Health Care Plans

Summary Plan Description
2002 Edition/Union-Represented Employees SPEEA WTPU

The summary plan description (SPD) for this Plan is this booklet and any summaries of material modifications (Updates). Updates are issued if the Company adds to or changes benefits in the Plan after the SPD is published. The Updates, if any, are incorporated at the end of this booklet.

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

This booklet describes the health care benefit plans that may be available to you and your dependents if you are an eligible employee of The Boeing Company who is represented by the Society of Professional Engineering Employees in Aerospace Wichita Technical and Professional Unit.

The provisions of each plan are effective January 1, 2002.

The plans are designed to protect you against large out-of-pocket health care expenses. In many cases, you will have a choice among medical and/or dental plans available in your area.

The eligibility and termination provisions for the coordinated care plans, Traditional Medical Plan, Preferred Dental Plan, Prepaid Dental Plan, and Scheduled Dental Plan are explained in this booklet. Also described are the benefits and exclusions for the Traditional Medical Plan, Preferred Dental Plan, and Scheduled Dental Plan. Benefits and exclusions for the coordinated care plans and Prepaid Dental Plan are described in separate booklets available from each plan.

Medical Plans

You can choose between two types of medical plans: the Traditional Medical Plan and a coordinated care plan.

Both types of medical plans offer comprehensive coverage for most medically necessary services and supplies, including prescription drugs, vision care services and supplies, and mental health treatment. Certain preventive care also is covered. Each plan uses networks of health care professionals and facilities to deliver care.

Generally, the coordinated care plans ask you to select one of their network providers as your primary care provider. You may select one primary care provider for your entire family or a different primary care provider for each family member.

The Traditional Medical Plan and coordinated care plans allow you to obtain care outside their networks of health care providers and receive a lower level of plan benefits.

Employee contributions are required for medical coverage, as described beginning on page 19.

Dental Plans

You can choose among three dental plans: the Preferred Dental Plan, Prepaid Dental Plan, and Scheduled Dental Plan.

Each plan covers most necessary and appropriate dental care, including specialty care. Under the Preferred Dental Plan, you may receive care from any licensed dentist. However, you will receive a higher level of benefits when you obtain treatment from a network dentist. Under the Prepaid Dental Plan, you choose a dentist for you and your family from a list of those participating in the plan; the plan covers the cost of most dental care received through your selected dentist. The Scheduled Dental Plan allows you and your family to receive care from any licensed dentist. You share the cost for all covered dental care, based on the type of care you receive.

The Company pays the full cost of dental coverage if you are regularly scheduled to work 17 or more hours each week.
General Plan Provisions

Please read this material carefully and share it with your family. If you have questions, contact the Boeing Service Center for Health and Welfare Plans at the telephone numbers listed in Exhibit 10 on page 82.

This booklet describes several types of medical and dental benefit options that may be available to certain employees of The Boeing Company and their eligible dependents. These benefit options generally are referred to as “plans” in this booklet. Although The Boeing Company (“the Company”) fully intends to continue the plans, it reserves the right to change, modify, amend, or terminate the plans at any time.

The benefits described in this booklet are provided under The Boeing Company Employee Health Benefit Plan (Plan 626), which is referred to in this booklet as “the Plan.” The Plan includes medical and dental benefit options for certain union-represented employees of The Boeing Company as well as other groups of Boeing employees. The Plan may be funded through The Boeing Company VEBA Master Trust.

Benefits payable under the Plan are limited to the benefits specified by the Plan. The Plan Administrator, Boeing Service Center for Health and Welfare Plans, and service representatives that make benefit payments administer the Plan strictly in accordance with its provisions. The Plan Administrator and service representatives have the right to recover overpayments, regardless of the cause, nature, or source of the overpayments.

The Company authorizes the Boeing Service Center to administer the Plan and interpret its terms. The Company authorizes the claim administrators, coordinated care plans, and Prepaid Dental Plan to interpret the Plan and to decide claim appeals. The Employee Benefit Plans Committee is authorized to decide eligibility appeals. Participants’ appeal rights and the responsibilities of the Boeing Service Center, service representatives, and Plan Administrator are specified in the Plan.

This booklet is the Plan document and summary plan description for the Traditional Medical Plan, Preferred Dental Plan, and Scheduled Dental Plan. This booklet and the insurance contracts are the Plan document for the coordinated care plans and Prepaid Dental Plan. The summary plan description is this booklet and the coverage-specific brochures issued by the coordinated care plans and Prepaid Dental Plan.
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Eligibility and Enrollment

Eligible Employees

You are eligible for coverage under the medical and dental plans described in this booklet if you are an employee of The Boeing Company who is represented by the union listed on page 1, are regularly scheduled to work 17 or more hours each week, and are on the active payroll and paid through the Company Payroll Department.

You are not eligible for coverage under these plans if you are working in a capacity that, at the sole discretion of the Plan Administrator, is considered as contract labor or independent contracting.

Eligible Dependents

Your eligible dependents may be covered under the medical and dental plans if you are covered as an employee. Eligible dependents include your legal spouse and unmarried children (natural children, adopted children, children legally placed with you for adoption, and stepchildren) who are under age 19.

You also may request coverage for the following dependents:

- Your common-law spouse if your relationship meets the common-law requirements for the state in which you entered into the common-law relationship.
- Your same-gender domestic partner if you and your domestic partner meet all of the following requirements. You and your partner are
  - Of the same gender.
  - Eighteen years of age or older.
  - Financially interdependent and share the same residence.
  - Not married to or legally separated from any other person or involved in another same-gender domestic partner relationship.
  - Not blood relatives to a degree of closeness that would prohibit marriage.

An eligible same-gender domestic partner is considered a spouse for the purpose of the plans described in this booklet. More information about same-gender domestic partner eligibility and coverage is available on the Boeing Compensation & Benefits web site (http://www.boeing.com/compensation/).

- The unmarried children of your eligible same-gender domestic partner who are under age 19. The eligible children of your same-gender domestic partner are considered stepchildren for the purpose of the plans described in this booklet.
- Other children, as follows, who are under age 19, unmarried, dependent on you for principal support (as defined, beginning on page 80), and living with you:
  - 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 have a pending application for legal custody or guardianship.

Unmarried children may continue to be eligible from age 19 through age 24 if they are attending school regularly or are dependent on you for principal support (as defined, beginning on page 80). Annual certification must be completed to continue coverage for dependent children age 19 through age 24.
A disabled child age 25 or older may continue to be eligible (or enrolled if you are a newly eligible employee) if he or she is incapable of self-support as a result of any mental or physical condition that began before age 25. The child must be unmarried and dependent on you for principal support (as defined, beginning on page 80). Coverage may continue under the medical and dental plans for the duration of the incapacity as long as you continue to be eligible under the plans and the child continues to meet these eligibility requirements.

In accordance with federal law, the Company also provides medical and dental coverage to certain 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. (A description of QMCSO procedures begins on page 72.)

Special applications for coverage are required for a disabled dependent child age 25 or older. Documentation also is required to request coverage for a child named in a QMCSO or for a child for whom you have legal custody or guardianship or for a same-gender domestic partner. See “Other Applications,” on page 18.

**Other Boeing Coverage**

No person may be covered both as an employee (active or retired) and as a dependent under any type of plan offered by The Boeing Company. If you and your spouse both are Boeing employees, you generally cannot cover your spouse on your medical and dental plans, and your spouse cannot cover you. Each of you must choose your own plans. However, if your spouse is a part-time Boeing employee who has waived medical and dental coverage, your spouse and other dependents may be covered under your plans as long as they meet the eligibility requirements. If your spouse is an employee of a wholly owned subsidiary of The Boeing Company, your spouse may waive medical and dental coverage under the subsidiary plans and enroll as a dependent in your medical and dental plans. In addition, special rules may apply if you are a union-represented employee married to a nonunion employee; contact the Boeing Service Center for more details. If your spouse is a retired Boeing employee (including a retired employee of a premerger or subsidiary company) who has waived medical coverage, your spouse may be covered under your active plans.

If you and your spouse both are Boeing employees and have dependent children, you may elect medical and dental coverage for your eligible children under one parent’s plans. As an alternative, you may elect medical coverage for your eligible children under one 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). Once enrolled under one parent’s plans, eligible children may transfer to the other parent’s plans only during an authorized enrollment period or because of a qualified change in status. (See pages 16 and 17, respectively.)

If you and another Boeing employee marry after your coverages become effective, special provisions apply. If you are covered under different medical and dental plans and you want to be covered under the same plan, you or your spouse has 60 days from the date of marriage to change coverage, as described in “Changes in Status,” beginning on page 17. The person who elects to change coverage must meet the eligibility requirements of the plan to which he or she is applying. You must elect coverage for all children under the medical plan of one spouse and the dental plan of one spouse within 60 days after you marry. The same provisions apply if you enter into a same-gender domestic partner relationship.
Choice of Plans

You may enroll in any one of the eligible Company-sponsored plans available in your location. The enrollment worksheet included in your enrollment kit lists the plans in which you are eligible to enroll.

Medical Plans

You can choose between two types of medical plans: the Traditional Medical Plan and a coordinated care plan. (Note: Some coordinated care plans do not offer same-gender domestic partner coverage. Call the Boeing Service Center for more information.)

The plans feature networks of health care providers. All the plans cover a wide range of medical services and supplies, including prescription drugs, vision care, and mental health treatment. The types of plans differ in how you access care and how benefits are paid. Exhibit 1, beginning on page 12, summarizes basic provider and payment information for the two types of plans.

Coverage of dependents living in other areas, including students living away during the school year, varies by plan. Contact the plans for more benefit information.

Coordinated Care Plans

Under a coordinated care plan, you choose a primary care provider from the network for yourself and your dependents. You may have a single primary care provider for the entire family or a different provider for each individual. The selected providers will coordinate care and refer you and your dependents to specialists as necessary.

When you and your dependents use a primary care provider to coordinate care, you pay a $5 copayment for each office visit. The plan pays 100 percent of most other covered services. There is no annual deductible for treatment provided or coordinated by your primary care provider.

You and your dependents also may use providers outside the plan’s network (called nonnetwork providers) or use network providers without primary care provider coordination or referral. However, unless it is an emergency, your benefit coverage will be lower. You will be required to pay a $400 annual deductible for each person. After the deductible is paid, the plan covers 60 percent of the usual and customary amount for most covered services.

If you transfer into a coordinated care plan from any other Company-sponsored medical plan, your lifetime maximum and benefit limits will be reduced by benefits paid under your prior plan (except to the extent benefits have been reinstated previously under the provisions of that plan).

Traditional Medical Plan

Under the Traditional Medical Plan, you will receive higher benefits (the network level) if you use a network provider. Network providers are available nationwide in nearly all employee locations, including all areas of Kansas.

For most expenses, an annual deductible applies whether you see network or nonnetwork providers. The individual deductible is $125 or 0.2 percent of your base annual wage, whichever is greater. (For example, if your base annual wage is $30,000, 0.2 percent of your pay is $60; your deductible would be $125.) The deductible maximum for three or more family members is $375 or 0.6 percent of your base annual wage, whichever is greater.

After you have paid the deductible, the plan pays 100 percent of most covered network services and supplies. Some services and supplies are paid at other percentages. For example, treatment of temporomandibular joint dysfunction and certain mental health and substance abuse care are paid at 50 percent.

If you or your dependents use nonnetwork providers, the plan pays 60 percent of the usual and customary amount for most covered services after you satisfy the annual deductible.

If you are in a U.S. location where there is no network provider qualified to provide medically necessary services, or outside the United States, you will receive the network level of benefits. To find...
out if you are in a location that has network providers, call the Traditional Medical Plan service representative at the telephone number listed in Exhibit 10 on page 82.

If you transfer into the Traditional Medical Plan from any other Company-sponsored medical plan, your lifetime maximum and benefit limits will be reduced by benefits paid under your prior plan (except to the extent benefits have been reinstated previously under the provisions of that plan).

**Dental Plans**

You have a choice among three dental plans: the Preferred Dental Plan, the Prepaid Dental Plan, and the Scheduled Dental Plan.

The plans generally cover the same kinds of services (diagnostic and preventive care, basic care, major care, and orthodontia) but differ in how you access care and how benefits are paid. Exhibit 2, on page 15, summarizes the three types of dental plans.

**Preferred Dental Plan**

Under the Preferred Dental Plan, you and your dependents have the opportunity to receive your dental care from any licensed dentist on a fee-for-service basis. However, you will receive a higher level of benefits if you obtain care from a network dentist.

The plan pays a percentage of the cost for covered services. The amount the plan pays depends on the service you receive and whether you use a network dentist, as follows:

- Diagnostic and preventive care: 90 percent network; 70 percent nonnetwork.
- Basic care (e.g., minor restorations, oral surgery, and gum treatments): 80 percent network; 70 percent nonnetwork.
- Major restorative care (e.g., crowns and bridges): 60 percent network; 50 percent nonnetwork.
- Orthodontia care: 60 percent network or nonnetwork.

If you transfer into the Preferred Dental Plan from any other Company-sponsored dental plan, your orthodontia lifetime maximum will be reduced by orthodontia benefits paid under your prior plan.

**Prepaid Dental Plan**

The Prepaid Dental Plan covers most dental care at no cost to you when received from your dental primary care provider. Under this plan, you select one dentist from the network as the primary care provider for you and your family. The dental primary care provider then will provide most care for you and your dependents and refer you to network specialists when necessary. Orthodontia care may be received from any licensed dentist and is paid at a constant 50 percent.

The plan does not cover care received outside the plan’s network or care that is not authorized by your dental primary care provider, except for limited emergency care.

If you transfer into the Prepaid Dental Plan from any other Company-sponsored dental plan, your orthodontia lifetime maximum will be reduced by orthodontia benefits paid under your prior plan.

**Scheduled Dental Plan**

Under the Scheduled Dental Plan, you and your dependents have the opportunity to receive care from any licensed provider on a fee-for-service basis. Your share of the cost will vary depending on the type of treatment you receive.

For most services, an annual deductible applies. The individual deductible is $25. The deductible maximum for three or more family members is $75. The annual deductible does not apply to covered diagnostic and preventive care services.

After you have paid the deductible, the plan pays the usual and customary charges for most covered services and supplies, up to the maximum scheduled amount. Orthodontia care is paid at 50 percent of usual and customary charges, up to the maximum scheduled amount.

If you transfer into the Scheduled Dental Plan from any other Company-sponsored dental plan, your orthodontia lifetime maximum will be reduced by orthodontia benefits paid under your prior plan.
### Provider Provisions

<table>
<thead>
<tr>
<th>Provider Choice</th>
<th>Coordinated Care Plans</th>
<th>Traditional Medical Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Choose a network primary care provider to coordinate your care and receive the plan's maximum coverage.</td>
<td>- Use any network provider and receive the plan’s maximum coverage.</td>
</tr>
<tr>
<td></td>
<td>- You may use providers outside the network or network providers without primary care provider coordination; however, benefits will be paid at the lower nonnetwork level.</td>
<td>- You may use providers outside the network; however, benefits will be paid at the lower nonnetwork level.</td>
</tr>
<tr>
<td>Provider Referrals</td>
<td>- Have your network primary care provider coordinate referrals and receive the plan’s maximum coverage.</td>
<td>- You do not need a referral to receive care; you may go directly to providers of your choice, except for mental health and substance abuse treatment.</td>
</tr>
<tr>
<td></td>
<td>- Most plans allow you to go to certain types of network providers without a referral (e.g., OB/GYNs, optometrists) and receive the plan’s maximum coverage; otherwise, self-referrals are paid at the plan’s lower nonnetwork level.</td>
<td>- Benefit levels are higher when you use network providers.</td>
</tr>
</tbody>
</table>

---

**Exhibit 1**

### Comparison of Medical Plan Types

This summary compares basic provider and payment information for the two types of medical plans. Some benefits for specific coordinated care plans will vary from this comparison. You may request a more detailed comparison showing covered services for the medical plans available in your area by accessing the Your Benefits Resources web site or calling the Boeing Service Center for Health and Welfare Plans. For information about specific covered services, contact the plans in your area. (Exhibit 10, beginning on page 82, provides information about how to access the Your Benefits Resources web site and how to contact the Boeing Service Center and the plans.)
### Payment Provisions

<table>
<thead>
<tr>
<th></th>
<th>Coordinated Care Plans</th>
<th>Traditional Medical Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network Providers*</td>
<td>Nonnetwork Providers</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per person</td>
<td>Not applicable</td>
<td>$400</td>
</tr>
<tr>
<td>3 or more persons</td>
<td>Not applicable</td>
<td>No family maximum</td>
</tr>
<tr>
<td><strong>Office Visits</strong></td>
<td>$5 copayment, no deductible</td>
<td>60% ** after deductible</td>
</tr>
<tr>
<td><strong>Most Other Covered Services</strong></td>
<td>100%, no deductible</td>
<td>60% ** after deductible</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Expense Limit</strong></td>
<td>$2,000 (network and nonnetwork combined)</td>
<td>$4,000 (network and nonnetwork combined)</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td>Varies by plan</td>
<td>Generally not covered</td>
</tr>
<tr>
<td>Mail service program</td>
<td>May be available</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Preventive Care</strong> (adult routine physical exams, well-baby care, tests, and screenings)</td>
<td>Varies by plan</td>
<td>Varies by plan</td>
</tr>
<tr>
<td><strong>Vision Care Exam</strong></td>
<td>Varies by plan</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Lenses and frames</strong></td>
<td>Varies by plan</td>
<td>Varies by plan</td>
</tr>
<tr>
<td><strong>Lifetime Maximum Benefit</strong></td>
<td>$1.25 million per person (network and nonnetwork combined)</td>
<td>$1.25 million per person (network and nonnetwork combined)</td>
</tr>
</tbody>
</table>

* Some benefits for specific plans will vary from this comparison.
* The benefit for network providers generally applies only when your care is provided by or coordinated through your primary care provider.
* The nonnetwork payment level is based on the usual and customary charge for a specific service in the geographic area where you are treated.
† Mental health and substance abuse services may have different payment provisions.
†† The annual deductible does not apply.
Location
Generally, you must live or work within the service area of a coordinated care plan, the Preferred Dental Plan, or the Prepaid Dental Plan to enroll in these plans. Under special circumstances, you may request enrollment in a coordinated care plan, the Preferred Dental Plan, or the Prepaid Dental Plan regardless of your, or your dependents’, area of residence or work; coverage is subject to specific application to, and approval by, the Company.

For More Information
Summary comparisons of medical and dental plan options in your area, as well as provider directories, are available through the Your Benefits Resources web site and on request from the Boeing Service Center for Health and Welfare Plans. (See page 16 for information about contacting the Boeing Service Center and accessing the web site.) In addition, you may request from a coordinated care plan or the Prepaid Dental Plan information about specific covered services, including required copayments, the nature of the services provided, conditions under which you and your family are eligible to receive such services, circumstances under which services may be denied, procedures to follow to obtain services, and procedures for a review when services are denied.

How to Enroll
If you are a newly eligible employee, you will receive an enrollment kit containing the following:

• An enrollment worksheet that shows your available health and welfare plan options, coverage levels, and costs.

• An enrollment guide that explains how to enroll or access plan information using the Your Benefits Resources web site or an automated phone system. The guide shows how you can get information such as comparisons of covered services for medical and dental plans and lists of network doctors, dentists, and other health care providers and facilities in your area.

To enroll, you will need Social Security numbers for yourself and your eligible dependents and birth dates for your eligible dependents. Once you have completed your enrollment worksheet, you can enroll using the Your Benefits Resources web site or by calling the Boeing Service Center automated phone system (as described on page 16).

If you enroll in one of the coordinated care plans, you will need the identification number for the primary care provider or facility you select for you and each of your eligible dependents. Identification numbers are listed in the provider directories available on line through the Your Benefits Resources web site and on request through the Boeing Service Center. (See page 16 for information about how to access the web site or contact the Boeing Service Center.) If a plan does not use identification numbers for its providers, you will need to supply your provider’s name. You will be asked if the family member is one of the primary care provider’s current patients. Remember, each family member can have a different primary care provider.

If you enroll in the Prepaid Dental Plan, you will need the identification number for the dental primary care provider you select for you and your family. Identification numbers are listed in the dental plan provider directories available on line through the Your Benefits Resources web site and on request through the Boeing Service Center.

You will need to provide information about your spouse’s employment and health care coverage. Your enrollment guide provides instructions on how to enroll. If you do not enroll by the date indicated on your enrollment worksheet, you automatically will have medical coverage under the Traditional Medical Plan and dental coverage under the Scheduled Dental Plan for yourself only. If employee contributions are required, your contributions will be deducted from your pay on a pretax basis. You will not be able to change your medical and dental coverage until the next annual enrollment period unless you have a qualified change in status, as described, beginning on page 17.
## Exhibit 2

### Comparison of Dental Plan Types

This summary compares the three types of dental plans. Some benefits for specific plans will vary from this comparison. You may request a more detailed comparison showing covered services for the dental plans available in your area by accessing the Your Benefits Resources web site or calling the Boeing Service Center for Health and Welfare Plans. For information about specific covered services, contact the plans in your area. (Exhibit 10, beginning on page 82, provides information about how to access the Your Benefits Resources web site and how to contact the Boeing Service Center and the plans.)

