Group Benefits Package for Employees Represented by SPEEA

Health and Insurance Plans
Attachment A

January 1, 2023

ATTACHMENT A

Attachment A – Table of Contents

ELIGIBILITY

Eligible Employees

You are eligible for the Package if you are an active Boeing employee represented by a 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 26.

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 spouse includes a domestic partner when enrolled in a fully-insured health care plan that is mandated by law to cover domestic partners or similar relationships.

Some states have laws that require insured health plans to offer coverage for certain registered domestic partners.

- Other children, (including children of domestic partners), as follows, who are under age 26, 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, or a spouse. 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 or dependent child is employed by Boeing and eligible for any type of benefit plan offered by Boeing, your dependent must either be covered on your policy or 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. 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).

Disabled Children

A disabled child age 26 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 26. 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 26 or older.

ENROLLMENT

Life and Disability Plans

You automatically are enrolled in the Life Insurance Plan, AD&D Plan, Short-Term Disability Plan, and Long-Term Disability Plan basic coverage 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. The Company will require periodic verification of data.

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, 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 until the earlier of:

– The next annual enrollment period.

– The date your spouse loses the option to be covered under the other employer-sponsored medical plan.

Dental Plans

In designated locations, the Company provides you with a choice of dental plans. You receive enrollment instructions at the time of employment and may elect dental coverage under 1 dental plan available in your location by the date indicated on the enrollment worksheet.

If you do not enroll in a dental plan by the date indicated on the enrollment worksheet, you will be enrolled automatically in the Preferred Dental Plan 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, 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.
- You or your dependent exhausts any continuation coverage from another employer; that is, coverage provided under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), ends.
- You gain a new dependent because of marriage, birth, adoption, or placement for adoption.

If you experience a special enrollment event, you can enroll yourself and/or your eligible dependents in a 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, 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 acquire a new, eligible dependent child, such as by birth, adoption, or placement for adoption.
- Your spouse or dependent child dies.
- You or your spouse or dependent child starts or stops working.
- You or your spouse 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 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 dependent child experiences a significant curtailment or cessation of employer-sponsored health care coverage.
- You or your spouse 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 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 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 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 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, 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, short-term disability, and long-term disability basic 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, 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 (H.R. 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.

LONG-TERM DISABILITY PLAN

The Company provides disability income coverage for you under the Long-Term Disability Plan, which pays benefits if you are disabled for an extended period. The Company provides basic long-term disability coverage at no cost to you. You may purchase supplemental long-term disability coverage if you enroll and make the required contributions.

Benefits

If you are unable to work for longer than 26 weeks due to a covered disability, the Long-Term Disability Plan will replace a portion of your income, as described below:

- Company-paid basic benefit—You receive 50% of your monthly salary.
- Employee-paid supplemental benefit—You may purchase coverage of an additional 10% of your monthly salary through after-tax contributions taken from your paycheck.
- Maximum—The maximum monthly benefit under this plan is $15,000 for basic and supplemental coverage combined.

Your benefits under the Long-Term Disability Plan are determined using the monthly salary reflected in Boeing Service Center records at the time your disability begins. This is called your predisability earnings.

If you are actively at work and your monthly salary either increases or decreases, your long-term disability benefit amount will change automatically on the first day of the month after your salary change. If you are not actively at work, your long-term disability benefit amount will change the first day of the month after the date you return to active work. If you are already on an approved disability, your benefit amount will not change until you return to active work. Any retroactive change to your monthly salary will not retroactively change your eligible benefit amount under this plan. Any change to your monthly salary will not affect a benefit payable for a second disability that is considered a continuation of the first disability.

Eligibility for Benefit Payments

You are eligible to receive long-term disability benefits after you have been disabled for 26 weeks. Your disability must begin while you are covered by the plan. You must be under the continuous care of a physician throughout your 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 disability.

All determinations of disability are made by the service representative within the terms of its contract with the Company.

Benefit Payment Period

The maximum time that long-term disability benefits may be paid depends on your age when your disability begins, as shown in the following table:

Long-Term Disability Benefit Period	
Age When Disability Begins	**Maximum Benefit Period***
59 or younger	Until age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months

Long-Term Disability Benefit Period	
66	21 months
67	18 months
68	15 months
69 and over	12 months
* Or to your Social Security normal retirement age, if later.	

Long-term disability benefits end on the earliest of these dates:

- The date you no longer are disabled.
- The date you return to work.
- The last day of your maximum benefit period.
- The date you are not under the regular care of a physician.
- The date you fail to provide proof of continued disability, refuse to be examined, or withhold information about any employment.
- The date you die.

Separate Periods of Disability

If you experience a second disability, the cause and the length of time between the first and second disability determine whether the second disability is treated as a continuation of the first or as a separate disability unrelated to the first.

Your second period of disability is considered a continuation of the first if:

- The recurrence is due to the same or related cause as the first, and
- You returned to work or were not considered disabled (a period of temporary recovery) for:

– 60 days or less during the initial 26-week waiting period, or

– 26 consecutive weeks or less (for each period of temporary recovery) during the payment period.

The following provisions apply to a period of temporary recovery:

- No new 26-week waiting period is required.
- The monthly salary amount used to determine your benefit during your previous period of long-term disability stays the same.
- No long-term disability benefits are paid for the time you are temporarily recovered.
- Your period of temporary recovery does not count toward your:

– Initial 26-week waiting period.

– Maximum benefit period.

– Initial 24-month payment period.

– 24-month limit on disabilities due to a mental health condition or substance use disorder (as

described below).

Your second period of disability is treated as a new and separate disability if you no longer are disabled or returned to active work for at least 1 day and:

- Your disability is due to a different cause than the first disability,
- Your disability is due to the same cause as the first disability, but your recovery is longer than the time limits listed above, or
- The first period of disability began before you were covered under this plan.

When any of these applies, you will need to initiate a new claim and meet the waiting period requirements before benefits are paid.

Disability Due to a Mental Health Condition or Substance Use Disorder

The Long-Term Disability Plan pays benefits to a maximum of 24 months if a mental health condition or substance use disorder is the primary cause of your disability. After 24 months, benefits continue only if you are confined to a hospital or similar institution for the condition causing the disability.

If inpatient confinement lasts:

- Less than 30 days—Benefits stop when you no longer are confined.
- 30 days or more—Benefits continue until you have not been confined because of that condition for a total of 90 days in any 12-month period.

The Separate Periods of Disability rules above do not apply to disabilities caused by a mental health condition or substance use disorder after the first 24 months of benefit payments.

Other Income Benefits

Certain other income that you may be entitled to receive will reduce your basic monthly disability benefit under this plan. However, your supplemental long-term disability benefit will not be reduced by income other than earnings from rehabilitative employment, as described below.

You must apply for all other income benefits for which you may be eligible, except retirement benefits before your normal retirement age. If Social Security, workers' compensation, or other benefits are denied, you must reapply and send the service representative evidence that you have reapplied.

Income That Reduces Your Long-Term Disability Benefit

The following income benefits reduce your disability benefit under this plan:

- Disability, retirement, or unemployment benefits required or provided under any law of a government, including but not limited to:

– Automobile no-fault wage replacement benefits to the extent required by law.

