3.

8.6(b)(2) The Company periodically will review with the Union the operation of 8.6(b)(1) in order to facilitate achievement of the mutual objective and desire stated above.

8.6(b)(3) Prior to layoff the Company will review those employees to determine eligibility for reemployment consideration under 8.6(b)(1). The review will be limited to those employees for whom there is supporting documentation of performance deficiencies and/or a pattern of unacceptable conduct. The review will be performed by the cognizant Skill Team Captain for the employee's job family and skills management code. Based on the review the employee will be advised no later than the time layoff notice is issued as to his or her eligibility for reemployment consideration under 8.6(b)(1). A determination of ineligibility shall

be supported by documentation of performance deficiencies. An employee determined ineligible may appeal such determination to the cognizant Skill Team Captain. If the appeal does not resolve the matter, the employee may then file a grievance in accordance with Article 3. Such grievance shall be limited to the first three steps of the grievance procedure and shall not be subject to arbitration.

8.6(b)(4) Priority Recall Registration Requirements:

8.6(b)(4)a To be considered for and maintain priority recall status, the following requirements must be completed:

1. The laid off employee must keep the Company informed of his or her interest in returning to active employment by registering for priority recall consideration using electronic filing via the online Recall Registration & Status Tool in TotalAccess. Initial filing for priority recall consideration for return to active employment must occur during the half calendar year in which they were laid off or within 60 days of their layoff date, whichever is greater.
2. A profile must be created and maintained in the Company's Employment Staffing System as required under 8.6(b)(1)a.
3. Priority recall consideration status must be maintained by registering via TotalAccess once each consecutive calendar half-year period (January through June; July through December) during the three-year period from the date of layoff. Electronic filing for the next calendar half-year must be completed via TotalAccess prior to the expiration of the current half-year period.

8.6(b)(4)b Individuals who do not properly register in each calendar period will be removed from the priority recall consideration eligibility list. Failure to register properly will result in priority recall consideration eligibility being revoked for the remainder of the three (3) year period. Eligible laid off employees on file for return to active employment are subject to the provisions of 8.6(a).

8.6(c) Salary and Level of Returning Laid-Off Employees. Company offers to laid-off employees for return to active employment will be extended at whatever salary and level is deemed by management to be appropriate and will be equal to or greater than the employee's salary at the time of layoff, plus any contractual minimum wage increases that were applied during the time period between layoff and recall.

8.6(d) Employees who remain on layoff status for the full period specified in 8.6(a)(1) will, for a period up to six (6) years from the date layoff was effective, remain eligible for certain additional retirement benefits as specified in the Retirement Plan.

8.6(e) The Company will maintain a record of all laid off employees who are on layoff status under the above provisions.

Section 8.7 General Provisions.

8.7(a) Compensable Injuries. Any employee who has been wholly or partially incapacitated for that employee's regular work by compensable injury or compensable occupational disease while in the employ of the Company may, while so incapacitated, be employed in the bargaining unit in work which the employee can do without regard to the provisions of this Article. The Union shall be notified of all persons to whom this waiver applies and the effective dates of such waiver.

8.7(b) Veterans. The Company and the Union, recognizing that the rights of employees entering or inducted into the Armed Forces of the United States to reemployment by the Company and the Company's obligation to these employees are the subject matter of legislation, agree that nothing contained in this Agreement will preclude the Company from re-employing such employees in compliance with the provisions of applicable laws.

8.7(c) Job Posting Process. The Company will maintain an environment in which employees can make known their interest in transferring to other positions for which they are qualified to perform and which may satisfy their personal needs. A job posting and transfer process will be maintained which will allow employees, without fear of reprisal, to make application for transfer and receive consideration as a candidate for positions for which they are qualified. All employees, including those involved in surpluses, shall have access to the Company's job posting process. Exceptions to the employee release requirements may be appealed to the Enterprise Senior Workforce Manager in cases where resolution is not obtained through discussions with management. Appeal decisions are not subject to Article 3. The Company will notify the Union in advance of implementation of any changes to the Company's job posting process.

ARTICLE 9

CONTRACT PERSONNEL

Section 9.1 Purpose

The Company and the Union recognize that contract personnel are a practical source of skilled temporary labor that allows the Company to acquire skilled engineering and technical support in a timely manner. The Company and Union recognize that requirements for experienced contract personnel must be balanced with the need to build and maintain the Boeing experience base and to support our mutual objective of workforce stabilization by minimizing employee layoffs.

Section 9.2 Definition

The term "contract personnel" refers to temporary personnel supplied by another business entity to perform Company work on Company premises under the daily control and supervision of Company management. The business entities that provide contract personnel normally are in the business of providing temporary services (such as temporary employment agencies and staffing

firms). Sources of contract personnel may also include businesses in the aerospace or related fields that make their employees available for temporary labor (so called "industry assist" arrangements). Excluded from the definition of contract personnel are consultants and their employees, and employees of subcontractors or vendors.

Section 9.3 Procedures and Limitations

9.3(a) The Company shall notify the Union of the basis for the need, the approximate number of contract personnel required and the job family and skills management codes normally held by employees performing the type of work involved.

9.3(b) If based on a variety of factors (including but not limited to the nature of the assignment, the status of the program, the overall need for the skills at issue, and the purpose of using contract personnel described above) the Company needs the skills supplied by contract personnel on a long-term basis, the position shall be made available in accordance with the Boeing job posting process.

9.3(c) The Company and the Union agree that it is normally inappropriate to hire contract personnel as direct hires in periods of surplus activity within a job family and skills management code. Deviations will be subject to approval by the appropriate senior level executive for the Major Organization. The granting of a deviation to allow such hiring shall not be subject to the grievance and arbitration procedure of Article 3.

9.3(d) Upon request by the Union, the Joint Oversight Committee will review situations where the use of contract labor has exceeded eighteen (18) months. The Union may request that the Company provide a rationale for the duration of the assignment.

9.3(e) Contract personnel shall not be authorized to make decisions normally associated with management responsibility including salary determination, retention, and discipline.

9.3(f) No employee from a surplusing Major Organization shall be laid off while contract personnel are still employed in that job family and skills management code within that Major Organization, except those employees as to whom there is supporting documentation of performance deficiencies.

9.3(g) Exceptions to this Article to avoid significant disruption or impact on committed packages of work will require the approval of the Enterprise Senior Workforce Manager. Notification will be provided to the Union as soon as practicable.

Section 9.4 Data

The Company shall supply the Union on a monthly basis with data that displays the number of contract personnel utilized, by job code and Major Organization, so that compliance with all limitations identified in 9.3 can be monitored. The data shall include names, BEMS identification numbers, work location, job title, group/organization name, contract labor type code, and start dates. The Company will survey and report recognized engineering categories of

work and classification changes on a monthly basis. Additionally, any inquiries brought forward by the Union relative to the use of engineering skill sets will be responded to by the Company.

ARTICLE 10
JOINT MEETINGS

Section 10.1 Joint Meetings.

10.1(a) Should either party desire to discuss with the other any matter affecting generally the relationship of the parties, a meeting of Union and Management representatives shall be arranged upon request of either party. Such meeting shall take place at a time mutually convenient to both parties. Any use of Company time for attendance at such meetings shall be arranged in advance by mutual agreement.

10.1(b) This Article is intended to provide a free avenue of communication between the Union and the Company, and suggestions, complaints, or other matters may be presented by either party, provided that neither party shall be required to discuss any item brought up by the other party nor be bound to act upon any item presented. However, both parties agree to discuss informal grievances and complaints.

ARTICLE 11

RATES OF PAY AND WORK SCHEDULES

Section 11.1 Pay Rates, and Cost of Living Adjustments.

11.1(a) The minimum salary will be the Salaried Reference Table minimum values as established by the Company for each Salaried Job Classification identified in Appendix A.

11.1(b) The Company will establish three (3) salary review adjustment funds in accordance with the dates set forth in Table I:

TABLE I
SALARY REVIEW ADJUSTMENT FUND PERIODS
AND INCREASE PERCENTAGES

Review Period	Fund Computation Date	Increase Effective Date	Base Salary Adjustment Fund **
1	1/30/09	2/27/09	3.0
2	1/29/10	2/26/10	3.0
3	1/28/11	2/25/11	3.0

** The Base Salary Adjustment Fund percentage for Review Periods 2 and 3 shall be the greater of the Base Salary Adjustment Fund percentage established for the Wichita Non-SPEEA salaried population or the Base Salary Adjustment Fund listed in Table I above, for each Review Period.

** Over the life of the contract, a minimum of three percent (3%) will be guaranteed for those employees who are on the active payroll and in the unit for the entire duration of the collective Bargaining Agreement.

11.1(b)(1) Following the ending date of each of the three (3) selective salary adjustment review periods, the Company will increase the base salaries of employees selected from among those who are eligible. The base salaries of eligible employees will be increased from a fund computed by multiplying the Increase Percentage by the total salaries of eligible employees. These increases will be effective on the Effective Date of the review period. Eligible employees are those who were in the bargaining unit prior to November 1st of each year, and on the active payroll on both the fund computation date and the increase effective date. In addition and for Review Period 1 only, eligible employees must be in the bargaining unit on the date of ratification of this agreement.

Employees on leave of absence for more than 180 days as of the Fund Computation Date are excluded from the Salary Review exercise.

For any Review Period identified in Table I, the Company may, at its discretion, increase the Salary Adjustment Fund, resulting in an equal decrease to the Salary Adjustment Fund of a subsequent Review Period.

11.1(c) Cost of Living Adjustments.

11.1(c)(1) Employees eligible to participate in the Salary Review adjustment funds under 11.1(b) may also receive Cost of Living Adjustments to the extent such adjustments become effective under and in accordance with all of the terms, conditions and limitations stated in 11.1(c). The

terms, definitions, and limitations stated in 11.1(b) and 11.1(c) also apply to such adjustments. Cost of Living Adjustments would be delivered to each eligible employee separately from those selective adjustment funds derived in 11.1(b). Cost of Living Adjustments would be effective on the dates specified in Table II.

11.1(c)(2) Determination of Cost of Living Adjustments shall be made in reference to the series U.S. city average "Consumer Price Index Urban Wage Earners and Clerical Workers" published by the Bureau of Labor Statistics, U.S. Department of Labor, with the following base period: 1982-1984 = 100, such Index being referred to herein as the BLS Index.

11.1(c)(3) Computations will be made using the three-month average of the BLS Index for July, August and September, 2008 (215.5), as the base period.

11.1(c)(4) During the life of this Agreement, Cost of Living Adjustments shall be computed using the three (3) month average of the BLS Index for the periods specified in Table II and the corresponding BLS Index threshold values expressed as percentage increases over the 2008 base period. The formula will be: percentage of Cost of Living equals fifty (50) percent of the percentage increase in the BLS Index, from the 2008 base period to the BLS Index Comparison Quarter that exceeds the BLS Index Threshold Percentage, as shown in Table II.

11.1(c)(5) In order to preclude recognition, on more than one effective date, of the same percentage increase in the BLS Index, any recognition on one effective date of a percentage increase over the applicable BLS Index Threshold Percentage will cause that percentage to be set aside and disregarded in ensuing computations. [e.g., if the BLS Index for October, November, December 2008 represented a 10.0 percent increase over the base period (yielding a 1.0 percent Cost of Living Adjustment effective 2/27/2009), no Cost of Living Adjustment would result for the 2/26/2010 effective date unless, and to the extent, the BLS Index for October, November, December 2009 represented an increase in excess of 18.0 percent over the base period.] BLS Index three-month averages, BLS Index increase percentages, and salary increase percentages will be rounded to the nearest tenth, with five hundredths rounded upward to the nearest tenth.

TABLE II

Effective Date	BLS Index	BLS Index Threshold
Of Adjustment	Comparison Quarter	Percentage
2/27/2009	Oct, Nov, Dec 2008	8.0%
2/26/2010	Oct, Nov, Dec 2009	16.0%
2/25/2011	Oct, Nov, Dec 2010	24.0%

11.1(c)(6) In connection with each of the effective dates in Table II, the computations set forth in 11.1(c)(4) will be made.

11.1(d) For payroll computation purposes, hourly rates of pay will be computed on the basis of 2080 compensable hours each calendar year.

Section 11.2 Classifications. When, pursuant to the provisions of Article 1, the Company classifies an individual in one of the Engineer classifications listed in Appendix A, it will give consideration to the nature of the work involved and the qualifications of such individual. Inclusion in these classifications shall be limited to those employees who, in the performance of their assigned work, regularly apply engineering disciplines to the research, design, development, test and evaluation of Company products or processes, and who satisfy the definition of "professional employee" as stated in Section 2(12) of the National Labor Relations Act as set forth below:

> "(a) any employee engaged in work (i) predominately intellectual and varied in character as opposed to routine mental, manual, mechanical, or physical work; (ii) involving the consistent exercise of discretion and judgment in its performance; (iii) of such a character that the output produced or the result accomplished cannot be standardized in relation to a given period of time; (iv) requiring knowledge of an advanced type in a field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction and study in an institution of higher learning or a hospital, as distinguished from a general academic education or from an apprenticeship or from training in the performance of routine mental, manual, or physical processes; or
>
> (b) any employee, who (i) has completed the courses of specialized intellectual instruction and study described in clause (iv) of paragraph (a) and (ii) is performing related work under the supervision of a professional person to qualify himself to become a professional employee as defined in paragraph (a)."

This Section shall not be construed as affecting the Company's unilateral right to select and determine the employees to be included in each classification listed in Appendix A, which right shall not be subject to Article 3.

Section 11.3 Overtime.

11.3(a) The hourly rate to be paid for scheduled overtime worked by employees will be straight time plus $6.50 per hour.

11.3(b) The term "scheduled overtime" as used in this paragraph will refer to a program of work in excess of 80 compensated hours in a two-week pay period authorized as scheduled overtime by the Company to meet increased workload.

11.3(c) The provisions of 11.3 will not be applicable to the following:

11.3(c)(1) Employees on part-time work schedules.

11.3(c)(2) Time enroute on travel assignments at the request of the Company.

11.3(c)(3) All hours worked in excess of the scheduled hours which are not requested by the Company.

11.3(d) Except as expressly provided in this Agreement, the Company shall have the right to require employees to record time worked (however categorized) and to administer the overtime and all other aspects of its labor charging system in the manner the Company may determine from time-to-time.

11.3(e) Effective July 17, 2009, when an employee records both overtime and PTO in the same pay period, the overtime will be reduced by the number of hours of PTO taken.

Section 1.4 Temporary Military Leave. Time off with pay up to a maximum of eighty (80) hours each military fiscal year will be granted to an employee who is a member of a reserve component of the Armed Forces and who is absent due to required annual active duty or to temporary special duty. The amount due the employee under 11.4 shall be reduced by the amount received from the government body identified with such active or temporary special duty, for the period of such duty (up to the maximum period mentioned above). Such items as subsistence, uniform, and travel allowance shall not be included in determining pay received from the state or federal government. An employee who elects to use available company paid holidays during the first 90 calendar days of a military leave, vacation credits, or sick leave credits while on temporary active duty will not be eligible for military pay differential for that period.

Members of a reserve component of a uniformed service ordered to annual active duty are eligible for military differential pay up to a maximum of 80 hours each military fiscal year (October 1 – September 30) or longer if required by applicable laws.

Members of a reserve component of a uniformed service ordered to temporary special duty under Military U.S. Code Title 10 or mobilized by the applicable state agency are eligible for military differential pay up to a maximum of 90 calendar days for each occurrence. Extension of military differential pay beyond 90 days may be approved on a case-by-case basis for each call-up. The approval will be based on the call-up and not on an individual employee basis. Military differential pay will end upon the employee's release from active duty

Employees will retain all compensation received from the uniformed services. If this compensation is less than their regular Company pay (base rate plus applicable additives), the Company will provide pay equal to the difference between the employee's base rate (plus applicable additives) and the compensation received from the uniformed services. This pay will be provided upon receipt of the employee's leave and earnings statement. Subsistence (does not

include quarters), uniform, and travel allowances will not be included in determining military pay.

Section 11.5 Jury Duty and Witness Service. Employees covered by this agreement will be subject to company policy and procedure referencing Jury Duty and Witness Service.

Section 11.6 Work Schedules and Shifts.

11.6(a) Each employee working full time shall be assigned one of the following work schedules:

(1) Category 1 Weekday Schedule: 40 hours in a workweek or 80 hours in a pay period, with regular workdays during the Monday through Friday period.

(2) Category 1 Weekend Schedule: 40 hours in a workweek or 80 hours in a pay period, with Saturday and/or Sunday as a regular workday.

(3) Category 2 Weekday Schedule: Less than 40 hours in a workweek or less than 80 hours in a pay period, with regular workdays during the Monday through Friday period.

(4) Category 2 Weekend Schedule: Less than 40 hours in a workweek or less than 80 hours in a pay period with Saturday and/or Sunday as a regular workday.

TABLE III
WORK SCHEDULES

Schedule Hours	**Category One** Schedules of 40 hours in a workweek or 80 hours in a pay period		**Category Two** Schedule with fewer than 40 hours in a workweek or 80 hours in a pay period	
Schedule Type	**Weekday**	**Weekend**	**Weekday**	**Weekend**
Shift	**Incentives**			
First	None	Weekend Rate	Schedule Factor	Weekend Rate Schedule Factor
Second	Shift Rate	Shift Rate Weekend Rate	Shift Rate Schedule Factor	Shift Rate Weekend Rate Schedule Factor
Third	Shift Rate Shift Percentage	Shift Percentage Shift Rate Weekend Rate	Shift Rate Schedule Factor	Shift Rate Weekend Rate Schedule Factor

TABLE IV

INCENTIVES DEFINITIONS

Shift Percentage Maintains "equity" with 3rd shift 6.5 hour schedule	Shift Rate Working other than 1st shift	Weekend Rate Working on a Saturday/Sunday as a regular day	Schedule Factor Works less than 40/80 hours, paid for 40/80
23%	$1.00 per hour	Sat. or Sun. $2.00 Sat. & Sun. $3.00	Pay period hours/ Scheduled hours

Employees may, at their request and with management's approval, work any of the above schedules. Management will staff Weekend Schedules with volunteers.

11.6(b) Employees may at their request and with management's approval, make a temporary modification of their work schedule through movement of hours from one day to another within an 80-hour pay period.

11.6(c) The Company may assign an employee to any shift to meet operational requirements. The following shift identification shall apply:

(1) First shift: Begins at any time from 5:00 a.m. to 11:59 a.m.
(2) Second shift: Begins at any time from 12:00 noon to 7:59 p.m.
(3) Third shift: Begins at any time from 8:00 p.m. to 4:59 a.m.

Section 11.7 Incentives.

11.7(a) Following the date of ratification of this agreement, employees assigned to second or third shift shall receive a shift rate incentive of one dollar per hour.

11.7(b) Following the date of ratification of this agreement, employees assigned to either Saturday or Sunday as a regular day of work shall receive $2.00 per hour. Employees assigned to both Saturday and Sunday as regular days of work shall receive $3.00 per hour.

11.7(c) Employees assigned to a Category 2 Schedule will receive a schedule factor incentive equivalent to the difference between the hours scheduled and forty hours in a workweek

11.7(d) Employees assigned to a Category 1 Schedule and identified to receive the "shift percentage" shall receive twenty-three percent (23%) of their base rate.

Section 11.8 Salary Adjustment and Promotion Fund

For each review period below, the Company will spend up to one half of one percent (.5%) of the total unit Base Salary Adjustment Funds as determined for Table I of this Article as of the computation date of the review period on either adjustments in salary accompanied by a change in level classification (promotion); or adjustments in salary outside of the annual salary review (Out of Sequence Selective Adjustment) or any combination of the two. In the event less than .5% is spent during the review period, the delta between the actual expenditure and .5% will be added to the next salary adjustment fund.

The minimum promotional increase will be $3,000.

There will be no selective adjustments or in-line promotions outside the competitive job selection process during the period scheduled by the Company for salary review (typically January 1 through mid-April).

Review Period	Start Date	Computation Date	End Date
One	December 6, 2008	January 30, 2009	December 31, 2009
Two	January 1, 2010	January 29, 2010	December 31, 2010
Three	January 1, 2011	January 28, 2011	December 31, 2011

Section 11.9 Direct Deposit.

11.9(a) In states where mandatory direct deposit is permitted by law, paychecks will be delivered via direct deposit by Thursday of every second week.

11.9(b) For employees working in other states, paychecks shall be delivered via direct deposit on or before Thursday of every second week, or placed in the U.S. mail on or before Tuesday of every second week.

ARTICLE 12

UNION REPRESENTATIVES

Section 12.1 Accredited Representatives.

12.l(a) The Union shall inform the Company in writing of the names and positions of its officials and, currently, any changes thereto. Only persons so designated to the Company will be accredited as representatives of the Union. Accreditation shall be effective on the third day following the Company's receipt of the notification.

12.1(b) Solicitation of Union membership, collection or checking of dues, or reading of Union newsletters or publications will not be permitted during working time. Distribution of Union newsletters or publications will not be made during working time or in work areas. The Company agrees not to discriminate in any way against any employee for legitimate Union activity, but such activity shall not be carried on during working time except as specifically provided for in this Agreement.

12.1(c) Each employee, before leaving his or her assigned work on Union business, shall have authorization therefore from the Union and shall notify his or her supervisor prior to taking such leave. The Union shall provide to the designated Company Representative written confirmation immediately thereafter. Such un-worked time, limited to regular working hours, shall be charged to a special charge account number and the Union agrees to reimburse the Company at the employee's regular hourly rate for all such time so spent.

12.1(d) Grievance and Contract Administration.

12.1(d)(1) The Union shall investigate and adjust grievances and perform contract administration, in work areas, exclusively through Executive Board members and Council Representatives, who shall be employees, and, if applicable, a Union Staff Representative.

12.1(d)(2) Each Executive Board Member and Council Representative shall notify and obtain permission from his or her supervisor before leaving the work assignment for the purpose of investigating complaints or claims of grievance on the part of employees in his or her work area. Such permission shall be granted except where the supervisor considers such absence would seriously interfere with the performance of the group of which the representative is a part. Time spent on such approved investigations and discussions shall be considered work time provided such activity does not extend beyond the time that the supervisor considers reasonable under the circumstances. Any Executive Board Member and Council Representative in the conduct of his or her investigation, and before contacting an employee, shall obtain permission of the supervisor of such employee and advise the supervisor of the nature of the complaint or grievance and the estimated time required for the discussion. Such permission shall be granted except where the visit would seriously interfere with the work of the group. Except as provided in 12.1(e) and 10.1(a), all time spent performing such Union business as well as time spent in joint committee and partnership activities shall be handled in accordance with the Company's overhead charging process and shall not be docked from the employee's pay.

12.1(d)(3) Access by Union Staff Representatives shall be governed by 12.2, below.

12.1(e) Leave of absence of at least thirty (30) days without pay shall be granted for the following reasons:

12.1(e)(1) Full-time employment by the Union or its national organization.

12.1(e)(2) Union business authorized by the Executive Board and approved in writing by the designated Company Representative, which approval shall not be withheld absent legitimate business circumstances.

The Company will reinstate employees on such leaves at not less than his or her former grade level and salary plus any general salary increases which occurred during the period of the leave of absence.

12.1(f) The Company and the Union recognize that each individual within the bargaining unit has a full-time work assignment for the Company and, if Union business impairs performance of such work assignment, the Company and Union agree to make arrangements to prevent such impairment in the future.

12.1(g) Council Representatives.

12.1(g)(1) The Union may designate one (1) Council Representative for each 200 employees, or major fraction thereof; provided, however, that until the SPEEA election currently set for March of 2011, or until March 31, 2011, whichever is later, the union may maintain a minimum of four (4) Council Representatives. In

unique circumstances where maintaining such a ratio creates a hardship to the Union, the Company will give due consideration to a written request from the Union for a waiver of the ratio requirement.

12.1(g)(2) The parties will review annually, prior to Council elections, the number of Council Representatives allowed under 12.1(g)(1). The number agreed upon as contractually allowable during these reviews may not be reduced prior to the next such review except by mutual agreement of the parties. Any increases to the number of Representatives must be in accordance with 12.1(g)(1) and is also subject to mutual agreement of the parties.

12.1(g)(3) Each designated Council position can be filled by only one (1) member. In the absence of a Council Representative for any reason, the Union may designate a temporary substitute.

12.1(h) Protection of Union Officials.

12.1(h)(1) Executive Board members and Council Representatives shall not be laid off during their respective terms of office except as described herein.

12.1(h)(1)a Executive Board members and Council Representatives will be given a retention rating while serving during their term of office that will be adjusted to indicate that the employee has the highest retention rating in the applicable Job Family and Skills Management Code. However any Council Representative with an active Corrective Action Memo or documented performance improvement plan will not be adjusted. So rated, the Board Members and Council Representatives will be subject to all terms and condition of Article 8. Once the Board Members and Council Representatives are no longer in office, the retention rating will be readjusted to the otherwise applicable rating.

12.1(h)(1)b Layoff protection does not apply to Executive Board members and Council Representatives who, at the time of election or appointment, have received an active advance notice of potential layoff, unless the Board Member or Council Representative is running for reelection to a consecutive term of office.

12.1(h)(1)c Nothing herein precludes an Executive Board member or Council Representative from requesting a voluntary or accelerated layoff.

12.1(h)(2) In the event management deems it necessary to involuntarily transfer or loan a Council Representative, and other employees then represented by the Council Representative would remain in the same skill code, when practicable the Company will inform the Union of the proposed transfer or loan thirty (30) days prior to its effective date and will discuss with the Union the feasibility of transferring or loaning another employee.

Section 12.2 Union Representatives - Access to Plants. Union Representatives not employed by the Company will be permitted access during working hours to areas in the Company's facilities where employees in the bargaining unit defined in Article 1 are assigned, to the extent government and customer regulations permit. Such access shall be only for the purpose of investigating complaints or claims of grievance on the part of employees or the Union and shall be subject to the following:

12.2(a) The Company shall be required to admit only those Union Representatives who have been agreed to in writing or as may be agreed to by the Company throughout the remainder of this Agreement. Except for visits to the Labor Relations office, Union Representatives shall notify the Labor Relations organization of their contemplated visits.

12.2(b) Union Representatives who are entitled to admittance to the Company facilities shall sign in where required through the Company designated organization at the plant or facility they desire to enter. Upon being admitted, they shall proceed to the organization they wish to visit, contact the supervisor then present, inform him or her of the purpose of their visit and obtain his or her permission prior to contacting any employee in such organization. Such permission will be granted except where there is a substantial reason for delaying the contact due to safety conditions or the fact that a critical operation is in process. Upon leaving the plant or facility they shall sign out where required and return any temporary identification badges which were issued for the purpose of the specific visit.

12.2(c) The Company shall supply identification badges so that each Union Representative can have access during working hours to the areas in which Bargaining Unit employees are assigned. Union Representatives may retain their badges affording such access during the period they are assigned such duties by the Union subject to 12.2(a), 12.2(b), and 12.2(d) of this Agreement.

12.2(d) Union Representatives who fail to comply with provisions of 12.2 shall forfeit their admittance rights.

Section 12.3 Union Representatives - Security Interviews. Each employee has the right, during a Security interview which the employee reasonably believes may result in discipline, to request the presence of his or her Union Representative, if a Union Representative is available. If his or her Union Representative is not available, such employee may request the presence of another immediately available Union Representative. If a Union Representative pursuant to the employee's request is present during such an interview, the Union Representative, in addition to acting as an observer may, after the Security representative has completed his or her questioning of the employee, ask additional questions of the employee in an effort to provide information which is as complete and accurate as possible. The Union Representative shall not obstruct or interfere with the interview.

ARTICLE 13
DEDUCTION OF UNION DUES

Section 13.1 Deduction of Union Dues. The Company agrees to make monthly payroll deductions for the Union's dues upon receipt by the office designated by the Company of a voluntary written assignment covering such deductions on a form mutually agreed to by the Union and the Company. Such assignment is to remain in effect until cancelled by the bargaining unit employee so signing on a Company form or in any other written manner acceptable to the Company. This notification of cancellation must be mailed or delivered separately to the Company and the Union (SPEEA, 973 S. Glendale, Wichita, Ks 67218). The cancellation shall become effective the month following the month in which the notification is received.

The Company will carry over dues authorizations of employees among and between the bargaining units represented by the Union, i.e., where a valid authorization card is on file with the Company for an employee within a bargaining unit and the employee thereafter is transferred directly to one of the other Union bargaining units and the employee has not in the meantime cancelled the authorization.

Section 13.2 Union Dues Tables. In the event the Union desires to change the present method of computing the amount of dues to be deducted, the Union will obtain written Company approval of the proposed method prior to the change becoming effective through payroll deduction.

Section 13.3 Indemnification and Waiver of Claims. The Union expressly agrees to indemnify the Company against any and all employee and governmental claims, demands, suits or other forms of liability that arise out of or by reason of action taken or not taken by the Company for the purposes of complying with this agreement to deduct Union dues.

Both the Company and the Union will utilize due diligence in administering and reviewing, respectively, the dues deductions system. In the event the Union discovers administrative errors in Company administration of the system, the Union will give the Company prompt and timely notice of same, whereupon the Company will endeavor to make reasonable administrative corrections consistent with applicable state and federal law. Respecting Company administration of the system, the Union expressly waives as against the Company any and all claims, demands, suits or other forms of liability that may arise out of or by reason of good faith action taken or not taken by the Company for purposes of complying with this Article.