<table>
<thead>
<tr>
<th>Provider Choice</th>
<th>Preferred Dental Plan</th>
<th>Prepaid Dental Plan</th>
<th>Scheduled Dental Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you are in a network service area, use any network provider to receive the maximum coverage available under the plan or use any nonnetwork dentist and receive the nonnetwork benefit level.</td>
<td>Choose a network primary care provider for yourself and your family; that dentist provides most services for you and your dependents and refers you to network specialists when necessary. Use any licensed dentist for orthodontia care.</td>
<td>Use any licensed dentist or other plan-approved licensed professional.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Annual Deductible</th>
<th>Network</th>
<th>Nonnetwork*</th>
<th>Network</th>
<th>Nonnetwork</th>
<th>Network</th>
<th>Nonnetwork</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per person</td>
<td>Pay no annual deductible</td>
<td>Pay no annual deductible</td>
<td>Not applicable</td>
<td>$25; annual deductible does not apply to diagnostic and preventive care services</td>
<td>$25; annual deductible does not apply to diagnostic and preventive care services</td>
<td></td>
</tr>
<tr>
<td>3 or more persons</td>
<td>Pay no annual deductible</td>
<td>Pay no annual deductible</td>
<td>Not applicable</td>
<td>$75; annual deductible does not apply to diagnostic and preventive care services</td>
<td>$75; annual deductible does not apply to diagnostic and preventive care services</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payment Levels</th>
<th>Network</th>
<th>Nonnetwork*</th>
<th>Network</th>
<th>Nonnetwork</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and preventive care</td>
<td>90%</td>
<td>70%</td>
<td>100%</td>
<td>No coverage, except limited coverage for emergencies</td>
</tr>
<tr>
<td>Fillings, oral surgery, and periodontic, endodontic, and pedodontic care</td>
<td>80%</td>
<td>70%</td>
<td>100%</td>
<td>No coverage, except limited coverage for emergencies</td>
</tr>
<tr>
<td>Crowns, dentures, partials, and bridges</td>
<td>60%</td>
<td>50%</td>
<td>100%</td>
<td>No coverage, except limited coverage for emergencies</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>60%</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Annual Maximum Benefit</th>
<th>Preferred Dental Plan</th>
<th>Prepaid Dental Plan</th>
<th>Scheduled Dental Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,000 per person (network and nonnetwork combined)</td>
<td>None</td>
<td>Not applicable</td>
<td>$2,000 per person</td>
</tr>
<tr>
<td>Orthodontia Lifetime Maximum Benefit</td>
<td>$2,000 per person (network and nonnetwork combined)</td>
<td>$2,000 per person (network and nonnetwork combined)</td>
<td>$2,000 per person</td>
</tr>
</tbody>
</table>

*Payments are based on the usual and customary charge for a specific service in the geographic area where you are treated.
Your Benefits Resources Web Site
You may enroll online through the Your Benefits Resources web site (http://resources.hewitt.com/boeing). You also can link to this site from the Boeing Compensation & Benefits web site (http://www.boeing.com/compensation/). Your Benefits Resources allows you to enroll, review your elections, add new dependents, request forms, and access provider information and medical and dental plan comparisons.

When you first enroll, you will be asked to establish a password/personal identification number (PIN). The password/PIN is needed whenever you access the Your Benefits Resources web site. You also will need your Social Security number and the Social Security numbers and birth dates for your dependents if you are enrolling them in the medical and dental plans.

Boeing Service Center for Health and Welfare Plans
As an alternative to the Your Benefits Resources web site, you may enroll by calling the Boeing Service Center automated phone system. Representatives are available on weekdays to answer questions or assist you in enrolling.

<table>
<thead>
<tr>
<th>Automated Phone System</th>
<th>Seven days a week, 24 hours a day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-888-747-2016</td>
</tr>
<tr>
<td></td>
<td>1-800-855-2880 (hearing impaired)</td>
</tr>
<tr>
<td></td>
<td>847-883-0746 (if calling from overseas)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Boeing Service Center Representatives</th>
<th>Available through the above numbers, Monday through</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Friday, 9 a.m. to 8 p.m. Eastern time, 8 a.m. to 7 p.m. Central time, 7 a.m. to 6 p.m. Mountain time, and 6 a.m. to 5 p.m. Pacific time</td>
</tr>
</tbody>
</table>

Your password/PIN is needed whenever you use the Boeing Service Center automated phone system. After your initial enrollment, you may use the automated phone system to review your elections, add new dependents, request forms, or connect directly to your selected medical or dental plan. For other changes and for additional help, you will need to speak with a Boeing Service Center representative.

Annual Enrollment Period
The Company establishes an enrollment period each year when you may change medical and dental plans, enroll, or drop coverage. The enrollment period and effective date of changes made during this period are announced in advance.

Special Enrollment
If you decline enrollment for yourself, your spouse, or your dependent children in the medical and dental plans because you have other employer-sponsored health care coverage (such as through your spouse’s employer), you may be able to enroll yourself, your spouse, or your dependent children in the Company-sponsored medical and dental plans during the year as long as you enroll within 60 days after your other coverage ends.

If you decline enrollment when you are first eligible and your other health care coverage was through continuation coverage from a previous employer (coverage mandated by the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA), you must exhaust your COBRA coverage to be eligible for the special enrollment period.

If your other health care coverage was not through COBRA, your coverage loss must be due to loss of eligibility for the other health care coverage (including from divorce, death, termination of employment, or reduction in hours of employment) or termination of employer contributions toward such coverage.

If you are not enrolled in the plan and you have a new dependent as a result of marriage, entering into a same-gender domestic partner relationship, birth, adoption, or placement for adoption, you may enroll yourself, your spouse or same-gender domestic partner, and any dependent children during the year as
long as you enroll within 60 days after the qualified event by accessing the Your Benefits Resources web site or calling the Boeing Service Center.

If you are enrolled in the plan and you have a new dependent as a result of marriage, entering into a same-gender domestic partner relationship, birth, adoption, or placement for adoption, you may enroll the new dependent during the year as long as enrollment is requested within 120 days after the qualified event. See “Changes in Status,” beginning on this page, for more information.

Changes in Status
You will not be able to make enrollment changes until the next annual enrollment period unless you experience one of the qualified changes in status described in this section. Any change in enrollment you elect must be consistent with the change in status. To be consistent, the event must cause you or a family member to gain or lose eligibility for Company-sponsored health care coverage or health care coverage sponsored by your spouse’s or dependent child’s employer, and your election change must be on account of and correspond with your or your family member’s gain or loss of eligibility. Qualified changes in status include the following:

• You marry, divorce, or become legally separated, or your marriage is annulled.
• You enter into or dissolve a same-gender domestic partnership.
• You acquire a new, eligible dependent child, such as by birth, adoption, or placement for adoption.
• Your spouse or dependent child dies.
• Your spouse or dependent child starts or stops working.
• You, your spouse, or your 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, or beginning or returning from a leave of absence.
• You, your spouse, or your 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.
• You, your spouse, or your dependent child experiences a significant curtailment or cessation of employer-sponsored health care coverage.
• You, your spouse, or your dependent child becomes eligible or ineligible for Medicare or Medicaid.
• Your dependent child becomes eligible for, or is no longer eligible for, health care coverage due to age limits, student status, or a similar eligibility requirement.
• 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, your spouse, or your dependent child changes place of residence or work, affecting access to care within your current plan.
• You are transferred to a different division, affecting your eligibility for benefits under Company-sponsored health care plans.

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

In most situations, you must request enrollment within 60 days after the qualified event. You can enroll a new dependent within 120 days following your marriage or entering into a same-gender domestic partner relationship or your dependent child’s birth, adoption, or placement for adoption. You may request enrollment by accessing the Your Benefits Resources web site or calling the Boeing Service Center at 1-888-747-2016. To request enrollment for a new dependent more than 60 days but within 120 days after your marriage or entering into a same-gender domestic partner relationship or your
dependent child’s 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 required supporting documentation within 31 days of the date you request enrollment or the coverage change request will be denied.

If you are enrolled in a coordinated care plan or the Prepaid Dental Plan and you move out of the service area, you can enroll in a plan available in your new location. Call the Boeing Service Center to enroll in a new plan.

**Other Applications**

As noted previously, a special application is required if you want to continue or provide coverage for a disabled child age 25 or older. Documentation also is required to request coverage for a child named in a QMCSO or a child for whom you have legal custody or guardianship.

In these situations, you must request enrollment by the date indicated on your enrollment worksheet or within 60 days after the qualified event by accessing the Your Benefits Resources web site or calling the Boeing Service Center. You then must provide the Boeing Service Center with supporting documentation within 31 days of the date you request enrollment or the coverage change request will be denied.

You may continue the coverage of a disabled child age 25 or older if, within 31 days of the child’s 25th birthday, a physician provides proof to the Boeing Service Center that the child is incapable of self-support because of a disability. You may be required to verify the incapacity from time to time.

**Affidavit for Domestic Partner Coverage**

Once you have enrolled your same-gender domestic partner or his or her eligible children for coverage under the medical or dental plans, you will receive an Affidavit of Domestic Partnership from the Boeing Service Center. The affidavit also is available on line on the Your Benefits Resources web site. The affidavit lists the full eligibility criteria for a same-gender domestic partner under a Company benefit plan. You should complete the form, have it notarized, and safeguard it. The Boeing Service Center or the service representative may request a copy of the affidavit at any time. Any request for coverage is subject to approval by the Company, the Boeing Service Center, or the service representative.

**Effective Date of Coverage**

**Employees**

If you are a newly hired employee, your coverage becomes effective on the first day of the month following one full calendar month of continuous employment, provided you make your election by the date indicated on your enrollment worksheet. To complete a full calendar month, you must be on the Company’s active payroll from the first regularly scheduled workday of a month through the last regularly scheduled workday of that month.

If you are recalled from a layoff within one year, return to work from retirement, or return to work from an approved educational leave of absence, coverage is effective on the first day of the month following or coinciding with the return.

If you are reemployed following uniformed service (and return to work promptly in accordance with federal law) or return from an approved leave of absence (other than an educational leave of absence), coverage is effective on the date you are reinstated to the active payroll.

If you are transferring from one payroll to another, contact the Boeing Service Center for information about your coverage effective date.

If you enroll in a coordinated care plan, the Preferred Dental Plan, or the Prepaid Dental Plan following a move of residence or work location into the plan’s service area, coverage is effective on the first day of the month following or coinciding with the date your address change is provided to the Boeing Service Center.
If you enroll or change your election during an annual enrollment period, coverage is effective on the date announced at the time of the enrollment period.

If you enroll or change your election as a result of a qualified change in status (described beginning on page 17), coverage is effective on the qualified status change event date.

You continue to be eligible for coverage as long as you are on the active payroll on the first day of each calendar month. For coverage during a leave of absence, see “Leaves of Absence,” beginning on page 67.

**Dependents**

If you are a newly eligible employee, coverage for your current dependents generally becomes effective on the same date your coverage begins if applied for at the same time.

A new dependent is covered on the date of marriage, date of birth, date the child is legally placed with you for adoption, or date you assume financial responsibility if you enroll the dependent within 120 days of the event.

Coverage for a common-law spouse is effective on the date of the common-law marriage.

Coverage for a same-gender domestic partner or the eligible children of a domestic partner is effective on the date you and your domestic partner first meet the domestic partner eligibility requirements.

The following dependent children are covered retroactively to the date dependency is established if you enroll the dependents within 60 days of the event:

- Children (other than your natural or adopted children or stepchildren) who are related to you directly or through marriage.
- Children for whom you have legal custody or legal guardianship.
- Children named in a QMCSO.

If you enroll your dependents during the annual enrollment period, coverage is effective on the date announced at the time of the enrollment period.

If you enroll your dependents as a result of a qualified change in status (described on page 17), coverage is effective on the qualified status change event date.

**Contributions for Medical Coverage**

The Company provides medical coverage as explained in the following paragraphs. You pay your share of any medical costs (including the working spouse contribution, explained on page 20) with pretax contributions. These pretax contributions are taken from your paycheck before your income is taxed, so you pay less in taxes.

Payroll deductions for coverage that becomes effective after the first day of a month (such as for new dependents) begin with the first paycheck of the next month. Contributions for a partial month of coverage will be taken retroactively. Retroactive contributions will be taken from your paycheck on an aftertax basis. Your enrollment in medical coverage authorizes the Company to deduct your contributions from your paychecks.

**Coordinated Care Plans**

The Company provides coverage for you and your eligible dependents under a coordinated care plan at no cost to you if you are regularly scheduled to work 32.1 or more hours each week. If you are regularly scheduled to work from 17 to 32 hours each week, you are required to make contributions toward the cost of coverage under a coordinated care plan, as specified by the collective bargaining agreement. A working spouse contribution may be required, as explained on page 20.
Traditional Medical Plan
Contributions required for the Traditional Medical Plan are specified in the collective bargaining agreement. In addition, a working spouse contribution may be required, as explained below.
The enrollment worksheet in your enrollment kit shows the pay period cost, if any, for the Traditional Medical Plan. Current contribution information also is available from the Boeing Service Center.

Working Spouse Contribution
The Company requires you to make a monthly contribution of $100 to cover a spouse or same-gender domestic partner as a dependent under a medical plan offered by or through the Company (including a coordinated care plan) if your spouse or same-gender domestic partner is not enrolled in the medical coverage available through his or her employer. You are not required to pay the $100 contribution if your spouse or same-gender domestic partner is
• Currently covered by his or her employer’s medical plan.
• Currently covered by other group health coverage as a retiree and not by his or her employer.
• Not offered medical coverage by his or her employer.
• Not employed.
• Employed by the Company.
• Not enrolled in his or her employer’s medical plan but commits to join his or her employer’s plan at the next opportunity, but no longer than one year from your spouse’s or same-gender domestic partner’s coverage effective date under the Company-sponsored plan. You will be required to verify this information.

You will need to provide information to the Boeing Service Center when you are first hired, you are newly married, or you first enter into a same-gender domestic partner relationship to determine whether this contribution applies to you.

The $100 monthly working spouse contribution is in addition to the amount you may be required to contribute for medical coverage.

Contributions for Dental Coverage
The Company provides coverage for you and your eligible dependents under the Preferred Dental Plan, Prepaid Dental Plan, or Scheduled Dental Plan at no cost to you if you are regularly scheduled to work 17 or more hours each week.

Tax Implications of Domestic Partner Coverage
If you enroll your same-gender domestic partner or his or her eligible children in a Boeing medical or dental plan, the value of the benefits provided may be taxable to you as ordinary income. The taxability of benefits depends on whether your domestic partner (and children, if any) qualifies as a dependent under Internal Revenue Code Section 152.

Under Section 152, you generally may claim as a dependent on your federal income tax return any individual who lives with you as a member of your household and relies on you for more than one-half of his or her support. Other eligibility criteria also apply.
The Section 152 status of your domestic partner (and children, if any) affects your taxable income as follows:

- If your covered domestic partner does not qualify as a dependent under Section 152, the value of Boeing health care coverage provided to your partner is included as taxable wages in your gross income. The amount will be subject to all usual payroll taxes, such as federal withholding, FICA, and most state payroll taxes.
- If your covered domestic partner qualifies as a dependent under Section 152, the value of your Boeing health care coverage provided to your partner is not included as income and is not taxable.

The same guidelines apply to the dependent children of your domestic partner.

If you enroll your domestic partner for health care coverage, the value of Boeing medical or dental coverage provided to your domestic partner (and children, if any) automatically will appear as taxable income on your W-2 form. The value of benefits is equal to the cost of coverage. Current cost information is available from the Boeing Service Center.

If your domestic partner (and children, if any) qualifies as a Section 152 dependent, you may request an adjustment to the annual income calculation that appears on your W-2 form by contacting the Boeing Service Center. Adjustment requests must be made and received by early December annually.

For more information regarding tax implications related to domestic partner benefits, please consult your tax adviser. Additional information is available on the Boeing Compensation & Benefits web site (http://www.boeing.com/compensation/).

**When Coverage Ends**

Under certain circumstances, you may arrange to pay the full cost of coverage during a period when coverage otherwise would end. See “Termination of Coverage,” beginning on page 67, for an explanation of the provisions and procedures related to self-pay arrangements.

When your medical and dental coverage ends, you automatically will receive a certificate of coverage. The certificate will provide proof of coverage under the plans. This certificate may be presented to another health care plan to reduce a preexisting condition waiting period, if applicable. (For more information, refer to “Certificate of Coverage,” on page 67.)
Traditional Medical Plan

The Traditional Medical Plan provides you and your eligible dependents with financial protection against large and often unforeseen medical expenses. The plan also covers many other medical services and supplies such as preventive care, physician and hospital services, prescription drugs, mental health and substance abuse treatment, and routine vision care.

Although you may obtain care from any licensed health care provider covered under the plan, you receive enhanced benefits if you receive care from a network provider. Use of network providers also offers you certain other advantages, as explained in Exhibit 3 on page 24.

The following sections summarize plan benefits and out-of-pocket expenses. You especially are encouraged to read the medical review program requirements (explained in Exhibit 4, beginning on page 28) because the regular benefit payment levels under the plan may be limited or denied if the program requirements are not followed.

Benefit and plan payment provisions are based on a benefit year (as defined on page 78).

The Traditional Medical Plan is administered by Regence BlueShield (the service representative). The Boeing Company may change the service representative at any time.

Deductible and Copayments

You and your eligible dependents are responsible for paying certain expenses, called deductible and copayment expenses, before the plan begins paying benefits. Your health care provider may not waive deductible and copayment expenses.

**Deductible**

Each covered person must satisfy an annual deductible (based on a benefit year). The deductible is the greater of $125 or 0.2 percent of your base annual wage. For families of three or more, the deductible maximum is the greater of $375 or 0.6 percent of your base annual wage.

For purposes of calculating the deductible, base annual wage is your base annual wage on July 1 of each year. In your year of hire, base annual wage is your base annual wage on your date of hire. Charges for all covered services and supplies apply toward the deductible, except those related to:

- Preventive care.
- Routine vision exams and eyewear.
- Mail service program prescription drugs.
- Smoking cessation treatment.

**Emergency Room Copayment**

A $50 copayment (in addition to the annual deductible described previously) applies to each visit to a hospital emergency room. The $50 copayment is waived if the patient:

- Is admitted as an inpatient immediately following emergency room treatment.
- Is treated in the emergency room for 12 or more hours.
- Dies in the emergency room.

**Mail Service Program Prescription Drug Copayments**

Under the mail service program, generic prescription drugs or refills obtained from the mail service pharmacy are provided to you at no cost. A $5 copayment applies to each brand-name prescription or refill obtained from the mail service pharmacy.
Benefit Payment Levels and Maximums

Once you have paid the required deductible and/or copayment expenses, any additional out-of-pocket expenses that are your responsibility depend on the type of service or supply you receive and the type of health care provider you use.

The plan pays benefits according to the following guidelines.

Network Providers

Covered services of network providers generally are paid in full. However, special provisions apply to
• Mental health and substance abuse treatment. (See pages 25 and 26, respectively.)
• Temporomandibular joint dysfunction and myofascial pain dysfunction syndrome (TMJ/MPDS) treatment. (See page 26.)

Physician services performed at a network hospital are paid in full only if the physician also is a network provider. See Exhibit 3, on page 24, for information about the advantages of using network providers and how to find a network provider in your location or while traveling. (For provisions relating to the coverage of specialty care when such care is not available through the network, contact the service representative at the claim questions telephone number listed in Exhibit 10 on page 82.)

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 as follows. (These payment levels do not apply to coverage of treatment for mental illness, substance abuse, or TMJ/MPDS.)

Services Received in a Location Where There Are Network Providers Qualified to Provide Medically Necessary Services

If services are received in a location where qualified network providers are available, covered services obtained from nonnetwork licensed providers are paid at 60 percent of usual and customary charges (after the deductible).

Services Received in a Location Where There Is No Network Provider Qualified to Provide Medically Necessary Services

If medically necessary services are not available from a network provider where a covered person lives or works, and services are received in a location where there is no network provider qualified to provide necessary diagnosis, consultation, or treatment, covered services obtained from a nonnetwork licensed provider are paid at the network level (100 percent of usual and customary charges after the applicable deductible or copayment).

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. If the plan does not have network contracts with providers in a specific license category in a particular location (such as podiatrists or chiropractors in certain locations), covered services and supplies received from providers in that category will be paid at 80 percent of usual and customary charges. Call 1-800-810-2583 to find out which types of providers are members of the network in your location.

Other Services and Supplies

Ambulance Services

Expenses for covered ambulance services are paid at 100 percent of usual and customary charges when obtained from network or nonnetwork providers. (Conditions of coverage begin on page 31.)
**Durable Medical Equipment, Orthopedic Appliances, and Prostheses**

Expenses for covered durable medical equipment, services, and supplies (including orthotics and prostheses) are paid at 80 percent of usual and customary charges when obtained from network or nonnetwork providers. (See pages 32, 33, and 36, respectively, for conditions of coverage.)

**Emergency Room Treatment**

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, if a patient receives care at a nonnetwork facility when the condition is not a true medical emergency, covered services are paid at the nonnetwork level. (See the definition of an emergency on page 78.)

**Hospital Alternatives**

The following covered services and supplies provided as an alternative to hospitalization are paid at 100 percent of usual and customary charges:

- Christian Science sanatorium services and supplies. (See page 36.)
- Hospice agency services and supplies. (See page 37.)
- Skilled nursing facility services and supplies. (See page 39.)