– Social Security, Railroad Retirement Act, Canada Pension Plan, and Quebec Pension Plan benefits.

– Statutory disability benefits.

– Unemployment compensation benefits.

– Veterans' benefits.

– Workers' compensation benefits.

- Group credit or mortgage disability insurance.
- Half of any award under The Jones Act or The Maritime Doctrine of Maintenance, Wages, and Cure.
- Insured or uninsured disability income plans of any employer, multiemployer or multiple employer welfare plan, union welfare plan, or welfare plan of a group or an association.
- Retirement income benefits from the Company or any Company subsidiaries, except:

– Any retirement benefit you are eligible to receive before the plan's normal retirement age but elect not to receive before that age. After normal retirement age, long-term disability benefits are reduced by retirement benefits you are eligible to receive (whether or not you receive them).

– The portion of any lump-sum distribution or retirement benefit attributable to employee contributions.

- Salary continuation.
- Salary, wages, other compensation from any employer, or income from any occupation for compensation or profit, except for approved rehabilitative employment.

Other income benefits include primary and family Social Security benefits as well as other benefits you, your spouse, and your other dependents receive.

Other income benefits paid in a lump sum are allocated over the period specified in the lump-sum settlement. If no period is specified, other income benefits paid in a lump sum will be allocated over the lesser of your remaining benefit period or 60 months.

Income That Does Not Reduce Your Long-Term Disability Benefit

Some sources of income do not reduce your long-term disability benefit, including:

- Accelerated benefits paid under a life insurance policy.
- Cost-of-living increases in other income benefits.
- Employer-sponsored deferred compensation, thrift, savings, profit-sharing, stock ownership, stock option, and tax-sheltered annuity plans, including plans qualified under Internal Revenue Code sections 401(k), 403(b), 457, and similar plans.
- Individual disability insurance policies.
- Keogh (H.R. 10) plans.
- Severance pay.
- Any retirement or disability benefits you were receiving from these sources when you became disabled:

– Military or other government service pensions.

– Retirement benefits from a previous employer.

– Veterans' benefits for service-related disabilities.

– Social Security.

- Traditional or Roth individual retirement accounts (IRA).

Increases in other income benefits will reduce your long-term disability benefits if due to other reasons, such as a change in the number of your family members, recomputation of other income benefits, or a change in the severity of your disability.

Rehabilitative Earnings

To encourage your return to gainful employment before you fully recover from your disability, the plan allows you to receive pay, called rehabilitative earnings, for approved rehabilitative work without a reduction in your disability benefits:

Payment Period	Maximum You May Earn From Long-Term Disability Benefits + Rehabilitative Earnings
First 24 months	100% of predisability earnings*
After 24 months	80% of predisability earnings*
* To help protect you from the effects of inflation, your predisability earnings are indexed to the cost of living.	

If the sum of your rehabilitative earnings, long-term disability benefits, and other sources of income goes over the maximum allowed, the excess will be subtracted from your long-term disability benefits.

Retirement Benefits

If you are eligible for long-term disability benefits after age 65, you must elect to start receiving any Boeing-sponsored retirement benefits to which you are entitled by the later of:

- 60 days after the end of the retirement plan year you reach age 65 (generally, December 31).
- 6 months after your disability begins.

If you have not elected retirement benefits by then, the service representative will estimate how much you would be eligible to receive and subtract that amount from your long-term disability benefits. The estimate will be used until you provide evidence of your exact retirement benefit amount.

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, the 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 the plan is injured by another party who is legally liable for the medical or dental bills or disability income, he or she may request the 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 the 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 the 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. The 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.

The Long-Term Disability Plan does not cover any disability that begins during the first 12 months of coverage if the disability results from a pre-existing condition or if the disability is caused by:

- Committing (or attempting to commit) an assault, battery, or felony.

- Declared or undeclared war or act of war (unless it occurs while you are traveling on Company business).
- Insurrection, rebellion, or taking part in a riot or civil commotion.
- Intentionally self-inflicted injury (while sane or insane).
- 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.

Disabled (long-term disability plan) means all of the following conditions apply to you:

- You become disabled as a result of accidental injury or illness (including a pregnancy-related condition).
- Your accidental injury or illness (including a pregnancy-related condition) prevents you from performing the material duties of your own occupation (or other work the Company makes available) during the 26-week elimination period and first 24 months of benefits.
- After 24 months of benefits, you must be unable to work at any reasonable occupation for which you may be fitted by training, education, or experience. (This period may exceed 24 months of benefits if interrupted by temporary or intermittent returns to work.)

Disabled (short-term disability plan) 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 below).
- Your accidental injury or illness prevents you from performing the material duties of your regular occupation or other appropriate work the Company makes available.

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 means the amount of salary (see definition below) you were receiving from the Company on the day before a period of disability started.

Pre-existing condition (long-term disability plan) means any illness, injury, or other medical condition, whether or not diagnosed before the effective date of coverage, for which you received medical treatment or advice, consulted with a medical professional, received a medical test (diagnostic, routine, or other), took prescribed medicines, or had medicines prescribed during the 3 months before your coverage becomes effective for employees not currently enrolled in a company-sponsored long-term disability plan.

For employees currently enrolled in a company-sponsored long-term disability plan, credit will be applied for the time period satisfied for a pre-existing condition period which began under the prior company-sponsored long-term disability plan.

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, 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 $3.5 million. Your coverage amount is rounded to the next highest $1,000 if it is not already an even $1,000. To avoid imputed income, you also may elect a basic life benefit of $50,000 instead of the benefit listed above.

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 65 while covered under the plan and you remain permanently and totally disabled for at least 6 months, 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 (including mental health and substance abuse) is administered by Blue Cross and Blue Shield of Illinois (the service representative).		
	Network	**Nonnetwork**
Plan Features	**Member Responsibility**	
Annual Deductible	$300 per individual; no more than $900 per family of 3 or more	$600 per individual; no more than $1,800 per family of 3 or more; nonnetwork charges will apply toward the network deductible
Office Visit (member pays after deductible is met)	10% after deductible is met	40% after deductible is met
Coinsurance (member pays	10% after deductible is met	40% after deductible is met

Traditional Medical Plan Schedule of Benefits The Traditional Medical Plan (including mental health and substance abuse) is administered by Blue Cross and Blue Shield of Illinois (the service representative).		
	Network	**Nonnetwork**
Plan Features	**Member Responsibility**	
after deductible is met)		for all non-emergency nonnetwork services
Annual Out-of-Pocket Maximum medical deductible and provider copayments (excluding vision plan and prescription drug copayments) included in medical annual out-of-pocket maximum)	$2,000 individual/$4,500 family, but not more than $2,000 for any person	
Lifetime Maximum Benefit	None	
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 (member pays after deductible is met)	10% after deductible for most covered network services and supplies, except as shown below	40% after deductible for most covered nonnetwork services and supplies, except as shown below
Ambulance	10% after deductible is met	See network provisions
Emergency Room		
• Emergency Medical Condition	10% after deductible is met	See network provisions