ARTICLE 14
STRIKES AND LOCKOUTS

Section 14.1 Strikes and Lockouts. The Union agrees that during the term of this Agreement, and regardless of whether an unfair labor practice is alleged (a) there shall be no strike, sit down or walkout and (b) the Union shall not directly or indirectly authorize, encourage or approve any refusal on the part of employees to proceed to the location of normal work assignment where no

rare or unusual physical hazard is involved in proceeding to such location. Any employee who violates this clause shall be subject to discipline. The Company agrees that during the term of this Agreement there shall be no lockout of employees covered by this Agreement. Any claim by the Company that the Union has violated this Article or any claim by the Union that the Company has violated this Article shall not be subject to the grievance procedure or arbitration provisions of this Agreement and the Company or the Union shall have the right to submit such claim to the courts.

ARTICLE 15
VOLUNTARY INVESTMENT PLAN

Section 15.1 Continuation of Plan. Subject to the continuing approval of the Commissioner of Internal Revenue and of other cognizant governmental authorities, as more particularly hereinafter specified, and to the provisions of 15.5, a Voluntary Investment Plan (hereinafter call the Plan) in the form as now in effect as to the employees within the units to which this Agreement relates shall continue to be effective while this Agreement is in effect as to such employees in accordance with and subject to the terms, conditions and limitations of the Plan.

Section 15.2 Approval of Plan. Approval of the Plan by the Commissioner of Internal Revenue as referred to in 15.1 means a continuing approval sufficient to establish that the Plan and related trust or trusts are at all times qualified and exempt from income tax under Section 401(a), Section 401(k) and other applicable provisions of the Internal Revenue Code of 1986, and that contributions made by the Company under the Plan are deductible for income tax purposes in accordance with law. The cognizant governmental authorities referred to in 15.1 include, without limitation, the Department of Labor and the Securities and Exchange Commission, and their approval means their confirmation with respect to any matter within their regulatory authority that the Plan does not conflict with applicable law.

Section 15.3 Continuation Beyond Agreement. The Company shall not be precluded from continuing the Plan in effect as to employees within the units to which this Agreement relates after expiration or termination of this Agreement, subject to the terms, conditions, and limitations of the Plan.

Section 15.4 Plan Updates. The parties agree that innovations in technology and administrative practices can give savings plan participants better access to information about their benefits, increased investment options, timely on-line transaction capability and enhanced administrative features. Accordingly, when the company identifies administrative services that in its estimation reflect industry best practices, the Employee Benefit Plans Committee has discretion to adopt these changes to the Savings Plan. The Company will notify the Union in advance of implementation of any changes adopted by the Employee Benefit Plans Committee.

Section 15.5 Company Matching Contributions and Employee Elective Contributions. The Company matching contributions shall be equal to 75% of the first 8% of the employee base pay contribution effective January 1, 2006, Employees hired or rehired on or after January 1, 2010, will be eligible for a Company Matching Contribution of 100% of the first 4% of

compensation (as defined in the plan) contributed, and 50% of the next 4% of compensation contributed by an employee. Effective January 1, 2009, employees may contribute up to 25% of base pay on a pre-tax basis, an after tax basis or a combination of both, in 1% increments.

Section 15.6 Changes to the Current Plan. Subject to action by the Company's Board of Directors (or its delegate) and to the approvals specified in 15.2, all provisions of the Plan applicable to employees covered by this Agreement are to remain unchanged with the exception of the following amendments

15.6(a) Effective January 1, 2009, employees may contribute up to 25% of base pay on a pre-tax basis, an after tax basis or a combination of both, in 1% increments.

15.6(b) Employees hired or rehired on or after January 1, 2010, will be eligible for a Company Contribution to the Plan. Each pay period, the Company will contribute to the Plan an amount equal to a percent of the employee's eligible pay for the pay period according to the following schedule. Employees will be 100% vested immediately in this Company Contribution. An employee is considered rehired if the employee returns to work from layoff and the return date is more than 6 years after the date of layoff. Eligible pay, for the purpose of calculating the Company Contribution is base pay, shift differential, and employee incentive pay earned on/after January 1, 2010.

Under Age 40	3%
Age 40 through 49	4%
Age 50 and over	5%

15.6(c) Employees hired or rehired on or after January 1, 2010, will be eligible for a Company Matching Contribution of 100% of the first 4% of compensation (as defined in the plan, and as distinct from "eligible pay" defined above) contributed, and 50% of the next 4% of compensation contributed by an employee. Employees will be 100% vested immediately in the Company Matching Contribution.

15.6(d) For purposes of determining Plan eligibility for tiered Company Contributions and the Company Matching Contribution, the employee will be considered hired before January 1, 2010, if:

- On an authorized leave of absence on December 31, 2009, and returns to active employment directly from that authorized leave of absence.
- On layoff on December 31, 2009, and returns to active employment within 6 years of the layoff date.
- An active employee on December 31, 2009, goes on an authorized leave of absence, and returns to active employment directly from that authorized leave of absence.
- An active employee on December 31, 2009, is laid off, and returns to active employment within 6 years of the layoff date.

An employee is considered rehired if the employee returns to work from layoff and the return date is more than 6 years after the date of layoff.

Section 15.7 Required Plan Amendments. The Company reserves the right to amend the Plan to satisfy all requirements and laws applicable to the Plan, including but not limited to Section 401(a), Section 401(k) or any other applicable provision of the Internal Revenue Code of 1986, as amended, or to satisfy fiduciary duties under the Employee Retirement Income Security Act of 1974, as determined by the Company, or to satisfy federal and state securities laws.

Section 15.8 Participant Elective Contributions Not Applicable for Other Purposes. It is acknowledged that the election of a Member to convert a portion of his or her base pay under the terms of the Plan will be effective for purposes of this Plan and will reduce the Member's compensation insofar as certain payroll taxes may be applicable. However, for all other employment related purposes, including all of the Member's rights and privileges under this labor agreement, his or her base pay or compensation will be considered as though no election had been made.

ARTICLE 16
GROUP BENEFITS

Section 16.1 Type of Group Benefits Package for Employees on the Active Payroll. The Company will continue until December 31, 2009, the Group Benefits Package agreed to in the collective bargaining agreement of December 6, 2005, between the Company and the Union. Thereafter, the Company will provide the life insurance benefits, accidental death and dismemberment benefits, short term disability benefits, medical benefits, and dental benefits for eligible employees and medical benefits and dental benefits for covered dependents of eligible employees as summarized in the document entitled Attachment A, effective January 1, 2010, or as otherwise stated, as the Group Benefits Package. The Company will provide access to the following plans on an optional basis: Supplemental AD&D, Long Term Disability Plan, and Health Care and Dependent Care Spending Account Plans.

Section 16.2 Cost of the Group Benefits Package for Employees on the Active Payroll.

16.2(a) Life, Accidental Death and Dismemberment, and Short Term Disability Benefits. The Company will pay the full cost of the Life Insurance, Accidental Death and Dismemberment, and Short Term Disability Plans for eligible employees.

16.2(b) Medical Benefits.

16.2(b)(1) The Company and the Union are committed to controlling health care costs through joint efforts under the Joint Benefits Discussion Group. In support of these efforts, the Company will continue to share the cost of medical coverage with employees.

16.2(b)(2) Effective January 1, 2010, in Kansas where employees may choose between the coordinated care plan or the Traditional Medical Plan, the Company will pay the full cost of a Company designated plan in the applicable region for eligible employees and dependents. For those employees and dependents whose coverage is with another plan, employees will contribute on a pretax basis 12 percent of the cost of the plan the employee chooses.

16.2(b)(3) For employees who live in areas where the Company designated plan fully paid by the Company is not available, the Company will pay the full cost of the Traditional Medical Plan.

16.2(b)(4) Effective January 1, 2010, the Company will pay the full cost of the PPO+*Account* for eligible employees and dependents.

16.2(b)(5) The employee is required to contribute an additional $100 each month for medical coverage under the Group Benefits Package to enroll a spouse or same-gender domestic partner if the spouse or same-gender domestic partner is eligible for medical coverage under another employer-sponsored plan and waives such coverage. This $100 contribution will not be required for a spouse or same-gender domestic partner who waived coverage under another employer-sponsored plan prior to eligibility for medical coverage under the Group Benefits Package, provided the spouse or same-gender domestic partner enrolls at the other plan's next enrollment period or, if earlier, at an enrollment date allowed by the other plan.

16.2(c) Dental Benefits. The Company will pay the full cost of the Preferred Dental Plan.

Section 16.3 Type of Retiree Medical Plan. The Company will continue until December31, 2009, the Retiree Medical Plan agreed to in the collective bargaining agreement of December 20, 2005, between the Company and the Union. For employees who are hired prior to January 1, 2007 and covered on or after January 1, 2007, the Company will provide for the duration of this Agreement the medical benefits for eligible retired employees and for covered dependents of eligible retired employees as summarized in the document entitled Attachment B, effective January 1, 2010, or on such later date when specifically stated therein and subject to all of the terms and conditions contained in or referred to in such Attachment B. The Company will also provide employees hired prior to January 1, 2007, access to the Medicare Supplement Plan.

Section 16.4 Cost of the Retiree Medical Plan. The Company will share the cost of medical coverage for current and future eligible retired employees, as follows:

16.4(a) Effective July 1, 2003, Company and retired employee contributions will be as follows:
For any health maintenance organization plan coverage or the TRICARE Supplement Plan, retired employees will contribute $10 for a retired employee only, $20 for a retired employee and spouse, or same gender domestic partner, $20 for a retired employee and child(ren), or $30 for a retired employee and family. For Traditional Medical Plan coverage, retired employees will contribute $20 for a retired employee only, $40 for a retired employee and spouse or same gender domestic partner, $40 for a retired employee and child(ren), or $60 for a retired employee and family. The Company will pay the cost of each plan in excess of the amount contributed by retired employees.

16.4(b) For employees who are hired from January 1, 1993 through December 30, 2006, the Company contributions are limited to three and one-third percent of the cost of the health maintenance organization plan, Traditional Medical Plan, or TRICARE Supplement Plan the retired employee chooses per year of service for the duration of the Agreement. Those retired

employees pay the difference (the cost of the plan minus the Company contributions). However, they must make contributions not less than the amount specified in 16.4(a).

16.4(c) The retired employee is required to contribute an additional $100 each month to enroll a spouse or same gender domestic partner in the Retiree Medical Plan if the spouse or same gender domestic partner is eligible for medical coverage under another employer-sponsored plan as an active employee and waives such coverage.

16.4(d) Company contributions will be made only for an eligible retired employee who retires during the term of this Agreement, provided the employee meets the eligibility requirements of the Retiree Medical Plan and is retired from or is deferring receipt of the benefit payments from The Boeing Company Employee Retirement Plan, and either authorizes deduction of the balance of plan rates, if any, from his or her retirement check or agrees to make timely self-payments for such coverage. Such Company contribution will continue for an eligible retired employee or eligible spouse or same gender domestic partner reduced by retired employee contributions required under 16.4(a) and 16.4(b) and the spouse or same gender domestic partner contribution in 16.4(c), if any, until such eligible person attains 65 years of age or is earlier eligible for Medicare or until this Agreement expires, if earlier, and for a dependent child, until such dependent child is no longer an eligible dependent or earlier qualifies for Medicare, or until this Agreement expires, if earlier.

Section 16.5 Details and Method of Coverage. The benefits summarized in the Group Benefits Package and the Retiree Medical Plan shall be procured by the Company under contracts and/or administrative agreements with insurance companies, health care contractors, or administrative agents which will be in the form customarily written by such carriers and administrative agents, and the Group Benefits Package and Retiree Medical Plan shall be subject to the terms and conditions of such contracts and/or administrative agreements, consistent with the summary in the Group Benefits Package or Retiree Medical Plan.

Such contracts and/or administrative agreements will require the administrative agents to develop various programs and procedures designed to contain costs based on those portions of the Group Benefits Package and the Retiree Medical Plan which contain the requirement that charges are covered only on the basis of medical necessity. Such cost containment programs or procedures may be utilized to determine the medical necessity of the treatment itself, the appropriateness of the services provided the place of treatment or the duration of treatment. The administrative agents and the Company will announce each such program or procedure before it is required or available to the affected employees or retirees. Any such cost containment program or procedure will not operate during the term of this Agreement to reduce or deny the benefit properly due or to shift the costs covered under the Plans to any eligible active employee or employee who retires during the term of this Agreement, or to his or her dependants.
The failure of an insurance company, health care contractor, or administrative agent to provide any of the benefits for which it has contracted shall result in no liability to the Company, nor shall such failure be considered a breach by the Company of the obligations that it has undertaken by this Agreement. However, in the event of any such failure, the Company shall immediately evaluate the need to replace the services of such insurance company, health care contractor, or administrative agent.

Section 16.6 Administration. The Group Benefits Package and the Retiree Medical Plan shall be administered by the insurance companies, health care contractors or administrative agents with whom the Company enters into contractual relationships for the purpose of providing and/or administering the coverage contemplated by the Group Benefits Package or the Retiree Medical Plan and no question or issue arising under the administration of such Group Benefits Package or the Retiree Medical Plan or the contracts and/or administrative agreements identified therewith shall be subject to the grievance and arbitration procedures of Article 3 of this Agreement.

Section 16.7 Copies of Policies to Be Furnished to Union. Copies of the policies, contracts, and administrative agreements executed pursuant to this Article 16 shall be furnished to the Union and the coverages and benefits indicated in the Group Benefits Package or the Retiree Medical Plan, the rights of eligible employees in respect of such coverages, and the settlement of all claims arising out of such coverages shall be in accordance with the provisions, terms, and rules set forth in such contracts.

Section 16.8 Federal or State Packages. If during the term of this Agreement there is mandated by federal or state government a program that affords to employees and/or retirees covered by this Agreement similar benefits (such as but not limited to medical benefits and dental benefits) to those that are afforded by this Agreement, benefits afforded by this Agreement will be replaced by such federal or state program. The Company will comply with the provisions for the furnishing of such program to the extent required by law. No question or issue regarding the level of benefits under the state or federal program will be subject to the grievance and arbitration procedures of Article 3 of this Agreement.

ARTICLE 17
RETIREMENT PLAN

Section 17.1 Continuation of Plan. Subject to the continuing approval of the Commissioner of Internal Revenue and of other cognizant governmental authorities, as more particularly hereinafter specified, and to the provisions of 17.5, a Retirement Plan (hereinafter called the Plan) in the form now in effect as to the employees within the units to which this Agreement relates shall continue to be effective while this Agreement is in effect as to such employees in accordance with and subject to the terms, conditions, and limitations of the Plan.

Section 17.2 Approval of Plan. Approval of the Plan by the Commissioner of Internal Revenue as referred to in 17.1 means a continuing approval sufficient to establish that the Plan and related trust(s) are at all times qualified and exempt from income tax under Section 401(a) and other applicable provisions of the Internal Revenue Code of 1986, and that contributions made by the Company under the Plan are deductible for income tax purposes in accordance with law. The cognizant governmental authorities referred to in 17.1 include, without limitation, the Department of Labor, the Pension Benefit Guaranty Corporation and the Securities and Exchange Commission, and their approval means their confirmation with respect to any matter within their regulatory authority that the Plan does not conflict with applicable law.

Section 17.3 Continuation Beyond Agreement. The Company shall not be precluded from continuing the Plan in effect as to employees within the units to which this Agreement relates after expiration or termination of this Agreement, subject to the terms, conditions, and limitations of the Plan.

Section 17.4 Grievances as to the Plan. Only questions concerning the amount of Credited Service under the Plan that an employee has accumulated by reason of employment after the effective date of the Plan shall be subject to the grievance and arbitration procedure of Article 3.

Section 17.5 Changes to the Current Plan. Subject to action by the Company's Board of Directors (or its delegate) and to the approvals specified in 17.2, except as the parties may otherwise agree pursuant to any Letter of Understanding, as well as any changes required by applicable law, all provisions of The Boeing Company Employee Retirement Plan applicable to employees covered by this agreement are to remain unchanged with the exception of the following amendments:

17.5(a) Basic Benefit. The Basic benefit will be increased to $81 per month for all years of Credited Service for Employees on the active Payroll of the Company on or after May 1, 2009 (including those who retire from the employ of the Company on May 1, 2009).

17.5(b) Eligibility. Employees hired or rehired on or after January 1, 2010, will not be eligible for participation in The Boeing Company Employee Retirement Plan. For purposes of determining Plan eligibility, the employee will be considered hired before January 1, 2010, if:

- On an authorized leave of absence on December 31, 2009, and returns to active employment directly from that authorized leave of absence.
- On layoff on December 31, 2009, and returns to active employment within 6 years of the layoff date.
- An active employee on December 31, 2009, goes on an authorized leave of absence, and returns to active employment directly from that authorized leave of absence.
- An active employee on December 31, 2009, is laid off, and returns to active employment within 6 years of the layoff date.

An employee is considered rehired if the employee returns to work from layoff and the return date is more than 6 years after the date of layoff.

Section 17.6 Administration of the Retirement Plan. The Company shall have the right to unilaterally make any changes in actuarial assumptions and funding methods, provided such changes are determined by the Plan’s enrolled actuary to be reasonable in the aggregate. The Company shall be entitled to unilaterally adopt such amendments to the Plan as may be required in order to obtain any approval referred to in 17.1 and described in 17.2 of the Agreement.

ARTICLE 18
NON-DISCRIMINATION

Section 18.1 Non-Discrimination. All terms and conditions of employment included in this Agreement shall be administered and applied without regard to race, color, religion, national origin, status as a disabled or Viet Nam era veteran, age, sex, marital status, sexual orientation or the presence of a disability except in those instances where age, sex or the absence of a disability may constitute a bona fide occupational qualification.

Administration and application of the Agreement that is not in contravention of federal or state law shall not be considered discrimination under this Article. The parties recognize that the Company is required to comply with applicable Federal and State disability discrimination laws, and agree that the Company may take actions necessary to stay in compliance.

Section 18.2 Non-Discrimination Grievances. Notwithstanding any other provision of Article 3, a grievance alleging a violation of this Article 18 shall be subject to the grievance and arbitration procedure of Article 3 only if it is filed on behalf of and pertains to a single employee. Class grievances under Article 18 shall not be subject to the grievance and arbitration procedure under this Agreement.

ARTICLE 19
SEPARABILITY

Section 19.1 Separability. Should any part hereof or any provision herein contained be rendered or declared invalid by reason of any existing or subsequently enacted legislation or by any decree by a court of competent jurisdiction, such invalidation of such part or portion of this Agreement shall not invalidate the remaining portions hereof and they shall remain in full force and effect.

ARTICLE 20
ED WELLS PARTNERSHIP
A JOINT SPEEA/BOEING INITIATIVE

Section 20.1 Mission. The Company, the Union, and SPEEA-represented employees agree working together for their mutual benefit helps maintain competitiveness and technical excellence and creates a model for union/management collaboration to make Boeing a workplace of choice.

The Ed Wells Partnership develops and offers a suite of products and services to the technical workforce for the benefit of all stakeholders.

The Ed Wells Partnership will seek to develop and implement initiatives approved by the Joint Policy Board to achieve the following goals: Effective partnership; a skilled, motivated,

productive and stable workforce; employability; lifelong learning; knowledge retention and sharing; and career development.

Section 20.2 Joint Policy Board. A Joint Policy Board will be established, comprised of an equal number of representatives of each party. The Board shall have responsibility for (1) providing the overall direction of the Ed Wells Partnership; (2) acting on the recommendations of the Joint Administrative Staff and providing oversight to the staff; and (3) determining the expenditure of funds provided to cover Ed Wells Partnership activities. The Board shall meet as required, but in no event less than quarterly.

Section 20.3 Joint Administrative Staff. The Company and the Union will appoint co-directors, who will assume responsibility for directing the Ed Wells Partnership activities. A Joint Administrative Staff shall be authorized by the Joint Policy Board and selected and managed by the co-directors within the budget as authorized by the Joint Policy Board.

Section 20.4 Meetings.

20.4(a) In order to meet its goals and aims, the Union must be able to speak confidently and authoritatively for its bargaining unit membership. Therefore, time will be allowed during the first week of employment for new hires into the bargaining unit to meet with a Union representative and learn about the Union's role in the Ed Wells Partnership, and by allowing regular quarterly meetings (up to two hours) of all Council Representative on work time to discuss the issues facing the Partnership. The Joint Policy Board may authorize additional Council Representative participation in approved activities.

20.4(b) To ensure open communication, Union leaders will meet periodically with Company leaders of engineering and technical functions for the geographical areas covered by this Agreement. The purpose of such meetings will be to review the activities of the Ed Wells Partnership and its progress toward meeting the goals identified in 20.1, above. Additionally, the parties agree that high level meetings for the geographical areas covered by this Agreement will be held no less than twice annually to review the activities of the Ed Wells Partnership. Either party may suggest meetings with the Company's Office of the Chairman or others as appropriate and mutually agreed-upon.

Section 20.5 Funding. Each party shall be responsible for the salaries of its representatives on the Joint Policy Board; expenses of Board members may be covered by the fund where the expense was authorized by the Board (whenever possible, such expenses will be authorized in advance of expenditure). The funding to the Ed Wells Partnership under this Agreement is allocated from funds provided under the Puget Sound Agreement between the Company and the Union. The annual allocation of these funds to the Wichita Engineering Unit under this Agreement will determined by the Joint Policy Board. This funding will support expenses including: facilities, administration, publicity, equipment, materials, and such other expenses as may be agreed to by the Joint Policy Board. In addition, work statement changes for the mutual benefit of the technical workforce and the Company may be allocated additional funds as deemed necessary by the Joint Policy Board, subject to approval of appropriate Company stakeholders.

Section 20.6 Retention Ratings and Salary Adjustments. For a maximum of two years of employment, bargaining unit employees appointed to work at the Ed Wells Partnership will (a) retain the same retention rating held prior to entering the Ed Wells Partnership, unless management assigns the employee a higher retention rating, and (b) receive annual salary increases that are, at a minimum, equivalent to the negotiated salary pool for the period of such employment.

Section 20.7 Disputes. Disputes concerning any aspect of this Article shall be referred to the Joint Policy Board for resolution. No matter involving the Ed Wells Partnership or any provision of this Article will be subject to the grievance and arbitration procedure of Article 3.

Section 20.8 Business Practices: The following business practices shall be applied

20.8(a) The Joint Policy Board shall establish the organization's budget. The amount set forth in Section 20.5 shall be separately accounted for and may not be used for any other program.

20.8(b) All labor and non-labor will be treated according to current Boeing accounting practices.

20.8(c) Labor support from other divisions will be burdened at the Boeing loaned labor rate.

20.8(d) To the extent permitted by law, a trust fund will be established pursuant to the Taft-Hartley Act, 29 U.S.C. Section 186, to contract with the Union for services of any individual employed by the Union who is named to the administrative staff established by Section 20.3. The trust shall be established pursuant to a written agreement between the parties that complies with clause (B) of the proviso to 29 U.S.C. Section 186(c)(5). In addition, the terms of any contract between the trust and the Union shall provide that the Union will be reimbursed for the services of these individuals on the basis of their base rate plus actual expenses for payroll taxes and the following employee fringe benefits: Union pension plan and package H and W insurance. The Company shall provide funds to the trust in a sufficient amount and in a timely manner to enable the trust to meet its contractual obligations to the Union.

20.8(e) Individuals employed by the Union who are named to the administrative staff established by Section 20.3 shall be full-time, dedicated to the administrative staff. On an exception basis, such individuals may perform Union business for brief periods of time. Time spent performing Union business will not be reimbursed through the trust as described in paragraph 5. The individuals performing Union business shall keep contemporaneous records of the dates such business was performed and the amounts of time so spent, which records shall be presented to the Company with the monthly invoices for reimbursement.

Section 20.9. Confidentiality. It is recognized by the parties that a free flow of information between them is necessary to insure the success of the Ed Wells Partnership. Information which could be disclosed to the Union and to the Union Administrative Staff includes information

relating to inventions, products, processes, machinery, apparatus, prices, discounts, costs, business affairs or technical data that the Company considers as confidential. In furtherance of their objective to facilitate full participation of the Union in these programs while recognizing the sensitivity of the Company's confidential information, the parties agree that any such information shall be held in confidence by the Union and the Administrative Staff and shall be used by them solely for purposes of this program. All Union Administrative Staff shall be provided a copy of this Letter of Understanding and advised of their obligations under it.

ARTICLE 21
LAYOFF BENEFITS

Section 21.1 Establishment of Plan. The Company will maintain a Layoff Benefit Plan to provide for lump sum or income continuation benefits as set forth in this Article. Such Plan will apply to employees who are laid off with an effective date on or after December 2, 1999.

Section 21.2 Eligibility. All bargaining unit employees who have at least one (1) year of Company service and who are involuntarily laid off from the Company (including such employees who accelerate their layoff dates and employees laid off because of declining an offer for less than equivalent employment as defined by Company policy) are eligible to receive the benefit described in 21.3; provided, however, the following employees shall not be eligible for the benefit: employees who volunteer for layoff; employees who upon their layoff become employed by a subsidiary or affiliate of the Company; employees who are laid off from the Company because of a merger, sale or similar transfer of assets and are offered employment with the new employer; employees who are laid off because of an act of God, natural disaster or national emergency; employees who are laid off because of a strike, picketing of the Company's premises, work stoppage or any similar action which would interrupt or interfere with any operation of the Company; and employees who terminate employment for any reason other than layoff, including, but not limited to, resignation, dismissal, retirement, death, or leave of absence.

Section 21.3 Amount and Payment of Benefit. An eligible employee's total lump sum or income continuation benefit shall equal one (1) week of pay based on the employee's base salary at the time of layoff (but excluding any shift differentials or other premiums) for each full year of Company service as of the employee's layoff date, subject to a maximum benefit of twenty-six (26) weeks of pay. Eligible employees may elect either of the following:

21.3(a) Benefits will be paid as a lump sum following the effective date of layoff. Employees who elect this option will have first consideration recall rights under Article 8 canceled.

21.3(a)(1) Income continuation benefits will be paid in eighty (80) hour increments, subject to an employee's total benefit, on regular paydays beginning with the second payday following the effective date of layoff. Income continuation benefits shall immediately cease upon the earlier of any of the following events: exhaustion of the employee's total income continuation benefit; re-employment with the Company or any

of its subsidiaries or affiliates; failure to accept a formal offer of recall from layoff within ten (10) workdays after it is extended or by such later date as may be stipulated by the Company; failure to report to work on the date designated by the Company; or change in the employee's employment status from layoff to resignation, dismissal, retirement, death, or leave of absence.

21.3(a)(2) Subject to continuation of the Plan, no employee shall be paid lump sum or income continuation benefits more than once during any three (3) year period; provided, however, if an employee is re-employed by the Company before payment of the employee's total income continuation benefit and is subsequently laid off in such three (3) year period under conditions which make the employee eligible for a benefit, any unused benefit will be payable to the employee under the procedures established by this Article.

Section 21.4 Benefit Not Applicable for Other Purposes. Periods for which an employee receives income continuation benefits shall not be considered as compensation or service under any employee benefit plan or program and shall not be counted toward Company service. Benefits under this Article may not be deferred into the Voluntary Investment Plan.

Section 21.5 Continuation of Medical and Dental Coverage**.** In the event of layoff, medical and dental coverage for employees and dependents will continue until the employee is covered by any other group medical or dental plan either as an employee or as a dependent, but in no event beyond three months after the date of layoff. However, if the layoff occurs during or after a leave of absence, the maximum total period of continued coverage is thirty (30) months in the case of medical leave or twenty-four (24) months in the case of non-medical leave, measured from the end of the month in which the leave of absence began, irrespective of the date of termination. Required contributions, if any, must be paid during any period of such continuation of coverage.

ARTICLE 22
JOB CLASSIFICATIONS

Section 22.1 Authorized Job Classifications. Each job classification listed in Appendix A shall, for the period of this Agreement, remain in effect, subject to revisions as provided in 22.4, unless made inactive by mutual agreement of the Union and the Company.

Section 22.2 Definition of Job Classification. A job classification is defined by occupation, job family, and level codes as identified within the Company’s Salaried Job Classification (SJC) system.

Section 22.3 Application and Intent of Job Descriptions.

22.3(a) Occupations are the broadest categories of work. Job families describe the organization of tasks. Level guides identify the various levels of responsibility within the job family. Each job classification is linked to Skills Management Codes (SMCs) within the SJC

system. SMCs identify unique knowledge, skills, abilities, and environments within the job family.

22.3(b) Each occupation code, job family code, level guide, and SMC is defined by a unique description as identified within the SJC system.

22.3(c) An employee may perform some of the work of a higher level and/or some of the work of a lower level in the performance of the work assignment. Any work assignment may include:

22.3(c)(1) Teaching, instructing, leading or providing assistance to others.

22.3(c)(2) The use of equipment to facilitate the work assignment.

22.3(c)(3) The submission of completed work or any portion thereof for checking or approval.

22.3(c)(4) The reporting of any work impairment such as errors in materials, processes, equipment, etc.

Section 22.4 New or Revised Job Family Level Guides, and SMC Descriptions. If, after the effective date of this Agreement, the Company or the Union determines that no existing job family level guide, or SMC description appropriately covers a new or reorganized work assignment, either party may initiate a request for evaluation and review through the established SJC Maintenance Process. The Union will participate as a voting member on the Company's SJC team in the identification, evaluation, and review of all proposed changes to job family descriptions and level guides for SJC job classifications listed in Appendix A and their associated SMC descriptions. The Company will implement changes (1) by revising or deleting an existing job family level guide, and/or SMC description; or (2) by developing a new job classification code with supporting descriptions, which will be incorporated into Appendix A through the issuance of an installation memo; or (3) the Company will establish a temporary job classification or SMC in accordance with 22.4(b).