Home health care services and supplies are paid according to network/nonnetwork provider benefit payment levels. (Conditions of coverage begin on page 36.)
Mental Health Treatment
Covered services are paid as follows:
• Covered inpatient, partial hospital, or intensive outpatient services obtained from a provider referred by the Boeing Helpline are paid in full.
• Covered outpatient services obtained from a provider referred by the Boeing Helpline are paid at a constant 80 percent of charges.
• Services obtained from a nonreferred provider are paid at a constant 50 percent of usual and customary charges, up to a maximum of 20 inpatient, partial hospitalization, or intensive outpatient days and 20 outpatient visits each benefit year if the services are certified as covered by the Boeing Helpline.
For details on mental health treatment coverage, see Exhibit 7, beginning on page 42.

Prescription Drugs and Medicines
Prescription drugs and medicines are covered under two programs.
• Preferred pharmacy card program
  • Covered generic prescription drugs purchased at a participating pharmacy with a PAID Direct identification card are reimbursed at 90 percent of PAID Direct discounted charges.
  • Covered brand-name prescription drugs purchased at a participating pharmacy with a PAID Direct identification card are reimbursed at 80 percent of PAID Direct discounted charges, regardless of whether a generic prescription drug is available.
  • Covered prescription drugs (generic and brand name) purchased without using a PAID Direct identification card are reimbursed at 70 percent of the preferred pharmacy card program’s discounted charges, regardless of whether the pharmacy is a participating pharmacy. If you make a purchase without using your PAID Direct identification card, the pharmacy may charge you the full retail price of the prescription.
• Mail service program
  • Covered maintenance generic prescription drugs obtained from the mail service program are paid in full.
  • Covered maintenance brand-name prescription drugs obtained from the mail service program are paid in full after a $5 copayment per prescription or refill.
For more information on prescription drug coverage, see Exhibit 5, beginning on page 34.

Preventive Care
Covered preventive care services, described on page 30, are paid according to the following network benefit payment levels:
• Routine physical exams for employees and spouses are paid in full, up to $200 per covered examination, including related laboratory and X-ray charges.
• Routine Papanicolaou (Pap) tests, mammograms, and prostate screenings are paid in full.
• Routine physical examinations for children under age six are paid in full.  
• Scheduled immunizations for children are paid in full.
Preventive care services obtained in a network service area are covered only if received from network providers.

Smoking Cessation Treatment
Expenses for covered smoking cessation services and supplies (described on page 36) are paid at 100 percent of usual and customary charges when received from network or nonnetwork providers, up to a $500 lifetime maximum benefit. The annual deductible does not apply.
**Substance Abuse Treatment**

Covered services are paid as follows:

- Covered inpatient, partial hospital, residential, intensive outpatient, or outpatient services obtained from a provider referred by the Boeing Helpline are paid in full.

- Services obtained from a nonreferred provider are paid at a constant 50 percent of usual and customary charges if the services are certified as covered by the Boeing Helpline. These covered nonreferred provider services are limited to a $5,000 maximum benefit per course of treatment.

- The plan pays benefits up to a lifetime maximum of two courses of treatment for referred and nonreferred provider services combined.

For details on substance abuse treatment coverage, see Exhibit 7, beginning on page 42.

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

Covered services for the treatment of TMJ/MPDS are paid at a constant 50 percent of usual and customary charges, up to a lifetime maximum benefit of $3,500.

**Vision Care Services and Supplies**

Covered services are paid as described in Exhibit 6 on page 38.

**Out-of-Pocket Expense Limits**

For certain services, you are required to pay 10 to 40 percent of charges (called your out-of-pocket expenses). Your responsibility is limited as follows:

- When a person’s out-of-pocket expenses reach $2,000 in any benefit year, most additional benefits that would have been paid at 60, 70, 80, or 90 percent are paid at 100 percent of usual and customary charges for the remainder of that benefit year, up to the maximum benefit amounts.

- When expenses for two or more family members reach the combined out-of-pocket expense maximum of $4,000 (but not more than $2,000 for any one person), most additional benefits that would have been paid at 60, 70, 80, or 90 percent are paid at 100 percent of usual and customary charges for the remainder of that benefit year, up to the maximum benefit amounts.

The following expenses do not count toward the individual or family out-of-pocket expense limits:

- Deductibles.
- Hospital emergency room copayments.
- The difference between usual and customary charges and the provider’s actual charge.
- Any balance remaining after a benefit maximum has been reached.
- Covered medical services paid at 100 percent of usual and customary charges or in full.
- Covered medical services for treatment of mental illness, smoking cessation, substance abuse, or TMJ/MPDS.
- Benefits paid at a reduced amount or denied when the patient fails to follow medical review program procedures and requirements.
- Expenses for services or supplies not covered by the plan.

**Lifetime Maximum Benefit**

The lifetime maximum benefit for all covered medical services (including prescription drugs) is $1,250,000, subject to all other plan provisions. This maximum applies separately to each covered family member. Benefits paid under any Company-sponsored medical plan for active or retired employees are applied against this maximum (except benefits previously reinstated under the provisions of that plan).
Medical Review Program

The medical review program is designed to let you and your physician know whether certain types of nonemergency care are covered under this plan before you undergo the care and incur the expense. Contact the program by calling the service representative at the medical review program telephone numbers listed in Exhibit 10 on page 82.

The medical review program includes preadmission certification requirements for inpatient hospital or skilled nursing facility care and prior approval procedures for home health and hospice care. Each of these features is explained in Exhibit 4, beginning on page 28.

If the medical review program advises you that a particular procedure or treatment is not covered as a benefit under this plan, this does not mean your physician is wrong or that you might not benefit from the treatment. It just means the plan will not reimburse the expense. Final decisions about any medical treatment ultimately rest with you and your physician; the medical review program simply assists by letting you know whether the treatment will be covered by the plan.

Precertification of all mental health and substance abuse treatment is handled separately through the Boeing mental health and substance abuse program (explained in Exhibit 7, beginning on page 42).

You are encouraged to review this information carefully because benefits may be limited or denied unless you follow the requirements of this program before undergoing certain types of care.
Exhibit 4

Medical Review Program

Among the issues a patient must consider when a physician recommends care is whether it will be covered under the plan. Recognizing this, the plan has a medical review program that provides the patient and physician with information about coverage for certain types of nonemergency care before the patient decides to undergo the care and incur the expense.

The plan pays regular benefits for certain types of nonemergency care only if you contact the medical review program before receiving the care. This section explains the requirements of the review program. Please remember that benefits may be limited or denied if these requirements are not followed.

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

Preadmission Review and Prior Approval Requirements

The plan requires you or your physician to contact the medical review program before a nonemergency admission to a hospital or skilled nursing facility or before home health or hospice care is received. This information is then reviewed against established medical criteria to determine whether the recommended care is covered under the plan.

If you receive care through a network provider, the physician may assist you by contacting the medical review program for you. However, you solely are responsible for obtaining any required preadmission review or prior approval.

You or your physician should contact the service representative at least 10 days before the proposed admission. (The telephone numbers for the medical review program are shown in Exhibit 10 on page 82.)

Under this portion of the medical review program, benefits are paid as follows:

- The plan pays its regular benefits if the hospital, skilled nursing facility, home health care, or hospice care is approved through the medical review program.
- If preadmission or prior approval is required but not obtained and later it is determined that the care was medically necessary, the first $2,000 of usual and customary charges are paid at 50 percent after the annual deductible.
- No benefits are paid if the admission or care is not considered medically necessary under the program's guidelines.

If the medical review program advises you that a particular procedure or treatment is not covered as a benefit under this plan, this does not mean your physician is wrong or that you might not benefit from the treatment. It just means the plan will not reimburse the expense. Final decisions about any medical treatment ultimately rest with you and your physician; the medical review program simply assists by letting you know whether the treatment will be covered by the plan.

Although contacting the program is not required before emergency or pregnancy-related admissions, you or your physician should contact the program shortly after the admission to be assured the remainder 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.
Individual Case Management
In the event of a severe or long-term illness or injury, the service representative will assist the patient's network provider in identifying treatment alternatives that offer cost-effective care and enhancements to the patient's quality of life.

Voluntary Second Surgical Opinion
The plan encourages you to get a second opinion before having any nonemergency surgery.
A second (or third) surgical opinion is covered under the network/nonnetwork provider benefit payment levels, subject to the plan's deductibles.
Second surgical opinions are recommended for the following procedures:
• Carotid endarterectomy—removal of the inner layer of the carotid artery.
• Cholecystectomy—removal of the gall bladder.
• Coronary artery bypass.
• Hysterectomy—removal of the uterus.
• Knee surgery.
• Laminectomy or spinal fusion—removal or fusion of parts of the spine.

Mental Health and Substance Abuse Treatment
Precertification of mental health and substance abuse treatment is handled separately through the Boeing mental health and substance abuse program. The program specializes in managing mental health and substance abuse treatment. Benefits are greater if you access the program through the Boeing Helpline and use providers referred by the program. See Exhibit 7, beginning on page 42, for more information.
Covered Medical Services and Supplies

In general, the plan covers medically necessary services and supplies when they are used to diagnose or treat a nonoccupational accidental injury or illness. Medically appropriate services and supplies generally are covered for certain types of preventive care and for other listed conditions, up to plan limits.

Coverage of the following services and supplies is subject to general plan provisions, including the exclusions, beginning on page 44, and the definitions, beginning on page 78.

Preventive Care

The plan covers one routine physical examination by a network physician every three benefit years for employees and spouses under age 35 and one examination every benefit year for employees and spouses age 35 and older. The plan pays up to $200 per covered examination, including related X-ray and laboratory charges.

The plan also covers routine screening Papanicolaou (Pap) tests, mammograms, and prostate screenings as recommended by the patient’s physician.

The plan covers up to eight routine physical examinations during the first 24 months of a dependent child’s life and one examination every year for a dependent child age two through age five.

The plan also covers routine immunizations according to American Academy of Pediatrics guidelines and the schedule recommended by the child’s physician.

The annual deductible does not apply to covered preventive care services.

Physician Services

The 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

• Preventive care, as described previously.
• Voluntary second surgical opinions, as described in Exhibit 4 on page 29.
• Injectable legend drugs administered in a physician’s office for covered conditions and medical devices (including contraceptive injections, devices, and implants) dispensed by a physician, subject to the plan’s deductible. (Preventive injections and immunizations are not covered except as noted under the preventive care benefit.) Antigen, allergy serum, and insulin are not covered as a physician’s service but are covered under the preferred pharmacy card program; insulin also is covered under the mail service program.
• 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 benefits, as described in Exhibit 6 on page 38.)

Other Professional Services

The plan covers certain health care services when provided by either a physician or another type of health care professional. All health care professionals must be licensed by the state in which 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

• Physician assistants when performing services that would be covered if performed by a physician licensed as an M.D.
• Registered nurses when performing services that would be covered if performed by a physician licensed as an M.D. The plan also covers intermittent visits by a registered nurse when skilled care in place of hospitalization is not available through an alternative provider at a lesser cost.
• Clinical psychologists and master’s level therapists for the treatment of mental illness or substance abuse conditions covered under the plan. (For the coverage terms related to mental health and substance abuse treatment, see Exhibit 7, beginning on page 42.)

• Neurodevelopmental, physical, occupational, and speech therapists for the services described on page 33.

• Dentists for dental work or surgery covered under the Traditional Medical Plan.

• Optometrists providing covered vision care services. (For coverage of routine vision care services, see the vision care payment levels and other terms described in Exhibit 6 on page 38.)

• Podiatrists providing covered podiatric services.

• Chiropractors providing covered chiropractic services. (For benefit limitations, see “Spinal Manipulations,” on page 36.)

• Christian Science practitioners listed in the current Christian Science Journal at the time they provide a service.

**Hospital Services and Supplies**

The plan covers the charges for a semiprivate room and medically necessary hospital services and supplies. Nonemergency admissions must be approved in advance under the medical review program, as explained in Exhibit 4, beginning on page 28. Treatment of mental illness and substance abuse must be precertified through the Boeing mental health and substance abuse program, as explained in Exhibit 7, beginning on page 42.

The plan covers the cost of a private room if a private room is medically necessary. If you use a private room when one is not medically necessary, you are 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 amount being charged for semiprivate rooms in similar facilities in the area.

Covered hospital services and supplies include

• Operating rooms and equipment.

• Surgical dressings and supplies.

• X-ray and laboratory services.

• Electrocardiograms.

• Anesthesia, including administration and materials.

• Pathology.

• Drugs, excluding blood and blood derivatives.

• Administration of blood.

Other covered services include outpatient surgery at a hospital and emergency room treatment of an accidental injury or severe illness. (See page 22 for information about the $50 emergency room copayment.)

**Medical Services and Supplies**

**Acupuncture**

The plan covers medically necessary acupuncture services for a covered illness or in place of covered anesthesia. Treatment must be provided by a licensed acupuncturist (L.A.C.) who also is a doctor of medicine (M.D.) or doctor of osteopathy (D.O.).

**Ambulance Services**

The plan covers professional ambulance services when the ambulance is used to transport the patient from the place where he or she is injured or becomes ill to the first hospital where treatment is given. These services also are covered when the physician requires an ambulance to transport the patient to a
hospital in the patient’s area of residence to protect the patient’s 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 the patient’s home is covered when medically necessary. No other expenses in connection with travel are covered.

**Diagnostic X-Ray and Laboratory Services**
The plan covers diagnostic X-ray and laboratory examinations, including such exams when used in connection with a voluntary second 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, be solely for the treatment or improvement of a critical function related to the medical condition, be appropriate for use in the home, and 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 a change in the patient’s condition, including growth of a child, also is covered. Examples of covered durable medical equipment are crutches, wheelchairs, kidney dialysis equipment, standard hospital beds, oxygen equipment, and diabetic equipment such as blood glucose monitors, insulin infusion devices, and insulin pumps.

Examples of equipment generally not covered by the plan include a specialized car seat, exercise equipment, a stair lift, a spa, and a whirlpool installed in your home. Equipment used primarily to prevent illness or injury, items designed primarily to assist a person caring for the patient, and items generally useful in the absence of the condition are not covered.

**Hearing Aids**
The plan pays up to $600 per ear toward the cost and installation of a hearing aid when recommended in writing by a physician or certified audiologist. Each covered person is limited to one hearing aid per ear during any consecutive period of three benefit years, including any time covered under another Company-sponsored medical plan. The plan also covers the overhaul of a hearing aid in place of a new hearing aid after three years.

The plan does not cover the following:
- Hearing or audiometric examinations, unless disease is present.
- Replacement of lost, broken, or stolen hearing aids, unless the three-year period has been exhausted.
- Replacement parts for hearing aid repair, unless part of an overhaul after three years.
- Replacement batteries.
- Hearing aids that do not meet professionally accepted standards, including any experimental services or supplies.
- Eyeglass-type hearing aids if the charge exceeds the covered amount for one hearing aid.
- Hearing aids ordered before a person becomes eligible for coverage or after coverage terminates.
- Hearing aids ordered before termination of coverage but delivered more than 60 days after coverage ends.

**Hemodialysis**
The plan covers repetitive hemodialysis treatment in the patient’s home for chronic, irreversible kidney disease. Covered services and supplies include the rental or lease of hemodialysis equipment.
Under certain conditions, the plan may cover the purchase of major hemodialysis equipment and supplies and expenses for the necessary training to operate the dialyzer. For purchased supplies to be covered in these instances, the items must be of no use to the patient in the absence of the disease and of no value to other household members. Specific conditions for purchasing the equipment, including an amortization period, are established by the service representative.

Hemodialysis treatment and equipment are covered by the plan for the first 30 months following Medicare entitlement as a result of end-stage renal disease. After this 30-month period, Medicare provides primary coverage and the Traditional Medical Plan provides secondary coverage.

**Neurodevelopmental, Physical, Occupational, and Speech Therapy Services**

The plan covers certain types of therapy, 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 the type and duration.

Services must be provided under a physician’s supervision while the patient remains under the attending physician’s care. The attending physician must evaluate the therapy treatment at least once every three months and certify that continuing therapy is required.

All therapy that continues beyond three months must be approved by the service representative. Benefit determination is based on the attending physician’s evaluation of the treatment and the therapist’s progress reports. Information from the physician and therapist is then reviewed against established medical criteria to determine whether the recommended care will continue to improve function and whether it will be covered under the plan.

The plan covers neurodevelopmental therapy for children age six or under, up to a maximum benefit of $1,000 each year.

Neurodevelopmental, physical, occupational, and speech therapists must meet licensing or certification requirements, as explained in “Definitions,” beginning on page 78.

**Orthopedic Appliances and Braces**

The plan covers braces, splints, orthopedic appliances, and orthotic supplies, including 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 are not covered.

**Oxygen and Anesthesia**

The plan covers oxygen and anesthesia.

**Prescription Drugs and Medicines**

The plan covers only drugs and medicines that legally require a physician’s prescription, such as contraceptive medications. The only exceptions to the prescription requirement are insulin and certain related supplies when provided for known diabetes.

The plan offers you and your dependents two coverage options for prescription drugs and medicines. Under the first option, you and your dependents may receive covered prescription drugs or medicines through the Boeing preferred pharmacy card program (PAID Direct) or any licensed pharmacist. This coverage is provided under the general terms of the plan. Payment levels vary, as described in Exhibit 5, beginning on page 34. As an alternative, you may use a mail service program to obtain maintenance prescription drugs and medicines that are taken on an ongoing basis for a chronic medical condition. Maintenance prescription drugs and medicines obtained through the mail service program are not subject to the plan’s annual deductible or general benefit payment levels.

Exhibit 5, beginning on page 34, explains your coverage under these two options.
Exhibit 5

Prescription Drug and Medicine Coverage

The Traditional Medical Plan offers two coverage options for prescription drugs and medicines. Coverage is subject to all Traditional Medical Plan provisions, including the general exclusions and limitations of the plan. You and your dependents may use the preferred pharmacy card program (administered by PAID Prescriptions, L.L.C.) to obtain any covered prescription. As an alternative, you and your dependents may use the mail service program (administered by Merck-Medco Rx Service of Washington) to order covered maintenance prescription drugs and medicines. Following is a description of each of the programs.

Preferred Pharmacy Card 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 contraceptive medications, insulin, and needles, syringes, chem strips, chem pads, and lancets when prescribed along with insulin.

The program covers up to a 90-day supply per prescription or refill if prescribed by your physician. Authorized refills are covered only after the initial order has been used. Certain controlled substances are subject to quantity limitations.

Any expenses for covered drugs and medicines are applied to your annual deductible. Once you have paid your deductible expenses in a benefit year, the level of benefits you receive depends on whether you use your PAID Direct identification card at a pharmacy participating in the preferred pharmacy card program. Participating pharmacies generally display the PAID Direct decal. You may also contact the Boeing Service Center to find out how to locate a participating pharmacy in your area.

When you use your PAID Direct identification card at a participating pharmacy, you are responsible for paying the pharmacist the full discounted price for the prescription. The pharmacist then will file a prescription drug claim for you electronically. No paperwork is required as long as you remember to use your card.

When you use your PAID Direct identification card at a participating pharmacy, the Traditional Medical Plan service representative (Regence BlueShield) reimburses you at one of the following benefit levels after you have met plan requirements:

- Generic drugs are reimbursed at 90 percent of the discounted charge, up to the plan’s out-of-pocket expense limit.
- Brand-name drugs are reimbursed at 80 percent of the discounted charge, up to the plan’s out-of-pocket expense limit, regardless of whether a generic prescription drug is available.

When you make a purchase without using your PAID Direct identification card, you may be required to pay the full retail price for your prescription, regardless of whether the pharmacy is a participating pharmacy. In addition, you must submit a Direct Reimbursement Claim form with an itemized receipt to PAID Prescriptions, L.L.C., for reimbursement. You are reimbursed 70 percent of the program’s discounted charge, up to the plan’s out-of-pocket expense limit. Claim forms are available from PAID Prescriptions, L.L.C., or Regence BlueShield. (Contact Regence BlueShield at 1-888-675-6570.)

Once you have reached the plan’s out-of-pocket expense limit, the plan pays 100 percent of the discounted charge.

Mail Service Program

This program is provided as an alternative to the preferred pharmacy card program for people who must take maintenance drugs or medicines on an ongoing basis for a chronic medical condition. Covered generic prescription drugs and medicines are provided at no cost to you through this program. You must pay the first $5 for each brand-name prescription you receive, including refills, regardless of whether a generic prescription is available.
As with the other program, you receive coverage for 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 contraceptive medications, insulin, and needles, syringes, chem strips, chem pads, and lancets when prescribed along with insulin.

This program covers up to a 90-day supply per prescription or refill if prescribed by your physician. Authorized refills are covered only after the initial order has been used. Certain controlled substances are subject to quantity limitations.

Unless your 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.

Forms for ordering prescription drugs through the mail service program are available from Merck-Medco Rx Service of Washington or Regence BlueShield. (Contact Merck-Medco Rx Services of Washington at 1-800-626-6080.) You will receive a new form each time a prescription is filled through this program.