Traditional Medical Plan Schedule of Benefits The Traditional Medical Plan (including mental health and substance abuse) is administered by Blue Cross and Blue Shield of Illinois (the service representative).		
	Network	**Nonnetwork**
Plan Features	**Member Responsibility**	
• Nonemergent Care	10% after deductible is met	40% after deductible is met
Hearing Aids	10% after deductible is met; up to $800 benefit per ear; limit 1 aid per ear every 3 benefit years Hearing aid overhaul in place of new hearing aid after 3 years	40% after deductible is met; up to$800 benefit 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	10% after deductible is met	40% after deductible is met
Hospital Alternatives		
• Ambulatory Surgical Facility	10% after deductible is met	40% after deductible is met
• Christian Science Sanatorium	10% after deductible is met	40% after deductible is met
• Home Health Care	10% after deductible is met	40% after deductible is met
• Hospice Care	10% after deductible is met	40% after deductible is met
• Skilled Nursing Facility	10% after deductible is met	40% after deductible is met
Mental Health Treatment (including eating disorders)		
• Covered Inpatient, Partial Hospital, Residential, or Intensive Outpatient Services	10% after deductible is met	40% after deductible is met
• Covered Outpatient Services	10% after deductible is met	40% after deductible is met
Neurodevelopmental Therapy	10% after deductible is met	40% after deductible is met
Occupational, Physical, and Speech Therapy	10% after deductible is met; benefits limited to 3 months; may be extended if approved by the service representative	40% after deductible is met; benefits limited to 3 months; may be extended if approved by the service representative
Preventive Care		
• Routine Physical • Routine Pap Tests,	No charge (deductible does not apply) as recommended by the U.S. Preventive Services	Not covered when received in the network service area

Traditional Medical Plan Schedule of Benefits The Traditional Medical Plan (including mental health and substance abuse) is administered by Blue Cross and Blue Shield of Illinois (the service representative).		
	Network	**Nonnetwork**
Plan Features	**Member Responsibility**	
Mammograms, Prostate Screenings, and Colorectal Screenings (including colonoscopies) • Routine Hearing Evaluation	Task Force (USPSTF), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration (currently the Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care guidelines) in accordance with the Patient Protection and Affordable Care Act	
Tobacco Cessation Treatment	10% (deductible does not apply)	
Spinal and Extremity Manipulations	10% after deductible is met up to 26 spinal and/or extremity manipulation visits per benefit year (network and nonnetwork combined)	40% after deductible is met up to 26 spinal and/or extremity manipulation visits per benefit year (network and nonnetwork combined)
Substance Use Disorder Treatment		
• Covered Inpatient, Partial Hospital, Residential, or Intensive Outpatient Services	10% after deductible is met	40% after deductible is met
• Covered Outpatient Services	10% after deductible is met	40% after deductible is met
Temporomandibular Joint Dysfunction and Myofascial Pain Dysfunction Syndrome (TMJ/MPDS) Treatment	50% after deductible is met	
Wigs	10% after deductible is met after the network deductible up to a $500 annual limit	

Annual Deductible

The annual deductible amount applies to all covered network and nonnetwork services and supplies except preventive care and tobacco cessation treatment.

Coinsurance

For some network services and all nonnetwork services, you are required to pay a certain percent of the covered charges, called coinsurance.

Generally, you must first satisfy the entire annual deductible before the plan pays its coinsurance percentage for services to which the annual deductible applies.

Your coinsurance percentage does not include any amounts you pay for services that the plan does not cover or any amounts that exceed the usual and customary charge.

Medical Out-of-Pocket Maximum

For some services, you are required to pay a certain percent of medical charges, called out-of-pocket expenses.

When your out-of-pocket medical expenses (or when your family members' combined out-of-pocket expenses) reach the annual medical out-of-pocket maximum, most other medical benefits are paid at 100% of usual and customary charges for the rest of that benefit year.

The following medical expenses do not count toward the out-of-pocket maximums:

- Any balance remaining after a benefit maximum has been reached.
- Benefits not paid, or penalties you incurred, because you fail to follow medical review program procedures and requirements.
- Covered medical services paid at 100% of usual and customary charges or in full.
- Expenses for services or supplies not covered by the plan.
- Retail and mail service prescription drug program coinsurance or copayments.
- Vision care expenses.
- 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.

Preferred Partnership

Boeing has entered into partnerships with health care systems in certain regions to offer a new health plan service delivery option called the Preferred Partnership. The Preferred Partnership option is designed to improve quality, provide a better experience for you and your family, and be more affordable.

This arrangement offers access to a Preferred Partnership option to certain eligible employees based on your home address ZIP code. If a Preferred Partnership option is available to you, you will receive enrollment and Preferred Partnership materials.

If you are eligible, when enrolling, you can choose between a “standard” or a “Preferred Partnership” option for the following plans:

- Traditional Medical Plan.
- Select Network Plan.
- Advantage+ health plan.

Preferred Partnership option features include:

- Enhanced services

– Quicker access to network primary care providers (PCPs) and specialists with more after-hours care availability.

– More personalized and coordinated care (especially for individuals with complex medical situations.

– Greater use of online access to communicate with providers and access medical records.

- Enhanced coverage under the Traditional Medical Plan and Select Network Plan Preferred Partnership options

– PCP office visits will be covered at no charge.

– Generic prescription drugs purchased through a network retail pharmacy or through the mail service program will be covered at no charge.

- Enhanced coverage under the Advantage+ health plan Preferred Partnership option

– PCP office visits will be covered at no charge after you meet the annual deductible.

– Generic prescription drugs purchased through a network retail pharmacy or through the mail service program will be covered at no charge after you meet the annual deductible.

– Company contributions to the Health Savings Account are higher than for the standard options.

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.

All inpatient medical treatment must be authorized by the service representative. Emergency hospital admissions must be reported and authorized within 48 hours of the admission.

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 inpatient mental health and substance use disorder treatment must be authorized by the behavioral health service representative. Emergency hospital admissions must be reported and authorized within 48 hours of the admission..

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 coinsurance 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.

Centers of Excellence

Employees covered by this agreement (and eligible dependents) who participate in the Traditional Medical Plan, Select Network Plan, Selections Plus PPO, or Advantage+ health plan may participate voluntarily in the Centers of Excellence program. The program offers a higher level of benefits for certain covered medical procedures (such as cardiac, spine surgery, and hip or knee replacement) at approved Centers of Excellence facilities that specialize in a particular treatment. At a Center of Excellence, eligible expenses will be paid at 100% (after the deductible, where applicable). If participants must travel 75 miles or more from their residence to a Center of Excellence, the plan also offers certain travel benefits.

The Company reserves the right to unilaterally alter, amend, and /or modify any or all terms of this and other voluntary programs at its sole discretion without further bargaining.

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

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

- 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.
- Another covered medical or mental health condition for which erectile dysfunction is a treatable symptom.

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. If you or your covered dependent does not enroll in Medicare when it becomes the primary plan, benefits under this plan will still be reduced in the same manner as if you (or your covered dependent) were enrolled in Medicare.

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.

All inpatient hospital services require preadmission review, except in an emergency.