22.4(a) Union Challenges of Level(s) for New or Revised Job Level Guide. In the event the Union disagrees with the number or description of level(s) of a new or revised job level guide, it must, within thirty (30) calendar days from the date the new or revised level guide is forwarded by the Company, challenge the level, setting forth in writing the reasons why the Union disagrees. Otherwise, the level guide as determined by the Company will stand.

22.4(a)(1) If the Union challenges a new or revised level guide, the Wichita Director of Compensation and Benefits and his/her appointees, and Union representatives shall meet promptly at a mutually agreed time for the purpose of attempting to reach agreement as to the appropriate level guide. Disagreements between the Union and the Company shall be resolved exclusively on the basis of the level guide assigned as a result of the Company's application of 22.4. A Union challenge shall in no way prevent or delay the Company from assigning personnel to the job classification involved in the challenge.

22.4(a)(2) If the Union challenges a new or revised level as submitted by the Company, and it is determined that the level is not correct, the Company will pay each employee involved at a rate that is within the range of the corrected level, for the time in which the employee has performed the duties of the corrected level.

22.4(b) Temporary Job Family, Level, or SMC. A temporary job family, level, or SMC may be established by the Company for new or revised work for which no current job family, level, or SMC is applicable and which requires a period of time to stabilize job duties. This period will not exceed ninety (90) days unless extended by mutual agreement. The Union will be notified of the effective date and approximate duration. Employees will be assigned to such new work at not less than their current levels until the job family and level is made permanent. If the temporary job family code or level is made permanent at a higher level than the levels of the assigned employees, these employees will be paid within the range of the higher level for the time assigned to the work covered by the permanent job family or level. Effective upon and after the Company's determination that a temporary job family and/or level has become permanent, the provisions of 22.4 shall apply.

Section 22.5 Individual Employee's Job Classifications.

22.5(a) It is a mutual objective of the Union and the Company that the job classification of each employee be an accurate and timely reflection of the work assigned and the demonstrated capabilities of the employee. However, the Company shall retain the exclusive right to reassign employees as necessary to meet work requirements, and employees shall comply with such reassignments notwithstanding the employees' job classifications of record at the time. If the Company determines, by reference to the applicable job family description, that an employee's level is higher than is appropriate for the work to which the employee is assigned, the Company may permit the employee to continue in the same assignment without reclassification for whatever period of time the Company elects, or the Company may add to the employee's current assignment or reassign the employee to other work for which the employee's level is appropriate.

22.5(b) Because an employee may be assigned work at a level lower than the employee's current level without being reclassified to the lower level, the levels of work assignments of individuals other than the employee shall not be introduced or regarded as pertinent evidence for the purposes of 3.6(a), unless by mutual agreement of the parties.

22.5(c) Employees may be reclassified to a higher level irrespective of their assigned retention index.

22.5(d) Challenges Concerning Individual Employee's Job Family, Level, **or SMC.** An individual employee may request a review of his or her job classification or level based on the contention the work assigned by the Company differs from the job classification or SMC to the extent and in such a manner as to warrant reclassifying the employee to a different existing job classification or SMC. Employees will attempt to resolve their classification first by discussion with first-line management. In the absence of a resolution mutually agreeable to both management and the employee, the following steps will be utilized in the review process:

22.5(d)(1) If the employee contends that a classification or level issue still exists, he or she along with his or her Union Representative will notify the Totem and/or Skill Team Manager to request a review.

22.5(d)(2) The Totem and/or Skill Team Manager will meet with the employee and the Union Representative to fully discuss the employee's issue in an effort to reach mutual resolution.

22.5(d)(3) If the employee and Union Representative do not agree with the Totem and/or Skill Team decision, the Totem and/or Skill Team Manager, the appropriate Human Resources Representative and the Union Representative will meet to resolve the matter by a majority decision.

22.5(d)(4) Short-term variations will from time to time occur in the amounts and types of work assigned to any activity, project, program or organization. Such variations, including, but not limited to, work assignment adjustments made necessary by vacations and other employee absences, are recognized by the Union and the Company as conditions which justify the short-term assignment of employees to work that is different than the employees' current job family classification or level. Accordingly, individual job family classification or level grievances acceptable under the provisions of this Article 22 are limited to assignments of not less than thirty (30) continuous calendar days.

22.5(d)(5) If subsequent to the processing of a grievance in accordance with 22.5(d) and 22.5(d)(1), it is determined by the Company that an existing higher level is appropriate, the Company will classify the employee and pay the employee at a rate that is within the range of the appropriate level for the time the employee has performed the work at the higher level subsequent to the date on which the written grievance was received by the Company and within thirty (30) calendar days prior to that date.

Section 22.6 Reclassification to a Lower Level. The Company may in its discretion alter employee work assignments or reassign employees to lower level bargaining unit work for which the Company deems they are qualified. In these cases, the employee shall retain their SJC level and will not be reclassified to a lower level. Reclassifications to lower levels may be made as a result of an employee's documented unacceptable performance.

Section 22.7 The provisions of 22.4, 22.5 and 22.6 are not subject to the grievance and arbitration procedures of Article 3.

ARTICLE 23

DURATION

Section 23.1 Duration.

23.1(a) This Agreement shall become effective December 6, 2008, and shall remain in full force and effect until December 2, 2011, and shall be automatically renewed for consecutive

periods of one (1) year thereafter, unless either party shall notify the other in writing, at least sixty (60) days and not more than ninety (90) days prior to December 2 of any calendar year, beginning with 2011, of its desire either (1) to amend this Agreement, or (2) to terminate this Agreement as of a date stated in such notice to terminate, which date shall be subsequent to such December 2, provided that, in any event, this Agreement shall expire at the close of December 2, 2016.

23.1(b) If either a notice to amend or a notice to terminate is timely given pursuant to 23.1(a), the parties agree to meet within thirty (30) days thereafter for the purpose of negotiating an amendment to this Agreement or a new contract.

23.1(c) If a notice to amend is timely given pursuant to 23.1(a)(1), either party may at any time thereafter notify the other in writing of its desire to terminate this Agreement as of a date stated in such notice to terminate, which date shall be subsequent to December 2 of the year in which such notice to amend is timely given, and at least sixty (60) days subsequent to the giving of such notice to terminate.

23.1(d) This Agreement, and any amendment thereof pursuant to this Article, shall continue in full force and effect until either (1) a new contract superseding it is consummated; (2) it is terminated by a notice to terminate timely given pursuant to 23.1(a)(2), or 23.1(c) hereof; or (3) it expires, whichever shall first occur.

Wichita Engineering Unit (WEU) Eligible Occupation/Discipline/Job Family			
Occupation		*Job Family*	
6B	Electronic & Electrical Engineering	1B	EE Sys Design Engineer
6B	Electronic & Electrical Engineering	1C	Wire Design & Install Engr
6B	Electronic & Electrical Engineering	1D	Elect Design and Analysis Engr
6B	Electronic & Electrical Engineering	1E	Electrophysics Engr/Scientist
6C	Engineering Multi-Skill Leadership	1L	Project Engineer
6D	Engineering Product Lifecycle Mgmt	2B	Information Technology Engr
6D	Engineering Product Lifecycle Mgmt	2E	Config Mgt & Prod Intgrtn Engr
6D	Engineering Product Lifecycle Mgmt	2H	Process Engineer
6E	Flight Engineering	3B	Aerodynamics Engineer
6E	Flight Engineering	3C	Propulsion Engineer
6E	Flight Engineering	3D	Guidance, Nav & Controls Engr
6E	Flight Engineering	3E	Weight & Mass Properties Engr
6E	Flight Engineering	3F	Acoustics Engineer
6E	Flight Engineering	3G	Configuration Design Engineer
6E	Flight Engineering	3H	Airport Engineer
6F	Materials, Process & Physics	4B	MP&P Engineer
6G	Mechanical & Structural Engineering	5B	Mech Sys Design & Anal Engr
6G	Mechanical & Structural Engineering	5C	Struct & Payload Design Engr
6G	Mechanical & Structural Engineering	5D	Structural Analysis Engineer
6G	Mechanical & Structural Engineering	5H	Design Specialities Engineer
6H	Def - Ops Integration & Support Engineering	6B	Product Review Engineer
6H	Def - Ops Integration & Support Engineering	6D	Tool Engineer
6H	Def - Ops Integration & Support Engineering	6H	Manufacturing Engineer
6J	Software Engineering	7B	Software Engineer
6K	Systems Engineering	8C	Systems Engineering Engineer
6L	Test & Evaluation Engineering	9B	Test & Evaluation Engineer
DF	Industrial Engineering	KE	Industrial Engineer
GB	Engineering and Systems Support Analysis	A1	System Support Engineer
GB	Engineering and Systems Support Analysis	A2	Maintenance Program Engineer
GB	Engineering and Systems Support Analysis	A3	Maintenance Engineer
GF	Retrofit, Repair, Modifications and Maintenance	D1	Retrofit & Repair Engineer
GJ	Engineering Customer Support	F1	Customer Support Engineer
GJ	Engineering Customer Support	F2	Service Engineer
GK	Flight Operations Services	F4	Flight Operations Engineer
GK	Flight Operations Services	F5	Flight Technical Data Engineer
GK	Flight Operations Services	F6	Flt Simulator Design Engineer
GL	Integrated Support Planning and Management	G1	Support Planning & Mgmt Engr

LETTER OF UNDERSTANDING NO. 1
RELATING TO SEX CRIMES

The Company and the Union recognize (1) the growing awareness and abhorrence in our society of sex crimes victimizing children, and (2) the deleterious effect the presence in the workforce of perpetrators of such crimes would have on the efficiency and morale of professional/engineering employees of the Company and on the reputation of the Company and its products. The Company and Union therefore agree as follows:

1. Any discipline or discharge of an employee who has committed a sex crime victimizing a child or children shall be deemed to be for "just cause" and shall not be subject to the grievance and arbitration provisions of the parties' Agreement or to any other challenge or proceeding by the Union.

2. For purposes of this Letter of Understanding, the term "sex crime victimizing a child or children" includes rape, sexual assault, statutory rape, incest, child molestation, child pornography, public indecency, indecent exposure, indecent liberties, communications with a minor for immoral purposes, promoting prostitution, and similar crimes as defined in the jurisdiction in which the offense is committed, where the victim of said crime(s) is under the age of 18 years at the time of the commission of the crime(s). An employee shall be considered to have committed such a crime if the employee is convicted of the crime, or if the employee pleads guilty or nolo contendere to the crime, or if the employee enters a special supervision program pursuant to a deferred prosecution arrangement relating to the crime.

3. The provisions of this Letter of Understanding shall not be deemed to define "just cause" or to affect the grievance and arbitration provisions in any other respect whatsoever, nor shall it be introduced or relied upon in any arbitration or other proceeding involving the parties which does not deal with the discipline or discharge of an employee who has committed a sex crime victimizing a child or children.

LETTER OF UNDERSTANDING NO. 2
RELATING TO CHILD/ELDER CARE PROGRAM

The Company will continue a comprehensive child and elder care program. The program will consist of referrals of employees to licensed care facilities, consultation with employees to determine individual needs, and providing educational materials and programs.

LETTER OF UNDERSTANDING NO. 3
RELATING TO OVERTIME

It is understood that the authority of the Company to require overtime is necessary for business planning and meeting operational objectives. The parties recognize, however, that the exercise of this authority may affect employee productivity.

Accordingly, the Company and the Union agree, subject to the exceptions noted below, that no employee shall normally be required, and need not be permitted, to work more than 144 overtime hours in any budget quarter, more than 576 overtime hours in a twelve (12) month period, more than two (2) weekends consecutively without the next weekend off, or more than eight (8) hours on a Saturday or a Sunday or other regularly-scheduled day of rest. Overtime work on either a Saturday and a Sunday, or a Saturday or a Sunday, shall constitute a weekend worked. All overtime on a holiday as set forth in Section 7.1 of the Agreement or on the weekend which immediately precedes a Monday holiday or immediately follows a Friday holiday shall be voluntary for those on weekday work schedules.

All overtime in excess of the above limits shall be strictly on a voluntary basis and no employee shall suffer retribution for his refusal or failure to volunteer. An employee may be required to perform overtime work beyond the above limitations where necessary for delivery of Company products to a customer, where necessary for the timely submission of proposals where related to customer-requested emergency repair of delivered products, or for Government DX or Government DO rated orders.

LETTER OF UNDERSTANDING NO. 4
RELATING TO DRUG AND ALCOHOL FREE WORKPLACE PROGRAM

The Company and the Union enter this Letter of Understanding to address the serious societal problem of drug and alcohol use and abuse. The Company and the Union affirm their joint objective to achieve a drug and alcohol free workplace while complying with applicable government laws and regulations. To that end, the parties agree to a drug and alcohol free workplace program with these principal components: a comprehensive employee assistance program emphasizing rehabilitation; employee awareness; training; and testing.

A. Employee Assistance Program

1. The Company will continue to provide a comprehensive Employee Assistance Program (EAP). One of the major purposes of the program is to rehabilitate employees experiencing drug and alcohol problems through a professional assessment and referral service with follow-up counseling. The service will be provided by trained, professional counselors employed by an EAP company under contract with Boeing.

2. Voluntary participation in the EAP may occur through referral (self, union, management, others). These employees will have their treatment monitored by the EAP and be subject to follow-up counseling and testing by the treatment provider.

3. Mandatory participation in the EAP will be offered as an alternative to discharge to employees who have (a) had a discharge for attendance or performance problems held in abeyance, or (b) a verified positive drug or alcohol test administered by the Company. Mandatory participants will be subject to the terms and conditions of the "Compliance Notification Memo" (attached hereto). Violation of any of the terms of the Compliance Notification Memo normally will result in discharge from employment.

B. Employee Awareness

1. The Company will continue its drug and alcohol awareness program designed to keep employees informed of the drug and alcohol free workplace program, including opportunities for rehabilitation through the EAP, the dangers of drug and alcohol use and abuse, and drug and alcohol testing.

2. The awareness program will disseminate the information through pamphlets, news articles, mail outs, video tapes, the Boeing Web, and other media.

C. Training

1. The Company will maintain a drug- and alcohol-free workplace training program for its managers, medical professionals, and other selected employees. The training will be designed to:

   a. Identify the extent and impact of drug and alcohol use.
   b. Describe the principal federal legislation and regulations for a drug and alcohol free workplace.
   c. Identify the Company rules pertaining to drugs and alcohol and the appropriate action to be taken upon violation.
   d. Identify the principal components of the Drug and Alcohol Free Workplace Program (rehabilitation, awareness, training, and testing).
   e. Explain the Employee Assistance Program, opportunities for rehabilitation, and the consequences of rehabilitation failure.
   f. Explain the facts of drug and alcohol testing accuracy and procedures, such as the chain of custody.
   g. Enable participants to effectively apply observed and documented performance criteria and appropriate procedures in referring the employee to the Employee Assistance Program.
   h. Enable participants to effectively apply observed and documented criteria typically indicative of drug or alcohol use and apply appropriate reasonable suspicion testing guidelines in referring employees to Medical for medical observation and possible testing.

i. Enable participants to apply appropriate post-accident testing guidelines in referring employees for testing.

2. The training will not be designed to teach participants to be substance abuse experts or professional counselors.

3. Union selected individuals, including but not limited to the Union's Executive Board, Council Representatives, and staff members, will be invited to participate in training. Once a year the Union will provide the Company with a list of those persons to be trained.

4. Whenever practicable, Union selected individuals and Company managers will be trained together.

D. Drug and Alcohol Testing

1. The Company will implement a drug and alcohol testing program designed to deter misuse and abuse and to provide a means for early identification, referral for treatment, and rehabilitation of employees with abuse problems, as outlined below.

2. The Company will at all times comply with its policy and procedures and with applicable government laws and regulations designed to safeguard the accuracy and reliability of drug and alcohol testing and to protect the confidentiality of those tested. Specifically, the Company will follow applicable regulations (49 C.F.R. Part 40, "Procedures for Transportation Workplace Drug and Alcohol Testing Programs"). For drug testing, these cover:

a. Collection procedures, including strict chain of custody to prevent mislabeling or alteration of urine samples and to account for the integrity of each sample from the point of collection to final disposition;

b. Use of a United States government certified laboratory with state-of-the-art testing methodologies, including confirmation testing using gas chromatography-mass spectrometry instrumentation;

c. Testing only for substances required by the regulations and for which the laboratory has been certified by the United States government, using government-mandated cutoff and confirmation levels; conducting validity testing to determine if the specimen has been adulterated or substituted;

d. Undertaking a quality assurance and quality control program designed further to ensure laboratory testing accuracy;

e. Periodic inspections of the laboratory;

f. Employment of qualified medical review officers (MRO) who are licensed physicians with knowledge of substance abuse disorders and with the medical training to interpret and evaluate a positive test result, medical history, and other

relevant data for the purpose of verifying positive results, determining adulteration or substitution, and making return-to-work recommendations;

g. Giving the employee an opportunity to provide a legitimate, alternative medical explanation for the result. Should such an explanation be provided, the test result will be reported as negative;

h. Advising the employee of the opportunity to request analysis of the split sample within 72 hours of being notified of a positive result. The Company will reimburse the employee for said expense if the retest result is negative. Portions of the original specimen not subjected to the testing process will be placed in proper storage and retained by the laboratories in case subsequent testing is requested or required.

i. Ensuring confidentiality of test results, of information provided by the employee to the MRO, and of employee participation in the EAP in accordance with existing Company policy and the federal regulations; and

j. Retaining all confirmed positive specimens at the laboratory for at least one (1) year in accordance with the federal regulations.

3. Alcohol testing will be conducted using breath samples. The instrument shall be approved by the Department of Transportation as an evidentiary breath testing device and used only by trained operators (Breath Alcohol Technicians). For alcohol testing, levels at or above .02 percent blood alcohol content will be considered positive (see para. 10).

4. The Company will conduct employee testing under the following circumstances:

   a. Reasonable suspicion drug and alcohol testing covering all employees. "Reasonable suspicion" means there is information that would cause a reasonable person to believe that an employee has used or is impaired by alcohol or drugs. The Company will use the following standards to determine when testing may be appropriate: signs of impairment, such as difficulty in maintaining balance, distinct odor of drugs and/or alcohol, slurred speech, abnormal or erratic behavior, or apparent inability to do assigned work in a safe or satisfactory manner.

      In addition, the Company will require that all information relied upon to initiate a reasonable suspicion test be documented prior to testing, that two designated individuals (at least one of whom has been trained as referenced in paragraph C.1) agree that testing is appropriate and sign required documentation, and that a trained medical professional examine the employee to determine if there is a medical condition requiring emergent medical care. In the event a Company location does not have a staffed medical facility when the employee is escorted for review, a trained manager will determine whether the employee should be escorted to an off-premises medical facility for the required evaluation.

b. Post-accident drug and alcohol testing or testing following a serious violation of a safety rule or standard, covering all employees. An employee may be tested when a work-related incident has occurred involving death, serious bodily injury or significant property/environmental damage, or the potential for death, serious injury, or significant damage, and when the employee's actions(s) or inaction(s) either contributed to the incident or cannot be completely discounted as a contributing factor.

c. Random drug and alcohol testing of designated employees as expressly required by United States government agencies. The Company will use neutral selection criteria to determine which of the designated employees will be tested. The Company will comply with random testing standards set forth in applicable government agency regulations.

d. Follow-up drug and alcohol testing of all employees who (1) have a first-time verified positive drug or alcohol test, or (2) have a discharge for performance or attendance problems held in abeyance.

e. Pre-assignment drug testing of employees selected to transfer into or otherwise perform in a position designated for random drug testing, where pre-assignment testing is expressly required by United States government agencies.

5. Refusal to (a) take a test following adequate explanation of the consequences of refusal, (b) accept EAP referral subsequent to a positive drug or alcohol test, (c) when required, accept EAP treatment recommendations, or (d) accept the terms and conditions of the Compliance Notification Memo shall result in corrective action, up to and including termination of employment. Failure to appear immediately for testing, or refusing to take a test, will be considered the same as a positive result.

6. For reasonable suspicion and post-accident testing only, the employee has the right to request the presence of a Union Representative at the collection site. The Union Representative shall not in any way interfere with or otherwise obstruct the collection process. The parties agree that the collection may be delayed a reasonable period, not to exceed thirty (30) minutes, to await the arrival of the Union Representative. The thirty (30) minute period will commence when the Union, to include a Union Representative, is notified.

7. **Consequences of a Positive Test Result**

   a. No employee will be discharged because of a first verified positive test result except pursuant to D.4.d(2) above. Instead, the employee will be required to submit to EAP evaluation and, if recommended, will have a one-time opportunity to enter a treatment program. Such employees remain subject to corrective action, up to and including discharge, for independent reasons.

b. An employee who has a second verified positive test result within three years of the first such result or on a Company-administered test conducted after that period, normally will be discharged from employment.

8. **Procedure Following a Positive Test Result**

a. An employee will not be removed from continuous pay status because of a drug or alcohol test result until the Medical Review Officer or the Breath Alcohol Technician verifies the test result.

b. As part of the verification process, the MRO will attempt, in accordance with applicable regulations, to contact the employee to determine whether an acceptable medical explanation for the confirmed positive result exists. The MRO will review in confidence any information provided by the employee. If the MRO determines there is an acceptable medical explanation for the positive test result, the result shall be reported as negative.

c. After verification of a positive test result, the employee shall be given one (1) workday to contact the EAP for an appointment so that an EAP assessment can be made. An appointment for an EAP assessment will be made. Failure to keep the appointment without an acceptable excuse will result in discharge from employment. The employee may be returned to work after an EAP evaluation is made and the treatment and/or education recommended begins as scheduled.

d. The employee may not return to work until results on drug and alcohol tests administered by the Company are negative. A validated positive return-to-work drug or alcohol test will be grounds for discharge from employment.

e. The employee is required to accept and comply with the terms of a Compliance Notification Memo.

f. The employee is subject to follow-up testing as directed by EAP. A minimum of six (6) unannounced tests per year will be conducted for three (3) years of active payroll status following return to work.

9. **Procedure Following a Positive Alcohol Test**

An employee having a positive blood alcohol content of .02 or greater, but less than .04, will not be required to submit to an EAP evaluation or to other provisions of the drug and alcohol free workplace program (see paragraph 7.a above), although voluntary participation will be encouraged. Such employees will, however, be removed from the assignment and suspended for the remainder of the shift. Such action shall be taken immediately when the Breath Alcohol Technician notifies management of the positive alcohol test result. If the employee's alcohol test result is .04 or greater, conditions described in paragraphs 7.a, 7.b, 8.a, and 8.c through 8.f above shall apply.

10. The Union reserves the right to grieve and arbitrate the question of whether the Company's program is consistent with the terms described in this letter.

BOEING

COMPLIANCE NOTIFICATION MEMO ("CNM")

This Compliance Notification Memorandum ("CNM") is being entered into pursuant to PRO 388.

_____ _____ is subject to the following requirements:

Employee Name BEMSID

1. Employee is REQUIRED to contact the Employee Assistance Program (EAP) within 24 hours of issuance of this CNM. Failure to do so will result in termination of employment. EAP contact phone number will be provided to the employee when the CNM has been signed.
2. Employee will successfully complete the required treatment and/or training program specified by the Employee Assistance Program (EAP) Counselor, and any amendments to the specified program created by the EAP Counselor. Employee's satisfactory participation in the specified program is required as a condition of continued employment by The Boeing Company ("the Company"), and shall continue until such time as the Company's EAP or its designee determines that Employee's participation is no longer necessary. Changes in the EAP specified program shall be in writing and coordinated in advance with EAP. Any failure by Employee to participate satisfactorily in the EAP specified program (as determined at the sole discretion of EAP) or any violation of this CNM shall be sufficient grounds for Employee's termination of employment. Employee's cooperation with personnel and functions administering and monitoring the EAP specified program is required, and any failure by Employee to cooperate will be deemed a failure to participate satisfactorily in the EAP specified program.
3. Employee will be subject to unannounced follow-up drug and alcohol testing for a three year period that will begin when the return to duty drug and alcohol negative test results are reported to the Enterprise Drug Free Workplace office. A verified positive drug test result, a confirmed alcohol test result or a refusal to test determination on the return to duty tests or during the unannounced follow-up testing period will be grounds for Employee's termination of employment. An interruption in Employee's active employment status because of EAP treatment, layoff, resignation, leave of absence, or any other reason will extend the three year period by the duration of the interruption.
4. Employee acknowledges that medical personnel, or other personnel involved in monitoring Employee's compliance with this CNM, will be obligated to report to cognizant management information about any violation by Employee of the terms and conditions of this CNM.

5. Employee will continue to be subject to corrective action, up to and including termination of employment, for reasons not related to the matters addressed in this memo.

6. The Union (if applicable) and I waive any right to challenge any termination pursuant to paragraphs (1) or (3) through any court, arbitration, or other form of proceeding.

7. Employee ☐IS ☐IS NOT (check one) a member of a collective bargaining unit. Name of collective bargaining unit, if applicable: _____. Employee ☐ REQUESTS ☐ DOES NOT REQUEST (check one) union involvement in this matter.

8. Discharge in Abeyance is contingent upon the confirmation of substance abuse by an Employee Assistance Program Counselor.
   ☐ DIA Attendance ☐ DIA Performance

ACKNOWLEDGMENT BY EMPLOYEE
Employee signature required.
I have received and read the above:

ACKNOWLEDGMENT BY THE UNION (If Applicable)

Signature of Employee	Date	Signature of Union Official	Date
Printed Name of Employee	Date	Printed Name of Union Official	Date

ACKNOWLEDGMENT BY THE COMPANY

CONCURRENCE OF EMPLOYEE ASSISTANCE PROGRAM (Required in Discharge in Abeyance only)

Signature of Company Official	Date	Signature of EAP Counselor	Date
Printed Name of Company Official	Date	Printed Name of EAP Counselor	Date

Original and all copies of CNM to be retained by the DFW Enterprise Office.

LETTER OF UNDERSTANDING NO. 5
RELATING TO WORK ENVIRONMENT AND HEALTH AND SAFETY

The Company and the Union recognize their mutual concern for the health and safety of Company employees; for the free flow of information to and from both parties and Company employees regarding issues of safety, health, and the use and handling of hazardous materials and equipment in the workplace; and for the physical conditions under which the work is performed.

The parties' longstanding commitment to individual employee safety and regulatory compliance extends to issues regarding personal protective equipment and safety devices and the value of working together to create an injury-free workplace. To further this commitment, the Company will provide employees up to $75 per year towards the purchase of approved safety shoes where such shoes are mandatory due to regulatory compliance or Company directive. The reimbursement process utilized will be the organization's existing process for reimbursement of incidental business expenses or any other mutually acceptable reimbursement process.

In addition, the Company agrees to present the Union, annually at their request, a review of current issues regarding the physical work environment and the activities of the Corporate Safety, Health and Environmental Affairs (SHEA) organization. The Union may request additional meetings in order to address its concerns. The agenda for each meeting shall be agreed to by both parties in advance of such meetings.

LETTER OF UNDERSTANDING NO. 6
RELATING TO DATA REPORTS

The Company will provide only that data to the Union which is listed in the memorandum from the Company to the Union, effective October 31, 2008 subject to such revisions in the future as may be made by mutual agreement of the parties. Nothing herein is intended to waive any right the Union may have to receive additional data.

LETTER OF UNDERSTANDING NO. 7
RELATING TO REPRODUCTION OF CONTRACTS

The parties agree, in the spirit of labor/management cooperation, that they will equally share the costs of reproduction of the labor agreement, as bound books.

LETTER OF UNDERSTANDING NO. 8
RELATING TO OVERSIGHT OF LABOR-MANAGEMENT COOPERATIVE INITIATIVES

The parties enter this Letter of Understanding to continue a joint committee to oversee labor management initiatives the parties undertake. These joint initiatives are intended to enhance and develop employees as the Company's key resource. The parties also recognize that a strong, competitive Company is the only assurance of job security and that an effective employment stabilization process must balance the legitimate need for flexibility to successfully compete in a global market. Employee involvement is providing the ideas, initiative, and leadership necessary to develop and implement effective and efficient processes as an essential element in making the Company strong and competitive.

The Joint Union-Company Oversight Committee shall consist of up to four persons representing the Company and four persons representing the Union. The Company representatives will be appointed from Business Unit, and Human Resources management. The Union representatives will include three employees and the Union's Executive Director or designee. Each party shall appoint a chairperson of its group.

The oversight function will include (1) establishing subcommittees to handle the initiatives; (2) reviewing, expanding where appropriate, and resolving issues related to ongoing initiatives; and (3) formulating future labor-management cooperative initiatives. The Company in its sole discretion will provide administrative staff and appropriate funding to support the initiatives.

Proposed initiatives may include but are not limited to the following:

- Employee Involvement
    - Horizontal Integration Leadership Teams
    - Cultural Change
- Employment Security
    - Employment /Skills Forecasting
    - Intellectual Capital Management

The Joint Oversight Committee shall meet as often as its members agree, but in no event less than quarterly. The Company and Union chairpersons will establish committee meeting locations, agendas, and procedures. To create a proper environment for the committee's work, no aspect of the committee's proceedings shall be used as the basis for, or as evidence in, any proceedings under Article 3.

LETTER OF UNDERSTANDING NO. 9
RELATING TO PRODUCTIVITY IMPROVEMENT PLAN

The Company and the Union agree to review the Company-developed productivity improvement plan and make revisions and/or improvements as required.

The Company agrees to notify the Union to the maximum practical extent, when an employee is subject to this process in order for the Union to provide representation to the employee if the employee so desires.

Nothing in this agreement precludes the Union from access to Article 3 for situations arising from implementation of this process.