**Exclusions**
The following items are excluded under both the preferred pharmacy card program and the mail service program:

- Appliances, devices, or other nondrug items, including but not limited to therapeutic devices and artificial appliances. However, this does not apply to needles, syringes, or other diabetic supplies, when prescribed along with insulin.
- Any charges for the administration or injection of any drug.
- 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 prescription filled in excess of the number prescribed by the physician or any refill after one year from the date of the physician’s order.
- Immunizing agents, except that allergy serum (antigen) is covered under the preferred pharmacy card program with a physician’s written prescription.
- All medications to treat sexual dysfunction, unless the patient is being treated for a diagnosed medical condition.
- Fertility agents, unless approved by the service representative.
- Obesity drugs.
- Drugs dispensed during an inpatient admission by a hospital, skilled nursing facility, sanatorium, or other facility.
- Experimental drugs or drugs used for investigational purposes.
- Drugs that are not medically necessary for the treatment of an illness, injury, or other covered condition, including vitamins, except as specifically provided by the plan.
- Infusion therapy drugs, except as described in the home health care benefit.
- Delivery or handling charges.
- Any service or supply otherwise excluded by the plan.
**Prostheses**
The plan covers artificial limbs, artificial eyes, and other prostheses to replace a missing body part, including the necessary repair and replacement required by normal usage or change in the patient’s condition such as growth of a child. Wigs and hair prostheses are not covered.

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

**Smoking Cessation Treatment**
The plan covers smoking cessation services and supplies, including physician visits, the services of an approved smoking cessation provider, and prescription drugs. To receive benefits for smoking cessation treatment, the patient must complete the full course of treatment. No smoking cessation benefits will be provided for inpatient services; vitamins, minerals, or other supplements; acupuncture; over-the-counter drugs or provider-prescribed prescription drugs to ease nicotine withdrawal; books; tapes; or hypnotherapy (unless performed by an approved provider). Prescription drugs prescribed by an approved provider to ease nicotine withdrawal are covered under the prescription drug benefit.

**Spinal Manipulations**
The plan covers the services of an approved provider, such as a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), or a chiropractic doctor (D.C.), for up to 26 spinal manipulations performed by hand each benefit year. Related services, such as an initial examination and spinal X-rays, also are covered.

**Vision Care Services and Supplies**
The plan covers vision care services and supplies, as explained in Exhibit 6 on page 38. The annual deductible and general benefit payment levels of the plan do not apply.

**Hospital Alternatives**

**Christian Science Sanatorium Services and Supplies**
The plan covers the charges for a semiprivate room in a sanatorium if the patient is admitted for the process of healing (not rest or study) and is 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 level being charged for semiprivate rooms in similar facilities in the area.

**Freestanding Surgical or Emergency Facilities**
The plan covers services of an approved freestanding surgical center or hospital-based emergency facility if such services would be covered if received in a hospital.

**Home Health Care Services and Supplies**
Home health care requires prior approval under the medical review program, as explained in Exhibit 4, beginning on page 28.

The plan covers medically necessary home health care visits and supplies if inpatient care in a hospital or skilled nursing facility would otherwise be required. In addition, the patient must be considered homebound, which means that leaving home involves a considerable and taxing effort and public transportation cannot be used without the help of another.

Before the patient begins receiving home health care, the physician must provide a written treatment plan. Then, at least once every two months, the physician must review the treatment plan and certify that the patient’s condition and treatment continue to meet these criteria.
The plan covers the following home health care visits and supplies if provided and billed by an approved home health agency:

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

The plan covers prescription drugs and medicines and durable medical equipment for home health care on the same basis as for other types of care.

A list of exclusions that apply to home health care services appears on page 45.

**Hospice Care Services and Supplies**

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

Hospice care requires prior approval under the medical review program, as explained in Exhibit 4, beginning on page 28.

Before the patient begins receiving hospice care, the physician must provide a written treatment plan. Then, at least once every two months, the physician must review the treatment plan and certify that the patient’s condition and treatment continue to meet the 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 it does for other types of hospital inpatient care (see page 31). Skilled nursing facility or hospital outpatient care also is covered for the hospice patient on the same basis as for other patients.

The plan covers the same home health care visits and supplies listed under “Home Health Care Services and Supplies,” beginning on page 36, if they are provided and billed by an approved hospice agency. In addition, the plan covers respite care services to provide temporary relief to family members and friends who care for the patient.

The plan covers visits of four or more hours per day by a registered nurse, licensed practical nurse, or home health aide to provide skilled care. Similarly, respite care visits of four or more hours per day are covered up to a total of 120 hours in a three-month period. If your physician recommends an extension, apply to the service representative at the address listed in Exhibit 10 on page 82.

The plan covers prescription drugs and medicines and durable medical equipment for hospice care on the same basis as for other types of care.

A list of exclusions that apply to hospice care services appears on pages 45.
Exhibit 6

Vision Care Benefits

The plan covers the following vision care services and supplies:

- Eye examinations, which must include refraction, when performed by a legally qualified ophthalmologist or optometrist.
- Prescription lenses and frames required for such lenses.
- Contact lenses when elected in place of conventional lenses and frames.

Benefit Payment Levels

Coverage of vision care services and supplies is subject to all plan provisions except the annual deductible and benefit payment levels. The plan pays benefits according to the following schedule:

<table>
<thead>
<tr>
<th>Services and Supplies</th>
<th>Maximum Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye examination</td>
<td>100% for network provider services; 60% up to $50 for nonnetwork provider services</td>
</tr>
<tr>
<td>Lenses</td>
<td></td>
</tr>
<tr>
<td>Single vision (two lenses)</td>
<td>$50</td>
</tr>
<tr>
<td>Bifocal (two lenses)</td>
<td>$80</td>
</tr>
<tr>
<td>Trifocal (two lenses)</td>
<td>$95</td>
</tr>
<tr>
<td>Lenticular (two lenses)</td>
<td>$155</td>
</tr>
<tr>
<td>Frames</td>
<td></td>
</tr>
<tr>
<td>$70</td>
<td></td>
</tr>
<tr>
<td>Contact lenses (two lenses)—covered in place of, or in combination with, conventional lenses and frames</td>
<td>$105</td>
</tr>
</tbody>
</table>

Benefit Limitations

The plan covers one eye examination each benefit year and up to two sets of lenses and frames every two benefit years while you or an eligible dependent is covered under this or another Company-sponsored plan. The repair or replacement of lost, stolen, or broken lenses and/or frames is considered part of the two-set limitation.

Exclusions

The plan does not cover the following vision care services or supplies:

- Special supplies such as nonprescription sunglasses and subnormal vision aids.
- Special lens treatments such as seamless or progressive lenses (e.g., Varilux and Ultra-vue), antireflective coatings, and tinting, when such treatment is provided for an extra charge.
- Services or supplies not specifically listed as covered.
- Services or supplies received while the person is not covered under the plan or lenses and frames furnished or ordered before the date the person becomes covered. However, lenses and frames ordered within 31 days after coverage terminates are covered if the person received a complete eye examination, including refraction, within 31 days before coverage ends, and the examination results in a new prescription or a change in the person’s prescription.
Skilled Nursing Facility Services and Supplies
The plan covers the charges for a semiprivate room in a skilled nursing facility and 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 under the medical review program, as explained in Exhibit 4, beginning on page 28.

If you use a private room in a skilled nursing facility, 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 level being charged for semiprivate rooms in similar facilities in the area.

Covered Conditions
The plan covers the services and supplies described in “Covered Medical Services and Supplies,” beginning on page 30, for the treatment of accidental injuries and illnesses. These services and supplies also are covered for certain specific conditions.

Congenital Abnormalities and Hereditary Complications
The plan covers medically necessary services and supplies 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. All other surgery performed for cosmetic purposes is excluded, except as specifically provided for treatment after a mastectomy. (See “Reconstructive Breast Surgery,” on page 41.)

Dental Repair of Accidental Injury
The plan covers services and supplies when provided for the prompt repair of natural teeth or other body tissues as a result of an accidental injury, 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 of the facial bones (maxilla or mandible).

Any teeth being repaired must have been free from decay or in good repair and firmly attached at the time of the accident. If crowns, dentures, bridgework, or in-mouth appliances are installed as a result of the accident, the plan covers only the first denture or bridgework to replace lost teeth, the first crown to repair each damaged tooth, or the in-mouth appliance installed as the first course of orthodontic therapy following the injury.

Charges made to remove, repair, replace, restore, or reposition teeth lost or damaged in the course of biting or chewing are not covered under the plan.

Erectile Dysfunction
The plan covers treatment of organic erectile dysfunction when the patient has a history of one or more of the following:
• Peripheral vascular disease or local penile vascular abnormalities.
• Peripheral neuropathy or autonomic insufficiency.
• Prostate cancer.
• Spinal cord disease or injury.
• Major pelvic surgery.
• Insulin-dependent diabetes appearing before age 50.
• Severe Peyronie’s disease.
Covered therapy includes vacuum erection devices, injection therapy, a penile prosthesis, urethral pellets, and prescription medications.

The plan does not cover treatment for nonorganic impotence such as psychosexual dysfunction.

**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 medications, that provides treatment for infertility.

The plan does not cover the infertility services or supplies listed on page 45.

**Mental Health Treatment**
The plan covers mental health treatment, as explained in Exhibit 7, beginning on page 42.

**Oral Surgery**
The plan covers certain services and supplies provided by a physician or dentist to the extent they are not covered under your Company-sponsored dental plan. This includes the following medical conditions:

- Excision of a tumor or cyst of the jaw, cheek, lips, tongue, or roof or floor of the mouth.
- Excision of exostoses of the jaw and hard palate.
- Incision and drainage of cellulitis.
- Incision of accessory sinuses, salivary glands, or ducts.

The plan also covers services in connection with the correction of developmental abnormalities of the jaw or malocclusion of the jaw by osteotomy (the surgical cutting of the bone or bony tissue) with or without bone grafting, when performed by either a physician or dentist.

The surgical placement of endosseous implants is covered if there is a reasonable expectation of success for a minimum of five years.

The plan does not cover any services or supplies related to correction of the gums, teeth, or tissues of the mouth for dental purposes.

Coverage of services and supplies related to the diagnosis or treatment of TMJ/MPDS is provided as described in “Temporomandibular Joint Dysfunction and Myofascial Pain Dysfunction Syndrome (TMJ/MPDS) Treatment,” on page 41.

**Pregnancy-Related Conditions and Coverage of Newborns**
Medically necessary services and supplies are covered for pregnancy-related conditions of employees and covered spouses if they are provided while the patient is covered under this plan.

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

The services of an approved birthing center are covered if such services would be covered when received in a hospital.

As required by federal law, following childbirth, mothers and newborns may stay in the hospital for 48 hours following a normal delivery or for 96 hours following a cesarean section, unless a shorter stay is authorized by the attending health care provider in consultation with the mother. Preadmission review is not required for these lengths of stay. Any length of stay beyond 48 hours or 96 hours must be approved through the plan’s medical review program. (See Exhibit 4, beginning on page 28.)
A newborn child is eligible from the date of birth if he or she qualifies as a dependent of the employee and is enrolled within 60 days. The following services and supplies are covered for a newborn child enrolled in the plan, subject to the plan’s annual deductible, copayments, 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 child continues as long as the child remains an eligible dependent and is enrolled in the plan.

**Reconstructive Breast Surgery**

Covered individuals receiving benefits for a mastectomy may elect breast reconstruction in connection with the mastectomy in a manner determined in consultation with the patient and attending physician. Covered services include the following:

- 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 and treatment of physical complications of all stages of mastectomy, including lymphedema.

**Substance Abuse Treatment**

The plan covers substance abuse treatment, as explained in Exhibit 7, beginning on page 42.

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

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

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

As explained on page 26, the plan payment level for TMJ/MPDS treatment is a constant 50 percent of usual and customary charges, up to a lifetime maximum benefit of $3,500.

This benefit does not cover restorative techniques to build occlusion unless the tooth is diseased or accidentally damaged; nonsurgical orthodontic treatment, except as noted above; or banding treatment.

**Transplant Benefits**

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. (Information about experimental or investigational services or supplies begins on page 78.) Contact the service representative for more information about covered transplant services and supplies.

If you or a covered dependent receives a human organ or tissue transplant covered by this plan, certain donor organ procurement costs also may be covered up to a maximum benefit of $30,000 per organ procurement and a lifetime maximum procurement benefit of $60,000. 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. Donor expenses covered under this plan are applied against the plan lifetime maximum benefit (described on page 26) for the recipient covered under this plan.
Boeing Mental Health and Substance Abuse Program

The Boeing mental health and substance abuse program provides benefits for treatment of mental illness (including eating disorders, such as anorexia nervosa or bulimia) and substance abuse (including abuse of or addiction to alcohol or recreational or prescription drugs). The program is administered by ValueOptions.

This program offers you and your dependents the opportunity to talk with trained professionals who will help you find appropriate care for a mental illness or alcohol or drug dependency. You may either call the Boeing Helpline directly at 1-800-892-1411 or contact your local Employee Assistance Program (EAP).

This program is strictly confidential. To be reimbursed under the plan, all mental health and substance abuse treatment must be determined medically necessary. When treatment is obtained from a provider referred by the Boeing Helpline, the plan payment level is higher. You can get a referral to a provider by calling the Boeing Helpline or your EAP. All care will be reviewed for medical necessity whether or not you contact the Boeing Helpline.

Boeing Helpline

The Boeing Helpline (1-800-892-1411) is available 24 hours a day, seven days a week. It is staffed by independent psychologists, psychiatrists, social workers, nurses, and other clinical professionals who specialize in managing mental health and substance abuse treatment.

These clinical case managers are responsible for reviewing and authorizing all levels of care to assure you of its appropriateness, effectiveness, and quality. To update claim payment authorization, your treatment provider periodically will submit clinical updates to these clinical case managers.

When you contact the Boeing Helpline, a clinician will assess your situation and treatment needs and refer you to a provider most suited to your needs. If you already have chosen a provider, the Boeing Helpline staff can confirm whether that provider is a member of the program’s provider network.

If you are not satisfied with the care you are receiving, you may contact the Boeing Helpline for an alternative referral.

Employee Assistance Program

You also may access the program by contacting your local EAP office. An EAP counselor will assess your treatment needs, either in person or over the telephone, and will refer you as necessary to an appropriate provider. The EAP will then coordinate the referral with the Boeing Helpline to authorize initial claim payment. Thereafter, your care will be reviewed periodically by Boeing Helpline clinicians. Your interaction with the EAP counselor is strictly confidential.

Emergency Care

If you are hospitalized in an emergency for treatment of mental illness or substance abuse and are unable to call the Boeing Helpline before admission, then you, your physician, a family member, or a friend must call the Boeing Helpline within 48 hours of the admission. The Boeing Helpline staff will determine whether the plan will cover your hospital stay and coordinate appropriate benefit coverage. If you are admitted to a facility that is not a member of the program’s network, you may be asked to transfer to another facility once your condition has stabilized. Plan payment levels will be lower for an individual who chooses to remain in a facility that is not a member of the network.

A situation is considered an emergency when there is imminent danger to yourself or others or you are medically compromised as a result of mental illness or substance abuse.

Benefits

**Mental Health Treatment (including eating disorders)** The plan covers the medically necessary treatment of mental illness. The following types of providers are eligible for reimbursement under the plan:

- Any provider contracted with the Boeing Helpline.
- Licensed psychiatric doctor (M.D.).
• Licensed clinical psychologist.
• Licensed psychiatric nurse (R.N.).
• Professional at the master’s level or above who is licensed in the area where the services are performed.
• Licensed hospital or treatment facility.

If the mental illness is related to, accompanies, or results from substance abuse, coverage of the treatment will be provided solely under the substance abuse provisions.

The following benefit payment levels and limits apply to treatment of mental illness:

• 100 percent after the annual deductible for covered inpatient, partial hospital, or intensive outpatient services obtained from a provider referred by the Boeing Helpline. Residential treatment may be covered under the plan when authorized in place of inpatient care.

• A constant 80 percent of charges after the annual deductible for covered outpatient services obtained from a provider referred by the Boeing Helpline.

• A constant 50 percent of usual and customary charges after the annual deductible for the covered services of a nonreferred provider if the care is certified as covered by the Boeing Helpline. The plan covers nonreferred provider services up to a maximum of 20 inpatient, partial hospitalization, or intensive outpatient days and 20 outpatient visits each benefit year.

**Substance Abuse Treatment**

The plan pays for the medically necessary treatment of alcoholism and other types of substance abuse. Coverage includes treatment at an approved treatment facility or hospital, physician and licensed therapist services, and prescription drugs when provided in connection with a specific treatment plan prepared by your physician and certified as covered under the plan.

The plan does not cover recovery houses, school programs, or emergency service patrols. The plan also does not cover detoxification unless it is followed immediately by a rehabilitation program. To receive coverage for substance abuse treatment, the patient must complete the prescribed course of treatment.

The following benefit payment levels and limits apply to treatment of substance abuse:

• 100 percent after the annual deductible for covered inpatient, partial hospital, residential, intensive outpatient, or outpatient services obtained from a provider referred by the Boeing Helpline.

• A constant 50 percent of usual and customary charges after the annual deductible for the covered services of a nonreferred provider if the care is certified as covered by the Boeing Helpline. The plan covers nonreferred provider services up to a $5,000 maximum benefit per course of treatment.

The plan pays benefits up to a lifetime maximum of two courses of treatment for referred and nonreferred provider services combined. A course of treatment is clinically determined but generally includes the intensive phase of treatment and follow-up care. If there is a relapse requiring treatment following a lapse in the use of aftercare and/or support groups, that treatment begins a new course of treatment.

**Claim Certification**

Contact the Boeing Helpline before your mental health or substance abuse treatment starts. If you are hospitalized in an emergency, the Boeing Helpline should be called within 48 hours. Failure to call can result in lower coverage or no coverage at all.

Contacting the Boeing Helpline before receiving treatment is to your advantage; your care can be authorized and your claim certified in advance. No additional review will be required for the period certified.

If you do not contact the Boeing Helpline, your claim will be denied. It will be reconsidered only after the Boeing Helpline staff has reviewed and certified your care as covered under the plan. The service representative will inform you of the denial. You should ask your provider to contact the Boeing Helpline staff and provide any information needed to review your claim.
The plan does not cover the following:

- Nonhuman, artificial, or mechanical transplants.
- Experimental or investigational services or supplies, unless they are part of an approved clinical trial. (See the definition, beginning on page 78.)
- Services and supplies for the donor 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 this plan.
- Lodging, food, or transportation costs, unless otherwise specifically provided under this plan.
- Donor and procurement services and costs incurred outside the United States, unless specifically approved by the service representative.
- Living (noncadaver) donor transplants (except kidney, liver, lobar lung, and bone marrow or stem cell transplants for covered conditions), including selective islet cell transplants of the pancreas.

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

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

- Any accident or illness covered by a workers’ compensation law.
- Intentionally self-inflicted injury, unless you are under treatment for a mental illness.
- Services or supplies that the plan’s 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, and other preventive services and supplies, except as specifically provided by the plan.

Inpatient hospital care (including physician visits while hospitalized) is not considered medically necessary when the care can be provided safely in an outpatient setting, such as a hospital outpatient department, physician’s office, or an ambulatory surgical facility, without adversely affecting the patient’s 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 aimed at controlling or changing the patient’s environment.

- Services or supplies not recommended and approved by a physician or other covered health care professional (see “Other Professional Services,” beginning on page 30) or those that were provided before the person becomes covered under this plan.
- Experimental or investigational services and supplies (as defined, beginning on page 78) and related complications.
- Custodial care.
- Skilled nursing facility services when the services 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 a terminal patient when the illness has reached a point of predictable end.
• Equipment or supplies that are not solely related to the medical care of a diagnosed illness or injury. Examples include but are not limited to any luxury or convenience item or supply; general exercise equipment; modification to home (e.g., wheelchair ramps, support railings), automobile, or van (e.g., ramps, lifts); environmental control devices (e.g., air conditioners, purifiers, humidifiers); a swimming pool, spa, or whirlpool; a Craftmatic or similar bed; an orthopedic chair; a special car seat; and any personal hygiene item.

• The following home health care or hospice care services:
  • Homemaker or housekeeping services.
  • Services provided by volunteers, household members, family, or friends.
  • Unnecessary or inappropriate services, food, clothing, housing, or transportation.
  • Social services.
  • Psychiatric care.
  • Maintenance or custodial care.
  • Supplies or services not included in the written home health or hospice care treatment plan or not otherwise covered.
  • Hospice services to other family members, including bereavement counseling.
  • Hospice services of financial, legal, or spiritual counselors.
  • Any treatment or services required in connection with a sex transformation.
  • Reversal of a sterilization procedure.
  • Infertility services and supplies, including but not limited to
    • Artificial insemination.
    • Embryo transfer.
    • Gamete intrafallopian transfer (GIFT).
    • In vitro fertilization.
    • Microinjections.
    • Sperm preparation.
    • Sperm separation.
    • Zona drilling.
    • Any tests, visits, consultations, or treatment related to, leading to, or resulting in one of the above listed noncovered services.
    • Consecutive follicular ultrasounds, cycle therapy, or corresponding laboratory tests when associated with any artificial means of conception.
    • Fertility drugs, including but not limited to Clomid, Serophene, Pergonal, or HCG, when associated with artificial means of conception.
  • Services or supplies to the extent they are covered under any Company-sponsored plan that has been discontinued.
  • Services or supplies to the extent they are covered under any federal, state, or other government plan, except where required by law.
  • 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 such contract or insurance is issued to or provides benefits available to the patient. Any benefits paid by this plan before benefits are paid under one of these other types of contracts or insurance are provided to assist the patient and do not indicate the service representative is acting as a volunteer or waiving any right to reimbursement or subrogation. (See “When an Injury or Illness Is Caused by the Negligence of Another,” on page 46.)
• Confinement, surgical, medical, or other treatment, services, or supplies received in or from a U.S. Government hospital, except as required by law.