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 Use Disorder Program

The Boeing mental health and substance use disorder program provides benefits for mental health treatment and substance use disorder 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 use disorder treatment must be determined medically necessary. 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.

The plan also covers medically necessary ABA therapy for the treatment of autism spectrum disorder when received from an ABA provider contracted with the service representative or from an eligible provider, including providers who are licensed or who possess a state-issued or state-sanctioned certification in such therapy, behavior analysts certified by the Behavior Analyst Certification Board ("BACB"), Registered Behavioral Technicians ("RBTs") certified by the BACB or equivalent paraprofessionals who work under the supervision of a licensed provider or a certified behavior analyst.

If the mental health treatment is related to, accompanies, or results from substance use disorder, coverage is provided solely under substance use disorder provisions.

Substance Use Disorder Treatment Coverage The plan covers medically necessary alcoholism treatment and other types of substance use disorder 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 use disorder 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.)

Neurodevelopmental Therapy

The plan covers neurodevelopmental therapy. 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 use disorder 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.
- Qualified providers of applied behavioral analysis (ABA) therapy.
- 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, coinsurance, 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. The plan also covers prescribed over-the-counter tobacco cessation drugs at the same level as other prescription drugs in the same category.

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 Use Disorder Treatment

See Mental Health and Substance Use Disorder 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 kinesiotherapy, 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.

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.

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 (other than medical)—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.

– 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 health condition.
- 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. However, the plan covers prescribed over-the-counter tobacco cessation drugs at the same level as other prescription drugs in the same category.
- 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 or required by law.

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, except when medically necessary to treat a mental health condition (e.g., gender dysphoria).
- 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.

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 and substance use disorder 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 health condition or substance use disorder.

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 Health Condition 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*, fifth edition (DSM-5).

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 Use Disorder 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*, fifth edition (DSM-5).

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 program.
- Mail service program.

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 Express Scripts (the service representative). *,**		
	Network	**Nonnetwork**
Prescription Drug Annual Out-of-Pocket Maximum	$4,000 individual/$8,000 family for network prescription drug expenses	Not applicable
Participating Retail Pharmacy*,**,*** (up to a 34-day supply)		
Generic	Member pays 10%; $5 minimum, $25 maximum	Member pays 10%; $5 minimum, $25 maximum

Traditional Medical Plan Prescription Drug Program Schedule of Benefits The prescription drug program is administered by Express Scripts (the service representative). *,**		
	Network	**Nonnetwork**
Brand-Name Formulary	Member pays 20%; $15 minimum, $75 maximum	Member pays 20%; $15 minimum, $75 maximum
Brand-Name Nonformulary	Member pays 30%; $30 minimum, no maximum	Member pays 30%; $30 minimum, no maximum
Mail Service Program (up to a 90-day supply)		
Generic	$10 copayment	Not covered
Brand-Name Formulary	$40 copayment	Not covered
Brand-Name Nonformulary	$70 copayment	Not covered
* 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; however these expenses will not apply to the prescription drug annual out-of-pocket maximum. ***Prescription drug program will cover emergency use at a nonparticipating pharmacy.		

Retail Pharmacy 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 program covers up to a 34-day supply per prescription or refill.

Coverage for generic contraceptives and single-source contraceptives will be 100%.

The prescription drug program will cover emergency use at a nonparticipating pharmacy as in network.

Mail Service Program

The 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.

The program 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.

Prescription Drug Annual Out-of-Pocket Maximum

A prescription drug out-of-pocket maximum, separate from the medical out-of-pocket maximum, will apply to covered out-of-pocket costs for network prescription drugs. All network prescription drug cost-sharing amounts apply to the prescription drug annual out-of-pocket maximum.

When your prescription drug out-of-pocket expenses (or when your family members' combined prescription drug out-of-pocket expenses) reach the prescription drug annual out-of-pocket maximum, the plan will pay 100% of your covered network prescription drug costs for the rest of that benefit year.

The following expenses do not apply toward the individual or family prescription drug out-of-pocket maximums:

- The cost difference between a brand-name drug and a generic drug that you pay when you (or your physician) request a brand-name drug and a generic is available.
- Prescription services or supplies the plan does not cover.

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 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, except the plan covers prescribed over-the-counter tobacco cessation drugs at the same level as other prescription drugs in the same category.
- 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 Davis Vision (the service representative).	
Services and Supplies	**Benefits**
Eye Examinations	Paid in full after $15 copayment for Davis Vision 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*
* Network providers offer discounts on retail frames, contact lenses, and contact lens examinations (evaluation and fitting); you pay the network provider only the excess over the amounts shown in the schedule above. Optional frames, lens types, and coatings are available from network providers with copayments. 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 Davis Vision Network

Davis Vision features a national network of licensed optometrists and ophthalmologists. These providers have contracted with Davis Vision 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 retail frames, contact lenses, and 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. Optional frames,

lens types, and coatings are available from network providers with copayments. 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 except when replaced under warranty.

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, Davis Vision 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 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.

ADVANTAGE+ HEALTH PLAN SCHEDULE OF BENEFITS

The Advantage+ health plan is available to active employees and their dependents. This section shows general plan features of the Advantage+ health plan, including benefit amounts and other plan information.

Schedule of Benefits

Advantage+ Health Plan Schedule of Benefits The Advantage+ health plan (including mental health and substance use) is administered by Blue Cross and Blue Shield of Illinois (the service representative).		
	Network	**Nonnetwork**
Plan Features	**Member Responsibility**	
Annual Deductible (applies unless otherwise noted)	The annual deductible will be the lowest permitted by federal regulations to maintain a HSA qualified plan. • $1,400 per individual • $2,800 per family of 2 or more Network and nonnetwork expenses apply to the deductible	
Coinsurance (member pays)	10%	40%
Annual Out-of-Pocket Maximum (medical deductible included in medical annual out-of-pocket maximum)	The network annual out-of-pocket maximum will be 2 times the applicable deductible.	The nonnetwork annual out-of-pocket maximum will be 3 times the applicable deductible.
Copayments	You pay the network copayment listed below for routine eye examinations	
Lifetime Maximum Benefit	None	
Ambulance	10%	10% (must meet definition of emergency medical condition); otherwise 40%
Christian Science Practitioner and Sanatorium	10%; limits apply	Same as network provisions
Diagnostic X-Ray and Laboratory Services	10%	40%
Durable Medical Equipment	10%	40%
Emergency Room Treatment		
• Emergency Medical Care	10%	Same as network provisions

Advantage+ Health Plan Schedule of Benefits The Advantage+ health plan (including mental health and substance use) is administered by Blue Cross and Blue Shield of Illinois (the service representative).		
	Network	**Nonnetwork**
Plan Features	**Member Responsibility**	
• Nonemergent Care	40%	40%
Hearing Aids	• 10% 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	• 10% for the first 30 months of Medicare entitlement due to end stage renal disease • Thereafter, Medicare is primary and this plan is secondary	40%
Home Health Care	10%	40%
Hospice Care	• 10%; 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	40%
Skilled Nursing Facility	10%	40%
Hospital	10%	40%
Mental Health Treatment (including eating disorders)	Care is managed by and claims are administered by the behavioral health service representative	
• Covered Inpatient, Residential, or Intensive Outpatient Services	10%	40%
• Covered Outpatient or Partial Hospital Services	10%	40%
Physician (inpatient and outpatient)	10%	40%