LETTER OF UNDERSTANDING NO. 10
RELATING TO TEMPORARY RECALL

The parties acknowledge that Article 9 limits the use of contract personnel during workforce reductions or when employees are on active recall status. The parties acknowledge further that occasionally situations arise when short-term assignments require additional staffing.

In recognition of the fact that the work under discussion involves short-term assignments, the parties agree to the implementation of the process described immediately below.

1. The process shall be known as Temporary Recall and shall be defined as the temporary re-employment of individuals on active layoff status (hereinafter "employees").

2. Temporary Recall assignments may be designated for specific programs or projects with a defined beginning and ending date. The normal minimum will be one (1) month and the normal maximum will be six (6) months. Assignments will normally be full time (average 80 hours in a pay period).

3. The Company will determine which employees will be offered Temporary Recall assignments. Temporary Recall will be strictly voluntary on the part of the employee. Refusing to consider an employee for Temporary Recall or an employee's rejection of an offer of Temporary Recall will not affect the employee's active layoff status.

4. Temporarily recalled employees will receive the same salary they were receiving prior to layoff, adjusted for any general wage increases implemented between the date of their original layoff and temporary recall.

5. If the temporarily recalled employee begins within one (1) year of the original layoff effective date, eligibility for coverage for medical/dental insurance, life insurance, accidental death and dismemberment insurance, business travel accident insurance, long-term and short-term disability insurance, and voluntary personal accident insurance begins on the first day of the month following the month in which the re-employment commences. If the temporarily

recalled employee begins at least one (1) year after the original layoff effective date, eligibility for coverage for such benefits begins the first day of the month following one full calendar month of continuous employment.

6. With regard to the Retirement Plan, unused sick leave, and vacation, employees on Temporary Recall will be set up in the system based on their respective layoff/recall circumstances. This will include the reactivation of unused but earned credits and the generation of future benefits consistent with standard policies. Voluntary Investment Plan contributions may be resumed, beginning on the first of the month following recall.

7. Company service will be earned beginning the first day back on the active payroll.

8. Active layoff status will not be interrupted. Filing requirements once during each half year for first consideration recall status will remain.

9. Employees on Temporary Recall will not receive a retention index based on Temporary Recall assignments.

10. Employees on Temporary Recall will generate funds for a selective adjustment exercise if they meet contractual criteria.

11. Employees on Temporary Recall will not be eligible for layoff benefits when their Temporary Recall assignment ends.

LETTER OF UNDERSTANDING NO. 11
RELATING TO PART-TIME EMPLOYMENT

The Company and the Union agree that employee requests to be placed on part-time work schedules to assist employees with personal concerns may be authorized when compatible with Company schedules and needs. The term "part-time work schedule" shall mean a work schedule consisting of a seven (7)-day cycle with fixed days and hours of work that are less than forty (40) hours over one (1) regular workweek, or a fourteen (14)-day cycle with fixed days and hours of work that are less than eighty (80) hours over two (2) regular workweeks. No minimum or maximum number of hours will be required, but fixed days and hours of work must be established. A part-time schedule must be approved by the employee’s immediate and second-level management and is applicable only to the particular position the employee occupies when the schedule is approved. Management may request an employee on a part-time work schedule to return to work on a full-time basis regardless of the employee’s retention index when part-time work is no longer appropriate.

Employees on part-time work schedules will be subject to all provisions of this Agreement and established Company policies and procedures.

LETTER OF UNDERSTANDING NO. 12
RELATING TO ACTING SUPERVISORS

The Company agrees to inform the Union in a timely manner when it intends to use a member of the bargaining unit as an acting supervisor. If the employee remains as an acting supervisor for more than six (6) consecutive months, the employee shall be reclassified to management or returned to his or her bargaining unit position. Deviations shall require the consent of the Union.

LETTER OF UNDERSTANDING NO. 13
RELATING TO SHAREVALUE PROGRAM

The Company and the Union agree that all eligible represented employees may participate in the Boeing ShareValue Program (also known as the ShareValue Trust) for the duration of this Agreement. The parties agree that the Company's success depends upon the ability to return long-term value to the shareholders. The intent of this incentive program is to help inform employees about what makes a business run and produces shareholder value, and to allow employees to share in the results of their efforts to increase shareholder value.

Employees will be eligible to participate in accordance with the governing provisions of the ShareValue Program as set forth in the official Program documents. In the event of any conflict between this Letter of Understanding and the official ShareValue program documents, the official ShareValue Program documents will prevail in every case.

Eligible participants will proportionally share in a ShareValue Program distribution based on the number of months they were eligible to participate during any investment period falling within the term of this Agreement or any preceding Agreement that provided for their participation in the ShareValue Program. If the ShareValue Program is continued beyond its current termination date, all eligible bargaining unit employees may continue to participate.

LETTER OF UNDERSTANDING NO. 14
RELATING TO VIRTUAL OFFICE/TELECOMMUTING

The parties enter into this Letter of Understanding as a result of the implementation of the Virtual Office/Telecommuting Program. Following is a summary of the general provisions of this Program as they apply to SPEEA-represented employees.

Telecommuting or "Work at Home" and other aspects of the Virtual Office have proven to be a viable work option that, when appropriately applied, benefit both the Company and the individual. The Virtual Office provides a balance between the tasks that are the responsibility of each individual and the requirements of each team and group.

The Virtual Office is a cooperative agreement between the manager and the employee, not an entitlement, and is based on (1) the needs of the job assignment, work group and the Company, and (2) the employee’s past and present levels of performance and defined personal

characteristics. Participation in the Virtual Office Program is entirely voluntary and may be terminated by the employee, his/her manager, or the Company at any time.

The employee's duties, obligations, responsibilities and conditions of employment with the Company remain unchanged. Employees remain obligated to comply with all Company rules, policies, practices and instructions.

The detailed terms and conditions of this Program are covered in the Virtual Office Program procedure, PRO - 497, which is subject to change at the Company's discretion.

Disputes concerning the content of this Letter of Understanding shall not be subject to the grievance and arbitration procedure of Article 3. Nothing in this Letter waives any rights reserved in Article 2.

LETTER OF UNDERSTANDING NO. 15
RELATING TO THE TRAVEL CARD PROCESS

The Company and the Union enter this Letter of Understanding to maintain their agreement to continue to monitor the process of paying business travel expenses and their ongoing mutual commitment for improvements in the same.

The terms and conditions of the travel card process as described by the Company and the travel card provider will apply to employees covered by this Agreement. The Company will notify the Union of any changes to the travel card process. Employees will not be required to pay the travel card company for late fees when such fees are incurred due to situations outside the employee's control, or if the employee has made a good faith effort to pay the travel card company or resolve disputed payments in a timely fashion. Any dispute over the imposition of late fees will be subject to Article 3. In addition to the terms and conditions defined by the Company and the travel card provider, the following provisions continue to apply to the travel card process:

1. Employees will not be required to pay the card company for authorized business expenses before receiving payment from Travel Accounting so long as the delay in receiving that payment is due to the Company's neglect or factors outside the employee's control.

2. Payment delinquencies will not be reported to a credit bureau.

3. Authorized management may exempt employees who engage in extensive/frequent travel or for whom special circumstances exist from the decentralized billing process. Any employee shall be free to request an exemption.

4. The Company will take reasonable steps to preserve the confidentiality of the employee's personal and financial information related to the use of the travel card, and will use such information only for legitimate business reasons. Such information will not be used for solicitations for activities not related to company travel.

LETTER OF UNDERSTANDING NO. 16
RELATING TO FREQUENT FLIER MILEAGE

The Company agrees that frequent flier mileage for business travel will be credited to personal employee accounts and may be applied towards personal travel. Employees must continue to comply with Company directives and Boeing Travel Office procedures including those designed to minimize travel-related costs without regard to frequent flier mileage program considerations.

LETTER OF UNDERSTANDING NO. 17
RELATING TO MAJOR ORGANIZATION

The parties agree that for the life of this Agreement “Major Organization” as that term is defined in 8.3(c) and used throughout Article 8 of the Agreement includes all bargaining unit employees in Sedgwick County, Kansas in a single major organization provided that the Company may, upon sixty (60) days' notice to the Union, modify the definition should a significant change in business or business operations occur, including but not limited to a significant reorganization of Company operations or structure. During that 60-day period the Company will meet with the Union to exchange issues and concerns regarding the reasons for the changes.

LETTER OF UNDERSTANDING NO. 18
RELATING TO QUARTERLY LABOR/MANAGEMENT BUSINESS MEETINGS

Regularly scheduled quarterly meetings will be held between the Company and the Union to share information about Company business plans such as workforce planning, business outlook, facility and safety issues, subcontracting, surplus activity, employment of contract engineers, and other areas of interest as agreed to by the parties.

Meetings shall be attended by appropriate Union, Human Resources and Business Unit Representatives.

LETTER OF UNDERSTANDING NO. 19
RELATING TO RETRAINING SKILL TRANSITION

Employees selected by management to participate in a program of formal training in a field outside their current prime skill designation, which training is conducted or approved by the Company, and employees who at management's request transfer from one major functional area to another for a Company-sponsored skill transition and retraining program will be assigned a unique skill code upon entering the training program or upon transfer to the new functional area respectively. The trainee shall retain this unique code for a period of six months following completion of training or transfer to the new functional area, as the case may be, in order to allow time for the trainee to demonstrate his/her adaptability to the new assignment.

During the period in which the trainee is assigned the unique code, he or she will retain the retention rating held at the time of assignment to the unique code.

In the event a surplus is declared in the trainee's new assignment and if the trainee's retention rating would cause him or her to be an individual surplused, the trainee will be returned for assignment to an area under his or her last held regular assigned primary skill code and the retention rating of record.

LETTER OF UNDERSTANDING NO. 20
RELATING TO SECONDARY SKILLS MANAGEMENT CODES

The Company and the Union enter this Letter of Understanding to address the use of "secondary" skills management codes.

Qualified employees will be eligible to be assigned a secondary skills management code. Assignment of such a skills management code will require that the employee satisfy qualifications identified by management responsible for administration of the skills management code. Such assignments will be reviewed by management every two (2) years. If concerns over the employee's ability to qualify for the assigned skills management code are raised, the employee shall have six (6) months to resolve those issues. During the six (6) month period the employee shall maintain the assigned skills management code. The functional manager must sign a Company form to verify that all such qualifications have been met.

Employees from a surplusing Major Organization shall not be laid off while contract personnel are employed in their secondary skills management code within that Major Organization, except those employees for whom there is supporting documentation of performance deficiencies. Exceptions to avoid significant disruption or impact on committed packages of work will require the approval of the affected organization Senior Human Resource Manager within the organization and the concurrence of the Senior Engineering Manager in the organization or their designees. Notification of exceptions will be provided to the Union as soon as practicable.

Subject to the limitations set forth in 8.6(b)(1), laid-off employees on file for recall pursuant to 8.6(b)(4) will be offered return to active employment within the applicable secondary skills management code, in approximate reverse order of layoff, after employees assigned to such skills management code as their primary skills management code have been offered return to active employment or been removed from layoff status under 8.6. All other provisions of 8.6 addressing job family skills management codes are equally applicable to secondary skills management codes.

LETTER OF UNDERSTANDING NO. 21
RELATING TO EMPLOYEE INCENTIVE PLAN

Eligible employees covered by this Agreement may participate in The Boeing Company Employee Incentive Plan ("EIP") for the duration of this Agreement as set forth below and subject to this Letter of Understanding and the terms of the EIP.

Employees will be eligible to participate in accordance with the governing provisions of the EIP as set forth in the official plan document. In the event of any conflict between this Letter of Understanding and the official EIP plan document, the official EIP plan document will prevail in every case.

The Board of Directors of the Company reserves the right to amend, modify, or terminate the EIP in its sole discretion. All terms and conditions of the EIP, as it may be amended or modified, will apply.

The Company shall not be required or obligated to provide any information to the Union that the Company determines to be proprietary or confidential, including but not limited to information regarding cost, pricing, and/or other financial information or data. Any information regarding cost, pricing, and/or other financial information or data will be provided at the Company's discretion if the Company deems it necessary or appropriate for Union review. If the Company so determines that such information should be released, the Union and/or its representatives may necessarily be required to execute a confidentiality agreement before such information is released. Any information that is released to the Union and/or its representatives will be held confidential and shall not be utilized by the Union and/or its representatives for any purposes that do not directly relate to the EIP.

Nothing in this Letter of Understanding or employee participation in the EIP will be subject to the grievance and arbitration procedure of Article 3.

LETTER OF UNDERSTANDING NO. 22
RELATING JOINT COMPENSATION DISCUSSION GROUP

The parties enter this letter of understanding to express their intent to establish a Joint Compensation Discussion Group.

The discussion group shall meet no less than annually during the term of this agreement. Subjects for discussion may include compensation philosophy, market relationships and the salary planning process.

It is understood that the group is established solely for the purpose of discussion, and that the group is not a forum for making recommendations or seeking agreement. Group discussions shall not reopen the parties' agreement or affect Article 2 thereof.

LETTER OF UNDERSTANDING NO. 23
RELATING PAYMENT LEVELS FOR NETWORK HOSPITALS IN COMPLIANCE WITH PATIENT SAFETY STANDARDS

After satisfaction of the deductible and any copayment requirements, the Traditional Medical Plan pays covered services and supplies **in full** when received from a network hospital that meets *patient safety standards*. Plan payment levels are subject to all provisions of the Plan, including medical review requirements, maximum benefits, coordination of benefits, exclusions and definitions.

Patient safety standards mean established criteria for patient safety related to hospital services. A hospital meets patient safety standards if it meets established criteria listed below. The hospital must publicly certify that it meets all criteria and the statements pertaining to standards are accurate and reflect normal operating procedures at the hospital. The criteria include:

Computerized Physician Order Entry: The hospital must publicly assure that, physicians will enter at least 75% of inpatient medication orders via a computer linked to error-prevention software. The software must be capable of alerting physicians to at least 50% of common, serious prescribing errors.

Intensive Care Unit Staffing: The hospital must publicly assure that its adult and/or pediatric intensive care unit is managed or co-managed by critical care specialists who:

1. Are present during daytime hours and exclusively provide clinical care in the ICU, and

2. At all other times, can return urgent ICU paging calls within five minutes and arrange for a physician or FCCS-certified non-physician specialist to reach ICU patients within five minutes at least 95% of the time.

Evidence-based Hospital Referrals: For patients admitted for one of several complex procedures (coronary artery bypass grafts, percutaneous coronary intervention, abdominal aortic aneurysm repair, pancreatic resection, esophagectomy and high risk deliveries), in addition to CPOE and ICU Staffing, network hospitals must meet experience criteria, consisting of process, volume, and/or outcome measures, for the performance of the specific procedure. If complex procedures as identified by national standards change in the future, the parties agree that they will meet and discuss the changes.

In geographical areas where scientifically rigorous, risk-adjusted outcome comparisons are publicly reported for intensive care unit performance, favorable risk-adjusted outcomes may replace the above criteria for intensive care unit staffing.

LETTER OF UNDERSTANDING NO. 24
RELATING TO HEALTH AND INSURANCE PLAN YEAR CHANGE

Effective January 1, 2010, the plan year for health care and insurance benefits will change from July 1 through June 30 to a calendar year, to January 1 through December 31. In order to transition to the new plan year effective January 1, 2010, the following changes for medical and dental benefits will apply:

- Deductible
  - Expenses applied toward medical and dental plan deductibles for claims incurred from July 1, 2009 through December 31, 2009 will also be credited toward medical and dental plan deductibles for claims incurred January 1, 2010 through December 31, 2010.

- Out-of-pocket maximums (applies to medical only)
  - Expenses applied toward the medical plan out-of-pocket maximum for claims incurred from July 1, 2009 through December 31, 2009 will also be credited toward the medical plan out-of-pocket maximum for claims incurred January 1, 2010 through December 31, 2010.

If the medical or dental plan that the employee was enrolled in during July 1, 2009 through December 31, 2009 did not have a deductible or out-of-pocket maximum, 2010 benefit levels will not be impacted by Benefit Year change. All other benefit levels will be paid accordingly.

LETTER OF UNDERSTANDING NO. 25

RELATING TO PREFERRED PLUS OF KANSAS CCP

The following letter reflects the understanding of the parties relative to potential Preferred Plus of Kansas HMO benefit changes.

Should the company change the Preferred Plus of Kansas plan from a CCP to an HMO for nonunion employees in Kansas, those same plan design changes will be implemented on the same date for employees covered under this Agreement. In no event during the term of this agreement will the office visit copay exceed $20 per visit or the hospital inpatient admission copay exceed $250 per admission. In addition, out-of-area dependent coverage under the HMO plan design will be the same as it is under the CCP.

Side Letters

December 2, 2008

Mr. Bob Brewer
Society of Professional Engineering
Employees in Aerospace
973 South Glendale Street
Wichita, KS 67218

Re: Extended Workweek Rate for Hours Worked in Excess of 144 Hours in a Budget Quarter

Dear Mr. Brewer:

The Company recognizes this is a period of unusually high workload resulting in situations where employees are exceeding 144 hours of EWW in a budget quarter.

In consideration of this, for the period March 27, 2009, through December 31, 2010, the hourly EWW rate for employees exceeding 144 EWW hours in any budget quarter will be straight time plus $15.00 per hour for those hours worked over the 144-hour threshold during that same budget quarter.

In the event that this practice is adopted for non union salaried Wichita employees, the period of the practice described in this letter will be extended to match the period of the non union salaried Wichita practice.

If you have any questions or concerns, please contact me,

Sincerely,

December 5, 2008

Mr. Bob Brewer
Society of Professional Engineering
Employees in Aerospace
973 South Glendale
Wichita, KS 67218

RE: Long Term Disability Open Enrollment

Dear Mr. Brewer:

This letter serves as confirmation that the Company agrees to provide SPEEA represented employees an opportunity to enroll in the Long Term Disability Plan currently insured by Aetna Life Insurance Company during the spring 2009 open enrollment period. The Company has confirmed that Aetna Life Insurance Company agrees to waive the evidence of insurability enrollment requirement for this open enrollment period with an 8% increase to the current rate which will be applied to all SPEEA participants. The pre-existing condition rule will continue to apply and a disability must commence while the employee is covered. All terms and conditions of the plan will continue to apply.

If you have any questions or concerns, please contact me,

Sincerely,

Thomas A. Easley

December 2, 2008

Mr. Bob Brewer
Society of Professional Engineering
Employees in Aerospace
973 South Glendale Street
Wichita, KS 67218

Re: Payout for Vacation Beyond the 2-Year Accumulation Maximum

Dear Mr. Brewer:

The Company recognizes this is a period of unusually high workload resulting in situations where employees may not have sufficient opportunity to use their vacation credits prior to reaching the 2 year vacation balance maximum.

In consideration of this, for the period March 27, 2009 through December 31, 2010, vacation credits not awardable due to the 2 year vacation balance maximum will be paid to the employee each pay period.

In the event that this practice is adopted for non union salaried Wichita employees, the period of the practice described in this letter will be extended to match the period of the non union salaried Wichita practice.

If you have any questions or concerns, please contact me,

Sincerely,

Thomas A. Easley

December 2, 2008

Mr. Bob Brewer
Society of Professional Engineering
Employees in Aerospace
973 South Glendale Street
Wichita, KS 67218

Re: Voluntary Layoff Program Pilot

Dear Mr. Brewer:

The Company agrees to establish a voluntary layoff pilot program for the SPEEA Wichita Engineering Unit following the date of ratification of this agreement. The specific practices of this pilot, including its duration, will be determined by practices developed for the voluntary layoff pilot described in our 2008 Puget Sound collective bargaining agreements with SPEEA. This voluntary layoff with modified benefits process shall be distinguished from any specific benefits provided for employees laid-off involuntarily applicable to SPEEA -represented employees. The Company intends for this pilot to include the following terms:

- One week of pay for every two (2) years of service (up to a maximum 13 weeks of pay) to be paid as a single lump sum payable within a reasonable period of time following the later of the effective date of the layoff and the Company's receipt of a valid release and waiver;

- Medical and dental coverage for laid off employees and their dependents will continue until the employee is covered by any other group medical or dental plan either as an employee or as a dependent, but in no event beyond three months after the date of layoff. However, if the layoff occurs during or after a leave of absence, the maximum total period of continued coverage is thirty (30) months in the case of medical leave or twenty-four (24) months in the case of non-medical leave, measured from the end of the month in which the leave of absence began, irrespective of the date of termination. Required contributions, if any, must be paid during any period of such continuation of coverage.

An employee classified in a job family and SMC that has been declared surplus may request that he or she be voluntarily laid off with modified layoff benefits. If the request is approved by management, subject to situational conditions and selection criteria as defined by the Company, the employee will be coded as a layoff and will be regarded for all Company purposes as a laid off employee (including for purposes of reporting to state employment security departments), entitled to receive layoff benefits provided under Article 21 of the Collective Bargaining Agreement (CBA), except that the provisions of Article 21.3(a)(1) shall not apply and the

provisions of Article 21.3(a)(2) shall apply only with respect to lump sum payments The Union will be advised of all employees approved for voluntary layoff.

The practice offered in this letter is not intended to alter any of the terms of the parties' CBA. And, nothing in this letter either precludes the Company from extending, or obligates the Company to extend, this voluntary layoff benefits practice in the event that it does so for any employee not represented by the CBA. Also, nothing in this letter will be subject to the grievance and arbitration procedure of Article 3 of the CBA.

If you have any questions or concerns, please contact me.

Sincerely,

Thomas A. Easley

Group Benefits Package for Wichita Engineering Unit Employees Represented by SPEEA

Health and Insurance Plans
Attachment A

January 14, 2009

ATTACHMENT A

January 14, 2009

CONTENTS

Eligibility

Eligible Employees

You are eligible for the Package if you are an active Boeing Wichita Engineering Unit employee represented by the Society of Professional Engineering Employees in Aerospace Collective Bargaining Agreement. You are not eligible to enroll if you are working in a capacity that, at the sole discretion of the plan administrator, is considered contract labor or independent contracting. Notwithstanding this provision, individuals represented under a Society of Professional Engineering Employees in Aerospace Collective Bargaining Agreement will be considered by the Company to be employees.

Eligible Dependents

Dependents eligible for the medical and dental plans are your legal spouse (as recognized under both applicable state law and the Internal Revenue Code) and children (natural children, adopted children, children legally placed with you for adoption, and stepchildren) who are under age 25, unmarried, and dependent on you for principal support.

You may request coverage for the following dependents:

- An opposite-gender common-law spouse if the relationship meets the common-law requirements for the state where you entered into the common-law relationship.
- A same-gender domestic partner if:
  - You and your partner live in the same permanent residence in a permanent, exclusive, emotionally committed, and financially responsible relationship similar to a marriage.
  - Your partner is at least 18 years old, is not related to you by blood, is not married to or separated from another person, and is not involved in another domestic partner relationship.
  - Your domestic partner relationship is not solely to obtain coverage under the Plan.

  A same-gender domestic partner is considered a spouse for the purpose of the medical and dental plans.

  Some states have laws that require insured health plans to offer coverage for certain registered domestic partners.
- Unmarried children of your same-gender domestic partner who are under age 25 and dependent on you for principal support. These children are considered stepchildren for the purpose of the medical and dental plans.
- Other children, as follows, who are under age 25, unmarried, and dependent on you for principal support:
  - Children who are related to you either directly or through marriage (e.g., grandchildren, nieces, nephews).
  - Children for whom you have legal custody or guardianship (or for whom you have a pending application for legal custody or guardianship) and are living with you.

Proof of dependent eligibility will be required.

In accordance with Federal law, the Company also provides medical and dental coverage to certain dependent children (called alternate recipients) if the Company is directed to do so by a qualified medical child support order (QMCSO) issued by a court or state agency of competent jurisdiction.

Documentation is required to request coverage for dependents, including a child named in a QMCSO, a child for whom you have been given legal custody or guardianship, a spouse, or a same-gender domestic partner and his or her children. You must provide the Boeing Service

Center with any supporting documentation by the date specified by the Boeing Service Center or your request will be denied.

Special Provisions When Family Members Are Boeing Employees

If your spouse, same-gender domestic partner, or dependent child is employed by Boeing and eligible for any type of benefit plan offered by Boeing, your dependent must be covered separately under the plan or plans available to that person.

No person may be covered both as an employee (active or retired) and as a dependent under any type of plan offered by Boeing, and no person will be considered a dependent of more than 1 employee. Eligible dependents do not include other Boeing employees covered under any Company-sponsored plan providing medical, vision care, prescription drug, dental, or similar services. However, if your spouse is a part-time Boeing employee, retired, on approved leave of absence or layoff, or an employee of a subsidiary company, your spouse and eligible dependent children are considered eligible dependents if other Boeing coverage is waived. If you and your spouse both are Boeing employees and have dependent children, you both may elect medical and dental coverage for eligible children under 1 parent's plans. As an alternative, parents may elect medical coverage for eligible children under 1 parent's plan and dental coverage under the other parent's plan. In either case, all eligible children must be enrolled in the same medical plan and the same dental plan (except as required by a QMCSO). The same provisions apply to a same-gender domestic partner and his or her children.

Disabled Children

A disabled child age 25 or older may continue to be eligible (or enrolled if you are a newly eligible employee) if a physician documents that the child is incapable of self-support due to any mental or physical condition that began before age 25. You may be required to confirm the disability from time to time. The child must be unmarried and dependent on you for principal support. Coverage may continue under the medical and dental plans for the duration of the incapacity as long as you continue to be enrolled in the plans and the child continues to meet these eligibility requirements.

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

Enrollment

Life and Disability Plans

You automatically are enrolled in the Life Insurance Plan, AD&D Plan, and Short-Term Disability Plan when eligible. You may designate a beneficiary for life and accident benefits through the Boeing Service Center.

Medical Plans

In designated locations, the Company provides you with a choice of medical plans.

You receive enrollment instructions at the time of employment and may elect medical coverage under 1 medical plan available in your location by the date indicated on the enrollment worksheet. You and all your eligible dependents must be enrolled in the same medical plan, except as specified in Eligibility.

- If you do not enroll in a medical plan by the date indicated on the enrollment worksheet, you will be enrolled automatically in the Traditional Medical Plan for employee-only coverage.
- You are not required to provide a Certificate of Creditable Coverage in order to enroll in the medical plans because Boeing medical plans do not exclude coverage for pre-existing conditions.
- For your spouse or same-gender domestic partner, you must provide information regarding coverage available through another employer to determine whether or not special

contributions are required to enroll him or her. If you do not authorize a required contribution, he or she will not be enrolled for medical coverage. You will not be able to enroll your spouse or same-gender domestic partner until the earlier of:

- The next annual enrollment period.
- The date your spouse or same-gender domestic partner loses the option to be covered under the other employer-sponsored medical plan.

The Company will require periodic verification of data.

Dental Plan

The Company provides you with dental coverage. You receive enrollment instructions at the time of employment and may elect dental coverage by the date indicated on the enrollment worksheet.

If you do not enroll in dental coverage by the date indicated on the enrollment worksheet, you will be enrolled automatically for employee-only coverage.

Annual Enrollment Period

The Company establishes an annual enrollment period on or before January 1 each year when you may change medical and/or dental plans.

Special Enrollment

If you declined coverage in the medical or dental plans for yourself and/or your eligible dependents when you were first eligible because you or your dependents had other health care coverage, you may enroll yourself and/or your eligible dependents if you or your dependent experiences one of these special enrollment events:

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

Note: For this purpose, "other health care coverage" does not include coverage through Medicare or Medicaid.

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

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

If you decline enrollment in the medical and dental plans because of other employer-sponsored health care coverage (such as through a spouse's employer), you may be able to enroll yourself

and eligible dependents in the Company-sponsored medical and dental plans during the year as long as enrollment is within 60 days after other coverage ends.
If you have a new dependent as a result of marriage, entering into a same-gender domestic partner relationship, birth, adoption, or placement for adoption, you may enroll the new dependent during the year as long as enrollment is requested within 120 days after the qualified event.

Qualified Status Changes
If you experience one of the qualified status changes listed below, you may be able to enroll in medical or dental coverage, change your current coverage, or drop your coverage midyear. Any change to your coverage must be consistent with the status change that affects your or your dependent's eligibility for Company-sponsored health care coverage or health care coverage sponsored by your eligible dependent's employer. Qualified status changes include the following events:

- You marry, divorce, or become legally separated, or the marriage is annulled.
- You enter into or dissolve a same-gender domestic partner relationship.
- You acquire a new, eligible dependent child, such as by birth, adoption, or placement for adoption.
- Your spouse or same-gender domestic partner or dependent child dies.
- You or your spouse or same-gender domestic partner or dependent child starts or stops working.
- You or your spouse or same-gender domestic partner or dependent child has any other change in employment status that affects eligibility for coverage such as changing from full time to part time (or part time to full time), salaried to hourly (or hourly to salaried), strike or lockout, a transfer between a nonunion salaried position and a union-represented position, or beginning or returning from an unpaid leave of absence, including an approved leave of absence in accordance with the Family and Medical Leave Act.
- You or your spouse or same-gender domestic partner or dependent child experiences a significant increase in the cost of employer-sponsored health care coverage or the employer-sponsored health care coverage ends, including expiration of COBRA coverage.
- The Company adds a new benefit option or significantly improves an existing benefit option.
- You or your spouse or same-gender domestic partner or dependent child experiences a significant curtailment or cessation of employer-sponsored health care coverage.
- You or your spouse or same-gender domestic partner or dependent child becomes eligible or ineligible for Medicare or Medicaid.
- Your dependent child becomes eligible for, or no longer is eligible for, health care coverage due to age limits, principal support status, or a similar eligibility requirement.
- You or your spouse or same-gender domestic partner or dependent child makes an enrollment change in his or her employer-sponsored health care coverage, either because of a qualified change in status or an annual enrollment.
- You or your spouse or same-gender domestic partner or dependent child changes place of residence or work, affecting access to care within the current plan or access to network providers.
- You are transferred to a different division, affecting eligibility for benefits under Company-sponsored health care plans.