• Services or supplies for which no charge is made or charges the employee or dependent is not required to pay.

• Dyslexia, visual analysis therapy, or training related to muscular imbalance of the eye or for orthoptics. However, coverage is provided for up to six months when necessary to correct muscle imbalance (strabismus, esotropia, or exotropia) if treatment begins before the person’s 12th birthday.

• Radial keratotomy or other eye surgery to correct refractive errors, except when preoperative visual acuity is 20/50 or less with a lens.

• Full body computerized axial tomography (CAT) scans other than those performed at a hospital or an institution having an agreement with a hospital to supply such services. However, expenses are covered under other circumstances if the equipment is required and certified by the physician for immediate use to diagnose a potentially life-threatening condition or if the services are provided at a physician’s office, clinic, or other institution approved by the Company for other than emergency use.

• Services or supplies related to the following:
  • Cosmetic surgery, except as described on page 39.
  • Obesity, unless approved in advance by the service representative according to written guidelines. You may request a copy of the guidelines by calling the service representative.
  • Treatment of mental illness (including eating disorders) or substance abuse, except as described in Exhibit 7, beginning on page 42.
  • Smoking cessation treatment, except as described on page 36.
  • Treatment of TMJ/MPDS, except as described on page 41.
  • Services or supplies for a pregnancy-related condition for dependent children, unless otherwise required by law.
  • Services or supplies required by law to be provided by any school system.
  • Education, special education, or job training whether or not provided by a facility that also provides medical or psychiatric care.
  • Marriage counseling, family counseling, child counseling, career counseling, social adjustment counseling, pastoral counseling, or financial counseling.
  • Amounts exceeding usual and customary charges.
  • Completion of claim forms or reports.
  • Missed appointments.

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

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

If you or your dependents have medical, dental, or other health coverage in addition to being covered under this Traditional Medical Plan, the following rules govern coordination of benefits with your 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 such as homeowner’s or automobile medical payments or personal injury protection.

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 medical 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:

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

Treatment of end-stage renal disease is covered by the Traditional Medical 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 Traditional Medical Plan provides secondary coverage.

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

The exclusion of government benefits and services is described in “Medical Plan Exclusions,” beginning on page 44.

How to Submit a Medical Claim

Regence BlueShield is the service representative for the Traditional Medical Plan. The service representative’s address and telephone numbers are listed in Exhibit 10 on page 82.

When receiving services, present your Traditional Medical Plan identification card to identify yourself as covered under the plan. The network provider will submit an itemized bill directly to the local Blue Cross or Blue Shield plan. The local plan then will route your claim electronically to the service representative for processing. The service representative will determine the amount of payment and respond to the local plan. Network providers are paid by the local Blue Cross or Blue Shield plan. You are responsible only for paying your copayments and/or annual deductible. You will receive a detailed Explanation of Benefits form from the service representative each time a claim is processed.

Many health care providers who are not network providers (such as Blue Cross or Blue Shield participating providers) may submit claims for you. Under these circumstances, no claim form is required.

If direct billing is not available to you (including billing for most vision services), submit the appropriate claim form and an itemized bill to the service representative. Nonnetwork and nonparticipating providers may require full payment for their services at the time you receive the care; in this instance the service representative will reimburse you according to plan payment levels.

Exhibit 8, on page 56, provides helpful tips on how to avoid claim problems.

For a description of how to claim benefits under the prescription drug coverage options, refer to Exhibit 5, beginning on page 34.

Claim forms are available from the service representative. Claims must be submitted to the service representative within 12 months of the date covered services or supplies are received or obtained.
Preferred Dental Plan

The Preferred Dental Plan currently is available in the Wichita area.

Although you and your dependents may receive your care from any licensed dentist or other plan-approved provider, the plan offers you certain advantages if you select a dentist who is a member of the Delta Dental organization in your state. As explained in “Recognized Fees,” beginning on this page, member dentists have agreed to accept certain fees as their charge for covered services and supplies. If you select a member dentist who also is a network dentist, you will receive a higher level of benefits. For a list of member dentists (including network dentists) in your area, contact the Preferred Dental Plan service representative at the telephone number listed in Exhibit 10 on page 83.

Many of the benefit and plan payment provisions are based on a benefit year (as defined on page 78). The Preferred Dental Plan is administered by Delta Dental (the service representative). The Boeing Company may change the service representative at any time.

Classes of Covered Services and Supplies

The plan pays benefits according to the following four classes of covered services and supplies. Covered services and supplies are described in more detail beginning on page 50.

• Class I includes covered services and supplies related to diagnostic and preventive care. The plan pays 90 percent of recognized fees for these covered services and supplies when received from a network dentist and 70 percent of recognized fees when received from a nonnetwork dentist.

• Class II includes certain covered services and supplies for minor restorations, oral surgery, periodontic care, endodontic care, and pedodontic care. The plan pays 80 percent of recognized fees for these covered services and supplies when received from a network dentist and 70 percent of recognized fees when received from a nonnetwork dentist.

• Class III includes most covered services and supplies related to major restorations, crowns, dentures, partials, and bridges. The plan pays 60 percent of recognized fees for these covered services and supplies when received from a network dentist and 50 percent of recognized fees when received from a nonnetwork dentist.

• Class IV includes services and supplies for orthodontia. The plan pays such care at 60 percent of recognized fees when received from a network or nonnetwork dentist.

The maximum benefit for all Class I, II, and III services and supplies combined is $2,000 per person each benefit year. When multiple treatment dates are required, the charges are applied toward this maximum in the benefit year in which the procedure or service is completed. A prosthesis is considered complete on the date it is seated or delivered.

The lifetime maximum benefit for Class IV orthodontia services and supplies is $2,000 per person. This limit applies to all periods during which the person is covered under any Company-sponsored dental plan.

Recognized Fees

The Boeing Company has contracted with the Delta Dental organization to provide the Preferred Dental Plan. All network dentists are members of Delta Dental. In addition, certain other dentists may be members of Delta Dental in your state.

The maximum fees recognized by the plan are the fees filed by the dentist with Delta Dental. A member dentist may not charge more than these filed fees. A network dentist has agreed not to charge more than the network allowed charge. Nonmember dentists are paid the Delta Dental allowable fee.
The following table summarizes your expenses for each type of dentist.

<table>
<thead>
<tr>
<th>When you use a . . .</th>
<th>You are responsible for . . .</th>
</tr>
</thead>
</table>
| Member dentist who is a network dentist| • Out-of-pocket expenses:  
Class I: 10%  
Class II: 20%  
Class III: 40%  
Class IV: 40%  
• Any amounts for services and supplies not covered by the plan |
| Member dentist who is *not* a network dentist| • Out-of-pocket expenses:  
Class I: 30%  
Class II: 30%  
Class III: 50%  
Class IV: 40%  
• Any amounts for services and supplies not covered by the plan |
| Nonmember dentist                      | • Out-of-pocket expenses:  
Class I: 30%  
Class II: 30%  
Class III: 50%  
Class IV: 40%  
• Any amounts that exceed the allowable fees recognized by the plan  
• Any amounts for services and supplies not covered by the plan |

Whenever alternative procedures are available, the Preferred Dental Plan considers the covered expense to be the amount charged for the least expensive procedure. However, if the dentist submits satisfactory evidence to the service representative that the more expensive procedure is the only professionally adequate procedure for the patient, the plan will cover the more expensive procedure according to the appropriate benefit payment level.

Covered Dental Services and Supplies

The Preferred Dental Plan covers the following services and supplies. Coverage is subject to the benefit payment levels and maximums previously explained as well as the exclusions and other provisions of the plan.

Diagnostic Services and Supplies

To determine the appropriate benefit payment level, covered diagnostic services and supplies are considered Class I services and supplies.

The plan covers the following diagnostic services and supplies:

• Routine examinations, once in a six-month period.
• Complete mouth or panographic X-rays, once in a five-year period.
• Supplementary bitewing X-rays, once in a 12-month period.
• Emergency examinations.
• Examinations by a specialist if the specialty is recognized by the American Dental Association.

The plan does not cover a review of a proposed treatment plan or case presentation by the attending dentist, study and diagnostic models, or caries (decay) susceptibility tests.
Preventive Services and Supplies
To determine the appropriate benefit payment level, covered preventive services and supplies are considered Class I services and supplies.

The plan covers the following preventive services and supplies:

- Prophylaxis (cleaning), either regular or periodontal, once in a four-month period.
- Topical application of fluoride, once in a six-month period when performed with prophylaxis for dependent children through age 18.
- Fissure sealants for dependent children through age 13. Fissure sealants are topically applied acrylic, plastic, or composite material used to seal developmental grooves and pits in the child’s teeth to prevent dental decay. The plan covers only sealants applied to permanent molar teeth that have intact occlusal surfaces, no decay, and no prior restorations. The repair or replacement of a sealant on any tooth within three years of its initial placement is considered part of the original service.

The plan does not cover home fluoride kits, cleaning of prosthetic appliances, plaque control programs, oral hygiene instruction, or dietary instruction.

Restorative Services and Supplies
To determine the appropriate benefit payment level for covered restorative services and supplies, restorations using filling materials are considered Class II services and supplies, while restorations using crowns, inlays, or onlays are considered Class III services and supplies.

The plan covers the following restorative services and supplies:

- Restoration of a hard tooth surface that is visibly decayed (known as a carious lesion) to a state of functional acceptability. Restorations may be accomplished using filling materials such as amalgam, silicate, or plastic or by using crowns, inlays, or onlays.
- Restorations on the same surface or surfaces of a tooth are covered once in a two-year period. Crowns, inlays, and onlays (whether gold, porcelain, plastic, gold substitute casting, or a combination of these materials) are covered on the same tooth once in a five-year period. Stainless steel crowns are covered once in a two-year period. The attending dentist must verify that the tooth cannot be restored with filling materials such as amalgam, silicate, or plastic.
- 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 restored adequately 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 covers the use of a crown as an abutment to a partial denture only when the tooth is decayed to the extent that a crown would be required whether or not a partial denture is required.

The plan does not cover appliances or restorations necessary to correct vertical dimension or to alter morphology (shape) or occlusion, overhang removal, or recontouring or polishing a restoration.

Oral Surgery
To determine the appropriate benefit payment level, services and supplies related to covered oral surgery are considered Class II services and supplies.

The plan covers the following surgical procedures:

- Surgical and nonsurgical extractions.
- Preparation of the alveolar ridge and soft tissues of the mouth for the insertion of dentures.
- Ridge extension for the insertion of dentures (vestibuloplasty).
- Treatment of pathological conditions and traumatic facial injuries.
- General anesthesia, but only when administered by a licensed dentist in connection with a covered oral surgery procedure.
The plan does not cover extraoral grafts (grafts from tissues outside the mouth or the use of artificial materials) or tooth transplants.

**Periodontic Services and Supplies**

To determine the appropriate benefit payment level, services and supplies related to covered periodontic treatment are considered Class II services and supplies.

The plan covers services and supplies for the following surgical and nonsurgical procedures when used to treat tissues that support the teeth:

- Root planing.
- Subgingival curettage.
- Gingivectomy.
- Limited adjustments to occlusion (for eight or fewer teeth) such as the smoothing of teeth or reduction of cusps.

The plan covers root planing or subgingival curettage, but not both, once in a 12-month period.

The plan does not cover periodontal splinting or any crown or bridgework provided with periodontal splinting, major (complete) occlusal adjustment, or periodontal appliances.

**Endodontic Services and Supplies**

To determine the appropriate benefit payment level, services and supplies related to covered endodontic care generally are considered Class II services and supplies. However, if root canal treatment is provided in conjunction with an overdenture, the plan pays benefits for such treatment as part of Class III services and supplies. The plan covers pulpal and root canal treatment on the same tooth (including pulpotomy and apicoectomy) once in a two-year period. General anesthesia is covered only when administered by a licensed dentist in connection with a covered endodontic surgery procedure.

Tooth bleaching, whether vital or nonvital, is not covered.

**Pedodontic Services and Supplies**

To determine the appropriate benefit payment level, pedodontic services and supplies are considered Class II services and supplies.

The plan covers space maintainers only when used to maintain space for the eruption of permanent teeth. No coverage is provided for the replacement of a space maintainer previously covered under the plan.

**Prosthodontic Services and Supplies**

To determine the appropriate benefit payment level, prosthodontic services and supplies are considered Class III services and supplies.

The plan covers dentures, bridges, partial dentures (including abutment crowns), and related items as well as the adjustment or repair of an existing prosthetic device as follows:

- Full denture, immediate denture, or overdenture. If any other procedure is provided (such as personalized restorations or specialized treatment), the plan applies the appropriate amount for a full or immediate denture or overdenture toward the cost. Coverage of root canal therapy performed in conjunction with overdentures is limited to two teeth per arch.

- Cast chrome or acrylic partial denture. If a more elaborate or precision device is used, the plan applies the appropriate amount for covered partial dentures toward the cost.

- Implant-related appliances attached to the implant. If you elect to receive implant-related appliances that are attached to the implant, the plan allows up to the amount that would have been provided for a full or partial denture.
The plan also limits the frequency that certain prosthodontic services and supplies are covered, as follows:

- Replacement of an existing prosthetic device once in a five-year period and only then if the device is unserviceable and cannot be made serviceable. Expenses related to making the device serviceable are covered.
- Denture adjustments and relines if performed more than six months after the initial placement occurs. Later relines and jump rebases, but not both, are covered once in a one-year period.
- If an implant-related appliance is covered within the terms explained above, the plan covers a replacement only if it is placed five or more years after the initial placement.

The plan does not cover duplicate dentures, cleaning of prosthetic appliances, temporary dentures, surgical placement or removal of implants or attachments to implants, or crowns and copings provided in conjunction with overdentures.

**Orthodontia Services and Supplies**
To determine the appropriate benefit payment level, orthodontia services and supplies are considered Class IV services and supplies.

The plan covers orthodontia treatment (including the correction or prevention of malocclusion) for you and your eligible dependents.

**Dental Plan Exclusions**
The following items are not covered under the Preferred Dental Plan:

- Services for injuries or conditions that are compensable under workers’ compensation or employers’ liability laws; provided by any federal, state, or provincial government agency; or provided without cost by any municipality, county, or other political subdivision or community agency. However, to the extent that payments by a government agency are insufficient to cover the charges for covered services or supplies or when benefits are provided by a government agency as an employer to its employees, coverage of dental services and supplies is not excluded but rather is subject to the coordination of benefit provisions (see the explanation, beginning on page 54).
- Procedures (including laminates and tooth bleaching), appliances, or restorations primarily for cosmetic purposes.
- Charges for services or supplies that are received while the person is not covered under the plan, except as explained under “Extended Dental Benefits Following Termination of Coverage,” on page 54.
- Analgesics such as nitrous oxide, intravenous sedation, euphoric drugs, injections, or prescription drugs.
- Application of desensitizing agents.
- Hospitalization charges.
- Full mouth reconstruction.
- Fees for broken appointments.
- Experimental services or supplies (and related complications), as defined, beginning on page 78.
- Services to treat temporomandibular (jaw) joints.
- Charges for the laboratory examination of a tissue specimen.
- Habit-breaking appliances.
- Patient management problems.
- Fees for completing insurance forms.
• Services specifically excluded in this dental coverage description.
• All other items not specifically included in this plan as covered dental benefits.

Extended Dental Benefits Following Termination of Coverage

The Preferred Dental Plan generally does not cover care that you or an eligible dependent receives while not covered under the plan. However, the plan covers certain services and supplies during the three calendar months following termination of the eligible person’s coverage if the dentist has determined before the eligible person’s coverage ends that the treatment is needed.

Services and supplies in connection with a prosthetic device, including the abutment crowns of a partial denture, are covered if the denture impressions were taken while the eligible person was covered under the plan. However, the prosthetic device must be installed or delivered to the eligible person within the three calendar months following termination of coverage. Services are not covered if the denture impressions were taken before the date coverage became effective. If the impressions were taken after coverage terminated, the services must meet the requirements described in the preceding paragraph.

Services and supplies in connection with a crown required for restoring a tooth (independent of the crown’s use in connection with a partial denture) are covered if the tooth was prepared for the crown before coverage terminated. Otherwise, the crown must be installed according to the requirements described in the first paragraph of this section.

The plan covers services and supplies in connection with covered orthodontia care if such services and supplies are provided during the three calendar months following termination of the eligible person’s coverage.

For other coverage continuation options following the termination of your coverage, see “Termination of Coverage,” beginning on page 67.

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

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

Coordination of Dental Benefits

If you or your dependents have medical, dental, or other health coverage in addition to being covered under this Preferred Dental Plan, the following rules govern coordination of benefits with your other coverage. Other coverage includes, whether insured or uninsured, another employer’s group benefit plan, other arrangement of individuals in a group, individual insurance or health coverage, and insurance that pays without consideration of fault such as homeowner’s or automobile medical payments or personal injury protection.
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 dental 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:

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

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 one Company-sponsored medical or dental plan. However, when dental services performed by a licensed dentist also are covered under the medical plan, the Preferred Dental Plan pays its benefits first and the medical plan is secondary.

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

The exclusion of government benefits and services is described in “Dental Plan Exclusions,” beginning on page 53.
How to Submit a Dental Claim

Washington Dental Service (a Delta Dental organization) is the primary service representative for the Preferred Dental Plan. Claims are processed by the regional service representative. The address and telephone number for the service representative are listed in Exhibit 10 on page 83.

Claim forms generally are not required under the Preferred Dental Plan as long as you receive services from a member dentist and identify yourself as covered under the plan at the time of the appointment. The service representative provides each member dentist with claim forms, and the member dentist usually will submit a claim directly to the plan on your behalf.

You will need to submit a claim for covered orthodontia care and care received from nonmember dentists. Claim forms are available from the service representatives. Exhibit 8 below provides helpful tips on how to avoid claim problems.

Claims must be submitted to the service representative within 12 months of the date covered services or supplies are received or obtained.

---

<table>
<thead>
<tr>
<th>Exhibit 8</th>
</tr>
</thead>
</table>

How to Avoid Claim Problems

In many cases, your physician or other health care provider will send a bill directly to the plan's service representative. If you are covered under the Traditional Medical Plan, simply present your Traditional Medical Plan identification card to your provider. If you are covered under the Preferred Dental Plan or the Scheduled Dental Plan, present your identification card and give the dentist your Social Security number.

If you are required to submit a claim, the following tips should help you avoid delays and other claim filing problems:

- Complete all the information requested on the form, including the employee's full name, address, and identification number (which can be found on the identification card), employee's Social Security number, patient's name and birth date, date of the service, diagnosis, and type(s) of service received.
- Always attach an itemized bill that includes the health care provider's name, address, and tax identification number. A notice from the provider that payment is overdue generally will not provide adequate information for determining benefits and payments.
- If additional information is requested, be sure the follow-up information includes the patient's full name and the employee's full name and Social Security number.
- If you or a dependent is eligible for coverage under another employer's group benefit plan, submit a claim first to the plan providing primary coverage (as determined under the coordination of benefit provisions described for each plan). When that plan sends you a written Explanation of Benefits form, send a copy of the explanation along with the appropriate claim form and an itemized bill to the second plan. If you are not sure which plan provides primary coverage, submit a claim to both plans at the same time.
Scheduled Dental Plan

The Scheduled Dental Plan is available in all areas of the country. The plan offers you and your dependents the opportunity to receive dental care from any licensed dentist on a fee-for-service basis. Your share of the cost will vary depending on the type of treatment you receive and, in many cases, on the level of your dentist’s fees.

Many of the benefit and plan payment provisions are based on a benefit year (as defined on page 78). The Scheduled Dental Plan is administered by Aetna U.S. Healthcare. The Boeing Company may change the service representative at any time.

Deductible

The annual deductible is $25 per person each benefit year. For families of three or more, the deductible for all family members will not exceed $75 each benefit year. The deductible applies to all covered services and supplies except covered diagnostic and preventive care, such as examinations, X-rays, prophylaxis (cleaning), fluoride treatments, and fissure sealants.

Benefit Payment Levels

Once you and your dependents have paid the required deductible expenses, the plan pays the usual and customary charges for necessary dental services and supplies, up to the amounts listed in the schedule of covered dental services in Exhibit 9, beginning on page 58. In addition, certain other dental treatment may be covered even though it is not listed in the schedule. If your dentist recommends a plan of treatment that includes services and supplies not listed in the schedule, you may ask your dentist to complete a claim form before treatment begins and submit it to the service representative for a predetermination review. Based on the information provided by your dentist, the service representative will advise you of the plan’s coverage for the proposed treatment. You also may contact the service representative to determine whether the charges quoted by your dentist for a proposed treatment plan are reasonable.

If two or more covered services are received at the same time, the plan pays up to the amount shown in the schedule in Exhibit 9, beginning on page 58, for each service, unless the schedule specifies a maximum for a particular combination of services.

Benefit Maximums

The maximum benefit for all services and supplies (except orthodontia) is $2,000 per person each benefit year. When multiple treatment dates are required, the charges are applied toward this maximum in the benefit year the procedure or service is completed. A prosthesis is considered complete on the date it is seated or delivered.