Advantage+ Health Plan Schedule of Benefits The Advantage+ health plan (including mental health and substance use) is administered by Blue Cross and Blue Shield of Illinois (the service representative).		
	Network	**Nonnetwork**
Plan Features	**Member Responsibility**	
Prescription Drugs	• Pharmacy benefits are provided through Express Scripts • Quantities and dosages for certain prescription drugs may be limited by general plan provisions, clinically established guidelines, and/or FDA-approved labeling	
• Retail Pharmacy Program	Supply limited to 30 days (for certain preventive medications, annual deductible does not apply)	
Generic drug	10%†	Not covered
Brand formulary drug	20%†	Not covered
Brand nonformulary drug	30%†	Not covered
• Mail-Order Pharmacy Program	Supply limited to 90 days (for certain preventive medications, annual deductible does not apply)	
Generic drug	10%	Not covered
Brand formulary drug	20%	Not covered
Brand nonformulary drug	30%	Not covered
† The plan will cover emergency use at a nonparticipating pharmacy.		
Preventive Care		
• Routine Physical • Routine Pap Tests, Mammograms, Prostate Screenings, and Colorectal Screenings (including colonoscopies) • Routine Hearing Evaluation	No charge (annual deductible does not apply) as recommended by the U.S. Preventive Care Task Force (USPSTF) , the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration (currently the Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care guidelines) in accordance with the Patient Protection and Affordable Care Act	Not covered when received in a network service area

Advantage+ Health Plan Schedule of Benefits The Advantage+ health plan (including mental health and substance use) is administered by Blue Cross and Blue Shield of Illinois (the service representative).		
	Network	**Nonnetwork**
Plan Features	**Member Responsibility**	
Wigs	10%; $500 annual limit for wigs if undergoing chemotherapy or radiation therapy (network and nonnetwork combined)	40%; $500 annual limit for wigs if undergoing chemotherapy or radiation therapy (network and nonnetwork combined)
Tobacco Cessation Treatment	10% (annual deductible does not apply)	Same as network provisions
Spinal and Extremity Manipulations (such as chiropractic care)	• 10% • Limited to 26 visits for spinal and extremity manipulations combined per year (network and nonnetwork combined)	• 40% • Limited to 26 visits for spinal and extremity manipulations combined per year (network and nonnetwork combined)
Substance Use Disorder Treatment	Care is managed by and claims are administered by the behavioral health service representative	
• Covered Inpatient, Partial Hospital, Residential, Intensive Outpatient, or Outpatient Services	10%	40%
TMJ/MPDS Treatment	50%	Same as network provisions
Therapies		
• Neurodevelopmental Therapy	10%	40%
• Occupational, Physical, and Speech Therapy	10%	40%

* 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.

ADVANTAGE+ HEALTH PLAN VISION CARE PROGRAM

The vision care provisions described for the Traditional Medical Plan also apply to the Advantage+ health plan.

Schedule of Benefits

Vision Care Program Schedule of Benefits

The vision care program is administered by Davis Vision (the service representative).	
Services and Supplies	**Benefits**
Eye Examinations	Paid in full after $15 copayment for Davis Vision 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*

* Network providers offer discounts on retail frames, contact lenses, and contact lens examinations (evaluation and fitting); you pay the network provider only the excess over the amounts shown in the schedule above. Optional frames, lens types, and coatings are available from network providers with copayments. Nonnetwork provider charges for lenses, frames, and contact lenses are reimbursed up to the amounts shown in the schedule above; no discount applies.

OTHER MEDICAL PLAN SCHEDULES OF BENEFITS— INFORMATION ONLY

Kaiser Permanente HMO (WA)	
Plan Features	**Member Responsibility**
Annual Deductible	None
Coinsurance (member pays)	No charge after applicable copayments
Annual Out-of-Pocket Maximum	$6,850 per individual; $13,700 per family
Lifetime Maximum Benefit	None
Inpatient Hospital Copayment	$250 copayment per admission
Emergency Room	$75 copayment
Primary Care Office Visit and Urgent Care	$20 copayment per visit
Specialist Office Visit	$25 copayment per visit
Prescription Drugs	
• Participating Pharmacy	$5 copayment generic formulary; $25 copayment brand-name formulary; nonformulary not covered; 30-day supply
• Mail Service Program	$10 copayment generic formulary; $60 copayment brand-name formulary; nonformulary not covered; 90-day supply
Vision	
• Eye Exams	$20 copayment for 1 exam every 12 months
• Frames and Lenses	$140 allowance per pair of lenses/frames or contacts; 2 pairs every 24 consecutive months
Nonnetwork services and supplies are not covered except for emergency care.	

Select Network EPO (WA)	
Plan Features	**Member Responsibility**
Annual Deductible	None
Coinsurance (member pays)	No charge
Annual Out-of-Pocket Maximum	$6,850 per individual; $13,700 per family
Lifetime Maximum Benefit	None
Inpatient Hospital Copayment	$250 copayment per admission
Emergency Room	$75 copayment
Primary Care Office Visit and Urgent Care	$20 copayment per visit
Specialist Office Visit	$25 copayment per visit
Prescription Drugs	
• Participating Pharmacy*	$5 copayment generic formulary; $25 copayment brand-name formulary; $40 copayment brand-name nonformulary; 30-day supply
• Mail Service Program	$10 copayment generic formulary; $40 copayment brand-name formulary; $70 copayment brand-name nonformulary; 90-day supply
Vision	
• Eye Exams	$20 copayment for 1 exam every benefit year
• Frames and Lenses	$50 to $155 limit for lenses; $90 limit for frames; $120 limit for contacts; 2 pairs every 2 benefit years
Referrals to network specialists are not required. Nonnetwork services and supplies are not covered except for emergency care. * The plan will cover emergency use at a nonparticipating pharmacy.	

Kaiser Permanente HMO (CA)	
Plan Features	**Member Responsibility**
Annual Deductible	None
Coinsurance (member pays)	No charge after applicable copayments
Annual Out-of-Pocket Maximum	$1,500 per individual; $3,000 per family
Lifetime Maximum Benefit	None
Inpatient Hospital Copayment	$250 copayment per admission
Emergency Room	$75 copayment
Primary Care Office Visit and Urgent Care	$20 copayment per visit
Specialist Office Visit	$25 copayment per visit
Prescription Drugs	
• Participating Pharmacy	$5 copayment generic formulary; $25 copayment brand-name formulary; $25 copayment nonformulary; 100-day supply
• Mail Service Program	$10 copayment generic formulary; $50 copayment brand-name formulary; $50 copayment nonformulary; 100-day supply
Vision	
• Eye Exams	$20 copayment per visit
• Frames and Lenses	$200 eyewear allowance for lenses/frames or contacts every 24 months
Nonnetwork services and supplies are not covered except for emergency care.	