- You or your spouse or same-gender domestic partner or dependent child loses coverage under a group health plan sponsored by a governmental or educational institution.

You also may change an election to comply with a qualified medical child support order (QMCSO) to provide or cancel coverage for a dependent child resulting from a divorce, annulment, or change in legal custody.

In most situations, you must request enrollment within 60 days after the qualified event. You can enroll a new dependent within 120 days following your marriage or entering into a same-gender domestic partner relationship or a dependent child's birth, adoption, or placement for adoption. To request enrollment for a new dependent more than 60 days but within 120 days after marriage, entering into a same-gender domestic partner relationship, birth, adoption, or placement for adoption, you must call the Boeing Service Center and speak with a customer service representative. You must provide the Boeing Service Center with any supporting documentation by the date specified by the Boeing Service Center or your request will be denied.

Effective Date of Coverage

Employees

If you are a newly hired employee, the Package becomes effective as follows:

- Medical and dental coverage becomes effective on the first day of the month following your first day of employment.
- Life insurance, AD&D, and short-term disability coverage becomes effective on the first day of the month following your first day of employment, provided you are actively at work on that date.

  Actively at work means you are attending to your normal duties at your assigned place of employment. On a holiday, vacation day, weekend day, or other regularly scheduled day off, actively at work means you are not ill, injured, or otherwise disabled or confined to a hospital or similar institution and are performing the normal activities of a person of your gender and age.

You must be on the active payroll on the first day of the month.

If you are rehired from a layoff within 5 years, are reemployed following uniformed service (and return to work promptly in accordance with Federal law), or return from an approved leave of absence, coverage is effective on the date you return to active employment.

Dependents

Current eligible dependents are covered for medical and dental benefits on the same date your coverage is effective. Eligible dependents acquired after your coverage is effective become covered on the date of marriage or entering into a same-gender domestic partner relationship, date of birth, or date the child is legally placed with you for adoption, if application is made within 120 days of the event. For other newly eligible dependents, coverage is effective on the date dependency is established, if application is made within 60 days.

You authorize required contributions when enrolling eligible dependents.

Short-Term Disability Plan

The Company provides disability income coverage for you under the Short-Term Disability Plan. You are eligible for a weekly benefit if you become totally disabled as a result of an accidental injury or illness, including a pregnancy-related condition, while covered under this plan.

Benefits
Your benefits under this plan will begin after your disability has lasted 7 consecutive calendar days. After this 7-day waiting period, you will receive a weekly benefit based on your weekly salary in accordance with the schedule of benefits below.

Short-Term Disability Benefit Schedule	
Benefit Period	**Benefit Amount**
Week 1	Waiting period; no benefits paid under the plan
Weeks 2 through 13	You receive 80% of your weekly salary
Weeks 14 through 26	You receive 60% of your weekly salary

Your benefit may be adjusted for other income benefits and rehabilitative employment. There is no minimum or maximum benefit payment under this plan.
Your benefits under this plan will be determined using the weekly salary reflected in the records of the Boeing Service Center for Health and Insurance Plans at the time your disability first begins (called your predisability earnings). If you are a part-time employee regularly scheduled to work more than 19 hours and less than 40 hours per week, your benefits under this plan will be determined using the average weekly salary that you actually earned for the 6 weeks immediately preceding your date of disability.
If you are actively at work and your weekly salary either increases or decreases, your short-term disability benefit amount will change automatically on the first day of the month after or coinciding with the date of the change in your salary. If you are not actively at work on the day the coverage change would become effective, the effective date for your new coverage amount will be delayed until the first day of the month after or coinciding with the day you return to work for 1 full day. Any retroactive change in your weekly salary will not retroactively change your disability coverage amount under this plan. If your period of disability has started, a change in your weekly salary will not change your benefit amount.

Eligibility for Benefit Payments
To be eligible for short-term disability benefit payments, you must be totally disabled; that is, you must be unable to perform the material duties of your regular occupation or other appropriate work the Company makes available and be earning 80% or less of your predisability earnings. You must be under the continuous care of a legally qualified physician throughout your period of total disability. In addition, the service representative may require you to be examined by a physician of its choice as often as is reasonably necessary to verify your continuous total disability.
All determinations of total disability are made by the service representative within the terms of its contract with the Company.

Benefit Payment Period
Benefits begin after a waiting period of 7 consecutive days and continue while you are totally disabled, through the 26th week of disability. Benefits stop when you no longer are disabled, at the end of your maximum benefit period, or when you die.

Separate Periods of Disability

A period of disability ends and benefit payments under this plan stop when you no longer are disabled or you return to work for 1 full day. If you incur a second period of disability, the cause of the second disability and the length of your recovery time between the disability periods will

determine whether the second disability is treated as a temporary recovery (that is, a continuation of the first disability claim) or as a separate disability claim.
Your recovery will be considered a temporary recovery if, during the benefit payment period, you cease to be disabled for a total of 60 days or less.
The following provisions apply to periods of temporary recovery:

- Only 1 benefit waiting period applies.
- Your weekly salary used to determine your initial short-term disability benefit does not change.
- No short-term disability benefits are paid for the period of temporary recovery.

Your second period of disability will be considered a separate disability claim if you have returned to work for 1 full day and

- It is due to a different cause than the first disability period, or
- It is due to the same cause or causes but your recovery is longer than 60 days, or
- The first period of disability began before you were covered under this plan.

You must submit a claim for benefits and meet the waiting period requirements before benefits will be paid.

Other Income Benefits
Certain other income benefits that you may be entitled to receive will reduce your weekly benefit from the Short-Term Disability Plan. There is no minimum benefit payment under this plan. You must apply for all other income benefits for which you may be eligible, including Social Security benefits (but excluding retirement benefits).
Your benefits under this plan are reduced by the following sources of income:

- Salary continuation (to the extent combined short-term disability, salary continuation, and other income benefits exceed 100% of predisability earnings).
- Benefits from insured or uninsured disability income plans of any employer, multiemployer or multiple-employer welfare plan, or union welfare plan.
- Benefits from a disability income plan of any state or other jurisdiction.
- Social Security disability or retirement benefits, including primary, spouse, and dependent child benefits.
- Railroad Retirement Act benefits, or other benefits paid under a Federal or state law.
- Workers' compensation benefits.
- No-fault wage replacement benefits paid under a no-fault automobile insurance law.
- Salary, wages, other compensation from any employer, or income from any occupation for compensation or profit, except as described in Rehabilitative Employment below.
- Benefits from group credit or mortgage disability insurance.
- Retirement income benefits from the Company or any Company subsidiaries, except:
  - The portion of any retirement benefit attributable to employee contributions.
  - The portion of any lump-sum distribution attributable to employee contributions.
  - Any retirement benefit you are eligible to receive but elect not to receive.

Other income benefits paid in a lump sum will be allocated over the time period specified in the lump-sum settlement or your life expectancy (as determined by the service representative). Short-term disability benefit payments will not be reduced for cost-of-living increases in other income benefits.

Short-term disability benefit payments also will not be reduced by benefits from:

- Employer-sponsored thrift, profit sharing, savings, stock ownership, or deferred compensation plans.
- Internal Revenue Code (IRC) Section 401(k) plans, Section 403(b) plans, Section 457 plans, or Keogh (HR-10) plans.
- Individual retirement arrangements (IRAs).
- Individual disability insurance policies.
- Accelerated benefits paid under a life insurance policy.
- Military retirement or disability benefits, unless related to the cause of the current disability.

Rehabilitative Employment

To encourage you to return to gainful employment before you fully recover from your total disability, the plan allows you to receive pay for certain work without a reduction in your plan benefits. During the period you are receiving short-term disability benefit payments, you may earn up to a maximum of 100% of your predisability earnings through a combination of your short-term disability benefits plus earnings from approved rehabilitative employment.

The service representative must approve the rehabilitation program. If the sum of rehabilitative earnings, other income benefits, and short-term disability benefits exceeds your predisability earnings, the excess will be considered other income benefits and will reduce your weekly benefit under this plan.

WHEN AN INJURY OR ILLNESS IS CAUSED BY THE NEGLIGENCE OF ANOTHER—

DISABILITY

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

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

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

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

constructive trust, equitable lien, right of subrogation, reimbursement, or any other equitable or legal remedy.

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

Exclusions

The Short-Term Disability Plan does not cover any disability directly or indirectly caused by

- Intentionally self-inflicted injury (while sane or insane).
- Committing or attempting to commit an assault, battery, or felony.
- War or any act of war (declared or not declared). The plan does, however, pay for disabilities caused by an act of war while you are traveling on business for the Company.
- Insurrection, rebellion, or taking part in a riot or civil commotion.
- Military duty other than temporary active duty of less than 31 days.

You are not considered to be disabled, and no benefits are paid for, any day you are confined in a penal or correctional institution for conviction of a crime or other public offense.

Definitions

Actively at work means you are attending to your normal duties at your assigned place of employment. On a holiday, vacation day, weekend day, or other regularly scheduled day off, actively at work means you are not ill, injured, or otherwise disabled or confined to a hospital or similar institution and are performing the normal activities of a person of your gender and age.

Physician means a legally qualified, licensed physician, with a course of treatment that is consistent with the diagnosis of the disabling condition and according to guidelines established by medical, research, and rehabilitation organizations.

Predisability earnings for a full-time employee means the amount of salary or wages (including shift, lead, and foreign and domestic pay differentials) you were receiving from the Company on the day before a period of disability started, calculated on a weekly basis. For a part-time employee, predisability earnings are based on the average weekly salary you received from the Company during the 6 weeks immediately preceding your date of disability.

Totally disabled means all of the following conditions apply to you:

- You are disabled as a result of accidental injury or illness (including a pregnancy-related condition).
- As a result, you are earning 80% or less of indexed predisability earnings (as defined above).
- Your accidental injury or illness prevents you from performing the material duties of your regular occupation or other appropriate work the Company makes available.

Weekly salary means your salary, including shift, lead, and foreign and domestic pay differentials, but excluding bonuses, overtime pay, cost-of-living allowances, incentive compensation, or other compensation you receive from the Company or a participating subsidiary. For part-time employees, benefits are determined using the average weekly salary you actually earned for the 6 weeks immediately preceding the disability date. If you have been employed by the Company for fewer than 6 weeks, the plan first figures your pay as if you were full time; your weekly salary is that amount multiplied by a percentage equal to your scheduled weekly hours divided by 40.

Life Insurance Plan

The life insurance benefit equals 2¼ times your base annual salary, to a maximum of $500,000. Your coverage amount is rounded to the next highest $1,000 if it is not already an even $1,000. Your life insurance benefit is determined by the annual salary reflected in the records of the Boeing Service Center for Health and Insurance Plans.

If you are actively at work and your annual salary either increases or decreases, your life insurance benefit will change automatically on the first day of the month after or coinciding with the date of the change in your salary. If you are not actively at work on the day the coverage change would become effective, the effective date for your new coverage amount will be delayed until the first day of the month after or coinciding with the day you return to work for 1 full day. Any retroactive change in your annual salary will not retroactively change your life insurance coverage amount under this plan. If your period of permanent and total disability has started, a change in your annual salary will not change your benefit amount.

The total amount is payable in the event of your death from any cause at any time or place while covered. Payment is made in a lump sum or installments to the designated beneficiary. You may change beneficiaries at any time by contacting the Boeing Service Center.

If you become permanently and totally disabled before age 60 and while covered under the plan, the Company will continue to pay the premium for your coverage as long as you remain disabled.

If you become permanently and totally disabled between the ages of 60 and 65 and while covered under the plan, the Company will continue to pay the premium for your coverage until the earlier of:

- Age 65, or
- Your recovery.

AD&D Plan

AD&D benefits are provided if your loss of life, paralysis, or loss of hand, foot, eyesight, hearing, or speech is caused by a covered accident (including an occupational accident) that occurs while you are covered under the plan.

The full principal sum, $25,000, is paid to your beneficiary if you die. This amount is in addition to any amount payable under the group life insurance coverage.

The following benefits are payable if the covered injury causes any of the following losses within 365 days after the covered accident:

Loss	Percentage of Principal Sum
Life	100%
Quadriplegia	100%
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
1 Hand and 1 Foot	100%
1 Hand and the Sight of 1 Eye	100%
1 Foot and the Sight of 1 Eye	100%
Speech and Hearing in Both Ears	100%
Paraplegia	75%
Hemiplegia	50%
1 Hand or 1 Foot	50%
Sight of 1 Eye	50%
Speech or Hearing in Both Ears	50%
Hearing in 1 Ear	25%
Thumb and Index Finger of Same Hand	25%

“Loss” of a hand or foot means the complete severance through or above the wrist or ankle joint. “Loss” of sight of an eye means the total and irrecoverable loss of the entire sight in that eye. “Loss” of hearing in an ear means the total and irrecoverable loss of the entire ability to hear in that ear. “Loss” of speech means the total and irrecoverable loss of the entire ability to speak. “Loss” of a thumb and index finger means the complete severance through or above the metacarpophalangeal joint of both digits.

“Quadriplegia” means the complete and irreversible paralysis of both upper and both lower limbs. “Paraplegia” means the complete and irreversible paralysis of both lower limbs.

“Hemiplegia” means the complete and irreversible paralysis of the upper and lower limbs of the same side of the body.

“Injury” means bodily injury caused by an accident occurring while you are covered under the plan, and resulting directly and independently of all other causes in death or loss as listed above.

If you sustain more than 1 loss as the result of the same accident, no more than 100% of the principal sum will be paid.

If you are unavoidably exposed to the elements due to an accident occurring while covered under this plan, and as a result of such exposure suffer a loss for which a benefit is otherwise payable, the loss will be covered under the terms of this plan.

If your body has not been found within 1 year of the disappearance, forced landing, stranding, sinking, or wrecking of a vehicle in which you were an occupant while covered under this plan, the loss will be covered as an accidental death under the terms of the plan.

No plan benefits will be paid for a death or loss caused in whole or in part by, or resulting in whole or in part from:

- Suicide or intentionally self-inflicted injury.
- Declared or undeclared war or act of declared or undeclared war occurring in the continental limits of the United States, unless it is an act of terrorism.

  ("Terrorism" means any violent act intended to cause injury, damage, or fear and committed by or purportedly committed by one or more individuals or members of an organized group to make a statement of the individual's or group's political or social beliefs, concepts, or attitudes and/or to intimidate a population or government into granting the individual's or group's demands.)
- An illness, sickness, disease, bodily or mental infirmity, medical or surgical treatment, or bacterial or viral infection, regardless of how contracted, except bacterial infection resulting from an accidental cut or wound or accidental food poisoning. However, if a covered loss results from medical or surgical treatment of an injury, benefits will be provided for the loss.

Traditional Medical Plan Summary of Benefits

The Traditional Medical Plan is available to active employees and their dependents, as well as retired employees and their dependents until they become eligible for Medicare.

This section shows general plan features of the Traditional Medical Plan, including benefit amounts and other plan information. See the Traditional Medical Plan Summary of Covered Medical Services and Supplies for benefit details.

Effective January 1, 2010, benefit and plan payment provisions will be based on a benefit year of January 1 through December 31.

Prescription drug benefits are shown in Traditional Medical Plan Prescription Drug Program. Vision care benefits are shown in Traditional Medical Plan Vision Care Program.

Schedule of Benefits

Traditional Medical Plan Schedule of Benefits The Traditional Medical Plan is administered by Regence BlueShield (the service representative). The mental health and substance abuse program is administered by ValueOptions (the behavioral health service representative).		
	Network	**Nonnetwork**
Plan Features		
Annual Deductible	Greater of $225 or 0.225% of base annual salary individual/$675 or 0.675% of base annual salary family of 3 or more, but not more than $225 or 0.225% of base annual salary for any person	
Office Visit Copayment (deductible does not apply)	$15 per visit	Does not apply; charges of nonnetwork providers are subject to deductible and coinsurance
Coinsurance	95%	60%
Annual Out-of-Pocket Maximum (in addition to deductible)	$2,000 individual/$4,000 family, but not more than $2,000 for any person	
Lifetime Maximum Benefit	$2,000,000 lifetime maximum benefit applies to all covered services and supplies	
Provider Choice		
• Network Providers	Special fee arrangements with the service representative make it possible for the plan to cover a higher percentage of most network services and supplies; in most cases, the only out-of-pocket expenses are: • Deductible, copayment, and coinsurance amounts • Expenses for services and supplies not covered by the plan • Any amounts that exceed plan maximum benefits	
• Nonnetwork Providers	In a location where qualified network providers are available, the plan covers a lower percentage of most nonnetwork services and supplies; in a location where there is no qualified network provider, the plan covers services and supplies at the network level; benefit payments are based on usual and customary charges	
• Providers in a Category Not Eligible to Participate in the Network	The plan covers services and supplies at 80%; you can call the service representative to find out which types of providers are network providers in a particular location; benefit payments are based on usual and customary charges	
Covered Services and Supplies	95% after deductible for most covered network services and supplies, except as shown below	60% after deductible for most covered nonnetwork services and supplies, except as shown below
Ambulance	95%	See network provisions

Traditional Medical Plan Schedule of Benefits The Traditional Medical Plan is administered by Regence BlueShield (the service representative). The mental health and substance abuse program is administered by ValueOptions (the behavioral health service representative).		
	Network	**Nonnetwork**
Emergency Room		
• True Medical Emergency	$50 copayment (waived if admitted as an inpatient immediately following emergency room treatment) 100% in a hospital that meets patient safety standards; 95% in a hospital that does not meet patient safety standards	See network provisions
• All Other Treatment	$50 copayment 100% in a hospital that meets patient safety standards; 95% in a hospital that does not meet patient safety standards	60% after $50 copayment
Hearing Aids	95% up to $800 per ear; limit 1 aid per ear every 3 benefit years Hearing aid overhaul in place of new hearing aid after 3 years	60% up to $800 per ear; limit 1 aid per ear every 3 benefit years Hearing aid overhaul in place of new hearing aid after 3 years
Hospital Services and Supplies	100% in a hospital that meets patient safety standards; 95% in a hospital that does not meet patient safety standards	60%
Hospital Alternatives	100%; limits apply	100%; limits apply
• Ambulatory Surgical Facility		
• Christian Science Sanatorium		
• Home Health Care		
• Hospice Care		
• Skilled Nursing Facility		
Mental Health Treatment (including eating disorders)		
• Covered Inpatient, Partial Hospital, Residential, or Intensive Outpatient Services	95% when referred by the behavioral health service representative	60% when *not* referred by the behavioral health service representative

Traditional Medical Plan Schedule of Benefits The Traditional Medical Plan is administered by Regence BlueShield (the service representative). The mental health and substance abuse program is administered by ValueOptions (the behavioral health service representative).		
	Network	**Nonnetwork**
• Covered Outpatient Services	95% when referred by the behavioral health service representative	60% when *not* referred by the behavioral health service representative
Neurodevelopmental Therapy (for children age 6 and under)	95% up to $1,500 each benefit year (network and nonnetwork combined)	60% up to $1,500 each benefit year (network and nonnetwork combined)
Occupational, Physical, and Speech Therapy	95%; benefits limited to 3 months; may be extended if approved by the service representative	60%; benefits limited to 3 months; may be extended if approved by the service representative
Preventive Care		
• Routine Physical Examinations (for employees, spouses, and children age 2 and older)	100% (deductible does not apply) up to $500 maximum per person per benefit year, including office visits, related laboratory and X-ray charges as well as childhood and adult immunizations and vaccines, excluding travel vaccines, as recommended by the U.S. Preventive Services Task Force (USPSTF) guidelines, including the applicable catch-up immunization schedule for children age 2 to 18 as recommended by the USPSTF guidelines; deductible and coinsurance apply after $500 limit Limited to 1 examination per child every benefit year for age 2 through age 18 Limited to 1 examination per person every 3 benefit years for age 19 through age 34, then 1 examination per person every benefit year	Not covered when received in the network service area

Traditional Medical Plan Schedule of Benefits The Traditional Medical Plan is administered by Regence BlueShield (the service representative). The mental health and substance abuse program is administered by ValueOptions (the behavioral health service representative).		
	Network	**Nonnetwork**
• Routine Physical Examinations for children to age 2)	100% (deductible does not apply) Limited to 8 examinations from birth to age 2 Immunizations and vaccines, excluding travel vaccines, as recommended by the U.S. Preventive Services Task Force (USPSTF) guidelines and as recommended by the physician, including the applicable catch-up immunization schedule for children age 4 months to 2 years as recommended by the USPSTF guidelines	Not covered when received in the network service area
• Routine Pap Tests, Mammograms, Prostate Screenings, and Colorectal Screenings (including colonoscopies)	100% (deductible does not apply) Covered as recommended by the physician	Not covered when received in a network service area
Tobacco Cessation Treatment	100% (deductible does not apply); $500 lifetime maximum	
Spinal and Extremity Manipulations	$15 copayment per visit up to 26 spinal and/or extremity manipulation visits per benefit year (network and nonnetwork combined)	60% up to 26 spinal and/or extremity manipulation visits per benefit year (network and nonnetwork combined)
Substance Abuse Treatment		
• Covered Inpatient, Partial Hospital, Residential, Intensive Outpatient, or Outpatient Services	95% when referred by the behavioral health service representative Limit 2 courses of treatment lifetime maximum (network and nonnetwork combined)	60% when *not* referred by the behavioral health service representative; $5,000 maximum per course of treatment Limit 2 courses of treatment lifetime maximum (network and nonnetwork combined)
Temporomandibular Joint Dysfunction and Myofascial Pain Dysfunction Syndrome (TMJ/MPDS) Treatment	50% up to $3,500 lifetime maximum	

Traditional Medical Plan Schedule of Benefits The Traditional Medical Plan is administered by Regence BlueShield (the service representative). The mental health and substance abuse program is administered by ValueOptions (the behavioral health service representative).		
	Network	**Nonnetwork**
Wigs	80% after the network deductible up to a $500 annual limit	

Hospital Patient Safety Standards
The plan will pay covered network hospital inpatient and outpatient facility charges at the highest benefit level for hospital services and supplies, after you satisfy the deductible, if:

- You are admitted for a specified high-risk procedure and the hospital meets Standard 1 below, or
- You are admitted for inpatient care or treated as an outpatient for any other reason and the hospital meets both Standard 2 and Standard 3 below.

Hospital Patient Safety Standards	
Criteria for Network Hospital Admissions for Complex Procedures	
Standard 1: evidence-based hospital referral	For patients admitted for one of several complex procedures (such as coronary artery bypass grafts, percutaneous coronary intervention, abdominal aortic aneurysm repair, pancreatic resection, esophagectomy, and high-risk deliveries), the hospital meets experience criteria consisting of process, volume, and/or outcome measures for performing the specific procedure.
Criteria for Other Network Hospital Admissions	
Standard 2: computerized physician order entry	The hospital publicly assures that physicians enter at least 75% of inpatient medication orders on a computer linked to error-prevention software capable of alerting physicians to at least 50% of common, serious prescribing errors.

Hospital Patient Safety Standards	
Criteria for Network Hospital Admissions for Complex Procedures	
Standard 3: **intensive care unit staffing**	The hospital publicly assures that patients in its adult and/or pediatric intensive care unit are managed or comanaged by critical care specialists who: • Are present during daytime hours and exclusively provide clinical care in the ICU, and • At all other times, can return urgent ICU paging calls within 5 minutes and arrange for a physician (or FCCS-certified non-physician specialist) to reach ICU patients within 5 minutes at least 95% of the time. In locations where scientifically rigorous, risk-adjusted outcome comparisons are publicly reported for ICU performance, favorable risk-adjusted outcomes may replace the above criteria for ICU staffing.

The hospital patient safety standards do not apply to mental health or substance abuse treatment.

Annual Deductible
The annual deductible amount applies to all covered network and nonnetwork services and supplies except network provider outpatient visits where the office visit copayment applies, preventive care, and tobacco cessation treatment.

Office Visit Copayment
The office visit copayment applies to network provider office, home, or outpatient visits; acupuncture visits; hearing examinations; and spinal and extremity manipulation visits.
The office visit copayment does not apply to preventive care visits or screening examinations, mental health or substance abuse outpatient visits, tobacco cessation treatment, or allergy injections separate from a physician office visit.

Out-of-Pocket Maximum
For some services, you are required to pay a certain percent of charges, called out-of-pocket expenses.
When your out-of-pocket expenses (or when your family members' combined out-of-pocket expenses) reach the annual out-of-pocket maximum, most other benefits are paid at 100% of usual and customary charges for the rest of that benefit year, up to any maximum benefit amounts.
The following expenses do not count toward the out-of-pocket maximums:

- Any balance remaining after a benefit maximum has been reached.
- Benefits paid at a reduced amount or denied when you fail to follow medical review program procedures and requirements.
- Covered medical services for TMJ/MPDS treatment.
- Covered medical services for treatment of mental illness or substance abuse.
- Covered services for tobacco cessation treatment.
- Covered medical services paid at 100% of usual and customary charges or in full.

- Deductibles.
- Expenses for services or supplies not covered by the plan.
- Hospital emergency room copayments.
- Retail and mail service prescription drug program coinsurance or copayments.
- Office visit copayments.
- The difference between usual and customary charges and the provider's actual charge.

Provider Choice

Network Providers

Network providers are physicians, hospitals, and other health care providers who have contracts with the plan's service representative to provide efficient, cost-effective health care. Although you may receive care from any licensed provider covered under the plan, the plan offers certain advantages if a network provider is used.

The contracts with network providers include direct billing and payment systems. This means you do not need to submit a claim form when a network provider is used.

Nonnetwork Providers

Covered services obtained from nonnetwork physicians, hospitals, and other covered health care providers in a license category eligible to participate in the network (for example, M.D.s) are paid according to whether network providers are available in that location.

Providers in a Category Not Eligible to Participate in the Network

Certain types of providers may or may not be network providers depending on their location. The plan may not have network contracts with providers in a specific category in a particular location (such as podiatrists or chiropractors in certain locations).

Medical Review Program

The medical review program lets you and your physician know whether certain types of nonemergency care will be covered under the plan before the care is provided and the expense is incurred.

The plan pays regular benefits for certain types of nonemergency care only if the medical review program is contacted before care is received. Benefits may be limited or denied if these requirements are not followed.

Medical review program requirements do not apply if primary coverage is provided through another employer's group medical plan.

If preadmission or prior approval is...	Then the plan pays...
Obtained through the medical review program	Regular benefit levels shown in the Traditional Medical Plan Schedule of Benefits
Required but not obtained and it is later determined that the care was medically necessary	50% of the first $2,000 of usual and customary charges (after the deductible)
Not obtained and the admission or care is not considered medically necessary under the medical review program's guidelines	No benefits; you are responsible for 100% of the charges

Although contacting the program is not required before emergency or pregnancy-related admissions, you or your physician should contact the program soon after admission to be assured whether the rest of the confinement is covered. Hospital preadmission review for childbirth is not required for a mother and newborn for the first 48 hours following a normal delivery or 96 hours following a cesarean section.

All mental health and substance abuse treatment must be authorized by the behavioral health service representative. Emergency hospital admissions must be reported and authorized within 48 hours of the admission. Nonemergency admissions and outpatient services must be authorized in advance. If you or your provider does not obtain authorization, the plan will not cover any charges for mental health or substance abuse treatment. If authorization is obtained after treatment is provided (except the first 48 hours of an emergency admission), covered services will be paid at the nonnetwork level of benefits, even if you use a network provider.

Voluntary Second Surgical Opinion

The plan encourages you to get a second opinion before having any nonemergency surgery. A second (or third) surgical opinion will be covered under the network/nonnetwork provider payment levels, subject to the plan's copayments and/or deductibles.

Individual Case Management

In the event of a severe or long-term illness or injury, the service representative assists your network provider in identifying treatment alternatives that offer cost-effective care and enhancements to quality of life.

Traditional Medical Plan Summary of Covered Medical Services and Supplies

This summary applies to the Traditional Medical Plan.

Covered Services and Supplies

In general, the plan covers medically necessary services and supplies used to diagnose or treat a nonoccupational accidental injury or illness as well as medically appropriate services and supplies for certain types of preventive care and other conditions, up to plan limits.

Acupuncture

The plan covers medically necessary acupuncture for a covered illness or in place of covered anesthesia. Treatment must be provided by a licensed acupuncturist (L.A.C.), doctor of medicine (M.D.), or doctor of osteopathy (D.O.). You can contact the service representative to determine if acupuncture is covered for a particular condition.

Ambulance

Professional ambulance services are covered to transport you from the place where you are injured or become ill to the first hospital where treatment is given. These services also are covered when the physician requires an ambulance to transport you to a hospital in your area of residence to protect your health or life. Air ambulance transportation is covered when medically necessary.

Ambulance service from one hospital to another, including return, is covered only if the facility is the nearest one with appropriate regional specialized treatment facilities, equipment, or staff physicians. Ambulance transportation from or to your home is covered when medically necessary. No other expenses in connection with travel are covered.

Ambulatory Surgical Facility

The plan covers charges of an ambulatory surgical facility for treatment of a covered condition provided the services would be covered if received in a hospital. Charges of hospital-based facilities are covered as hospital services. Charges of approved free-standing facilities are covered as hospital alternatives.