The lifetime maximum benefit for orthodontia services and supplies is $2,000 per person. This maximum applies to all periods during which the person is covered under any Company-sponsored dental plan.

Benefit Limitations

The plan limits the coverage of necessary dental services and supplies, as shown in the schedule in Exhibit 9, beginning on page 58. Additional limits and exclusions are described on page 62.

Continued on page 62
### Scheduled Dental Plan—Schedule of Covered Services

The following schedule lists the maximum dollar amount payable for services covered under the Scheduled Dental Plan. All coverage is subject to the general terms of the plan, including the exclusions listed on page 62.

<table>
<thead>
<tr>
<th>American Dental Association Code</th>
<th>Maximum Covered Expense ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic</strong></td>
<td></td>
</tr>
<tr>
<td>00110</td>
<td>Initial oral exam 48</td>
</tr>
<tr>
<td>00120</td>
<td>Periodic oral exam 26</td>
</tr>
<tr>
<td>00130</td>
<td>Emergency oral exam 37</td>
</tr>
<tr>
<td>00210</td>
<td>Intraoral (including bitewings) 69</td>
</tr>
<tr>
<td>00330</td>
<td>Panoramic 53</td>
</tr>
<tr>
<td><strong>Intraoral Periapical X-Rays</strong></td>
<td></td>
</tr>
<tr>
<td>00220</td>
<td>Single, first film 14</td>
</tr>
<tr>
<td>00230</td>
<td>Each additional film 11</td>
</tr>
<tr>
<td><strong>Bitewings</strong></td>
<td></td>
</tr>
<tr>
<td>00270</td>
<td>Single film 13</td>
</tr>
<tr>
<td>00272</td>
<td>Two films 21</td>
</tr>
<tr>
<td>00274</td>
<td>Four films 32</td>
</tr>
<tr>
<td><strong>Preventive</strong></td>
<td></td>
</tr>
<tr>
<td>01120</td>
<td>To age 14 37</td>
</tr>
<tr>
<td>01110</td>
<td>Age 14 or older 58</td>
</tr>
<tr>
<td><strong>Fluoride Treatment</strong></td>
<td></td>
</tr>
<tr>
<td>01203/01204</td>
<td>Topical application of fluoride 21 (limited to once in a six-month period)</td>
</tr>
<tr>
<td><strong>Fissure Sealants</strong></td>
<td></td>
</tr>
<tr>
<td>01351</td>
<td>Topical application of fissure sealants 26 (per quadrant), to age 16</td>
</tr>
<tr>
<td><strong>Minor Restorations</strong></td>
<td></td>
</tr>
<tr>
<td>02110</td>
<td>Primary—one surface 48</td>
</tr>
<tr>
<td>02120</td>
<td>Primary—two surfaces 63</td>
</tr>
<tr>
<td>02130</td>
<td>Primary—three surfaces 79</td>
</tr>
<tr>
<td>02140</td>
<td>Permanent—one surface 58</td>
</tr>
<tr>
<td>02150</td>
<td>Permanent—two surfaces 74</td>
</tr>
<tr>
<td>02160</td>
<td>Permanent—three surfaces 95</td>
</tr>
<tr>
<td>02161</td>
<td>Permanent—four surfaces 116</td>
</tr>
<tr>
<td>02951</td>
<td>Pin retention—exclusive of amalgam 16</td>
</tr>
<tr>
<td><strong>Other Minor Restorations</strong></td>
<td></td>
</tr>
<tr>
<td>02210</td>
<td>Silicate cement 58</td>
</tr>
<tr>
<td>02310</td>
<td>Acrylic 58</td>
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<tr>
<td>02330</td>
<td>Resin—one surface anterior 69</td>
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<tr>
<td>02331</td>
<td>Resin—two surfaces anterior 90</td>
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<tr>
<td>02332</td>
<td>Resin—three surfaces anterior 116</td>
</tr>
<tr>
<td>02335</td>
<td>Resin—four or more surfaces anterior 127</td>
</tr>
<tr>
<td>02380</td>
<td>Resin—one surface posterior primary 58</td>
</tr>
</tbody>
</table>
### American Dental Association Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Maximum Covered Expense ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>02381</td>
<td>Resin—two surfaces posterior primary</td>
<td>79</td>
</tr>
<tr>
<td>02382</td>
<td>Resin—three surfaces posterior primary</td>
<td>106</td>
</tr>
<tr>
<td>02385</td>
<td>Resin—one surface posterior permanent</td>
<td>74</td>
</tr>
<tr>
<td>02386</td>
<td>Resin—two surfaces posterior permanent</td>
<td>100</td>
</tr>
<tr>
<td>02387</td>
<td>Resin—three surfaces posterior permanent</td>
<td>127</td>
</tr>
</tbody>
</table>

### Major Restorations

**Inlays and Onlays**
- 02510 Gold inlay—one surface | 217 |
- 02520 Gold inlay—two surfaces | 275 |
- 02530 Gold inlay—three surfaces | 317 |
- 02540 Onlay—per tooth (in addition to inlay) | 95 |
- 02910 Recement inlay | 32 |

**Crowns**
- 02720 Resin with high noble metal | 380 |
- 02721 Resin with predominantly base metal | 380 |
- 02722 Resin with noble metal | 380 |
- 02740 Porcelain/ceramic noble | 380 |
- 02750 Porcelain fused to high noble | 380 |
- 02751 Porcelain fused to predominantly base metal | 380 |
- 02752 Porcelain fused to noble | 380 |
- 02790 Full cast high noble metal | 380 |
- 02791 Full cast predominantly base metal | 380 |
- 02792 Full cast noble metal | 380 |
- 02810 3/4 cast metallic | 380 |
- 02930/02931 Stainless steel | 85 |
- 02970 Temporary (fractured tooth) | 63 |
- 02950 Crown buildup | 116 |
- 02920 Recement crown | 42 |

### Endodontics

- 03110 Pulp cap—direct | 32 |
- 03120 Pulp cap—indirect | 26 |
- 03220 Vital pulpotomy | 69 |

Root Canal Therapy (includes treatment plan, clinical procedures, and follow-up care; excludes final restoration)
- 03310 Single rooted | 312 |
- 03320 Bi-rooted | 412 |
- 03330 Tri-rooted | 512 |
- 03410 Apicoectomy (performed as a separate surgical procedure) | 412 |

### Periodontics

**Nonsurgical Services**
- 04110 Periodontal exam | 74 |
- 04100 Periodontal prophylaxis (limited to once in a four-month period) | 79 |
- 04330 Occlusal adjustment (limited) | 106 |
- 04331 Occlusal adjustment (complete) | 306 |

*Continued on page 60*
### Exhibit 9 (continued)

<table>
<thead>
<tr>
<th>American Dental Association Code</th>
<th>Maximum Covered Expense ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>04340</td>
<td>Periodontal scaling and/or root planing (full)</td>
</tr>
<tr>
<td>04341</td>
<td>Periodontal scaling and/or root planing (per quadrant)</td>
</tr>
<tr>
<td><strong>Surgical Services</strong></td>
<td></td>
</tr>
<tr>
<td>04210</td>
<td>Gingivectomy (per quadrant)</td>
</tr>
<tr>
<td>04220</td>
<td>Gingival curettage</td>
</tr>
<tr>
<td>04260</td>
<td>Osseous surgery (per quadrant)</td>
</tr>
<tr>
<td>04271</td>
<td>Free soft tissue grafts</td>
</tr>
<tr>
<td>07340</td>
<td>Vestibuloplasty</td>
</tr>
<tr>
<td><strong>Prosthodontics</strong></td>
<td></td>
</tr>
<tr>
<td>05110/05120</td>
<td>Complete upper or lower</td>
</tr>
<tr>
<td>05130/05140</td>
<td>Immediate upper or lower</td>
</tr>
<tr>
<td>05211/05212</td>
<td>Partial upper or lower acrylic base (including any conventional clasps and rests)</td>
</tr>
<tr>
<td>05213/05214</td>
<td>Partial upper or lower, predominantly cast base with acrylic saddles (including any conventional clasps and rests)</td>
</tr>
<tr>
<td>05215/05216</td>
<td>Partial upper or lower, high noble cast base with acrylic saddles (including any conventional clasps and rests)</td>
</tr>
<tr>
<td><strong>Related Denture Services</strong></td>
<td></td>
</tr>
<tr>
<td>05410–05422</td>
<td>Denture adjustment (complete or partial)</td>
</tr>
<tr>
<td>05510</td>
<td>Repair broken denture (no teeth damage)</td>
</tr>
<tr>
<td>05520</td>
<td>Replace missing or broken tooth (per tooth)</td>
</tr>
<tr>
<td>05710–05721</td>
<td>Denture conversion</td>
</tr>
<tr>
<td>05730–05741</td>
<td>Reline denture—office</td>
</tr>
<tr>
<td>05750–05761</td>
<td>Reline denture—laboratory</td>
</tr>
<tr>
<td><strong>Bridgework</strong></td>
<td></td>
</tr>
<tr>
<td>06210–06213</td>
<td>Pontic—cast high noble, noble, and predominantly base</td>
</tr>
<tr>
<td>06240–06242</td>
<td>Pontic—porcelain high noble, noble, and predominantly base</td>
</tr>
<tr>
<td>06250–06252</td>
<td>Pontic—resin high noble, noble, and predominantly base</td>
</tr>
<tr>
<td>06930</td>
<td>Recement bridge</td>
</tr>
<tr>
<td><strong>Oral Surgery</strong></td>
<td></td>
</tr>
<tr>
<td>07110</td>
<td>Single tooth (uncomplicated)</td>
</tr>
<tr>
<td>07120</td>
<td>Each additional tooth (uncomplicated)</td>
</tr>
<tr>
<td>07210</td>
<td>Erupted tooth</td>
</tr>
<tr>
<td>07220</td>
<td>Impacted tooth—soft tissue</td>
</tr>
<tr>
<td>07230</td>
<td>Impacted tooth—partially bony</td>
</tr>
<tr>
<td>07240</td>
<td>Impacted tooth—completely bony</td>
</tr>
<tr>
<td>07250</td>
<td>Root recovery (per tooth)</td>
</tr>
</tbody>
</table>
### Exhibit 9 (continued)

<table>
<thead>
<tr>
<th>American Dental Association Code</th>
<th>Maximum Covered Expense ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>07310 Alveoloplasty (per quadrant)</td>
<td>106</td>
</tr>
<tr>
<td>07510 Incision and drainage of abscess—intraoral</td>
<td>85</td>
</tr>
<tr>
<td>07960 Frenectomy (separate procedure)</td>
<td>190</td>
</tr>
</tbody>
</table>

General Anesthesia (not covered when provided at a hospital; see “Dental Plan Exclusions,” on page 62)

<table>
<thead>
<tr>
<th>09220 First 30 minutes</th>
<th>185</th>
</tr>
</thead>
<tbody>
<tr>
<td>09221 Each additional 15 minutes (or major fraction thereof)</td>
<td>63</td>
</tr>
</tbody>
</table>

**Orthodontia (coverage for employees and dependents)**

50 percent of usual and customary charges up to a lifetime maximum benefit of $2,000

**Other Covered Expenses**

Certain procedures not listed in this exhibit may be covered under the Scheduled Dental Plan. The service representative will determine the allowance for such a procedure based on the nature and complexity of the procedure. The allowance will be consistent with those listed in the schedule.
For the replacement of dentures and bridgework, the plan covers the replacement as shown in the schedule only if you can present satisfactory evidence to the service representative that the existing denture or bridgework was installed at least five years earlier and cannot be made serviceable. Similarly, the plan covers the replacement of an immediate temporary denture or bridgework with a permanent denture or bridgework only if the replacement is required and takes place within 12 months from the date the temporary denture or bridgework was installed.

Fissure sealants include the application of sealants only to permanent molar teeth with the occlusal surfaces intact, no caries (decay), and no restorations. Fissure sealants do not include any repair or replacement of a sealant on any tooth within three years of its application. Such repair or replacement is considered included in the fee for the initial placement of the sealant.

**Dental Plan Exclusions**

The following items are not covered under the Scheduled Dental Plan:

- Treatment provided by a professional other than a dentist or licensed dental hygienist when provided under the supervision and direction of the dentist.
- Services or supplies partially or wholly for cosmetic purposes. Cosmetic services include, but are not limited to, personalization or characterization of dentures.
- Charges for services or supplies received while the person is not covered under the plan, except as explained in “Extended Dental Benefits Following Termination of Coverage,” on page 63.
- Charges for the replacement of a lost or stolen prosthetic appliance.
- Orthodontic treatment, including correction or prevention of malocclusion, except as specifically provided for under the plan.
- Injuries or conditions in connection with an occupational accident or covered under a workers’ compensation law.
- Charges for prophylaxis more often than once in each four-month period.
- Separate charges for anesthetics, their administration, or anesthetic supplies or drugs, except general anesthesia when medically necessary.
- The portion of a charge that exceeds the usual and customary charge or that exceeds the maximum covered expenses listed in the schedule.
- Periodontal services and supplies, including periodontal splinting and bridgework, except as specifically listed in the schedule.
- Treatment of temporomandibular joint dysfunction and myofascial pain dysfunction syndrome.
- Charges that would not have been made if no dental plan existed, or charges that neither you nor your dependents are required to pay.
- Services or supplies furnished or paid for by reason of the past or present service of any person in the armed forces of a government.
- Services or supplies paid or otherwise provided for under any law of a government. However, to the extent that benefits are provided by the government as an employer to its own civilian employees and their dependents, coverage of dental services and supplies is not excluded but rather is subject to the coordination of benefit provisions (see the explanation, beginning on page 63).
- Charges for services or supplies not necessary for treatment of the injury or illness or are not recommended and approved by the attending dentist or charges that are unreasonable.
- Charges for the failure to keep a scheduled dental appointment.
- Charges for completing claim forms.
Extended Dental Benefits Following Termination of Coverage

The Scheduled Dental Plan generally does not cover care that you or an eligible dependent receives while not covered under the plan. However, the following exceptions apply.

The plan covers necessary services and supplies related to a prosthetic device, including the abutment crowns of a partial denture, if the denture impressions were taken while the eligible person was covered under the plan. However, the device must be delivered and installed within two calendar months following termination of coverage. No coverage is provided if the denture impressions were taken before a person became eligible for plan benefits. Necessary services and supplies in connection with a crown required for restoring a tooth (independent of the crown’s use in connection with a partial denture) are covered if the tooth was prepared for the crown before coverage terminated. However, the crown must be placed within two calendar months after coverage ends.

For other coverage continuation options following the termination of your coverage, see “Termination of Coverage,” beginning on page 67.

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

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

Coordination of Dental Benefits

If you or your dependents have medical, dental, or other health coverage in addition to being covered under this Scheduled Dental Plan, the following rules govern coordination of benefits with your other coverage. Other coverage includes, whether insured or uninsured, another employer’s group benefit plan, other arrangement of individuals in a group, individual insurance or health coverage, and insurance that pays without consideration of fault, such as homeowner’s or automobile medical payments or personal injury protection.

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 dental 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:

1. A plan that covers a person as an employee, retiree, member, or subscriber pays before a plan that
   covers the person as a dependent.

2. A plan that covers a person as an active employee or dependent of an active employee is primary.
   The plan that covers a person as a retired, laid-off, or other inactive employee or dependent of a
   retired, laid-off, or other inactive employee is secondary.

3. If a dependent child is covered under both parents’ group plans, the child’s primary coverage is
   provided through the plan of the parent whose birthday comes first in the calendar year, with
   secondary coverage provided through the plan of the parent whose birthday comes later in the
   calendar year.

4. If a dependent child’s parents are divorced or separated and a court decree establishes financial
   responsibility for the health care coverage of the child, the plan of the parent with such financial
   responsibility is the primary plan of coverage. If the divorce decree is silent on the issue of
   coverage, the following guidelines are used:
   a. The plan of the parent with custody pays benefits first.
   b. The plan of the spouse of the parent with custody pays second.
   c. The plan of the parent without custody pays third.
   d. The plan of the spouse of the parent without custody pays fourth.

5. If none of the aforementioned rules establish which group plan should pay first, then the plan that
   has covered the person for the longest period is considered the primary plan of coverage.

6. Continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985
   (COBRA) always is secondary to other coverage, except as required by law.

7. If you or an eligible dependent is confined to a hospital when first becoming covered under this
   plan, this plan is secondary to any plan already covering you or your dependent for the eligible
   expenses related to that hospital admission. If you or your dependent does not have other coverage
   for hospital and related expenses, this plan is primary.

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 one Company-
sponsored medical or dental plan. However, when dental services performed by a licensed dentist also
are covered under the medical plan, the Scheduled Dental Plan pays its benefits first and the medical
plan is secondary.

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

The exclusion of government benefits and services is described in “Dental Plan Exclusions,” on
page 62.

How to Submit a Dental Claim

Aetna U.S. Healthcare is the service representative for the Scheduled Dental Plan. The address and
telephone number for the service representative are listed in Exhibit 10 on page 83.

You will need to submit a claim for benefits when receiving care covered under the Scheduled Dental
Plan. Claim forms are available from the service representative. Exhibit 8, on page 56, provides helpful
tips on how to avoid claim problems.

Claims must be submitted to the service representative within 12 months of the date covered services
or supplies are received.
Review and Appeal Procedures

The Plan has established the following procedures for review and appeal of denied claims or denial of eligibility to participate under the medical and dental plans described in this booklet.

Claim Review and Appeal

**Note:** This section describes claim review and appeal procedures for the Traditional Medical Plan, Preferred Dental Plan, and Scheduled Dental Plan. Claim review and appeal procedures for the coordinated care plans and the Prepaid Dental Plan are described in their respective member handbooks.

When you receive services from network providers under the Traditional Medical Plan or member dentists under the Preferred Dental Plan, you generally do not need to submit a claim for benefits. The network provider or member dentist will submit a claim to the plan’s service representative on your behalf, and the service representative will pay the network provider or member dentist directly. You will receive an Explanation of Benefits form in the mail each time a claim is processed.

When you receive services from a nonnetwork provider, nonmember dentist, any vision care provider under the Traditional Medical Plan, or any dentist under the Scheduled Dental Plan, you generally must pay the provider’s bill and submit a claim to the plan’s service representative for reimbursement. See pages 48, 56, and 64 for additional information about how to submit a claim under the Traditional Medical Plan, the Preferred Dental Plan, and the Scheduled Dental Plan, respectively.

Your initial claim for reimbursement of covered medical or dental expenses is considered a claim for benefits.

When you submit a claim for benefits, the service representative will respond within 90 days of receiving the claim. If special circumstances require more time, the review period may be extended up to an additional 90 days. You will be notified in writing of this extension. If your claim is denied, you will be notified in writing, given the specific reasons for the denial, advised of your right to obtain copies of documents relating to the decision, without charge, and advised of your appeal rights.

Often, you can resolve questions about a denied claim without a formal appeal. If you think a benefit has been denied in error, the issue often can be resolved by calling the service representative’s claim office and discussing the situation. If the claim is not resolved through an informal review process, you may file a formal appeal seeking review of that decision.

You or a person you appoint may appeal any denial or partial denial by writing to the service representative identified on the claim denial notice within 60 days after receiving the denial or partial denial of plan benefits. You must indicate the reason for your appeal and may include any information or documents that you believe are relevant to the claim.

The service representative will review the appeal and render a decision. In reviewing your appeal, the service representative will apply the terms of the Plan and will use its discretion in interpreting the terms of the Plan. The service representative will notify you of its decision within 60 days after receiving your appeal. If special circumstances require more time, the review period may be extended up to an additional 60 days. You will be notified in writing of this extension. The service representative will provide you with its final decision in writing and will indicate the specific Plan provision upon which the decision is based.

You must proceed through the full claim and appeal process before pursuing other remedies. If you have not received notification within the time periods described above, you should consider your claim denied and proceed to the next step of the appeal process.
The addresses and telephone numbers of all medical and dental service representatives are listed in Exhibit 10, beginning on page 82.

You may not take legal action against the Company for any claim for benefits under this Plan unless you instigate legal action within two years after the rendering of services upon which the claim is based.

**Eligibility Review and Appeal**

If you believe you have been improperly denied participation in any of the health and welfare plans or denied the opportunity to make a qualified status change, you should follow the general appeal procedure described in the previous section. The only difference is that your initial appeal should be made to the Boeing Service Center for Health and Welfare Plans instead of the service representative. Any appeal must be made within 60 days of the date you or your dependent is denied participation or denied a qualified status change.

For eligibility or participation appeals, you or a person you appoint may request a review by the Employee Benefit Plans Committee, or its delegate, if the Boeing Service Center denies your request for participation or request to change your election due to a qualified change in status. It is the Committee's exclusive right to interpret the terms of the Plan and, exercising its discretion, to determine all questions arising under the Plan. The decisions of the Committee are final and binding. Benefits will be paid under the Plan only if the Committee decides in its discretion that you have met the eligibility and participation requirements and the service representative has determined that you are entitled to the benefits.

Your request to the Committee must be made in writing within 60 days after you receive the Boeing Service Center's decision. You must indicate the reasons for your appeal, and you may include any information or documents that you believe are relevant to the appeal. The Committee will advise you of its decision, usually within 60 days of receiving your request. Up to an additional 60 days may be required in special circumstances. You will be notified in writing of this extension.