Selections Plus PPO (OR)		
	Network	**Nonnetwork**
Plan Features	**Member Responsibility**	
Annual Deductible	None	$400 per individual
Coinsurance (member pays)	No charge after applicable copayments	40%; deductible applies
Annual Out-of-Pocket Maximum	$6,850 per individual; $13,700 per family	$2,000 per individual; $4,000 per family
Lifetime Maximum Benefit	None	
Inpatient Hospital Copayment	$250 copayment per admission	40%; deductible applies
Emergency Room		
• Emergency Medical Condition	$75 copayment	$75 copayment
• Nonemergent Care	40% after copayment	40% after copayment; deductible applies
Primary Care Office Visit and Urgent Care	$20 copayment per visit	40%; deductible applies
Specialist Office Visit	$25 copayment per visit	40%; deductible applies
Prescription Drugs		
• Participating Pharmacy	$5 copayment generic formulary; $25 copayment brand-name formulary; $40 copayment brand-name nonformulary; 30-day supply	Not covered*
• Mail Service Program	$10 copayment generic formulary; $40 copayment brand-name formulary; $70 copayment brand-name nonformulary; 90-day supply	Not covered
Vision		
• Eye Exams	$20 copayment for 1 exam every benefit year	$50 allowance
• Frames and Lenses	$50 to $155 limit for lenses; $90 limit for frames; $120 limit for contacts; 2 pairs every 2 benefit years	

Selections Plus PPO (OR)
* The plan will cover emergency use at a nonparticipating pharmacy.

Kaiser Permanente HMO (OR)	
Plan Features	**Member Responsibility**
Annual Deductible	None
Coinsurance (member pays)	No charge after applicable copayments
Annual Out-of-Pocket Maximum	$600 per individual; $1,200 per family
Lifetime Maximum Benefit	None
Inpatient Hospital Copayment	$250 copayment per admission
Emergency Room	$75 copayment
Primary Care Office Visit and Urgent Care	$20 copayment per visit
Specialist Office Visit	$25 copayment per visit
Prescription Drugs	
• Participating Pharmacy	$5 copayment generic formulary; $25 copayment brand-name formulary; $25 copayment nonformulary; 30-day supply
• Mail Service Program	$10 copayment generic formulary; $50 copayment brand-name formulary; $50 copayment nonformulary; 90-day supply
Vision	
• Eye Exams	$20 copayment per visit
• Frames and Lenses	$250 eyewear allowance for lenses/frames or contacts every 24 months
Nonnetwork services and supplies are not covered except for emergency care.	

SelectHealth HMO (UT)	
Plan Features	**Member Responsibility**
Annual Deductible	None
Coinsurance (member pays)	No charge after applicable copayments
Annual Out-of-Pocket Maximum	$6,850 per individual; $13,700 per family
Lifetime Maximum Benefit	None
Inpatient Hospital Copayment	$250 copayment per admission
Emergency Room	$75 copayment
Primary Care Office Visit and Urgent Care	$20 copayment per visit
Specialist Office Visit	$25 copayment per visit
Prescription Drugs	
• Participating Pharmacy	$5 copayment generic formulary; $25 copayment brand-name formulary; $40 copayment nonformulary; 30-day supply
• Mail Service Program	$10 copayment generic formulary; $40 copayment brand-name formulary; $70 copayment nonformulary; 90-day supply
Vision	
• Eye Exams	$25 copayment per visit
• Frames and Lenses	Discounts available through local vendors, depending on the prescription
Nonnetwork services and supplies are not covered except for emergency care.	

Preferred Partnership Option (where available)		
Coverage is the same as the standard plan with the following enhancements:		
Plan Features	**Member Responsibility**	
Traditional Medical Plan	Network	Nonnetwork
Primary Care Office Visit	No charge	40%
Retail Pharmacy Program	No charge for generic	10%; $5 minimum, $25 maximum
Mail Service Program	No charge for generic	Not covered
Select Network Plan	Network	
Primary Care Office Visit	No charge	
Participating Pharmacy	No charge for generic formulary	
Mail Service Program	No charge for generic formulary	
Advantage+ health plan	Network	Nonnetwork
Primary Care Office Visit	No charge after annual deductible is met	40%
Retail Pharmacy Program	No charge for generic after annual deductible is met	Not covered
Mail Service Program	No charge for generic after annual deductible is met	Not covered

HEALTH SAVINGS ACCOUNT

If you enroll in the Advantage+ health plan medical plan, you will have the opportunity to set up a special tax-advantaged bank account, the Health Savings Account (HSA), for paying health care services.

The Company has contracted with a service representative to sponsor and administer your HSA. The service representative will answer questions, process transactions, maintain accounts, provide account information, and perform other account services. The current service representative is HealthEquity.

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

Contributing to Your 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 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 if you confirm your eligibility for the HSA.

The amounts Boeing contributes to your HSA are shown below.

Boeing Annual HSA Contributions		
	Boeing contributes:	
Your coverage level:	Advantage+ health plan standard option	Advantage+ health plan Preferred Partnership option
Employee only	50% of applicable deductible	80% of applicable deductible
Employee + spouse or child(ren)	50% of applicable deductible	80% of applicable deductible
Employee + spouse and child(ren)	50% of applicable deductible	80% of applicable deductible

HSA contributions shall be deposited into the employee's account maintained by the HSA custodian of Boeing's choice on or about January 15 of each year.

If you establish an HSA after the start of the year, the Boeing contribution will be prorated.

Withdrawals and Tax Implications

Money withdrawn from an HSA for qualified health care expenses generally is tax free. Money withdrawn from an HSA for anything other than qualified health care expenses generally is taxable under Federal law as ordinary income and in some cases is subject to a 20% tax penalty.

Important HSA Information

- HealthEquity 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 HealthEquity, 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 of Washington (the service representative).		
	Network	**Nonnetwork***
Plan Features	**Member Responsibility**	
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 (member pays)		
• Class I (diagnostic and preventive services)	No charge(deductible does not apply)	20%
• Class II (restorative services using filling materials, oral surgery, periodontics, and endodontics)	20%	50%
• Class III (restorative services using crowns, inlays, and onlays; prosthodontics)	40%	50%
• Class IV (orthodontia services)	50% (network and nonnetwork combined; deductible does not apply)	
Annual Maximum Benefit (for Classes I, II, and III)**	$2,500 per individual (network and nonnetwork combined)	
Lifetime Maximum Benefit (for Class IV)***	$2,000 per individual (network and nonnetwork combined)	

Preferred Dental Plan Schedule of Benefits The Preferred Dental Plan is administered by Delta Dental of Washington (the service representative).		
	Network	**Nonnetwork***
* If your provider is not a Delta Dental of Washington 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.

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 of Washington and participate in the Delta Dental of Washington preferred provider network in your state.
- Nonnetwork member providers are members of Delta Dental of Washington, but do not participate in the preferred provider network.
- Nonmember providers are not members of Delta Dental of Washington.

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, 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.

Class III Covered Services and Supplies

The plan covers the following Class III services and supplies:

- Prosthodontics, including:

– A cast metal 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.

SCHEDULED DENTAL PLAN SUMMARY

The Scheduled 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.