Christian Science Sanatorium

Charges for a semiprivate room in a sanatorium are covered if you are admitted for the process of healing (not rest or study) and are under the care of an authorized Christian Science practitioner. If a private room in a sanatorium is used, you are responsible for the difference between the charge for the private room and the sanatorium's average charge for a semiprivate room. If the facility provides only private rooms, the plan covers up to the charge for semiprivate rooms in similar local facilities.

A Christian Science sanatorium is a facility that, at the time of the healing treatment, is operated (or listed) and certified by the First Church of Christ, Scientist, in Boston, Massachusetts.

Congenital Abnormalities and Hereditary Complications

Medically necessary services and supplies are covered when required for the treatment of congenital abnormalities and hereditary complications. This coverage applies to newborn children as well as to all other persons covered under the plan.

Cosmetic Surgery

The plan covers necessary services and supplies for cosmetic surgery only if the surgery is required for the prompt repair of an accidental injury or improvement of function due to congenital abnormality. All other surgery performed for cosmetic purposes is excluded, except as specifically provided for treatment after a mastectomy (see Reconstructive Breast Surgery).

Dental Repair of Accidental Injury

Services and supplies for the prompt repair of sound natural teeth or other body tissues as a result of an accidental injury are covered, but only to the extent they are not covered by your Company-sponsored dental plan. This may include surgical procedures of the jaw, cheek, lips, tongue, and other parts of the mouth and treatment of fractures in the facial bones (maxilla or mandible).

Diagnostic X-Ray and Laboratory Services

Diagnostic X-ray and laboratory examinations are covered, including those in connection with a voluntary second or third surgical opinion.

Durable Medical Equipment

The plan covers the rental (or purchase, when approved by the service representative) of medically necessary durable medical or surgical equipment when prescribed by a physician. Covered equipment must be:

- Able to withstand repeated use.
- Solely for the treatment or improvement of a critical function related to the medical condition.
- Appropriate for use in the home.

Examples of covered durable medical equipment are crutches, wheelchairs, kidney dialysis equipment, standard hospital beds, oxygen equipment, and diabetic supplies and equipment such as blood glucose monitors, insulin infusion devices, and insulin pumps. Covered equipment must not be useful to a person in the absence of the medical condition.
The repair or replacement of durable medical equipment due to normal usage or change in the patient's condition, including growth of a child, also is covered.

Emergency Room

Emergency room treatment at either a network or nonnetwork facility is paid at the network level if it is a true medical emergency. A patient admitted to a nonnetwork hospital retains emergency status (and benefits are paid at the network level) for 24 hours or until the patient can be transferred safely to a network facility. However, for care at a nonnetwork facility when the condition is not a true medical emergency, covered services are paid at the nonnetwork level.

Erectile Dysfunction

Organic erectile dysfunction treatment is covered when the patient has a history of one or more of the following:

- Insulin-dependent diabetes.
- Major pelvic surgery.
- Peripheral neuropathy or autonomic insufficiency.
- Peripheral vascular disease or local penile vascular abnormalities.
- Prostate cancer.
- Severe Peyronie's disease.
- Spinal cord disease or injury.
-

Covered therapy includes vacuum erection devices, injection therapy, a penile prosthesis, urethral pellets, and prescription medications.

Hearing Aids

Plan benefits include cost and installation of a hearing aid when recommended in writing by a physician or certified audiologist as well as the overhaul of a hearing aid in place of a new hearing aid. Benefit periods are described in the Traditional Medical Plan Summary of Benefits.

Hemodialysis

The plan covers repetitive hemodialysis treatment for chronic, irreversible kidney disease. Covered services and supplies include the rental or lease of hemodialysis equipment.

Hemodialysis treatment and equipment are covered by the plan for the first 30 months following Medicare entitlement due to end-stage renal disease. After this 30-month period, Medicare provides primary coverage and the plan provides secondary coverage.

Home Health Care

Medically necessary home health care visits and supplies are covered if inpatient care in a hospital or skilled nursing facility otherwise would be required. In addition, you must be considered homebound, which means leaving home involves a considerable and taxing effort and public transportation cannot be used without the help of another. Benefits are limited to 120 visits each benefit year.

Home health care requires prior approval; see Medical Review Program in the Traditional Medical Plan Summary of Benefits. Before receiving home health care, the attending physician must provide a written treatment plan (a written program for continued care and treatment).

Then, at least once every 2 months, the physician must review the treatment plan and certify that your condition and treatment continue to meet home health care criteria.

The following home health care visits and supplies are covered if provided and billed by an approved home health care agency:

- Home health aide visits.
- Medical social visits provided by a person with a master's degree in social work (M.S.W.).
- Medical supplies that would have been provided on an inpatient basis.
- Nursing visits provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.).
- Nutritional guidance by a registered dietitian.
- Nutritional supplements (such as diet substitutes) administered intravenously or through hyperalimentation.
- Occupational therapy visits provided by an occupational therapist.
- Physical therapy visits provided by a physical therapist.
- Physician services.
- Respiratory therapy visits provided by an inhalation therapist certified by the National Board of Respiratory Therapists.
- Services and supplies for infusion therapy. (Patients do not need to meet the treatment plan and homebound requirements.)
- Speech therapy visits provided by a speech therapist.

Hospice Care

Hospice care is provided to terminally ill patients in an effort to control pain and other symptoms associated with terminal illness. The plan covers these services for a patient whose life expectancy has been determined to be 6 months or less.

Hospice care requires prior approval; see Medical Review Program in the Traditional Medical Plan Summary of Benefits. Before receiving hospice care, the attending physician must provide a written treatment plan (a written program for continued care and treatment). Then, at least once every 2 months, the physician must review the treatment plan and certify that the patient's condition and treatment continue to meet hospice care criteria.

An approved hospice treatment plan may include both inpatient and outpatient care. If hospital inpatient care is approved, the plan covers hospice care on the same basis as for other types of hospital inpatient care. Skilled nursing facility or hospital outpatient care also are covered for the hospice patient on the same basis as for other patients. The plan also covers prescription drugs and durable medical equipment for hospice care on the same basis as for other types of care. The plan covers home health care visits and supplies listed in Home Health Care above if they are part of an approved hospice treatment plan and provided and billed by an approved hospice agency. An approved hospice agency is a public or private organization that administers and provides hospice care and is either Medicare approved or operating under the direction and control of the licensing or regulatory agency in its location.

In addition, the plan covers respite care visits of 2 or more hours to provide temporary relief to family members and friends who care for the patient, up to 120 hours every 3 months.

Hospital Services

The plan covers charges for a semiprivate room and medically necessary hospital services and supplies.

The cost of a private room is covered if medically necessary. If a private room is used when it is not medically necessary, the patient is responsible for the difference between the charge for the private room and the hospital's average charge for a semiprivate room. If the hospital provides only private rooms, the plan covers up to the charge for semiprivate rooms in similar local facilities.

Advance approval is needed for:

- Nonemergency admissions.
- Mental health and substance abuse treatment.

See Medical Review Program in the Traditional Medical Plan Summary of Benefits for more information.

Infertility

The plan covers the following services in connection with the diagnosis and treatment of infertility:

- Diagnostic tests necessary to determine the cause of infertility.
- Surgical correction of a condition causing or contributing to infertility.

- Conventional medical treatment such as office visits, laboratory services, and prescription drugs for infertility.

Mental Health and Substance Abuse Program

The Boeing mental health and substance abuse program provides benefits for mental health treatment and substance abuse treatment (including abuse of or addiction to alcohol, recreational drugs, or prescription drugs). The program is administered by the behavioral health service representative shown in the Traditional Medical Plan Summary of Benefits.
To be reimbursed under the plan, all mental health and substance abuse treatment must be determined medically necessary. When treatment is obtained from a referred provider, the plan payment levels are higher. All care is reviewed for medical necessity whether or not you contact the behavioral health service representative.

Mental Health Treatment Coverage

The plan covers medically necessary mental health treatment from any provider contracted with the behavioral health service representative, including any licensed clinical psychologist, hospital or treatment facility, psychiatric doctor (M.D.), psychiatric nurse (R.N.), or professional at the master's level or above who is licensed in the area where services are performed.
If the mental health treatment is related to, accompanies, or results from substance abuse, coverage is provided solely under substance abuse provisions.

Substance Abuse Treatment Coverage

The plan covers medically necessary alcoholism treatment and other types of substance abuse treatment at an approved treatment facility or hospital as well as physician and licensed therapist services and prescription drugs. The treatment, services, and drugs must be part of a specific treatment plan prepared by your attending physician and certified as covered under the plan. (An approved substance abuse treatment facility is one that treats chronic alcoholism and/or drug abuse that is licensed and regulated by the appropriate governmental agency in its location.)

The plan covers detoxification only if followed immediately by a rehabilitation program. To receive coverage for substance abuse treatment, you must complete the prescribed course of treatment.

Neurodevelopmental Therapy

The plan covers neurodevelopmental therapy for children age 6 or under, up to the maximum benefit shown in the Traditional Medical Plan Summary of Benefits. In-home neurodevelopmental therapy is covered if the patient is homebound. Therapists must meet licensing or certification requirements as described below.
Neurodevelopmental therapy is physical, occupational, and speech therapy for treatment of neurodevelopmental delay. Neurodevelopmental delay means lack of development of motor or speech function not due to injury or trauma.

Occupational, Physical, and Speech Therapy

Certain types of therapy are covered, but only to the extent that the therapy will significantly restore function. To be covered, the services of a physical therapist for physical therapy, an occupational therapist for occupational therapy, and a speech therapist for speech therapy must be prescribed by a physician as to type and duration of treatment.

Services must be provided under a physician's supervision while you remain under the attending physician's care. The service representative will review the therapy periodically.

Benefit determination is based on the attending physician's evaluation of the therapy as well as the therapist's progress reports. The information from the physician and therapist is then reviewed against established medical criteria to determine medical necessity.

No benefits are payable for therapy given at the therapist's discretion, elected by the covered person, for any treatment for delayed development or therapy that is solely for the purpose of slowing body degeneration rather than restoring functional improvement, custodial maintenance, self-help, recreational, or educational therapy.

Licensing and Certification Requirements

Occupational, physical, and speech therapists must meet licensing or certification requirements as follows:

- The therapist must be duly licensed in the areas where services are performed and must be practicing within the scope of that license.
- In the absence of licensing requirements, the therapist must be certified as a registered:
  - Occupational therapist by the American Occupational Therapy Association.
  - Physical therapist by the American Physical Therapy Association.
  - Speech therapist by the American Speech and Hearing Association.

Oral Surgery

The plan covers certain services and supplies provided by a physician or dentist to the extent they are approved by the service representative and are not covered under a dental plan.

Orthopedic Appliances and Braces; Orthotics

Braces, splints, orthopedic appliances, and orthotic supplies are covered. This includes necessary repair and replacement required by normal usage or change in the patient's condition such as growth of a child. Orthopedic shoes, lifts, wedges, and inserts (orthotics) are covered if prescribed by a physician and custom made for the patient. These items are covered as part of the durable medical equipment benefits. Over-the-counter items will not be covered.

Oxygen and Anesthesia

The plan covers oxygen and anesthesia.

Physician Services

Services of a licensed physician generally are covered when medically necessary for the diagnosis or treatment of nonoccupational accidental injuries, illnesses, or other covered conditions.

Physician services also are covered for:

- An eye examination (including refraction) if performed because of another medical condition such as diabetes, glaucoma, or cataracts (routine eye examinations are covered under the vision care program).
- Antigen, allergy vaccine, insulin, and other drugs and devices (including contraceptive injections, devices, and implants) dispensed by a physician.
- Injectable legend drugs administered in a physician's office and used to treat a covered condition.
- Preventive care.
- Voluntary second or third surgical opinions.

Other Professional Services

The plan covers certain health care services when provided either by a physician or another type of health care professional. All health care professionals must be licensed by the state where the services are performed and must be acting within the scope of that license. In the absence of licensing requirements, appropriate certification is required.
Covered health care professionals include:

- Acupuncturists (L.A.C.) for covered acupuncture services.
- Chiropractors providing covered chiropractic services.
- Christian Science practitioners listed in the current *Christian Science Journal* at the time they provide a service.
- Clinical psychologists and master's level therapists for mental health or substance abuse treatment for conditions covered under the plan.
- Dentists for covered dental work or surgery.
- Neurodevelopmental, occupational, physical, and speech therapists.
- Physician assistants for services that would have been covered if performed by a physician licensed as an M.D.
- Podiatrists providing covered podiatric services.
- Registered nurses (R.N.) for services that would have been covered if performed by a physician licensed as an M.D. The plan also covers intermittent visits by an R.N. when skilled care in place of hospitalization is not available through an alternative provider at a lesser cost.

Pregnancy-Related Conditions and Coverage of Newborns

Medically necessary services and supplies are covered for pregnancy-related conditions of you and your dependents if they are provided while covered under the plan.

Covered pregnancy-related conditions include normal delivery, cesarean section, spontaneous abortion (miscarriage), legal abortion, and complications of pregnancy.

Approved birthing center services are covered if they would be covered when received in a hospital. (A birthing center is a facility for normal delivery operating under the direction and control of the licensing or regulatory agency in its location.)

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

A newborn is eligible from the date of birth if he or she qualifies as your dependent and is enrolled within applicable changes in status time frames. The following services and supplies are covered for an enrolled newborn, subject to the plan's annual deductible, copayment, and benefit payment levels:

- Routine hospital services and supplies and physician services during the first 48 hours following a normal delivery or 96 hours following a cesarean section.
- Medically necessary hospital and physician services and supplies.

Coverage of a newborn continues as long as the child remains an eligible dependent and is enrolled in the plan.

Preventive Care

The plan covers preventive care services if you use a network provider and you live in the network service area. (If you do not live in the network service area, you may use any licensed provider.) See the Traditional Medical Plan Summary of Benefits for details.

Prostheses

Artificial limbs, artificial eyes, and other prostheses to replace a missing body part are covered, including the necessary repair and replacement required by normal usage or change in the patient's condition such as growth of a child.

Radiation and Chemotherapy

The plan covers radiation therapy (including X-ray therapy) and chemotherapy.

Reconstructive Breast Surgery

Covered individuals who have had or are going to have a mastectomy may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided, in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits are provided subject to the same deductible, copayment, and coinsurance applicable to other medical and surgical benefits provided under the plan.

Skilled Nursing Facility

The plan covers charges for a semiprivate room in a skilled nursing facility as well as medically necessary services and supplies when provided in place of covered hospital inpatient care. Skilled nursing facility services also are covered for a terminally ill patient when the illness has reached a point of predictable end. Nonemergency admissions must be approved in advance; see Medical Review Program in the Traditional Medical Plan Summary of Benefits.

A skilled nursing facility is an institution approved as such by Medicare. If a private room is used, you are responsible for the difference between the charge for the private room and the facility's average charge for a semiprivate room. If the facility provides only private rooms, the plan covers up to the charge for semiprivate rooms in similar local facilities.

Tobacco Cessation

The plan covers tobacco cessation services and supplies that are provided by a physician, another health care professional who is practicing within the scope of his or her license, and an approved tobacco cessation provider.

However, the plan will cover the cost only if the patient completes the full course of treatment. Tobacco cessation treatment is subject to the benefit maximum shown in the Traditional Medical Plan Summary of Benefits.

Spinal and Extremity Manipulations

The plan covers spinal and extremity manipulations by an approved provider, such as a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), or a chiropractic doctor (D.C.), for spinal and extremity manipulations performed by hand. Multiple spinal and extraspinal manipulations performed by hand during the same visit are considered 1 manipulation visit. Related services, such as an initial examination and initial X-rays, also are covered.

Substance Abuse Treatment

See Mental Health and Substance Abuse Program.

Temporomandibular Joint Dysfunction and Myofascial Pain Dysfunction Syndrome (TMJ/MPDS) Treatment

The plan covers the following surgical and nonsurgical services and supplies to treat TMJ/MPDS when provided by a physician or dentist:

- Appliance management, including kinesitherapy, physical therapy, biofeedback therapy, joint manipulation, prescription drugs, injections of muscle relaxants, and therapeutic drugs or agents.
- Appliances, including night guards, bite plates, orthopedic repositioning devices, or mandibular orthopedic devices.
- Follow-up office visits.
- Initial diagnostic examinations and X-rays.
- Surgical procedures and related hospitalizations.

  TMJ/MPDS treatment must be approved in advance in accordance with written guidelines.
  Transplants

The plan covers medically necessary services and supplies related to covered transplants. Transplants that are part of an approved clinical trial also may be covered. Contact the service representative for more information about covered services and supplies as well as maximums. If you or your covered dependent receives a human organ or tissue transplant covered by the plan, certain donor organ procurement costs also may be covered. Benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ, and other medically necessary procurement costs.

Covered donor expenses are applied against the recipient's lifetime maximum benefit.

Vasectomy and Tubal Ligation

The plan covers services and supplies required for a vasectomy or tubal ligation, but not those related to a reversal.

Wigs

The plan covers wigs (or hair prostheses) if hair loss is a result of chemotherapy or radiation therapy.

Exclusions

Charges for the following items are deducted from a health care provider's bill before the plan pays benefits for covered services and supplies. The plan does not pay charges for or related to the following:

- Accident or illness covered by a workers' compensation law.
- Amounts exceeding allowed charges or usual and customary charges. An allowed charge is the amount that would have been paid for like services or supplies to a network provider.
- Benefits payable under any automobile medical, personal injury protection (PIP), automobile no-fault, automobile uninsured or underinsured motorist, homeowner's, or commercial premises medical coverage, when that contract or insurance is issued to or provides benefits available to the patient. Any benefits paid by the plan before benefits are paid under one of these other types of contracts or insurance are to assist the patient, and

do not indicate the service representative is acting as a volunteer or waiving any right to reimbursement or subrogation.

- Completion of claim forms or reports.
- Confinement or surgical, medical, or other treatment, services, or supplies received in or from a U.S. Government hospital, except as required by law.
- Counseling—career, child, family, financial, marriage, pastoral, or social adjustment.
- Custodial care as follows:

– Care that does not require the continuing services of skilled medical or health professionals and primarily is provided to assist in activities of daily living.
– Institutional care primarily to support self-care and provide room and board.

Custodial care includes, but is not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding, preparing special diets, and supervising medications that ordinarily are self-administered.

- Dental services except as otherwise specifically provided.
- Dyslexia, visual analysis therapy, or training related to muscular imbalance of the eye or for orthoptics. However, coverage is provided for up to 6 months when necessary to correct muscle imbalance (strabismus, esotropia, or exotropia) if treatment begins before the person's 12th birthday.
- Education, special education, or job training—whether or not by a facility that also provides medical or psychiatric care.
- Equipment or supplies not solely related to the medical care of a diagnosed illness or injury; examples include, but are not limited to:

– Adjustable bed.
– Any luxury or convenience item or supply.
– Environmental control devices (air conditioners, purifiers, humidifiers).
– Equipment used primarily to prevent illness or injury.
– General exercise equipment.
– Items designed primarily to assist a person caring for the patient.
– Items generally useful in the absence of a medical condition.
– Modification to home (wheelchair ramps, support railings), automobile, or van (ramps, lifts).
– Orthopedic chair.
– Personal hygiene items.
– Special car seat.
– Swimming pool, spa, or whirlpool.

- Experimental or investigational services or supplies or related complications.
- Full-body computerized axial tomography (CAT) scans or other full-body imaging.

- Hearing aid care as listed below:
  - Eyeglass-type hearing aids to the extent the charge exceeds the covered amount for hearing aids.
  - Hearing or audiometric examinations, unless disease is present; however, hearing examinations are covered if performed as part of a covered preventive care physical examination.
  - Hearing aids ordered before you become eligible for coverage or after coverage terminates.
  - Hearing aids ordered before termination of coverage but delivered more than 60 days after coverage ends.
  - Hearing aids that do not meet professionally accepted standards, including any experimental services or supplies.
  - Replacement batteries.
  - Replacement of lost, broken, or stolen hearing aids, unless the 3-year period has been exhausted.
  - Replacement parts for hearing aid repair, unless part of an overhaul after 3 years.
- Home health care and hospice care services as listed below:
  - Homemaker or housekeeping services.
  - Hospice services of financial, legal, or spiritual counselors.
  - Hospice services to other family members, including bereavement counseling.
  - Maintenance or custodial care.
  - Psychiatric care.
  - Services provided by volunteers, household members, family, or friends.
  - Social services.
  - Supplies or services not included in the written home health or hospice care treatment plan or not otherwise covered.
  - Unnecessary or inappropriate services, food, clothing, housing, or transportation.
- Infertility services or supplies not specifically covered, including but not limited to:
  - Any tests, visits, consultations, or treatment related to, leading to, or resulting in one of the noncovered services listed below.
  - Artificial insemination.
  - Consecutive follicular ultrasounds, cycle therapy, or corresponding laboratory tests when associated with any artificial means of conception.
  - Embryo transfer.
  - Fertility drugs when associated with artificial means of conception.
  - Gamete intrafallopian transfer (GIFT).
  - In vitro fertilization.
  - Microinjections.
  - Sperm preparation.
  - Sperm separation.
  - Zona drilling.

- Intentionally self-inflicted injury, unless you are under treatment for a diagnosed mental illness.
- Missed appointments.
- Nonorganic impotence such as psychosexual dysfunction.
- Obesity services and supplies unless approved in advance by the service representative in accordance with written guidelines. (A copy of the guidelines may be requested by calling the service representative.)
- Over-the-counter items, including but not limited to medications, orthopedic appliances, and braces.
- Prescription drugs unless covered as part of a hospital stay; see Traditional Medical Plan Prescription Drug Program for outpatient prescription drug benefits.
- Recovery houses, school programs, or emergency service patrols.
- Reversal of a sterilization procedure.
- Refractive surgery including radial keratotomy, Lasik, or other eye surgery to correct refractive errors, except when preoperative visual acuity is 20/50 or less with a lens.
- Services or supplies the service representative determines are not medically necessary for treatment of an accidental injury, illness, or other condition covered under the plan. This includes routine physical examinations, immunizations, or other preventive services or supplies, except as specifically provided by the plan.

  Inpatient hospital care (including physician visits while hospitalized) is not considered medically necessary when the care can be provided safely in an outpatient setting—such as a hospital outpatient department, physician's office, or an ambulatory surgical facility—without adversely affecting your physical condition.
  Examples of care that generally should be provided in an outpatient setting include observation and/or diagnostic studies, surgery that can be performed on a same-day basis, and psychiatric care primarily to control or change the patient's environment.
- Services or supplies for which no charge is made or charges you or your dependent is not required to pay.
- Services or supplies not recommended and approved by a physician or other covered health care professional or those provided before the person becomes covered under the plan.
- Services or supplies required by law to be provided by any school system.
- Services or supplies to the extent they are covered under any discontinued Company-sponsored plan.
- Services or supplies covered under any Federal, state, or other government plan, except where required by law.
- Sex transformation treatment or services.
- Skilled nursing facility services when they are not usually provided by such facilities or are not expected to lessen the disability and enable the person to live outside the facility. However, skilled nursing facility services are covered for the terminal patient when the illness has reached a point of predictable end.

- Transplant services or supplies as listed below:
  - Donor or procurement services or costs incurred outside the United States, unless specifically approved by the service representative.
  - Donor services or supplies when donor benefits are available through other group coverage.
  - Expenses for that portion of treatment funded by government or private entities as part of an approved clinical trial.
  - Expenses when the recipient is not covered under the medical plan.
  - Experimental or investigational services or supplies unless they are part of an approved clinical trial.
  - Living (noncadaver) donor transplants that are not specifically authorized and covered by the medical plan.
  - Lodging, food, or transportation costs, unless otherwise specifically provided under the medical plan.
  - Nonhuman, artificial, or mechanical transplants, unless specifically approved by the service representative.
- Vision care (routine or refractive) except as specifically provided.
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Definitions

Benefit Year is January 1 through December 31, annually.

Company-Sponsored Plan is a group medical or dental plan provided by the Company (or a subsidiary or affiliate) for employees and dependents. This includes the Traditional Medical Plan. (To find out whether a particular plan is Company-sponsored, contact the Boeing Service Center for Health and Insurance Plans.)

Dentist is a legally qualified dentist practicing within the scope of his or her license.

Emergency is the sudden, unexpected onset of serious illness or severe injury that could result in (or a prudent person would have reason to believe could result in) death, permanent damage or impairment of bodily function, or loss of limb use if not treated immediately. For mental health coverage, a situation is also considered an emergency when there is imminent danger to you or others, or you are medically compromised as a result of mental illness or substance abuse.

Medically Necessary Service or Supply meets the following criteria, as determined by the service representative. A service or supply may be medically necessary in part only. The fact the service or supply is furnished, prescribed, recommended, or approved by a physician does not, by itself, make it medically necessary. A service or supply is medically necessary if it is:

- Appropriate as good medical practice.
- Consistent with the condition's symptom or diagnosis and treatment.
- Not able to be provided safely in an outpatient setting (for an inpatient service or supply).
- Professionally and broadly accepted as the usual, customary, and effective means of diagnosing or treating the illness, injury, or condition.
- Required to diagnose or treat your condition and the condition could not have been diagnosed or treated without it.

- The most appropriate service or supply essential to your needs.
-

Mental Illness is a disorder (including an eating disorder) that exhibits signs, symptoms, history, and other characteristics congruent with those required for a mental disorder diagnosis enumerated in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM IV).

Nurse is a person duly licensed as a registered nurse (R.N.) in the area where his or her services are performed and practicing within the scope of that license.

Physician is a person licensed as a medical doctor (M.D.) or doctor of osteopathy (D.O.) duly licensed to prescribe and administer all drugs and to perform surgery.

Psychologist is a person duly licensed as a clinical psychologist in the area where his or her services are performed and practicing within the scope of that license.

Service Representative is an agent that has a contract with the Company to make benefit determinations and administer benefit payments under the plan and programs described in this summary. The Company may change a service representative at any time.

Substance Abuse is an alcohol or drug-related disorder that exhibits signs, symptoms, history, and other characteristics congruent with those required for a substance-related disorder as enumerated in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM IV).

Traditional Medical Plan Prescription Drug Program

The prescription drug program described here is available to active and retired employees and dependents enrolled in the Traditional Medical Plan.

This program offers 2 coverage options for prescription drugs and medicines:

- Retail pharmacy card program—you can use the pharmacy card to facilitate reimbursement when you obtain covered prescriptions from a participating retail pharmacy.
- Mail service program—called Medco By Mail.

A formulary applies to all retail pharmacy and mail order purchases. (A formulary is a list of drugs determined to be effective in both cost and treatment and approved by the Food and Drug Administration (FDA). A nonformulary drug also may be effective for treatment, but is not as cost-effective as formulary or generic drugs. A group of practicing physicians and pharmacists routinely reviews drugs to include in the formulary. If clinical data show several drugs are equally effective, the most cost-effective drug usually is chosen. The formulary may change from time to time.)

There are 3 categories of prescription drug purchases:

- **Generic**—drugs that are chemically and therapeutically equivalent to their brand-name counterparts but usually cost less.
- **Brand-name formulary**—brand-name drugs selected for the formulary based on cost and effectiveness.
- **Brand-name nonformulary**—brand-name drugs not selected for the formulary.

  The program includes utilization management services (see Pharmacy Management) to help ensure cost-effective, clinically appropriate treatment.

Schedule of Benefits

Traditional Medical Plan Prescription Drug Program Schedule of Benefits The prescription drug program is administered by Medco Health Solutions, Inc. (the service representative).			
	Generic	**Brand-Name Formulary**	**Brand-Name Nonformulary**
Participating Retail Pharmacy (up to a 34-day supply)	90%*,**; $5 minimum, $25 maximum	80%*,**; $15 minimum, $75 maximum	70%*,**; $30 minimum, no maximum
Mail Service Program (Medco By Mail; up to a 90-day supply)	$10 copayment	$30 copayment	$60 copayment
* The annual deductible does not apply. ** Prescriptions purchased from a nonparticipating retail pharmacy will be reimbursed based on the covered charges for a participating retail pharmacy.			

Retail Pharmacy Card Program

This program covers medically necessary prescription drugs required by Federal or state law to be prescribed in writing by a physician or dentist and dispensed by a licensed pharmacist.

Covered prescriptions include legend drugs, contraceptive medications, tobacco cessation drugs, self-administered injectable drugs, insulin, needles and syringes, test strips, lancets, and alcohol swabs.

Prior authorization may be required for certain medications.
The retail pharmacy card program covers up to a 34-day supply per prescription or refill.

Mail Service Program

The Medco By Mail program covers medically necessary prescription drugs and medicines required by Federal or state law to be prescribed in writing by a physician or dentist and dispensed by a licensed pharmacist. Covered prescriptions include legend drugs, contraceptive medications, tobacco cessation drugs, self-administered injectable drugs, insulin, needles and syringes, test strips, lancets, and alcohol swabs.

Prior authorization may be required for certain medications.

Medco By Mail covers up to a 90-day supply per prescription or refill. Authorized refills are covered only after the initial order has been used. Certain controlled substances are subject to quantity limits.

Unless the physician indicates otherwise, you will receive a generic equivalent of the prescribed drug when available and permissible under the law. You also may receive a different brand that is medically equivalent.

Pharmacy Management

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

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

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

In certain situations, it may be more clinically appropriate to take a stronger dose once a day than to take a lower dose twice a day. If this opportunity exists, the service representative may ask your physician to approve the changes to the dosage and strength before authorizing payment with your pharmacist.
Should a drug require preapproval, your physician will be required to furnish the service representative with clinical information. You, the pharmacy, or the physician may initiate the request for this review by calling the service representative.