The address of the Committee is Employee Benefit Plans Committee, The Boeing Company, 100 North Riverside Plaza, MC 5002-8421, Chicago, IL 60606-1596.

You may not take legal action against the Company for any claim for denied participation under this Plan unless you instigate the legal action within two years of the date you or your dependent initially is denied participation in the Plan.
Termination of Coverage

Termination Dates
Coverage for you and your eligible dependents under the medical and dental plans generally ends on the last day of the month you are employed or the last day of the month for which required contributions are paid, whichever comes first. If you or a dependent becomes ineligible for coverage because of a qualified change in status, coverage ends on the last day of the month the qualified change in status event occurs. Coverage for an eligible dependent ends on the last day of the month the person no longer meets the dependent eligibility requirements or when your coverage ends, whichever comes first, as described beginning on page 8.

If you retire, coverage ends on the last day of the calendar month in which you retire. Coverage for your eligible dependents ends at the same time your coverage ends.

Coverage may be continued beyond these normal termination dates under certain special circumstances, as described in this section. You must continue to pay any required contributions during these periods for coverage to continue.

If you (or your eligible dependent) are confined in a hospital when coverage ends, health care coverage continues for the duration of hospitalization or 31 days, whichever occurs first.

Certificate of Coverage
When coverage under the health care plans ends for you or your eligible dependents, you automatically will receive a certificate of coverage. The certificate will provide you with evidence of the insurance coverage (periods and types of coverage) you or your dependents had under the plans.

You may present this certificate to a new health care plan to reduce or eliminate any preexisting condition waiting period the new plan may have.

Separate certificates will be issued to your covered spouse and dependent children if their coverage periods differ from yours.

You may request a duplicate copy of your certificate of coverage by calling the Boeing Service Center up to 24 months after your coverage ended.

Leaves of Absence
Medical Leave of Absence
If you are eligible for coverage and begin an approved medical leave of absence from the Company, you and your eligible dependents will be covered under the medical and dental plans as if you were an active employee until the end of the calendar month in which your leave began.

If you remain on an approved medical leave of absence and your leave is the result of continuous total disability, coverage under your medical and dental plans will continue for you and your covered dependents for up to an additional six calendar months. The Company will contribute its regular portion of the cost.

If your approved medical leave of absence continues beyond the period described above due to continuous total disability, your medical coverage will continue for up to 24 more months. The Company will contribute its regular portion of the cost. Your medical coverage will stop earlier if you become eligible for Medicare or are no longer considered totally disabled. During this 24-month continuation period, you may continue dental coverage for yourself and medical and dental coverage for your covered dependents by paying the full cost of the coverage.
If your total disability continues beyond 30 months or a covered family member is considered disabled by Social Security during the seventh or eighth month of your absence, you may continue medical and dental coverage for yourself and your covered dependents for up to five more months by paying 150 percent of the cost of coverage for the disabled person and 102 percent of the cost for all other covered family members.

Two medical leaves of absence that are separated by fewer than 30 days of continuous work will be considered one leave of absence, unless the second leave is due to entirely unrelated conditions.

**Other Leaves of Absence**

If you are eligible for coverage and begin an approved leave of absence from the Company for nonmedical reasons, you and your covered dependents will be covered under the medical and dental plans until the end of the month in which your leave began. If you remain on an approved leave of absence, coverage under your medical and dental plans will continue until the end of the third full calendar month of your leave as if you were an active employee, and the Company will continue to contribute toward your coverage.

When your coverage ends, you may continue medical and dental coverage for yourself and your eligible dependents under a self-pay option as described in “Continuation Coverage (COBRA),” beginning on page 69.

**Changes in Leave Types**

If you change directly from an approved nonmedical leave to an approved medical leave or from an approved medical leave to an approved nonmedical leave, the coverage period provided to you with Company contributions under one type of leave reduces the coverage period provided to you with Company contributions under the other type of leave.

**Family and Medical Leave Act**

The Family and Medical Leave Act of 1993 applies to family and medical leaves when employees work at locations with 50 or more employees within a 75-mile radius. This federal law requires coverage to continue under the Company-sponsored medical and dental plans while the employee is on certain types of family or medical leave. The continuation rules and employee contributions described previously generally are more generous than required by the law. However, if a situation arises in which these rules do not provide the required coverage, the Company will comply with federal law.

**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 and your covered dependents will be covered under the medical and dental plans until the end of the month in which your leave began. If you remain on an approved leave of absence, coverage under your medical and dental plans will continue until the end of the third full calendar month of your leave as if you were an active employee on an approved nonmedical leave of absence.

If your uniformed service extends beyond three months, you may continue your medical and dental coverage under the self-pay option for approved leave of absence, as described in “Continuation Coverage (COBRA),” beginning on page 69, in accordance with your rights under the Uniformed Services Employment and Reemployment Rights Act.

If you return to active employment promptly after your uniformed service, in accordance with federal law, your medical and dental coverage will be reinstated on the date you return to the active payroll.
Layoff
If you are laid off, you may continue your medical and dental coverage for up to 18 months under a self-pay option as described in “Continuation Coverage (COBRA)” beginning on this page. The Company will contribute its regular portion of the cost of medical coverage until you are covered by any other group health plan as an employee or dependent or for the first three months of coverage, whichever comes first. To continue coverage for the remaining 15 months, you must pay the full cost of coverage.

Death
If you die, your eligible dependents may continue their medical and dental coverage for up to 36 months under a self-pay option as described in “Continuation Coverage (COBRA),” beginning on this page. The Company will contribute its regular portion of the cost for the first 12 months of coverage. To continue coverage for the remaining 24 months, your dependents must pay the full cost of coverage.

If your death is the result of an industrial accident, the Company will contribute its regular portion of the cost for the full 36 months of continuation coverage.

Change in Employment Class
If you continue to be employed by the Company but change to a different employee classification that is not covered by these medical and dental plans, your coverage under these plans will stop at the end of the month you transfer. However, if you are eligible for medical or dental coverage under your new employee classification, your coverage under the plans described in this booklet will end when your coverage under your new plans starts.

Contribution Information
If you fail to make required contributions, coverage will stop at the end of the period for which the last contribution was paid. Monthly contributions must be paid within 31 days of the due date.

For information regarding contribution rates for the Traditional Medical Plan, coordinated care plans, and dental plans, contact the Boeing Service Center. (See Exhibit 10, beginning on page 82.)

More information about contributions during leaves of absence begins on page 67. For more information about continuation coverage, see below.

Continuation Coverage (COBRA)
When coverage under the Company-sponsored medical and dental plans would otherwise end, you and your dependents (including your same-gender domestic partner and his or her children) may be eligible to continue your medical and dental coverage under a self-pay option if the loss of coverage is the result of the termination of your employment or a reduction in your hours, such as an approved leave of absence. Your eligible dependents also may continue their medical and dental coverage if they would otherwise lose coverage as the result of your death or in the event of divorce or a child’s loss of eligibility under the plans. This continuation coverage complies with rules established by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Continuation coverage also is referred to as COBRA coverage.

Under continuation coverage, you or your dependent generally must pay the full cost of coverage. However, this coverage is provided at the group rate and is available without preexisting condition limitations.
Coverage may be continued for up to a total of 36 months if coverage otherwise would end because of your death, divorce, or a child’s loss of eligibility. If coverage otherwise would end because of your termination of employment or reduction in hours, the maximum continuation period for you and your dependents is 18 months. (For approved leaves of absence, the plans include an option that permits you to continue coverage under your entire package of benefits during all or part of your leave of absence depending on the type and duration of your leave.)

If Social Security considers you or a covered dependent disabled during the first 60 days of continuation coverage, you and your dependents may continue coverage for up to 29 months. To qualify for this 29-month disability continuation, Social Security must have determined that the disability started before or within the first 60 days of continuation coverage. A copy of Social Security’s letter approving the disability application must be sent to the Boeing Service Center within the first 18 months of continuation coverage and within 60 days after you or your dependent receives the letter. The Boeing Service Center also must be notified within 31 days after Social Security no longer considers the person disabled. After the first 18 months of disability continuation coverage, the required contribution may be higher as allowed by federal law.

If you become covered by Medicare while you are an active employee, then lose your Boeing coverage because of retirement, termination of employment, or reduction of hours, you may elect continuation coverage for up to 18 months. Your eligible dependents may elect continuation coverage for the balance of the 36-month period starting when you became eligible for Medicare or 18 months, whichever is longer.

You or your dependent may convert to an individual policy, as described in “Conversion of Your Medical Plan Coverage,” on page 71, at the end of the 18-, 29-, or 36-month continuation period. Extended coverage of up to 12 weeks required by the Family and Medical Leave Act of 1993 for family and medical leaves will not count against the continuation period.

If you stop active work because of a medical or other leave of absence, you will be notified of the period for which your coverage can be extended, the period for which you may elect continuation coverage, and the amount of required contributions.

If your employment terminates, your hours are reduced, you retire, or you die while covered under the medical and dental plans, you or your spouse will receive a continuation coverage notice and election instructions.

If your spouse loses coverage as a result of divorce or if your dependent child is no longer eligible because he or she no longer meets the definition of a dependent child (see page 8), you, your former spouse, or your child must notify the Company within 60 days by calling the Boeing Service Center. Otherwise, no information will be sent, and your former spouse or child will not be eligible for continuation coverage after the 60-day period.

At the time of the COBRA event, the Boeing Service Center will notify you of the premium amount you and your dependents must pay to participate in COBRA continuation coverage. This amount may include a two percent charge for administrative expenses, or a 50 percent surcharge during a disability extension beyond 18 months.

To elect continuation coverage, you, your spouse, or your child must call the Boeing Service Center within 60 days of receiving the continuation coverage notice, or, if later, within 60 days after coverage ends. Within 45 days after making the election, you or your dependent must make full payment for the period after coverage ended. Thereafter, payment must be made each month within 31 days of the due date.
The continuation coverage will end at the earliest of

- The end of the person’s 18-, 29-, or 36-month continuation period.
- The last day of a month for which a required contribution is not paid within 31 days of the due date.
- The date (after the continuation coverage election date) a person becomes covered under another group health plan either as an employee or a dependent. However, if the other group plan limits coverage for a preexisting condition, being covered by the other group plan will not cause continuation coverage to end during the other plan’s preexisting condition waiting period. A federal law effective July 1, 1997, might allow you to have a shorter preexisting condition waiting period under your new plan. Check with the administrator of your new group plan to see if this law applies to you.
- The date (after the continuation coverage election date) a person becomes covered by Medicare (Part A, Part B, or Medicare+Choice).
- The date the Company no longer provides health care benefits to any of its employees.

If your coverage ends during a period of continuation coverage because you became covered by Medicare, your eligible dependents can continue coverage for the balance of 36 months from the date your continuation coverage started.

If the required monthly contributions are not paid within 31 days of the due date, coverage will end as of the end of the month for which the last contribution was received. Thereafter, coverage cannot be reinstated, even by making up delinquent contributions.

For more information about the continuation options that may be available to you, contact the Boeing Service Center at the telephone number listed in Exhibit 10 on page 82.

Conversion of Your Medical Plan Coverage

If medical coverage terminates for you or an eligible dependent, that person may convert to an individual group medical conversion policy offered by the service representative for your medical plan. Benefits under the individual policy will not be the same as benefits under this plan, so be sure to read the application materials carefully.

To convert to an individual policy, you must complete an application and submit it to the service representative within 31 days of the date your Boeing coverage ends. You then will be billed for the applicable rate, which generally is higher than the group rate. Conversion applications are available from the Boeing Service Center.

No evidence of insurability will be required.

Retiree Coverage

The Company sponsors medical programs for certain retirees and their dependents. For information about any retiree medical program that may be available to you, contact the Boeing Pension Service Center at 1-800-356-7240 (hearing impaired: 1-800-356-7287).
Qualified Medical Child Support Orders

The Company provides medical and dental coverage to employees’ dependent children as long as they meet the eligibility requirements of the plans. The Company also provides medical and dental coverage to certain 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.

Under this law, courts may require an employee, in certain events such as a divorce, to provide medical and dental coverage to a child who might not otherwise be covered. In addition to requiring the employee to provide coverage for the child, the law authorizes the Company to take the applicable payroll deduction.

A QMCSO is a “medical child support order” that is “qualified” under requirements of the Omnibus Budget Reconciliation Act of 1993.

A medical child support order

- Is any decree, judgment, or order (including approval of settlement agreement) from a state court with jurisdiction over the child’s support, or an order or administrative notice from a state agency with such jurisdiction under state law.
- Recognizes the child as an alternate recipient for plan benefits.
- Provides, based on a state domestic relations law (including a community property law), for the child’s support or health plan coverage.
- Specifically requires a plan to provide coverage.

A medical child support order is qualified if it creates or recognizes the existence of an alternate recipient’s right to receive plan benefits and specifies

- The employee’s name and last known address.
- Each alternate recipient’s name and address (or, if the order provides, the name and address of a state official or agency may be substituted for the alternate recipient’s address).
- A reasonable description of the coverage to which the alternate recipient is entitled.
- The coverage effective date.
- How long the child is entitled to coverage.
- That this plan is subject to the order.

When the Company receives a medical child support order, it promptly will notify both the employee and the alternate recipient that the order has been received and what procedures the Company will use to determine whether the order is qualified. Then the Company will decide, based on written procedures and within a reasonable time, whether the order is qualified. Once the decision is made, the Company will notify the employee and alternate recipient by mail.

If the medical child support order is a QMCSO, the Company will notify the employee and each alternate recipient specified in the QMCSO of the plan’s procedures and allow the alternate recipient an opportunity to designate a representative to receive copies of any notices due under the QMCSO.

Coverage for the alternate recipient will begin on the date specified in the QMCSO. This is not necessarily the first day of a calendar month.

If a dependent contribution is required, specific authorization from the employee is not required for the payroll deduction to be established. Any applicable payroll deduction will be retroactive to the alternate recipient’s effective date.
The plan pays network providers directly for covered services. When a covered expense has been paid by an alternate recipient, custodial parent, legal guardian, or the employee, the plan reimburses the person who paid the expense.

If the medical child support order is not a QMCSO, the Company will notify the employee and each alternate recipient within a reasonable time of the specific reasons that the medical child support order does not qualify as a QMCSO and the procedures for submitting a corrected medical child support order.
Special Disclosure and Other General Plan Information

Plan Name
The name of the Plan providing the health care benefits described in this booklet is The Boeing Company Employee Health Benefit Plan (Plan 626).

Plan Sponsor
The Plan is sponsored by The Boeing Company, 100 North Riverside Plaza, MC 5002-8421, Chicago, IL 60606-1596.

Plan Administrator and Agent for Service of Legal Process
The Plan Administrator is the Employee Benefit Plans Committee (EBPC), which may be reached through the above address or by calling 312-544-2297. Legal process may be served upon the EBPC at the above address.

The EBPC is appointed by the Board of Directors of The Boeing Company. As Plan Administrator, the EBPC has authority over administration of the Plan and has all powers necessary to enable it to carry out its duties as Plan Administrator, such as determining questions of eligibility and benefit entitlement. The Plan Administrator has authority to make these determinations in its sole discretion. The Plan Administrator’s decision upon all such matters is final and binding.

The Plan Administrator also has been delegated authority by the Board of Directors to amend the Plan. The Board of Directors has authority to terminate the Plan.

The Plan Administrator may establish rules and procedures to be followed by participants and beneficiaries in filing applications for benefits and in other matters required to administer the Plan. In addition, the Plan Administrator may:

- Prescribe forms for filing benefit claims and for annual and other enrollment materials.
- Receive all applications for benefits and make all determinations of fact necessary to establish the right of the applicant to benefits under the provisions of the Plan, including the amount of such benefits.
- Appoint accountants, attorneys, actuaries, consultants, and other persons (who may be employees of the Company) to advise the Plan Administrator; also, the Plan Administrator may rely upon the opinion of counsel and upon reports furnished by others that it selects.
- Delegate these and other administrative duties and responsibilities to persons or entities of its choice (including delegation to employees of the Company).

In general, members of the EBPC are not individually liable for their actions or the actions of others, but if held liable, will be indemnified to the fullest extent permitted under the Company bylaws.

Type of Administration
The Plan is administered according to the terms of the applicable administrative agreements and insurance contracts with the service representatives for each benefit coverage.

Type of Plan
The Boeing Company Employee Health Benefit Plan (Plan 626) is a welfare benefit plan that provides medical and dental benefits. This booklet describes coverage of medical and dental services and supplies.
This Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended, and is intended to comply with all other applicable federal and state laws. The EBPC has full discretionary authority to interpret the Plan under these laws. If any part of this Plan is held to be invalid, the remaining provisions continue in force.

**Funding and Contributions**

The cost of coverage under this Plan is funded primarily by employer contributions. Employee contributions, if any, are determined by the provisions of the applicable collective bargaining agreement and are fixed for each benefit year. The Company pays the full cost of the Plan in excess of employee contributions, including any costs that are higher or lower than expected. Any claims experience dividends, refunds, or other adjustments in premium, fees, or other Plan costs related to benefits provided under the Plan will be used to reduce employer contributions.

Plan benefits provided under The Boeing Company Employee Health Benefit Plan (Plan 626) and related expenses may be funded through The Boeing Company VEBA Master Trust (“the Trust”). All or part of the employer and employee contributions for Plan benefits may be directed to the Trust and held in the Trust until used to pay Plan premiums, benefits, and administrative expenses that are authorized by the Plan Administrator.

In connection with the Trust, the Company may authorize a minimum contribution that will be made under the Plan for each year. The minimum contribution requires that employer contributions to the Trust will never be less than the specified minimum amount. The Company has established a minimum contribution for 2001; however, there is no assurance that the Company will establish a minimum contribution in future years. This minimum contribution will be used to provide benefits and expenses under the Plan and Trust.

The enrollment worksheet shows the contributions required for each type of coverage an employee may elect. Necessary and proper expenses for administration of the Plan will be paid from assets of the Trust fund except for those expenses the Company is required by law or chooses to pay.

**Benefit Payments**

Benefit payments are administered by the service representatives according to the provisions of the applicable administrative agreements and insurance contracts.

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

In the event an incorrect amount is paid to you or on your behalf, any remaining payments may be adjusted to correct the error, including withholding from future reimbursements. The Plan Administrator also may take other action it determines is necessary or appropriate to correct any such error.

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

Finally, nothing in this Plan, including the receipt of benefits, is to be construed as a contract of employment, and nothing in the Plan gives any employee the right to be retained in the employ of the Company or to interfere with the rights of the Company to discharge any employee at any time.
Plan Records
Records of the Plan are kept on a calendar year basis. The Plan Administrator (or its delegates) will keep records of all acts and determinations made under the Plan, as well as any other documents that may be necessary for the administration of the Plan.

Plan Number and Employer Identification Number
The Plan number assigned by the Company pursuant to instructions by the U.S. Department of Labor to The Boeing Company Employee Health Benefit Plan (Plan 626) is 626. The Company employer identification number is 91-0425694.

Trustee
The trustee of The Boeing Company VEBA Master Trust is The Chase Manhattan Bank (“the Trustee”). The address of the Trustee is Global Investor Services, 3 Chase MetroTech Center, Fifth Floor, Brooklyn, NY 11245. The telephone number of the Trustee is 718-242-2051.

Union
The plans described in this booklet are provided in accordance with agreements with the Society of Professional Engineering Employees in Aerospace Wichita Technical and Professional Unit.

Service Representatives
The Company contracts with various medical and dental service organizations to provide health care services to Plan participants. These are called service representatives for purposes of this Plan. For purposes of certain federal regulations, they are classified as health insurance issuers.

Exhibit 10, beginning on page 82, shows the Plan’s health care service representatives and their addresses and telephone numbers. It also indicates whether they only administer claims for the Plan or also provide insurance for the benefits they administer.

Participant Rights and Protections Under ERISA
The Employee Retirement Income Security Act of 1974 (ERISA), as amended, guarantees certain rights and protections to participants of welfare benefit plans such as the Plan described in this booklet. ERISA provides that all Plan participants will be entitled to:

Receive Information About Your Plan and Benefits
• You may examine, without charge, at the Plan Administrator’s office and at other specified locations, such as work sites with 50 or more participants and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.
• If you want a personal copy of these documents or related material, send a written request to the Plan Administrator. You can obtain copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and updated summary plan descriptions. You will be charged a reasonable cost.
• You may receive a summary of the Plan’s financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
• You can continue health care coverage for yourself or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. This summary plan description and the documents governing the Plan explain the rules governing your COBRA continuation coverage rights.
• You are entitled to the reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. (Eligible charges related to preexisting conditions covered under a prior medical plan are treated the same as any other eligible charges.) You should receive a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for Plan participants, ERISA imposes duties on the people responsible for operating the Plan. The people responsible for operating the Plan are called fiduciaries. These individuals have an obligation to administer the Plan prudently and to act in the interest of you and other Plan participants and beneficiaries. No one, including your employer, union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from receiving benefits or exercising your rights under ERISA.

Enforce Your Rights
If you believe you are eligible for benefits from the Plan, you should follow the appropriate steps for filing a claim. If your claims are denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial all within certain time schedules. If your claim is denied, you will receive a written explanation of the reasons for the denial. You have the right to have the Plan review and reconsider your claim. See the description of review and appeal procedures and time schedules, beginning on page 65.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions
If you have any questions about your Plan, contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hot line of the Pension and Welfare Benefits Administration at 1-800-998-7542.
Definitions

**Benefit Year** A benefit year is January 1, 2002, through June 30, 2002, and July 1 through June 30 annually thereafter.