The Scheduled Dental Plan reimburses you and your covered dependents for necessary dental care received from any licensed dentist based on a schedule of maximum covered charges. Your out-of-pocket cost will vary depending on the type of treatment you receive and, in many cases, on your dentist's charges. This plan is available in all areas of the country.

Annual Deductible

Generally, the annual deductible is the amount you must pay out of your own pocket each benefit year before the plan begins to pay benefits. The deductible applies to most covered services and supplies. The following services and supplies are excluded from the annual deductible:

- Examinations, including specialist examinations and emergency oral exams.
- Fissure sealants.
- Fluoride treatments.
- Prophylaxis (teeth cleaning), including periodontal cleanings.
- X-rays.

This means that the plan begins to pay immediately for these basic dental services. Certain limits apply; see the Scheduled Dental Plan Schedule of Covered Services in this document.

This 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 will be required to pay in any benefit year.

The annual deductibles are shown in the following Scheduled Dental Plan Schedule of Benefits.

Maximum Covered Charges

The plan pays the maximum covered charges listed in the Scheduled Dental Plan Schedule of Covered Services in this document for necessary dental services and supplies. If 2 or more covered services are received at the same time, the plan pays up to the scheduled benefit for each service, unless the schedule has a maximum for a particular combination of services.

In addition, certain other dental treatments may be covered even though they are not listed in the schedule; details are available from the service representative. (See Predetermination of Benefits in this document.)

Scheduled Dental Plan Schedule of Benefits

Scheduled Dental Plan Schedule of Benefits The Scheduled Dental Plan is administered by Delta Dental of Washington (the service representative).	
Annual Deductible (based on the January 1 – December 31 benefit year)	$25 per individual; $75 per family of 3 or more, but not more than $25 per individual
• Diagnostic and preventive care	• Plan pays up to the amounts listed in Scheduled Dental Plan Schedule of Covered Services • Annual deductible does not apply to examinations, X-rays, cleaning, fluoride treatment, and fissure sealants
• Minor and major restorations • Endodontics and periodontics • Prosthodontics • Oral surgery • Orthodontia	• Plan pays up to the amounts listed in Scheduled Dental Plan Schedule of Covered Services • Annual deductible applies
Annual Maximum Benefit (generally for all services and supplies, except orthodontia)*	$2,000 per individual
Lifetime Maximum Benefit (for orthodontia)**	$2,000 per individual

* 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.

Scheduled Dental Plan Schedule of Covered Services

Scheduled Dental Plan Schedule of Covered Services The Scheduled Dental Plan is administered by Delta Dental of Washington (the service representative).		
American Dental Association Code	**Service or Supply**	**Maximum Allowable Fee ($)**
	Diagnostic	
	Examinations (limited to 1 per course of treatment)	
D0150	Comprehensive oral evaluation	48
D0120	Periodic oral exam (limited to twice in a 1-year period)	26
D0140	Limited oral evaluation	37
	Radiographs (X-rays)	
	Complete Mouth X-rays (limited to once in a 5-year period)	
D0210	Intraoral (including bitewings)	69
D0330	Panoramic (limited to once in a 36-month period)	53
	Intraoral Periapical	
D0220	Single, first film	14
D0230	Each additional film	11
	Bitewings (limited to once in a 12-month period)	
D0270	Single film	13
D0272	2 films	21
D0274	4 films	32
	Preventive	
	Prophylaxis (limited to once in a 4-month period)	
D1110	Adult	58
D1120	Child	37
	Fluoride Treatment (limited to once in a 6-month period)	
D1206	Topical application of fluoride varnish	21
D1208	Topical application of fluoride excluding varnish	21
	Fissure Sealants (to age 16)	
D1351	Topical application of fissure sealants (per tooth)	26
	Minor Restorations	
	Amalgam Restorations	

Scheduled Dental Plan Schedule of Covered Services The Scheduled Dental Plan is administered by Delta Dental of Washington (the service representative).		
American Dental Association Code	**Service or Supply**	**Maximum Allowable Fee ($)**
D2140	Primary or permanent—1 surface	58
D2150	Primary or permanent—2 surfaces	74
D2160	Primary or permanent—3 surfaces	95
D2161	Permanent—4 or more surfaces	116
D2951	Pin Retention—per tooth, in addition to restoration	16
	Other Minor Restorations	
D2330	Resin—1 surface anterior	69
D2331	Resin—2 surfaces anterior	90
D2332	Resin—3 surfaces anterior	116
D2335	Resin—4 or more surfaces anterior	127
D2391	Resin-based composite—1 surface posterior	74
D2392	Resin-based composite—2 surfaces posterior	100
D2393	Resin-based composite—3 surfaces posterior	127
	Major Restorations	
	Inlays and Onlays	
D2510	Metallic inlay—1 surface	217
D2520	Metallic inlay—2 surfaces	275
D2530	Metallic inlay—3 surfaces	317
D2542	Metallic onlay—2 surfaces	379
D2543	Metallic onlay—3 surfaces	412
D2544	Metallic onlay—4 or more surfaces	412
D2910	Recement or rebond of inlay, onlay, veneer, or partial coverage restoration	32
	Crowns	
D2720	Resin with high noble metal	380
D2721	Resin with predominantly metal	380
D2722	Resin with noble metal	380
D2740	Porcelain/ceramic substrate	380
D2750	Porcelain fused to high noble metal	380
D2751	Porcelain to predominantly base metal	380
D2752	Porcelain fused to noble metal	380
D2790	Full cast high noble metal	380
D2791	Full cast predominantly base metal	380
D2792	Full cast noble metal	380

Scheduled Dental Plan Schedule of Covered Services The Scheduled Dental Plan is administered by Delta Dental of Washington (the service representative).		
American Dental Association Code	**Service or Supply**	**Maximum Allowable Fee ($)**
D2782	Crown ¾ cast noble metal	380
D2930/D2931	Stainless steel—primary/permanent tooth	85
D2799	Provisional crown	63
D2950	Crown buildup, including any pins	116
D2920	Recement or rebond crown	42
	Endodontics	
D3220	Therapeutic pulpotomy (excluding final restoration)	69
	Root Canal Therapy (includes treatment plan, clinical procedures, and follow-up care; excludes final restoration)	
D3310	Anterior	312
D3320	Bicuspid	412
D3330	Molar	512
D3410	Apicoectomy/periradicular-anterior (performed as a separate surgical procedure)	412
	Periodontics	
	Nonsurgical Services	
D0180	Comprehensive periodontal evaluation	74
D4910	Periodontal maintenance (limited to once in a 4-month period)	79
D9951	Occlusal adjustment (limited)	106
D9952	Occlusal adjustment (complete)	306
D4341	Periodontal scaling and/or root planing (4+ teeth per quadrant)	95
	Surgical Services	
D4210	Gingivectomy (4+ teeth per quadrant)	291
D4260	Osseous surgery (including elevation of a full thickness flap and closure)—4 or more contiguous teeth or tooth bounded spaces per quadrant	644
D4277	Free soft tissue graft—first tooth	417
D7340	Vestibuloplasty—ridge extension (secondary epithelialization)	349
	Prosthodontics	
	Dentures (includes 6 months post-delivery care)	
D5110/D5120	Complete upper or lower	481