Generic Incentive Program

To encourage the use of generic drugs, if a brand-name drug is purchased when a chemically equivalent generic is available (for both retail pharmacy and mail service)—whether you or your physician requests the brand-name drug—you will pay the generic coinsurance/copayment plus the cost difference between the brand-name drug and generic drug.

If for any reason your physician believes that you must use a brand-name drug, he or she can ask for a coverage review by calling the service representative. The service representative will request information from your physician and review it to determine if your need for the brand-name drug meets the conditions to qualify for coverage. If coverage is approved, you will be charged the brand coinsurance/copayment for the brand-name drug. If coverage is not approved, coverage will be provided according to the generic incentive program.

Specialty Care Pharmacy

Specialty medications are typically injectable medications administered by you or a health care professional, and they often require special handling. Newly prescribed medications may be purchased at any participating retail pharmacy up to 2 times. After that, the plan will cover these prescriptions only if they are purchased through the service representative's specialty care pharmacy.

The specialty care pharmacy program will not apply to medications ordered and billed through a physician's office.

Prescription Drug Program Exclusions

The following items are excluded under both the retail pharmacy card program and the mail service program:

- Any prescription filled in excess of the number prescribed by the physician or any refill after 1 year from the date of the prescription.
- Any prescription for which the person is eligible to receive benefits under another employer's group benefit plan or a workers' compensation law or from any municipal, state, or Federal program.
- Any service or supply otherwise excluded by the Traditional Medical Plan or the vision care program.
- Appliances or devices, such as blood glucose monitors or other nondrug items, including but not limited to therapeutic devices and artificial appliances. This exclusion does not apply to needles or syringes or to test strips, lancets, or alcohol swabs.
- Charges for the administration or injection of any drug.
- Delivery or handling charges.
- Drugs dispensed during an inpatient admission by a hospital, skilled nursing facility, sanatorium, or other facility.
- Experimental drugs or drugs used for investigational purposes.
- Fertility agents, unless approved by the service representative.
- Immunizing agents or allergy serum.
- Infusion therapy drugs, except as described in the home health care benefit.
- Medications to treat sexual dysfunction, unless the patient is being treated for a diagnosed medical condition.
- Obesity drugs, unless approved by the service representative.
- Over-the-counter drugs.

- Prescriptions that are not medically necessary to treat an illness, injury, or other covered condition, except as specifically provided by the program.
- Replacement of lost or misplaced prescriptions.

Traditional Medical Plan Vision Care Program

The vision care program described here is available to active and retired employees and their dependents enrolled in the Traditional Medical Plan.

Schedule of Benefits

Traditional Medical Plan Vision Care Program Schedule of Benefits The vision care program is administered by Vision Service Plan (VSP, the service representative).	
Services and Supplies	**VSP Plan**
Eye Examinations	Paid in full after $15 copayment for VSP network provider; up to $50 for nonnetwork provider
Lenses (2):	
Single vision	$50*
Bifocal	$80*
Trifocal	$95*
Lenticular	$155*
Frames	$90*
Contact Lenses (in place of allowances for conventional lenses and frames above)	$120*

* VSP network providers offer a 20% discount on complete pairs of prescription glasses and a 15% discount on contact lens examinations (evaluation and fitting); you pay the VSP network provider only the excess over the amounts shown in the schedule above. Nonnetwork provider charges for lenses, frames, and contact lenses are reimbursed up to the amounts shown in the schedule above; no discount applies.

Accessing the VSP Network

VSP features a national network of licensed optometrists and ophthalmologists. These providers have contracted with VSP to provide vision care services and supplies. Although you may receive care from any covered licensed provider, the program offers certain advantages when using a network provider.

Network providers offer discounts on complete pairs of prescription glasses and on contact lens examinations (evaluation and fitting). The program pays the network provider the amounts shown in the Schedule of Benefits. You pay the excess over those amounts. Network providers also submit claims to the service representative.

Covered Vision Services and Supplies

The program covers the following vision care services and supplies (up to the amounts shown in the Schedule of Benefits):

- Complete eye examination of visual function, performed by a licensed ophthalmologist or optometrist.
- Contact lenses if elected in place of conventional lenses and frames.
- Frames required for prescription lenses.
- Prescription lenses.

Benefit Payment Levels

See the Schedule of Benefits for payment levels.

Patients incur an additional charge for noncovered lens options such as lens coatings or hardening, tints, photochromic, polycarbonate, and scratch-resistant or shatter-resistant lenses. Other vision care services are not covered under this program, but some may be covered as a medical condition under the Traditional Medical Plan.

Benefit Limitations

Benefits are provided for 1 eye examination every benefit year and 2 sets of lenses and 2 frames every 2 years (network and nonnetwork combined). The program covers contact lenses when purchased in place of conventional lenses and frames. Any replacement of lost, stolen, or broken lenses and/or frames is subject to the 2-set limit.

Vision Care Program Exclusions

The following vision care expenses are not covered:

- Corrective vision treatment of an experimental nature. (Experimental nature means a procedure or lens not used universally or accepted by the vision care profession, as determined by the service representative.)
- Costs above the maximum covered expenses.
- Lens options (such as coatings or hardening, tints, photochromic, polycarbonate, or scratch-resistant or shatter-resistant lenses).
- Medical or surgical treatment of the eye. (However, VSP network providers will offer discounts for refractive surgery.)
- Orthoptics or vision training or any associated supplemental testing; dyslexia.
- Plano lenses (less than a ± 0.38 diopter power), nonprescription glasses, 2 pair of glasses instead of bifocals, or extra charge for progressive lenses in excess of the bifocal allowance.
- Services or supplies not listed as covered expenses.

- Services or supplies received more than 60 days after the service representative authorizes vision care benefits.
- Services or supplies received while not covered or lenses or frames furnished or ordered before coverage begins.
- Solutions and/or cleaning products for glasses or contact lenses.
- Special supplies, such as nonprescription sunglasses or subnormal vision aids.
-

PPO+*ACCOUNT* SCHEDULE OF BENEFITS

The PPO+*Account* is available to active employees and their dependents. This section shows general plan features of the PPO+*Account*, including benefit amounts and other plan information.

Schedule of Benefits

PPO+*Account* Schedule of Benefits The PPO+*Account* is administered by Aetna (the service representative).		
Annual Deductible (applies unless otherwise noted)	• $1,500 employee only • $2,625 employee + spouse or child(ren) • $3,750 employee + spouse and child(ren) The deductible may be met by 1 person or a combination of family members Network and nonnetwork expenses apply to the deductible	
Coinsurance Percentage	Network: Plan pays 95%	Nonnetwork: Plan pays 60%
Annual Coinsurance Maximum	Network: • $1,600 employee only • $2,800 employee + spouse or child(ren) • $4,000 employee + spouse and child(ren)	Nonnetwork: • $3,200 employee only • $5,600 employee + spouse or child(ren) • $8,000 employee + spouse and child(ren)
	Annual coinsurance maximum is in addition to the annual deductible; it is combined for all family members; individual annual coinsurance maximums do not apply	
Copayments	You pay the network copayment listed below for routine eye examinations	
Lifetime Maximum Benefit	$2.0 million per individual (network and nonnetwork combined)	

PPO+*Account* Schedule of Benefits The PPO+*Account* is administered by Aetna (the service representative).		
	Network Provider*	**Nonnetwork Provider**,†**
Ambulance	95%	90% (must meet definition of emergency medical condition); otherwise 60%
Christian Science Practitioner and Sanatorium	95%; limits apply	Same as network provisions
Diagnostic X-Ray and Laboratory Services	95%	60%
Durable Medical Equipment	95%	60%
Emergency Room Treatment		
• Medical Emergency (must meet the definition of emergency medical condition)	95%	Same as network provisions
• All Other Treatment	95%	60%
Hearing Aids	• 95% up to $800 per ear • Limited to 1 aid per ear every 3 benefit years • Hearing aid overhaul in place of new hearing aid after 3 benefit years	Same as network provisions
Hemodialysis	• 95% for the first 30 months of Medicare entitlement due to end stage renal disease • Thereafter, Medicare is primary and this plan is secondary	60%
Home Health Care	95%	60%
Hospice Care	• 95%; 6-month maximum • Skilled care of 4 or more hours per day by a registered nurse, licensed practical nurse, or home health aide • Respite care visits of 2 or more hours per day up to 120 hours per 3 months	Same as network provisions

PPO+*Account* Schedule of Benefits The PPO+*Account* is administered by Aetna (the service representative).		
	Network Provider*	**Nonnetwork Provider**,†**
Hospital	95%	60%
Mental Health Treatment (including eating disorders)	Care is managed by and claims are administered by Aetna	
• Covered Inpatient, Residential, or Intensive Outpatient Services	95% when obtained from a provider referred by Aetna	60% when obtained from a provider not referred by Aetna
• Covered Outpatient or Partial Hospital Services	95%; no precertification required for first 8 outpatient visits with a network provider; subsequent visits must be approved by Aetna or will be paid at nonnetwork level	60% when obtained from a provider not referred by Aetna
Physician (inpatient and outpatient)	95%	60%
Prescription Drugs	• Pharmacy benefits are provided through Aetna and Aetna Rx Home Delivery • Quantities and dosages for certain prescription drugs may be limited by general plan provisions, clinically established guidelines, and/or FDA-approved labeling	
• Retail Pharmacy Card Program	Supply limited to 30 days (for certain preventive medications, annual deductible does not apply)	
Generic drug	• 90%	
Brand formulary drug	• 80%	
Brand nonformulary drug	• 70%	
• Mail-Order Pharmacy Program	Supply limited to 90 days (for certain preventive medications, annual deductible does not apply)	
Generic drug	• 90%	
Brand formulary drug	• 80%	
Brand nonformulary drug	• 70%	

PPO+*Account* Schedule of Benefits The PPO+*Account* is administered by Aetna (the service representative).		
	Network Provider*	**Nonnetwork Provider**,†**
Preventive Care		
• Routine Physical Examinations (for employees, spouses, and children age 2 and older)	• 100% (annual deductible does not apply) up to $500 each year per covered person, including physical examinations, related laboratory and X-ray charges as well as childhood and adult immunizations as recommended by the U.S. Preventive Care Task Force guidelines; deductible and coinsurance apply after $500 limit • Limited to 1 examination per child every benefit year for age 2 through age 18 • Limited to 1 examination per person every 3 benefit years for age 19 through age 34, then 1 examination per person every benefit year	Not covered when received in a network service area
• Routine Physical Examinations (for children to age 2)	• 100% (annual deductible does not apply) • Limited to 8 examinations from birth to age 2 • Immunizations as recommended by the U.S. Preventive Care Task Force guidelines and as recommended by physician	Not covered when received in a network service area
• Routine Pap Tests, Mammograms, Prostate Screenings, and Colorectal Screenings (including colonoscopies)	• 100% (annual deductible does not apply) • Covered as recommended by the physician	Not covered when received in a network service area
Prostheses	95%; $500 annual limit for hair prostheses if undergoing chemotherapy or radiation therapy (network and nonnetwork combined)	60%; $500 annual limit for hair prostheses if undergoing chemotherapy or radiation therapy (network and nonnetwork combined)

PPO+*Account* Schedule of Benefits The PPO+*Account* is administered by Aetna (the service representative).		
	Network Provider*	**Nonnetwork Provider**,†**
Tobacco Cessation Treatment	• 100% (annual deductible does not apply) • $500 lifetime maximum benefit	Same as network provisions
Spinal and Extremity Manipulations (such as chiropractic care)	• 95% • Limited to 26 visits for spinal and extremity manipulations combined per year (network and nonnetwork combined)	• 60% • Limited to 26 visits for spinal and extremity manipulations combined per year (network and nonnetwork combined)
Substance Abuse Treatment	Care is managed by and claims are administered by Aetna	
• Covered Inpatient, Partial Hospital, Residential, Intensive Outpatient, or Outpatient Services	• 95% when obtained from a provider referred by Aetna • No precertification required for first 8 outpatient visits with a network provider; subsequent visits must be preapproved by Aetna or will be paid at the nonnetwork level • Up to $7,500 per course of treatment • Limited to 2 courses of treatment lifetime maximum (network and nonnetwork combined)	• 60% when obtained from a provider not referred by Aetna • Up to $2,500 per course of treatment; maximum will count toward $7,500 network maximum • Limited to 2 courses of treatment lifetime maximum (network and nonnetwork combined)
TMJ/MPDS Treatment	• 50% • $3,500 lifetime maximum benefit	Same as network provisions
Therapies		
• Neurodevelopmental Therapy (for children 6 and younger)	• 95% • Limited to $1,000 each benefit year (network and nonnetwork combined)	• 60% • Limited to $1,000 each benefit year (network and nonnetwork combined)
• Occupational, Physical, and Speech Therapy	95%	60%

* The network payment level is based on the approved fees that the service representative negotiated for specific providers and services covered by the plan.

** The nonnetwork payment level is based on the usual and customary charge (as defined by this plan). You are responsible for paying any charges in excess of the amount the service representative determines to be the usual and customary charge.

† For certain benefits, the plan will pay 90% of usual and customary charges if the service representative does not maintain a network of providers in a particular license category in a certain area.

PPO+*Account* Vision Care Program

Schedule of Benefits

PPO+*Account* Vision Care Program Schedule of Benefits The vision care program is administered by Vision Service Plan (VSP, the service representative).	
Services and Supplies	**VSP Plan**
Eye Examinations	Paid in full after $15 copayment for VSP network provider; up to $50 for nonnetwork provider
Lenses (2):	
Single vision	$50*
Bifocal	$80*
Trifocal	$95*
Lenticular	$155*
Frames	$70*
Contact Lenses (in place of allowances for conventional lenses and frames above)	$105*
* VSP network providers offer a 20% discount on complete pairs of prescription glasses and a 15% discount on contact lens examinations (evaluation and fitting); you pay the VSP network provider only the excess over the amounts shown in the schedule above. Nonnetwork provider charges for lenses, frames, and contact lenses are reimbursed up to the amounts shown in the schedule above; no discount applies.	

The VSP provisions described for the Traditional Medical Plan also apply to the PPO+*Account*.

Preferred Plus CCP (KS)		
	Network	**Nonnetwork**
Annual Deductible	None	$400 per individual
Coinsurance	100% after applicable copayments	60%; deductible applies
Annual Out-of-Pocket Maximum	None	$2,000 per individual; $4,000 per family
Lifetime Maximum Benefit	$1,500,000 per individual	
Emergency Room	$50 copayment	$50 copayment
Office Visit and Urgent Care	$10 copayment per visit	60%; deductible applies
Prescription Drugs		
• Participating Pharmacy	$5 copayment generic formulary; $15 copayment brand-name formulary; $30 copayment brand nonformulary; 34-day supply	Not covered
• Mail Service Program	$10 copayment generic formulary; $30 copayment brand-name formulary; $60 copayment brand nonformulary; 90-day supply	Not covered
Vision		
• Eye Exams	$10 copayment per visit	Not covered
• Frames and Lenses	$50 to $95 limit for lenses; $70 limit for frames; $105 limit for contacts; 2 pairs every 2 benefit years	See network provisions

Note: Should the Company change the Preferred Plus of Kansas plan from a CCP to an HMO for nonunion employees in Kansas, those same plan design changes will be implemented on the same date for employees covered under this Agreement. In no event will the office visit copayment exceed $20 per visit or the hospital inpatient admission copayment exceed $250 per admission. In addition, out-of-area dependent coverage under the HMO plan design will remain the same as it is under the CCP.

AETNA HEALTH SAVINGS ACCOUNT

If you enroll in the PPO+*Account* medical plan, you will have the opportunity to set up a special tax-advantaged bank account, the Aetna Health Savings Account (HSA), for paying health care services.

The Company has contracted with service representatives to sponsor and administer your HSA. Service representatives answer questions, process transactions, maintain accounts, provide account information, and perform other account services. The current service representatives are as follows:

Current HSA Service Representative	HSA Transactions Are Processed by
Aetna/JPMorgan Chase	JPMorgan Chase

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

Contributing to Your Aetna HSA

The amount Boeing will contribute to your account is based on the coverage level you elect. The contributions will be made on the same frequency as your paychecks.

You can make your own optional contributions to your Aetna HSA through payroll deductions. The amount you contribute can be changed at any time during the year, for any reason. Even if you decide not to contribute, you still will receive Boeing's contribution.

2010 Annual HSA Contributions			
Your coverage level:	**Boeing contributes:**	**You can contribute up to:**	**Total maximum contributions (from Boeing and you):**
Employee only	$1,000	$2,000*	$3,000**
Employee + spouse or child(ren)	$1,750	$4,200*	$5,950**
Employee + spouse and child(ren)	$2,500	$3,450*	$5,950**

* If you are age 55 or older (or will turn 55 in 2010), you can contribute up to an additional $1,000 as a "catch-up" contribution in 2010.

** Contributions are subject to Federal limits and are adjusted annually. The contribution limits shown here are for 2009; 2010 limits are not known at this time, but will apply to the Aetna HSA on January 1, 2010.

The amount Boeing contributes to your HSA will change each year. 2011, 2012, and 2013 contribution amounts are shown below.

2011–2013 Boeing Annual HSA Contributions	
Your coverage level:	**Boeing contributes:**
Employee only	$700
Employee + spouse or child(ren)	$1,250
Employee + spouse and child(ren)	$1,750

Withdrawals and Tax Implications

If you withdraw money to pay qualified health care expenses, there is no Federal or state tax in any state. Money withdrawn from an HSA for anything other than qualified medical expenses generally is taxable under Federal law as ordinary income and is subject to a 10% tax penalty. The additional 10% tax does not apply if the withdrawal is made after your death, disability, or reaching age 65.

Important HSA Information

- Aetna sponsors and administers the HSA; neither Boeing nor the Employee Benefit Plans Committee will have any involvement in HSA administration or claims issues.
- Because the HSA is your personal account with Aetna, Boeing cannot sponsor or endorse it.

Preferred Dental Plan Summary

The Preferred Dental Plan described here is available to active employees and their dependents. This plan helps you and your covered dependents pay for minor and major dental work, including routine examinations, crowns, and orthodontia.

You and your covered dependents may receive dental care from any licensed dentist or other licensed professional who is approved by the plan. However, your out-of-pocket costs generally will be lower if you use a network dentist. If you use a nonnetwork dentist, your out-of-pocket costs generally will be higher. If you live outside of the network service area, the plan generally will cover dental care at the network benefit level.

Preferred Dental Plan Schedule of Benefits

Preferred Dental Plan Schedule of Benefits The Preferred Dental Plan is administered by Delta Dental (the service representative).		
	Network	**Nonnetwork***
Annual Deductible	$50 per individual; $150 per family of 3 or more (network and nonnetwork combined)	$75 per individual; $225 per family of 3 or more (network and nonnetwork combined)
Coinsurance Percentage		
• Class I (diagnostic and preventive services)	100% (deductible does not apply)	80%
• Class II (restorative services using filling materials, oral surgery, periodontics, and endodontics)	80%	50%
• Class III (restorative services using crowns, inlays, and onlays; prosthodontics)	60%	50%
• Class IV (orthodontia services)	50% (network and nonnetwork combined; deductible does not apply)	
Annual Maximum Benefit (for Classes I, II, and III)**	$2,000 per individual (network and nonnetwork combined)	
Lifetime Maximum Benefit (for Class IV)***	$2,000 per individual (network and nonnetwork combined)	

* If your provider is not a Delta Dental member, you pay any amounts that exceed the maximum allowable fees recognized by the plan.

** When multiple treatment dates are required, the charges apply toward the annual maximum benefit for the benefit year in which the procedure is completed. (A prosthesis is considered complete on the date it is seated or delivered.)

*** This lifetime maximum benefit for orthodontia applies to all periods during which the person is covered under any Company-sponsored dental plan.

Note: The plan reimburses 100% of a network provider's recognized fees for prompt repair of damage to sound natural teeth as a direct result of accidental bodily injury.

You and your covered dependents are responsible for paying all charges for services and supplies that the plan does not cover.
Note: In Kansas, the nonnetwork deductible and coinsurance percentages do not apply. Benefits are based on the maximum allowable fees determined by Delta Dental and paid at the network coinsurance percentage. If your provider is not a Delta Dental member, the provider may bill you for the difference between the maximum allowable fees and the actual charge; this difference is your responsibility.

Annual Deductible

Generally, the annual deductible is the amount you must pay out of your own pocket each year before the plan begins to pay benefits for Class I services received from a nonnetwork provider and for all (network and nonnetwork) Class II and III services. The following services and supplies are excluded from the annual deductible:

- Class I services and supplies received from network providers.
- Class IV services and supplies received from network or nonnetwork providers.
-

This means that the plan begins to pay its coinsurance percentage immediately for these dental services. The coinsurance percentage you pay for these services (if applicable) does not count toward your annual deductible.

The plan has an individual annual deductible and a family annual deductible. If you and 3 or more of your dependents are covered under the plan, the family annual deductible limits the total annual deductible you are required to pay in any benefit year.

The annual deductibles are shown in the Preferred Dental Plan Schedule of Benefits above.

Coinsurance Percentages

For many services and supplies, you and the plan each pay a percentage of the recognized fee. These percentages are called coinsurance percentages. A coinsurance percentage does not apply to:

- Class I services and supplies received from network providers.
- Any amounts you pay for services and supplies that the plan does not cover.
- Any amounts that exceed the maximum allowable fees recognized by the plan.

Coinsurance percentages are shown in the Preferred Dental Plan Schedule of Benefits above.

Benefit Maximums

For Classes I, II, and III, an annual maximum applies to each covered person. The annual maximum amount is shown in the Preferred Dental Plan Schedule of Benefits above. You are responsible for paying any charges over the annual maximum benefit.
For Class IV, a lifetime maximum benefit applies to each covered person. The lifetime maximum benefit amount is shown in the Preferred Dental Plan Schedule of Benefits.

Recognized Fees

This plan pays benefits based on the recognized fees. A recognized fee is the provider's charge for a covered service, up to the plan's maximum allowance. The amount of the recognized fee depends on whether you see a network or nonnetwork provider.

Under this plan, recognized fees are determined as follows:

- For a network dentist, recognized fees are network-allowed charges.
- For a member dentist who is a nonnetwork dentist, recognized fees are the fees that the dentist filed with the service representative for specific dental services and supplies. The service representative approves these fees and agrees to pay the plan's nonnetwork benefit based on them.
- For a nonmember dentist, recognized fees are the lesser of either
  - The amount charged by the dentist, or
  - The maximum allowable fee that the service representative approved for member dentists in the state where services are performed.

When alternative procedures are available, the plan covers the least expensive procedure. However, if your dentist submits satisfactory evidence to the service representative that a more expensive procedure is the only one professionally adequate for you, the plan will cover the more expensive procedure according to the appropriate benefit payment level.

Three Classes of Providers

The Preferred Dental Plan covers the charges of any licensed dental provider. The level of coverage is highest for network providers.

- Network providers are members of Delta Dental and participate in the Delta Dental preferred provider network in your state.
- Nonnetwork member providers are members of Delta Dental, but do not participate in the preferred provider network.
- Nonmember providers are not members of Delta Dental.

Covered Dental Services and Supplies

The Preferred Dental Plan covers the following services and supplies in accordance with the benefit payment levels and maximums shown in the Preferred Dental Plan Schedule of Benefits above.

Class I Covered Services and Supplies

The plan covers the following Class I services and supplies:

- Diagnostic examinations, including
- – Biopsy/tissue examinations (also called histopathic examinations).
- – Complete mouth or panographic X-rays, once in each 5-year period.
- – Emergency examinations.
- – Examinations by a specialist (if the specialty is recognized by the American Dental Association and if you are not receiving treatment from the specialist), up to 3 times in a 6-month period.
- – Routine examinations, 2 in each 1-year period.
- – Comprehensive oral examinations, once in each 3-year period, which count as 1 of the 2 routine examinations in a year.
- – Supplementary bitewing X-rays, once in each 1-year period.
- Preventive care, including:
- – Fissure sealants through age 14 for permanent molars with intact occlusal surfaces, no decay, and no prior restorations. The plan covers repair or replacement within a 3-year period as part of the original service. (Fissure sealants are acrylic, plastic, or composite materials that are applied topically to prevent decay by sealing developmental grooves and pits in the child's teeth.)
- – Prophylaxis (cleaning), either regular or periodontal maintenance, twice in each 1-year period; 2 additional cleanings are allowed if periodontal disease is present.
- – Space maintainers when used to maintain space for eruption of permanent teeth.
- – Topical application of fluoride or preventive therapies (such as flouridated varnishes), twice in each 1-year period for dependent children through age 18.

Class II Covered Services and Supplies

The plan covers the following Class II services and supplies:

- Endodontics for the following procedures once in each 2-year period on the same tooth:
- – Pulpal and root canal treatment.
- – Pulpotomy and apicoectomy.

For more information on root canals performed in connection with an overdenture, see Class III Covered Services and Supplies below.

- General anesthesia or intravenous sedation, but not both, when administered by a licensed dentist in connection with certain covered:
- – Endodontic surgery.
- – Oral surgery.
- – Periodontic surgery.
- Oral surgery, including:
- – Preparation of the alveolar ridge and soft tissues of the mouth to insert dentures.
- – Surgical and nonsurgical extractions.

- Treatment of pathological conditions and traumatic facial injuries.
- Periodontics—surgical and nonsurgical procedures to treat tissues that support the teeth, including:
- Gingivectomy.
- Limited adjustments to occlusion (8 or fewer teeth), such as smoothing teeth or reducing cusps.
- Osseous surgery, once in each 3-year period per area.
- Periodontal scaling or root planing, once in each 2-year period.
- Site-specific therapies for patients with pockets of at least 5 mm but not more than 10 mm.
- Restorative services:
- Amalgam, composite, or filled resin restorations (fillings).
- Stainless steel crowns.
- Composite or filled resin restorations placed in the front surface of bicuspids.

Restorations on the same surface or surfaces of a tooth are covered once in a 2-year period. Stainless steel crowns are covered once in a 5-year period (once in a 2-year period for primary teeth).

If a composite or plastic restoration is placed on a posterior tooth, the plan covers up to the amount allowed for an amalgam restoration. If a tooth can be adequately restored with a filling material but a crown, inlay, or onlay is elected instead, the plan covers the restoration as if a filling material had been used.

The plan does not cover restorations necessary to correct vertical dimension or to alter morphology (shape) or occlusion, overhang removal, or recontouring or polishing a restoration.

The plan does not cover restorations necessary to correct vertical dimension or to alter morphology (shape) or occlusion, overhang removal, or recontouring or polishing a restoration.

Class III Covered Services and Supplies

The plan covers the following Class III services and supplies:

- Prosthodontics, including:
- A cast chrome or acrylic partial denture. If a more elaborate or precision device is used, the plan covers up to the appropriate amount for covered partial dentures.
- A fixed bridge.
- A full denture, immediate denture, or overdenture. For any other procedure (such as personalized restorations or specialized treatment), the plan covers up to the appropriate amount for a full denture, immediate denture, or overdenture. Root canal treatment in conjunction with overdentures is limited to 2 teeth per arch.
- Crown buildups when approved by the service representative, once in each 2-year period.
- Denture adjustments and relines provided more than 6 months after initial placement. Later relines and jump rebases (but not both) are covered once in each 1-year period.

– Replacement of an existing prosthetic device once in each 5-year period if it is unserviceable and cannot be made serviceable. (Services to correct the device, if serviceable, are covered.)
– Stayplate dentures to replace anterior teeth during the healing period or, for children age 16 or younger, to replace missing anterior permanent teeth.

- Restoration of a visibly decayed hard tooth surface (carious lesion) to a state of proper function by using crowns (including stainless steel crowns), inlays, or onlays (gold, porcelain, plastic, gold substitute casting, or a combination of these materials) once in each 5-year period. Your dentist must verify that the tooth cannot be restored with filling materials (amalgam, composite, plastic, or glass ionomer).
- Surgical placement or removal of implants or attachments to implants. Replacement is covered only after 5 years have elapsed and only if the implant or superstructure is not serviceable and cannot be made serviceable.
- Use of a crown as an abutment to a partial denture only when the tooth is decayed to the extent a crown would be required whether or not a partial denture is required.

Class IV Covered Services and Supplies

Orthodontic services and supplies are in Class IV. The plan covers:

- Nightguards and occlusal splints.
- Straightening of teeth, including correction or prevention of malocclusion.

To facilitate benefit payments, your orthodontist or you should submit the treatment plan to the service representative before treatment starts.

Pretreatment Estimate

If your dental care will be extensive, you may ask your dentist to submit a request for a pretreatment estimate, called a “predetermination of benefits.” This predetermination will allow you to know in advance what procedures are covered, the amount the service representative will pay toward the treatment, and your financial responsibility.

Preferred Dental Plan Exclusions

The Preferred Dental Plan does not cover the following services or supplies.

- Analgesics such as nitrous oxide, intravenous sedation, euphoric drugs, injections, prescription drugs, or application of desensitizing agents.
- Appliances or cleaning of appliances and certain restorations as follows:

– Appliances or restorations necessary to correct vertical dimension or to alter morphology (shape) or occlusion, overhang removal, or recontouring or polishing a restoration.
– Cleaning of prosthetic appliances.
– Duplicate dentures, temporary dentures, personalized dentures, or crowns and copings provided in connection with overdentures.
– Fixed prosthodontics for children under age 16.

- Habit-breaking appliances.
- Replacement of a space maintainer previously covered by the plan.

- Cosmetic procedures (including laminates and tooth bleaching, whether vital or nonvital), appliances, or restorations primarily for cosmetic purposes.
- Experimental services or supplies (or related complications)—the plan does not cover experimental services or supplies whose use and acceptance as a course of dental treatment for a specific condition still are under investigation or observation. To determine whether services are experimental, the service representative uses American Dental Association guidelines and considers whether the services

- Are in general use in the local dental community.
- Are proven to be safe and effective.
- Are under continued scientific testing and research.
- Show a demonstrable benefit for a particular dental condition.