Scheduled Dental Plan Schedule of Covered Services The Scheduled Dental Plan is administered by Delta Dental of Washington (the service representative).		
American Dental Association Code	**Service or Supply**	**Maximum Allowable Fee ($)**
D5130/D5140	Immediate upper or lower	528
D5211/D5212	Partial upper or lower resin base (including any conventional clasps and rests)	317
D5213/D5214	Partial upper or lower, predominantly cast frame with resin base (including any conventional clasps and rests)	581
	Related Denture Services	
D5410–D5422	Denture adjustment (complete or partial)	34
D5520	Replace missing or broken tooth complete denture	48
D5710–D5721	Rebase denture (complete or partial)	148
D5730–D5741	Reline denture—(complete or partial) chairside	79
D5750–D5761	Reline denture—(complete or partial) lab	148
	Bridgework	
D6240–D6242	Pontic—porcelain fused to high noble metal, predominantly base metal, and noble metal	370
D6250–D6252	Pontic—resin with high noble metal, predominantly base metal, and noble metal	370
D6930	Recement or rebond fixed partial denture	63
	Oral Surgery	
	Extractions (includes local anesthesia and routine postoperative care)	
D7140	Extraction, erupted tooth or exposed root	63
D7210	Surgical removal of erupted tooth	127
D7220	Impacted tooth—soft tissue	143
D7230	Impacted tooth—partially bony	185
D7240	Impacted tooth—completely bony	227
D7250	Surgical removal of residual tooth roots	132
	Related Oral Surgical Procedures	
D7310	Alveoplasty—in conjunction with extractions, 4 or more teeth	106
D7510	Incision and drainage of abscess—intraoral soft tissue	85
D7960	Frenectomy (separate procedure)	190
	General Anesthesia (not covered when provided at a hospital)	
D9223	Deep sedation/general anesthesia—each 15-minute increment	93

Scheduled Dental Plan Schedule of Covered Services The Scheduled Dental Plan is administered by Delta Dental of Washington (the service representative).		
American Dental Association Code	**Service or Supply**	**Maximum Allowable Fee ($)**
	Orthodontia (coverage for employees and dependents)	
	50% of covered charges to a lifetime maximum benefit of $2,000 per individual	

In addition to the limits shown in the schedule above, the plan also limits the following services and supplies:

- Replacement of dentures and bridgework is covered once in a 5-year period if it is unserviceable and cannot be made serviceable.
- Replacement of temporary denture or bridgework with permanent denture or bridgework is covered only if necessary and occurs within 12 months from the date the temporary denture or bridgework is installed.

Fissure sealants are covered to age 16 only for permanent molars with chewing surfaces intact, no caries (decay), and no restorations. Repair or replacement of a fissure sealant within 3 years is considered part of the original service.

Predetermination of Benefits

Before you receive expensive dental treatment or services and supplies not listed in the Scheduled Dental Plan Schedule of Covered Services, you or your dentist should request a predetermination of benefits under the plan. This is a review by the service representative of your dentist's description of planned treatment and expected charges, including charges for related services.

The service representative will tell you in advance which procedures the plan will cover, the amount that the plan will pay toward treatment, and your out-of-pocket costs. The amount covered will be consistent with the allowances listed in the Scheduled Dental Plan Schedule of Covered Services.

Scheduled Dental Plan Exclusions

The Scheduled Dental Plan does not cover the following services or supplies:

- Anesthetics, administration of anesthetics, or anesthetic supplies or drugs, except general anesthesia when medically necessary.
- Charges that would not have been made if no dental plan existed, or charges that you or your dependents are not required to pay.
- Costs that exceed the allowances listed in the Scheduled Dental Plan Schedule of Covered Services or the usual and customary fee as determined by the service representative.
- Experimental services or supplies (or related complications) 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.

- Fees for completing claim forms.
- Fees for missed appointments.
- Fees that are not reasonable for the services performed.
- Injuries or conditions covered under a workers' compensation law.
- Myofascial pain dysfunction syndrome.
- Orthodontia treatment, including correction or prevention of malocclusion, except as specifically provided for under the plan.
- Periodontal splinting and bridgework.
- Procedures (including personalization or characterization of dentures) primarily or partly for cosmetic purposes.
- Replacement of a lost or stolen prosthetic appliance or an appliance damaged by abuse, misuse, or neglect.
- Services or supplies received because of past or present service in the armed forces of a government.
- Services or supplies received while the patient is not covered under the plan.
- Services or supplies that are paid or provided under government law. (However, if the government, as an employer, provides benefits to its employees, dental coverage will not be excluded and will be subject to coordination of benefits.)
- Temporomandibular joint treatment.
- Treatment by a professional other than a dentist or licensed dental hygienist under the supervision and direction of the dentist.
- Treatment of an injury or illness that is not necessary or is not recommended or approved by the attending dentist.

How Dental Coverage May Be Extended

The plan generally does not cover services and supplies that you receive while you are not covered under the plan. However, the plan will cover certain prosthetic devices and crowns described below:

- Prosthetic device (including abutment crowns of a partial denture) if the impressions are taken while you are covered and the device is delivered and installed within 2 months after your coverage ends.
- Crown that is required for restoring 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 placed within 2 months after your coverage ends.

DELTACARE DENTAL PLAN DESCRIPTION OF BENEFITS

The DeltaCare Dental Plan is administered by Delta Dental of Washington (the service representative).	
Participating Providers	
• Necessary Care	You select a participating provider to supply necessary dental care for you and your covered dependents
• Orthodontic Care	Orthodontic care may be obtained from any licensed dentist
Payment Levels	
• Necessary Care	Covered dental services are provided at no cost to you and your covered dependents
• Optional Treatment	You are responsible for charges above the cost of standard covered services
• Orthodontic Care	The plan pays 50% of covered charges for orthodontic services
• Emergency Care	The plan pays up to $50 of reasonable charges for out-of-area emergency services and supplies
Lifetime Maximum Benefits	
• Necessary Care	No lifetime maximum applies
• Orthodontic Care	$2,000 per individual

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 of Company-sponsored coordinated care plans, HMO, and EPO plans vary by plan.

Dental Plans

Benefits payable under the Company-sponsored dental plans take 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 plans pay first when dental expenses performed by a dentist also are covered by any medical plan sponsored by the Company.

The dental plans pay 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, the 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 the plan is injured by another party who is legally liable for the medical or dental bills or disability income, he or she may request the 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 the 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 the 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. The 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.

Long-Term Disability Coverage

Long-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, short-term disability, and basic long-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 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.
- 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, basic long-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, basic long-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.

Servicemember Family Leave and Continuation Coverage

If you take a leave of absence to care for a family member injured in the line of military duty (Servicemember Family Leave) your coverage will continue for 24 months, provided this leave continues in accordance with the Family and Medical Leave Act. The first 6 months of coverage are provided at active employee rates, with the remaining 18 months at 100% of the total cost of coverage.

Coverage continuation during the first six months of Servicemember Family Leave is not considered COBRA coverage. However, your COBRA continuation period runs concurrently with the last 18 months of your Servicemember Family Leave continuation period.

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.