- Other dental exclusions as follows:

- Caries (decay) susceptibility tests.
- Charges for services or supplies that are received while the patient is not covered under the plan.
- Consultations or elective second opinions.
- Crowns used as abutments to a partial denture for purposes of recontouring, repositioning, or to provide additional retention, unless the tooth is decayed to the extent that a crown would be required to restore the tooth in the absence of a partial denture.
- Crowns used to repair microfractures of tooth structure when the tooth displays no symptoms.
- Diagnostic services or X-rays related to temporomandibular joints (jaw joints).
- Fees for broken appointments.
- Fees for completing insurance forms.
- Full mouth (major) occlusal adjustment.
- Gingival curettage.
- Home fluoride kits.
- Hospitalization charges or any additional dental fees associated with hospitalization.
- Iliac crest or rib grafts to alveolar ridges.
- Injuries or conditions covered under workers' compensation or employers' liability laws.
- Oral hygiene or dietary instruction.
- Orthognathic surgery.
- Patient management problems.
- Periodontal splinting; any crown or bridgework provided with periodontal therapy or periodontal appliances.
- Plaque control programs.
- Porcelain or resin inlay bridges.
- Proposed treatment plan review or case presentation by the attending dentist.
- Restorations on the same surface or surfaces of a tooth within 2 years of the original service.

- Ridge extension to insert dentures (vestibuloplasty).
- Services or supplies covered by any Federal, state, or provincial government agency or provided without cost by any municipality, county, or other political subdivision or community agency. However, if government agency payments are insufficient for covered services or supplies or if benefits are provided by a government agency as an employer to its employees, dental coverage will not be excluded and will be subject to coordination of benefits.
- Services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.
- Services specifically excluded in this plan description and all other items that are not specifically included in this plan as covered dental benefits.
- Study or diagnostic models.
- Tooth transplants or materials placed in extraction to generate osseous filling.
- Treatment of temporomandibular (jaw) joints.

How Dental Coverage May Be Extended

The plan generally does not cover services or supplies that you receive while you are not covered under the plan. However, the plan will cover certain services and supplies for an additional period after the date coverage would otherwise end. These services and supplies and the conditions for extending care are described below if the dentist started the course of treatment *before* your coverage ends:

- A crown that is required to restore a tooth (independent of the crown's use in connection with a partial denture) if the tooth is prepared for the crown while you are covered and the crown is installed during the 31 days after your coverage ends.
- A prosthetic device (including abutment crowns of a partial denture), if the impressions are taken while you are covered, and the device is installed or delivered within 31 days after your coverage ends.
- Orthodontia care provided within 3 calendar months after your coverage ends.
- Restorative, endodontic, periodontic, and oral surgical procedures completed within 31 days after your coverage ends.

Coordination of Benefits

If you or your dependent has medical, dental, or other health coverage in addition to being covered under these medical and dental plans, the following rules govern coordination of benefits with the other coverage. Other coverage includes, whether insured or uninsured, another employer's group benefit plan, other arrangement of individuals in a group, Medicare (to the extent allowed by law), individual insurance or health coverage, and insurance that pays without consideration of fault.

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

Order of Payment

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

- A plan is considered primary if:
  - It has no order of benefit determination rules.
  - It has benefit determination rules that differ from coordination of benefit rules under state regulations or, if not insured, that differ from these rules.
  - All plans that cover an individual use the same coordination of benefit rules, and under those rules, the plan is primary.
- If the aforementioned rules do not determine which group plan is considered primary, this plan applies the following coordination of benefit rules:
  - A plan that covers a person as an employee, retiree, member, or subscriber pays before a plan that covers the person as a dependent.
  - A plan that covers a person as an active employee or dependent of an active employee is primary. The plan that covers a person as a retired, laid-off, or other inactive employee or as a dependent of a retired, laid-off, or other inactive employee is secondary.
  - If a dependent child is covered under both parents' group plans, the child's primary coverage is provided through the plan of the parent whose birthday comes first in the calendar year, with secondary coverage provided through the plan of the parent whose birthday comes later in the calendar year.
  - If a dependent child's parents are divorced or separated and a court decree establishes financial responsibility for the health care coverage of the child, the plan of the parent with such financial responsibility is the primary plan of coverage. If the divorce decree is silent on the issue of coverage, the following guidelines are used:
    - The plan of the parent with custody pays benefits first.
    - The plan of the spouse of the parent with custody pays second.
    - The plan of the parent without custody pays third.
    - The plan of the spouse of the parent without custody pays fourth.

– If none of the aforementioned rules establishes which group plan should pay first, then the plan that has covered the person for the longest period is considered the primary plan of coverage.
– Continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, always is secondary to other coverage, except as required by law.
– If an employee or dependent is confined to a hospital when first becoming covered under this plan, this plan is secondary to any plan already covering the employee or dependent for the eligible expenses related to that hospital admission. If the employee or dependent does not have other coverage for hospital and related expenses, this plan is primary.
–

Benefits under a Company-sponsored medical or dental plan are not coordinated with benefits paid under any other group plan offered by the Company. You can receive benefits from only 1 Company-sponsored medical or dental plan. However, when dental services performed by a licensed dentist also are covered under the medical plan, the dental plan pays its benefits first and the medical plan is secondary.

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

Medical Plans

The primary plan pays benefits without regard to any other plan. When the Company-sponsored plan is secondary, it adjusts benefits so that the total payable under both plans for expenses covered under the Company-sponsored plan is not more than would be payable under the Company-sponsored plan. Neither plan pays more than it would without coordination of benefits.
Plan means any plan providing medical, dental, vision care, hearing aid benefits, or treatment under individual insurance, group insurance, or any other coverage for individuals in a group, whether on an insured or uninsured basis.

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

Coordination of benefit provisions for the Company-sponsored HMO or CCP may differ.

Dental Plan

Benefits payable under the Company-sponsored dental plan takes into account any coverage (including orthodontic coverage) you or your eligible dependents have under other plans.

Plan means any plan providing medical, dental, vision care, hearing aid benefits, or treatment under group insurance or any other coverage for individuals in a group, whether on an insured or uninsured basis. However, plan excludes any medical plan sponsored by the Company. This means the dental plan pays first when dental expenses performed by a dentist also are covered by any medical plan sponsored by the Company.

The dental plan pays regular benefits in full or a reduced amount which, when added to benefits payable by another plan, equals 100% of allowable expenses.

When an Injury or Illness Is Caused by the Negligence of Another—Health care

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

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

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

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

If an individual fails, refuses, or neglects to reimburse the plan or otherwise comply with the requirements of this provision, or if payments are made under the plan based on fraudulent

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

Termination of Coverage

Life Insurance Coverage

Life insurance coverage stops on the date your active employment terminates.

You may convert your life insurance coverage to an individual life insurance policy. This individual policy will be issued, without medical examination, at the insurer's regular rates. The amount of life insurance converted cannot exceed the amount in force on the date insurance terminates.

To apply for conversion, you must complete the appropriate application and make your first premium payment to the service representative within 31 days after the date coverage ends or the date the Boeing Service Center provides written notice of your conversion rights (provided the notice is sent within 90 days of when coverage ends), whichever is later.

If, after an individual conversion policy is issued, benefits under the Life Insurance Plan are continued due to total disability, the individual policy must be surrendered without claim other than the return of paid premiums.

If you die during your conversion period, a life insurance benefit is payable equal to the amount you could have converted to an individual policy.

AD&D Coverage

AD&D coverage stops on the date your active employment terminates.

Short-Term Disability Coverage

Short-term disability coverage stops on the date your active employment terminates.

Medical Coverage

Medical coverage for you and your dependents stops at the end of the calendar month your active employment terminates or the end of the last month required contributions are paid,

whichever occurs first. If earlier, your dependent's coverage stops at the end of the month in which he or she no longer qualifies as a dependent.

However, coverage may be continued under certain circumstances as specified below. Any required contributions must be paid during these periods for coverage to continue.

If you are terminating employment, the service representative will make available an individual program of medical benefits similar to those then being issued for group conversion. The benefits provided under the individual plan will not exactly duplicate the benefits provided under this group medical plan. This conversion privilege is also available to your covered dependents who cease to qualify under the group policy and to surviving covered dependents if you die. No evidence of insurability is required.

Dental Coverage

Dental coverage for you and your dependents stops at the end of the calendar month your active employment terminates. If earlier, your dependent's coverage stops at the end of the calendar month in which he or she no longer qualifies as a dependent.
However, coverage may be continued under certain circumstances as specified below.
Any required contributions must be paid during these periods for coverage to continue.

Retirement

If you are eligible for, and enroll in, a retiree medical plan, medical coverage for you and your dependents ends at the end of the month following the month in which your active employment ends.

Change in Eligible Class of Employment

When you remain employed by the Company but no longer in the class eligible for coverage under this Package, coverage for you and your dependents stops at the end of the month in which your transfer is effective. If you become totally disabled before coverage ends under the Package, the life insurance, AD&D, and short-term disability benefits of the Package, which would have continued if you had stayed in the eligible class, will continue according to the terms governing benefits during leaves of absence instead of all other Company life insurance, AD&D, and disability benefits.

Continuation of Medical and Dental Coverage (COBRA)

If medical and dental coverage for you and your dependents (including a same-gender domestic partner and his or her children) otherwise would terminate due to one of the following reasons, these benefits may continue for specified periods under Public Law 99-272, Title X, as amended, if the individual makes a timely request to the Company and pays the required contribution.

- Reduction in hours or termination of employment for any reason.
- Your death.

- Your divorce or dissolution of a same-gender domestic partner relationship.
- A dependent child ceasing to be a dependent as defined under this Package. (A child eligible to be continued under the Package's incapacitated child provision will still be considered to have dependent status.)
- Your dependent's loss of eligibility because you became eligible for Medicare.
-

If you are laid off, the Company will contribute to the cost of COBRA medical and dental coverage for you and your dependents. Company contributions will continue at the same rate as for active employees until you are covered by any other group medical or dental plan either as an active employee or as a dependent, but in no event beyond the expiration of the COBRA period or 3 months after the date of layoff, whichever occurs first.

If you die (other than from an industrial accident), the Company will contribute to the cost of your dependents' COBRA medical and dental coverage for up to 12 months. Your dependents' contributions for the first 12 months of COBRA medical and dental coverage will be the same as for dependents of active employees.

If you die from an industrial accident, the Company will contribute to the cost of your dependents' COBRA medical and dental coverage for up to 36 months. Your dependents' contributions for COBRA medical and dental coverage will be the same as for dependents of active employees.

Leaves of Absence

When you are absent with leave, coverage may continue as follows; any required contributions must be paid during these periods for coverage to continue.

Approved Medical Leaves of Absence

If you are eligible for coverage and begin an approved medical leave of absence due to a total disability, you are eligible for the Package the same as an active employee until the last day of the calendar month in which your leave began. (Your eligible dependents also are eligible for medical and dental benefits.)

If you are totally disabled and remain on an approved medical leave of absence that extends beyond this period, your life insurance, AD&D, short-term disability, medical, and dental benefits (and dependent medical and dental benefits) continue up to 6 full consecutive calendar months during the approved medical leave with Company contributions.

If the approved medical leave extends beyond this 6-month period due to continuous total disability, your medical coverage continues for up to an additional 24 months with Company contributions. Medical coverage ends earlier if you become eligible for Medicare or are no longer considered totally disabled. You also may continue the life insurance, AD&D, and dental benefits (and medical and dental benefits for eligible dependents) during this time by paying 100% of the cost of coverage on or before the tenth day of the month in which they are due.

If you or your covered dependent is considered disabled by Social Security during the seventh or eighth month of the absence, you may continue medical and dental coverage for yourself and eligible dependents for up to 5 additional months by paying 150% of the cost of coverage.

Medical and dental coverage continued after the sixth calendar month of medical leave is considered COBRA continuation coverage.

Other Approved Leaves of Absence

If you are eligible for coverage and begin an approved leave of absence, you are eligible for the Package the same as an active employee until the last day of the calendar month in which your leave began. (Your eligible dependents also are eligible for medical and dental benefits.)

If the approved leave extends beyond this time, your life insurance, AD&D, short-term disability, medical, and dental benefits (and dependent medical and dental benefits) continue for up to 3 full consecutive calendar months with Company contributions.

After this 3-month period, you may continue medical and dental coverage for up to an additional 21 months by self-paying 100% of the cost of coverage; this is considered COBRA continuation coverage. You also may continue life insurance coverage for the duration of the approved leave of absence by self-paying 100% of the cost of coverage.

Family and Medical Leave Act of 1993

If the required coverage for family and medical leaves of absence under the Family and Medical Leave Act of 1993 is more generous than that already described here, the Company provides any required additional coverage under its group health plans.

Uniformed Services Leave of Absence

If you take a leave of absence for service in the U.S. uniformed services (including the military, National Guard, and the Commissioned Corps of the Public Health Service), you are covered under the Package until the end of the month in which your leave began. If you remain on an approved leave of absence, coverage under the Package continues until the end of the third full calendar month of the leave as if you were an active employee on an approved nonmedical leave of absence.

If uniformed service extends beyond 3 months, you will be offered COBRA coverage that will start the beginning of the fourth full calendar month of your leave. You must enroll in COBRA coverage in order for coverage to continue. You may continue COBRA coverage for an additional 21 months while your uniformed services leave continues, in accordance with your rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA). During a temporary period after September 11, 2001, military leave of absence can be extended for a total of 60 months if your military leave is associated with the September 11, 2001 terrorist attacks on the United States or subsequent military action related to those attacks, including the war in Iraq. Your life insurance, medical, and dental coverage continue during this period. The cost of coverage during this 60-month period is the same as for active employees.

Your COBRA continuation period runs concurrently with coverage during USERRA leave.
If you return to active employment promptly after uniformed service, according to USERRA, the Package is reinstated on the date you return to the active payroll.

Changes in Leave Types

If your type of leave changes from a medical leave of absence to a nonmedical leave of absence (or vice versa), your periods of leave will be considered separate leaves of absence. However, if the type of your nonmedical leave of absence changes (for example, from family leave to personal leave), your maximum period of coverage in your new leave category will be reduced by the number of days or months for which you already received an extension of your active coverage.

Successive Periods of Leaves of Absence

Two medical leaves of absence separated by less than 30 days of continuous work are considered 1 leave of absence unless the second leave is due to entirely unrelated conditions.

Group Benefits Package for Wichita Engineering Unit Employees Represented by SPEEA

Retiree Medical Plan
Attachment B

January 14, 2009

ATTACHMENT B

CONTENTS

Eligibility

You are eligible for the retiree medical plan if you retire from the service of the Company under the Company-sponsored retirement plan as follows:

You are an active employee and age 55 or older with 10 or more years of vesting service under a Company-sponsored retirement plan.

You are disabled, become eligible for disability benefits under the Company-sponsored retirement plan, and are age 50 or older with 10 or more years of vesting service at retirement.

You are on an approved leave of absence, you are age 55 or older with 10 or more years of vesting service at retirement, and you retire under the Company-sponsored retirement plan directly from your approved leave of absence.

You are on layoff, you are at least age 55 with 10 or more years of vesting service at retirement, and you retire under the Company-sponsored retirement plan within 6 years following your layoff.

If you are eligible for retiree medical coverage as described above, you can defer your retiree medical coverage or receipt of your retirement plan benefit. See Effective Date of Retiree Medical Coverage and the Deferred Enrollment section of Retiree Medical Plan Enrollment for more information.

If you are hired on or after January 1, 2007, you will not be eligible for retiree medical coverage when you retire from the Company. For purposes of determining retiree medical plan eligibility, you are considered to be hired before January 1, 2007, if:

You are on an authorized leave of absence on December 31, 2006, and return to active employment directly from that authorized leave of absence.

You are on layoff on December 31, 2006, and return to active employment within your recall rights period.

You are an active employee on December 31, 2006, go on an authorized leave of absence, and return to active employment directly from that authorized leave of absence.

You are an active employee on December 31, 2006, are laid off, and return to active employment within your recall rights period.

You are no longer eligible for coverage under the retiree medical plan after attaining age 65 or becoming eligible for Medicare.

Eligible Dependents of Retired Employees

Dependents eligible for the retiree medical plan are your legal spouse (as recognized under both applicable state law and the Internal Revenue Code) and children (natural children, adopted children, children legally placed with you for adoption, and stepchildren) who are under age 25, unmarried, and dependent on you for principal support.

You may request coverage for the following dependents:

An opposite-gender common law spouse if the relationship meets the common-law requirements for the state where you entered into the common-law relationship.

A same-gender domestic partner if:

- You and your partner live in the same permanent residence in a permanent, exclusive, emotionally committed, and financially responsible relationship similar to a marriage.
- Your partner is at least 18 years old, is not related to you by blood, is not married to or separated from another person, and is not involved in another domestic partner relationship.
- Your domestic partner relationship is not solely to obtain coverage under the Plan.

Unmarried children of your same-gender domestic partner who are under age 25 and dependent on you for principal support. These children are considered stepchildren for the purpose of the medical plans.

Other children, as follows, who are under age 25, unmarried, and dependent on you for principal support:

- Children who are related to you either directly or through marriage (e.g., grandchildren, nieces, nephews).
- Children for whom you have legal custody or guardianship (or for whom you have a pending application for legal custody or guardianship) and are living with you.

Proof of dependent eligibility will be required.

In accordance with Federal law, the Company also provides medical coverage to certain dependent children (called alternate recipients) if the Company is directed to do so by a qualified medical child support order (QMCSO) issued by a court or state agency of competent jurisdiction.
Documentation is required to request coverage for dependents, including a child named in a QMCSO or a child for whom you have been given legal custody or guardianship, or a spouse or same-gender domestic partner. You must provide the Boeing Service Center with any required supporting documentation by the date specified by the Boeing Service Center or your request will be denied.

Special Provisions

If you or any of your dependents is covered or becomes covered (or eligible for benefits by reason of having been covered) under another Company-sponsored plan providing medical benefits, that person is not eligible for the retiree medical plan. If you and your spouse or same-gender domestic partner are both employed by or retired from Boeing, you each must be covered by your own Boeing-sponsored medical coverage. However, if your spouse or same-gender domestic partner is a part-time Boeing employee or on an approved leave of absence or layoff, your spouse or same-gender domestic partner and eligible children are considered eligible dependents if other Boeing coverage is waived. If your spouse or same-gender domestic partner and eligible children are covered under your spouse’s or same-gender domestic partner’s Boeing-sponsored plan, they will be considered eligible for the retiree medical plan at the time they no longer are eligible for coverage under your spouse’s or same-gender domestic partner’s plan.

No person may be covered both as a retired employee and as a dependent, and no person will be considered as a dependent of more than 1 retired or active employee. Upon your death, your spouse or same-gender domestic partner and any other covered dependents remain eligible for coverage under the retiree medical plan until the earliest of these dates:

Your spouse or same-gender domestic partner or other dependent attains 65 years of age.

Your spouse or same-gender domestic partner or other dependent becomes eligible for Medicare.

The end of the last month for which contributions are paid.

Disabled Children

A disabled child age 25 or older may continue to be eligible if a physician documents that the child is incapable of self-support due to any mental or physical condition that began before age 25. You may be required to confirm the disability from time to time. The child must be unmarried and dependent on you for principal support. Coverage may continue under the retiree medical plan for the duration of the incapacity as long as you continue to be enrolled in the plan and the child continues to meet these eligibility requirements.

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

Retiree Medical Plan Enrollment

Initial Enrollment

You and your eligible dependents automatically will be enrolled at the time you become eligible, provided you pay any required contributions. You and your dependents will be enrolled in the same plan as immediately before retirement, if available.

You may elect to change medical plans by calling the Boeing Service Center within 31 days of the date you retire. The Company will supply enrollment instructions at the time of your retirement.

All family members, including you, must be enrolled in the same medical plan.

Spouse or Same-Gender Domestic Partner Coverage

Each retired employee enrolling a spouse or same-gender domestic partner must provide information regarding coverage available through another employer to determine whether special contributions are required to enroll the spouse or same-gender domestic partner. If you do not authorize a required contribution, your spouse or same-gender domestic partner will not be enrolled for medical coverage. You will not be able to enroll your spouse or same-gender domestic partner until the date your spouse or same-gender domestic partner loses the option to be covered under the other employer-sponsored medical plan.

The Company will require periodic verification of data.

Special Enrollment Events

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

You or your dependent loses or becomes ineligible for other employer-sponsored medical coverage because of an event such as loss of dependent status under another employer's plan (through divorce, legal separation, termination of a same-gender domestic partnership, or dependent child reaching the limiting age), death, termination of employment, reduction in hours of employment, termination of employer contributions toward the coverage, elimination of coverage for the class of similarly situated employees or dependents, moving out of the plan's service area with no other coverage available from the other employer, or reaching the lifetime limit on all benefits under the other employer's plan.

If you or your dependent reaches the lifetime limit under a Company plan, and you are eligible for another Company plan in your area, you and your dependents may enroll in that other plan.

You or your dependent exhausts any continuation coverage from another employer; that is, coverage provided under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), ends.

You gain a new dependent because of marriage, same-gender domestic partnership, birth, adoption, or placement for adoption.

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

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

Deferred Enrollment

If you decline enrollment in the retiree medical plan because of other employer-sponsored health care coverage (such as through your spouse's or same-gender domestic partner's employer), you may be able to enroll yourself and your eligible dependents in the Company-sponsored retiree medical plan at a later date as long as enrollment is within 60 days after other coverage ends.

If you are *not* enrolled in the Company-sponsored retiree medical plan and have a new dependent as a result of an event such as marriage, same-gender domestic partnership, birth, adoption, or placement for adoption, you may enroll yourself, your spouse or same-gender domestic partner, and any dependent children during the year as long as enrollment is requested within 60 days after the event by contacting the Boeing Service Center.

If you *are* enrolled in the retiree medical plan and have a new dependent as a result of marriage, same-gender domestic partnership, birth, adoption, or placement for adoption, you may enroll your new dependent during the year as long as enrollment is requested within 120 days after the qualified event.

If you *are* enrolled in the retiree medical plan and have not enrolled your eligible dependents because of other employer-sponsored health care coverage, you may be able to enroll your eligible dependents in the Company-sponsored retiree medical plan at a later date as long as enrollment is within 60 days after the other coverage ends. The coverage loss must be due to loss of eligibility for the health care coverage (including from divorce, legal separation, termination of same-gender domestic partnership, death, termination of employment, or reduction in hours of employment), termination of employer contributions toward such coverage, or reaching the other plan's lifetime maximum benefit.

Transfer Between Plans

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

Annual enrollment period.

The Company establishes an annual enrollment period on or before January 1 each year when you may change medical plans.

Change of residence.

If you move out of an HMO or coordinated care plan service area, you have 60 days to select a medical plan available in the new location by calling the Boeing Service Center. It is your responsibility to notify the Company of the change in residence within the 60-day period.

Status Changes

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

- You acquire a new, eligible dependent through marriage, entering a same-gender domestic partnership, birth, adoption, or placement for adoption.
- You lose a dependent through divorce, legal separation, dissolving a same-gender domestic partnership, or annulment of your marriage.
- Your covered dependent dies.
- Your covered dependent starts or stops working.
- Your covered dependent has any other change in employment status that affects eligibility for coverage such as changing from full time to part time (or part time to full time), salaried to hourly (or hourly to salaried), strike or lockout, a transfer between a nonunion salaried position and a union-represented position, or beginning or returning from an unpaid leave of absence.
- You or your covered dependent experiences a significant increase in the cost of employer-sponsored health care coverage or the employer-sponsored health care coverage ends, including expiration of COBRA coverage.
- The Company adds a new benefit option or significantly improves an existing benefit option.
- You or your covered dependent experiences a significant curtailment or cessation of employer-sponsored medical coverage.
- You or your covered dependent becomes eligible or ineligible for Medicare or Medicaid.
- Your dependent child becomes eligible for, or no longer is eligible for, health care coverage due to age limits, principal support status, or a similar eligibility requirement.
- Your covered dependent makes an enrollment change in his or her employer-sponsored health care coverage, either because of a qualified change in status or an annual enrollment.
- You or your covered dependent changes place of residence or work, affecting access to care within the current plan or access to network providers.
- You also may change an election to comply with a qualified medical child support order (QMCSO) to provide or cancel coverage for a dependent child resulting from a divorce, annulment, or change in legal custody.
- If you are eligible to add new dependents, you must request the dependent enrollment change within 60 days after the qualified event. You can enroll a new dependent within 120 days following your marriage or entering a same-gender domestic partnership or your dependent child's birth, adoption, or placement for adoption. Enrollment may be requested by calling the Boeing Service Center. To request enrollment for a new dependent more than 60 days but within 120 days after marriage or entering a same-gender domestic partnership, birth, adoption, or placement for adoption, you must call the Boeing Service Center and speak with a customer service representative. You must provide the Boeing Service Center with any supporting documentation by the date specified by the Boeing Service Center or your request will be denied.
- You may drop coverage for yourself or your dependents at any time. However, you may reenroll only if you and your dependents are continuously covered by an

employer-sponsored plan and that coverage ends, as described in Deferred Enrollment.

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Effective Date of Retiree Medical Coverage

Retired Employees

If you are a newly retired employee, the plan becomes effective on the first day of the second month following the month in which your active employment ends, provided you pay any required contributions.

If you are eligible for retiree medical coverage at the time active employment with the Company ends, or as otherwise described in Eligibility, you may:

- Defer enrollment in the retiree medical plan until the date your benefits begin under the Company-sponsored retirement plan, or
- Enroll in the retiree medical plan and defer receipt of benefit payments under the Company-sponsored retirement plan, or
- Defer enrollment in the retiree medical plan until your coverage ends under another employer-sponsored health care plan (such as through your spouse's employer), as described in the Deferred Enrollment section of Retiree Medical Plan Enrollment.
-

You are not eligible for the retiree medical coverage described in this Agreement after becoming eligible for Medicare or attaining age 65.

Dependents

Current eligible dependents are covered for retiree medical benefits on the same date your coverage is effective, provided proper application is made and you pay any required contributions. Eligible dependents acquired after your coverage is effective become covered on the date of marriage or entering a same-gender domestic partnership, date of birth, or date the child is legally placed with you for adoption, if application is made within 120 days of the event and you pay any required contributions. For other newly eligible dependents, coverage is effective on the date dependency is established, if application is made within 60 days and you pay any required contributions.

Summary of Medical Plan Benefits

The medical plans offered to retired employees are the same as the plans offered to active employees except that the TRICARE Supplement Plan is available to retirees only.

Effective January 1, 2010, benefit and plan payment provisions will be based on a benefit year of January 1 through December 31.

Termination of Retiree Medical Coverage

Retiree Coverage

Your medical coverage stops on whichever of the following dates occurs first:

You attain 65 years of age.

You become eligible for Medicare.

The end of the last month that any required contributions are paid.

Your covered dependents can continue their coverage until they reach their termination date, as described below.

Dependent Coverage

Coverage for your eligible dependents terminates on whichever of the following dates occurs first:

- Your dependent no longer qualifies as an eligible dependent.
- Your dependent attains 65 years of age.
- Your dependent becomes eligible for Medicare.
- The end of the last month you are covered under this retiree medical plan or the Company-sponsored Medicare Supplement Plan, except in the case of your death.
- The end of the last month that any required contributions are paid.
-

Continuation of Medical Coverage (COBRA)

If medical coverage for your dependents otherwise would terminate due to one of the following reasons, these benefits may continue for specified periods under Public Law 99-272, Title X, as amended, if the individual makes a timely request to the Company and pays the required contribution:

- Your death.
- Your divorce or dissolution of domestic partnership.
- You become entitled to Medicare.
- Your dependent child ceases to be a dependent as defined under this plan. (A child eligible to be continued under the plan's incapacitated child provision will still be considered to have dependent status.)

Conversion Privilege

If medical coverage terminates for reasons other than voluntary cancellation of coverage or by becoming eligible for another Company-sponsored plan, the service representative will make available an individual program of medical benefits similar to those then being issued for group conversion. The benefits provided under the individual plan will not exactly duplicate the benefits provided under this group medical plan. This conversion privilege is available to your covered dependents who cease to qualify under the group policy and to surviving covered dependents if you die. No evidence of insurability is required.

TRICARE Supplement Plan Description of Benefits

The plan is insured by Hartford Life and Accident Insurance Company and administered by Association & Society Insurance Corporation. The benefits described below are for illustrative purposes only and subject to change at the discretion of the plan administrator.	
Eligible Employees and Dependents*	Individuals enrolled in TRICARE (Department of Defense coverage): – Military retirees and their dependents – Dependents of active duty military personnel
Annual Deductible	$100 per individual $200 per family
Benefits Supplementing TRICARE Standard/ Extra	100% of annual deductible amounts 100% of military hospital subsistence charges 100% of civilian hospital coinsurance amounts 100% of outpatient services coinsurance amounts 100% of deductibles and copayments for prescription drugs 100% of charges in excess of usual and customary
Benefits Supplementing TRICARE Prime/POS	100% of HMO network and pharmacy copayments 50% of nonnetwork deductibles 50% of nonnetwork coinsurance amounts 100% of charges in excess of usual and customary
Vision Care	Provided through the Boeing vision care program
Coverage Ends	For retiree and spouse at age 65 or earlier entitlement to Medicare For dependent children at age 21 or 23 if full-time students
* Includes retired employees and their dependents who are not eligible for Medicare	

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