**Birth Center** A birthing center is a facility for normal delivery operating under the direction and control of the licensing or regulatory agency in its location.

**Chiropractor** A chiropractor is a person duly licensed in the area where his or her services are performed and practicing within the scope of such license.

**Christian Science Sanatorium** 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.

**Company-Sponsored Plan** A Company-sponsored plan is a group health care or dental plan approved by The Boeing Company or one of its subsidiaries or affiliates for its employees and dependents. This includes the Traditional Medical Plan, coordinated care plans, Preferred Dental Plan, Prepaid Dental Plan, and Scheduled Dental Plan. (To find out whether a particular plan is Company sponsored, contact the Boeing Service Center.)

**Cost of Coverage** The total cost of employee or dependent coverage is based on the Company’s estimate of the full cost of that coverage for the benefit year. Claims experience dividends, refunds, and other reductions in cost that might occur in a future year as a result of the Plan’s financial experience in a particular year are not taken into account in determining the total cost of coverage for that year.

**Custodial Care** Custodial care is care that does not require the continuing services of skilled medical or health professionals and primarily is provided to assist the patient in activities of daily living, including 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.

**Day or Night Care Center** A day or night care center is a facility associated with a hospital or approved by the service representative that provides a planned program of psychiatric services for patients with mental illnesses who do not require full-time hospitalization. This excludes facilities primarily providing custodial, recreational, social, or educational services.

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

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

**Experimental or Investigational Service or Supply (Traditional Medical Plan)** An experimental or investigational service or supply is one that meets at least one of the following criteria:

- It requires approval by the Food and Drug Administration or other government agency, and such approval has not been granted when the service or supply is ordered.
- It has been classified by the national Blue Cross and Blue Shield Association as experimental or investigational.
- It is under clinical investigation by health professionals.
- It is not generally recognized by the medical profession as tested and accepted medical practice. However, a service or supply will not be considered experimental or investigational if it is part of an
approved clinical trial. An approved clinical trial is one that meets each of the criteria in either Category 1 or 2:

**Category 1:**
- The trial has been approved by the National Institutes of Health, the Food and Drug Administration, the Department of Veterans Affairs, or a research center approved by the plan’s service representative.
- The trial has been reviewed and approved by a qualified institutional review board.
- The facility and personnel have sufficient experience or training to provide the treatment or use the supplies.

**Category 2:**
- The trial is to treat a condition that is too rare to qualify for approval under Category 1.
- The trial has been reviewed and approved by a qualified institutional review board.
- The facility and personnel have sufficient experience or training to provide the treatment or use the supplies.
- The available clinical or preclinical data provide reasonable expectation that the trial treatment will be at least as effective as noninvestigational therapy.
- There is no therapy clearly superior to the trial treatment.

**Experimental Service or Supply (Preferred Dental Plan)** An experimental service or supply is one whose use generally is not recognized by the American Dental Association as tested and acceptable dental practice. This exclusion also applies to items requiring Food and Drug Administration or other governmental agency approval if not granted when the service or supply was ordered.

**Home Health Aide** A home health aide is an individual employed by a home health care agency or a hospice agency who provides, under the supervision of a registered nurse or physical or speech therapist, part-time or intermittent personal care, ambulation and exercise, household services essential to home health care, and assistance with medications normally self-administered, and who reports on changes in patients’ conditions and needs and completes appropriate records.

**Home Health Care Agency** An approved home health care agency is a public or private agency or organization that administers and provides home health care and is either Medicare approved or operating under the direction and control of the licensing or regulatory agency in its location.

**Home Health or Hospice Care Treatment Plan** A home health or hospice care treatment plan is a written program for continued care and treatment by the patient’s attending physician. This plan must be reviewed and the continued need for care must be certified by a physician at least every two months.

**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.

**Hospital** A hospital is an accredited facility licensed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a general hospital.

**Legend Drug** A legend drug is any drug required by federal or state law or by regulation of the state board of pharmacy to be dispensed only by prescription or restricted to use only by practitioners.

**Medically Necessary Service or Supply** A medically necessary service or supply is one that the service representative has determined meets the following criteria. 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 required to diagnose or treat the patient’s condition and the condition could not have been diagnosed or treated without it.
- It is consistent with the symptom or diagnosis and the treatment of the condition.
• It is the most appropriate service or supply essential to the patient’s needs.
• It is appropriate as good medical practice.
• It is professionally and broadly accepted as the usual, customary, and effective means of diagnosing or treating the illness, injury, or condition.
• When applied to an inpatient, it cannot safely be provided to the patient as an outpatient.

**Mental Illness**  A mental illness is a disorder (including an eating disorder) that exhibits symptomatology, etiology, and features congruent with a *Diagnostic and Statistic Manual of Mental Disorders IV* diagnosis of mental disorder.

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

**Occupational Therapist**  An occupational therapist is a person duly licensed in the area where his or her services are performed and is practicing within the scope of such license. In the absence of such licensing requirements, the therapist must be certified as a registered occupational therapist by the American Occupational Therapy Association.

**Optometrist**  An optometrist is a person duly licensed in the area where his or her services are performed and is practicing within the scope of such license.

**Participating Pharmacy**  A participating pharmacy is a pharmacy that has an agreement with the preferred pharmacy card program service representative to accept payments in excess of the prescription drug coinsurance as payment in full for covered prescription costs.

**Physical Therapist**  A physical therapist is a person duly licensed in the area where his or her services are performed and is practicing within the scope of such license. In the absence of such licensing requirements, the therapist must be certified as a registered physical therapist by the American Physical Therapy Association.

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

**Physician Assistant**  A physician assistant is a person duly licensed in the area where his or her services are performed and is practicing within the scope of such license.

**Podiatrist**  A podiatrist is a person duly licensed in the area where his or her services are performed and is practicing within the scope of such license.

**Preadmission Review and Prior Approval**  Preadmission review and prior approval under the medical review program (see Exhibit 4, beginning on page 28) include the review and evaluation of proposed elective hospital and skilled nursing facility admissions and proposed home health and hospice care. Such review and evaluation are performed by qualified health care professionals using accepted medical standards and criteria to determine the medical necessity of the admission or care. In addition to certifying the appropriate length of stay for an admission, the program may include the ongoing (or concurrent) and retrospective review and evaluation of provider treatment plans to ensure services are medically necessary and rendered in the appropriate setting.

**Precertification**  Precertification under the Boeing mental health and substance abuse program (see Exhibit 7, beginning on page 42) includes the following services:
• Assessment of the patient’s condition, including crisis intervention.
• Preapproval of the appropriate level and length of care.
• Referrals to network providers.
• Initial, ongoing, and retrospective review and evaluation of provider treatment plans to ensure services are medically necessary and rendered in the appropriate setting.

**Principal Support**  Principal support means you continuously provide more than 50 percent of the child’s financial support and claim the child as a dependent on your federal income tax return. If you are unable to claim the child as a dependent for tax purposes because of a divorce settlement, you are
considered to be providing principal support if the child resides with you or you have been issued a court order to provide substantial support.

**Prosthetic Appliance (Preferred Dental Plan or Scheduled Dental Plan)** A prosthetic appliance is a denture, partial denture, fixed or removable bridge, crown when used as a bridge abutment, and other related items.

**Psychologist** A psychologist is a person duly licensed in the area where his or her services are performed and is practicing within the scope of such license.

**Referred Provider** A referred provider is a mental health or substance abuse professional or facility to whom the patient has been referred by the Boeing Helpline (ValueOptions), the Boeing mental health and substance abuse program manager. Benefit payments are higher for treatment received from referred providers.

**Service Representative** A service representative is an agent who has a contract with The Boeing Company to make benefit determinations and administer benefit payments under the plans described in this booklet. A list of service representatives appears in Exhibit 10, beginning on page 82. The Boeing Company may change a service representative at any time.

**Skilled Nursing Facility** A skilled nursing facility is an institution approved as such by Medicare.

**Speech Therapist** A speech therapist is a person duly licensed in the area where his or her services are performed and is practicing within the scope of such license. In the absence of such licensing requirements, the therapist must be certified as a registered speech therapist by the American Speech and Hearing Association.

**Substance Abuse** Substance abuse is alcohol or drug dependence as classified in categories 303.0 through 304.9 of the most current edition of *International Classification of Diseases, 9th Revision, Clinical Modification*.

**Substance Abuse Treatment Facility** An approved substance abuse treatment facility is a facility that provides treatment for chronic alcoholism and/or drug abuse and is operating under the direction and control of the licensing or regulatory agency in its location.

**Usual and Customary Charges (Dental Plans)** Usual and customary charges are the least of the following:

- The usual fee charged by your dentist for a given service or supply to all private patients.
- The customary fee for a given service or supply. For the Preferred Dental Plan, this is the Delta Dental allowable fee. For the Scheduled Dental Plan, this is the prevailing fee charged by dentists in the geographic area where services are rendered.
- The reasonable fee for a given service or supply, which means the charge is usual and customary, and in the opinion of the service representative, is justifiable in view of the special circumstances of the particular case in question.

**Usual and Customary Charges (Traditional Medical Plan)** Usual and customary charges are the least of the following:

- The health care provider’s actual charge to the patient after any discounts or other reductions.
- The charge most frequently made by the provider to all other patients for comparable services and supplies.
- The charge most frequently made by providers with similar professional qualifications for comparable services or supplies in the same geographic area.
- In a network service area, the amount that would have been paid for like services or supplies to a provider who has a participating agreement with the service representative.

When an unusual or complicated service or supply is provided, the usual and customary charge will be determined by taking into consideration the charges for treatment of a comparable nature or complexity.
Exhibit 10

Where to Get Information

**Boeing Service Center for Health and Welfare Plans**
Address: 100 Half Day Road  
P.O. Box 1466  
Lincolnshire, IL 60069-1466
Telephone: Seven days a week, 24 hours a day  
1-888-747-2016  
1-800-855-2880 (hearing impaired)  
847-883-0746 (if calling from overseas)
Representatives available: Monday through Friday  
9 a.m. to 8 p.m. Eastern time  
8 a.m. to 7 p.m. Central time  
7 a.m. to 6 p.m. Mountain time  
6 a.m. to 5 p.m. Pacific time
Your Benefits Resources web site: http://resources.hewitt.com/boeing
Services: Participant eligibility processing and records

**Traditional Medical Plan Service Representative**
Address for claims and appeals: Regence BlueShield  
P.O. Box 91015  
Seattle, WA 98111-9115
Claim questions: 206-464-0255 (Western Washington)  
1-800-422-7713 (nationwide)
Medical review program: 1-800-367-2766 (in all states except Alabama)  
1-800-248-2342 (in Alabama)
Network provider information: 1-800-810-2583
Services: Claim administration and network management

**Boeing Mental Health and Substance Abuse Program (Boeing Helpline)**
Address: ValueOptions  
340 Golden Shore  
Long Beach, CA 90802
Telephone: 1-800-892-1411
Services: Claim review and network management

**Preferred Pharmacy Card Program (PAID Direct)**
Address: PAID Prescriptions, L.L.C.  
P.O. Box 713  
Parsippany, NJ 07054-0713
Services: Pharmacy network management

*Note:* If you have a pharmacy card claim question, call the Traditional Medical Plan service representative.
Exhibit 10 (continued)

**Prescription Mail Service Program**

Address: **Merck-Medco Rx Service of Washington**
P.O. Box 3938
Spokane, WA 99220-9990
Telephone: 1-800-626-6080
Services: Mail service pharmacy

**Coordinated Care Plan Service Representatives**

**Kansas (Wichita Area)**

Plan name and address: **Preferred Plus (also known as Preferred Plus of Kansas, Inc.)**
for claims and appeals: P.O. Box 49288
Wichita, KS 67201
Telephone: 1-888-242-0345
Services: Insurance, claim administration, and network management

Plan name and address: **Premier Blue (also known as Premier Health, Inc.)**
for claims and appeals: 1133 S.W. Topeka Blvd.
Topeka, KS 66629
Telephone: 1-800-332-0028
Services: Insurance, claim administration, and network management

**Preferred Dental Plan Service Representative**

Plan name and address: **Delta Dental of Kansas (also known as Washington Dental Service)**
for claims and appeals: P.O. Box 49198
Wichita, KS 67201-9198
Telephone: 1-877-521-2101
Services: Claim administration and network management

**Prepaid Dental Plan Service Representative**

Plan name and address: **Prepaid (also known as Delta Dental of Kansas or Washington Dental Service)**
for claims and appeals: P.O. Box 49198
Wichita, KS 67201-9198
Telephone: 1-877-289-5114
Services: Insurance, claim administration, and network management

**Scheduled Dental Plan Service Representative**

Plan name and address: **Aetna U.S. Healthcare**
for claims and appeals: P.O. Box 6610
Leawood, KS 66206
Telephone: 1-800-221-7371 (inside Kansas)
1-800-824-6411 (outside Kansas)
Services: Claim administration
February 2002

Summary of Benefit Plan Changes and Clarifications
IAFF I-17 and I-66; IAM 24, 70, 86, and 751; IBEW 271; IUOE 286 and 286W; Pilots Association; Space City Lodge 2766; SPEEA; SPEEA WTPU; SPFPA 2, 5, 255, and 506; and UAW 1069

This Benefits Update summarizes the changes and clarifications that affect your benefit plans and updates your summary plan descriptions. The effective date of each change and clarification is January 1, 2002.

This Benefits Update is your summary of material modifications and an amendment to the Plans described in the following sections. (“Plan” refers to the benefit plans subject to the Employee Retirement Income Security Act of 1974 [ERISA], as amended.) The Plan document for your health and welfare plans includes this and other Benefits Updates, your summary plan descriptions, and if applicable, any insured health and welfare contracts. If there is a discrepancy between this Benefits Update and applicable insured health and welfare contracts, the insured health and welfare contracts will control.

This Benefits Update is for your information and is being provided to you as required by federal law. No action on your part is required. Please keep this Benefits Update with your summary plan descriptions for future reference.

Extension of Medical, Dental, and Basic Life Insurance Benefits for Certain Uniformed Services Leaves of Absence

Effective September 11, 2001, you will be eligible for six months of medical, dental, and basic life insurance coverage if you are on a uniformed services leave of absence as a result of the September 11, 2001, terrorist attacks. The Plans affected by this change include The Boeing Company Employee Health and Welfare Benefit Plan (Plan 503) and The Boeing Company Employee Health Benefit Plan (Plan 626).

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 will be covered under your medical, dental, and basic life insurance plans until the end of the month in which your leave began. If you remain on an approved uniformed services leave of absence, coverage under your medical, dental, and basic life insurance plans will continue until the end of the sixth full calendar month of your leave.

If your uniformed service extends beyond six months, you may continue your medical and dental coverage under the self-pay option for approved leaves of absence, as described in your summary plan.
description, in accordance with your rights under the Uniformed Services Employment and Reemployment Rights Act.

If you return to active employment promptly after your uniformed service, according to federal law, your medical, dental, and basic life insurance coverage will be reinstated on the date you return to the active payroll.

The extension of medical, dental, and basic life insurance benefits does not affect the continuation provisions of your other coverages. The extension also does not apply to a uniformed services leave of absence that is not related to the September 11, 2001, terrorist attacks.

Note: If the terms of your bargaining agreement require the Company to provide more than six months of medical, dental, and/or basic life insurance coverage for uniformed services leaves of absence, your benefits will be provided in accordance with the terms of your collective bargaining agreement.

Clarification of Coordination of Benefit Rules

Plans that offer medical or dental benefits follow certain rules when determining their obligation to pay benefits for participants who have other medical or dental insurance coverage. The Plan subject to these rules is The Boeing Company Employee Health Benefit Plan (Plan 626).

If you or your dependents have medical, dental, or other health coverage in addition to coverage under one of these plans, the following rules govern coordination of benefits with your 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, such as homeowner’s or automobile medical payments or personal injury protection.

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 medical or dental 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, the Company-sponsored plan applies the following coordination of benefit rules:

1. A plan that covers a person as an employee, retiree, member, or subscriber pays before a plan that covers the person as a dependent.

2. A plan that covers a person as an active employee or dependent of an active employee is primary. The plan that covers a person as a retired, laid-off, or other inactive employee or as a dependent of a retired, laid-off, or other inactive employee is secondary.
3. If a dependent child is covered under both parents’ group plans, the child’s primary coverage is provided through the plan of the parent whose birthday comes first in the calendar year, with secondary coverage provided through the plan of the parent whose birthday comes later in the calendar year.

4. If a dependent child’s parents are divorced or separated and a court decree establishes financial responsibility for the health care coverage of the child, the plan of the parent with such financial responsibility is the primary plan of coverage. If the divorce decree is silent on the issue of coverage, the following guidelines are used:
   a. The plan of the parent with custody pays benefits first.
   b. The plan of the spouse of the parent with custody pays second.
   c. The plan of the parent without custody pays third.
   d. The plan of the spouse of the parent without custody pays fourth.

5. If none of the aforementioned rules establish which group plan should pay first, then the plan that has covered the person for the longest period is considered the primary plan of coverage.

6. Continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is always secondary to other coverage, except as required by law.

7. If you or an eligible dependent is confined to a hospital when first becoming covered under the plan, the plan is secondary to any plan already covering you or your dependent for the eligible expenses related to that hospital admission. If you or your dependent does not have other coverage for hospital and related expenses, the plan is primary.

Benefits under the medical or dental plan are not coordinated with benefits paid under any other group plan offered by the Company. You can only receive benefits from one 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.

Treatment of end-stage renal disease is covered by the medical 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 plan provides secondary coverage.

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

The plan does not pay benefits if you (or an eligible dependent) have medical or dental benefits or services provided by a state, a subdivision of a state, or the Federal Government, as described in your summary plan description.
Claim and Eligibility Review and Appeals for Disability, Life, and Accident Plans

Effective January 1, 2002, plans that offer disability, life, or accident insurance benefits are required by federal law to implement the following new procedures for review of claims and eligibility determinations. The Plan affected by this change is The Boeing Company Employee Health and Welfare Benefit Plan (Plan 503).

You may obtain a complete copy of the claim review and appeal procedures for a plan by calling the service representative (claim administrator) at the telephone numbers listed in this section.

Disability Benefits

Claim Review and Appeal

You may send disability claims to the plan’s service representative (claim administrator), which is Aetna Life Insurance Company, P.O. Box 1460, Portland, OR 97207, telephone 1-800-882-5968. The service representative will process your claim within 45 days of receipt. If the service representative requires more time, you will be notified in writing before the end of the initial 45-day period of the need for an extension of up to 30 days. If your claim cannot be processed during this initial 30-day extension, you will be notified in writing that a second extension of up to 30 days is necessary.

If your claim is denied, you will be notified in writing of the reasons for the denial, your right to appeal, and your right to obtain copies of all documents related to your claim that were reviewed by the service representative in making its determination. If you disagree with the claim denial, you or your designated representative has the option of attempting to resolve any misunderstanding by calling the service representative and providing additional information. If you prefer to communicate in writing or you are unable to resolve the issue with a telephone call, you may file an appeal in writing with the service representative. You have 180 days after receiving notification of the claim denial to file a written appeal. Please include the reasons for your appeal and any information or documentation that will be helpful to the review of your claim.

The service representative will review the written appeal and notify you of its decision within 45 days after your appeal is received. If the service representative requires additional time to consider your appeal, you will be notified in writing before the end of the initial 45-day period that an additional period of up to 45 days is necessary.

The service representative will provide you with its written decision and explain the specific plan provisions for the denial (if applicable). The service representative has the sole discretionary authority to determine payment of benefits under the disability plan. The decisions of the service representative are final and binding. In reviewing your claim, the service representative will apply the terms of the plan and will use its discretion in interpreting the terms of the plan. Benefits will be paid under the plan only if you have met the eligibility and participation requirements and the service representative has determined that you are entitled to the benefits.

If your appeal is denied, you may pursue legal remedies under ERISA. Before you may pursue these legal remedies, however, you must exhaust this claim appeal process. If you do take legal action, you must file suit within two years after the date of the event upon which the claim is based.
Eligibility Review and Appeal

If you believe you have been improperly denied participation in a disability plan or the opportunity to make an election change due to a qualified change in status, follow the appeal procedures previously described. However, instead of contacting the service representative, contact the Boeing Service Center for Health and Welfare Plans at 100 Half Day Road, P.O. Box 1466, Lincolnshire, IL 60069-1466, telephone 1-888-747-2016 (hearing impaired: 1-800-855-2880; from overseas: 847-883-0746). Any appeal must be made within 180 days of the date you are denied participation or the opportunity to make an election change due to a qualified change in status. If the denial is upheld, you may file an appeal with the Employee Benefit Plans Committee (the “Committee”). Appeals must be sent to the Employee Benefit Plans Committee, The Boeing Company, 100 North Riverside Plaza, MC 5002-8421, Chicago, IL 60606-1596.

Your appeal to the Committee must be in writing and must be filed within 180 days after receiving notification of the denial of your eligibility appeal. The Committee will advise you of its decision no later than 45 days after your appeal is received. If the Committee requires additional time to consider your appeal, you will be notified in writing before the end of the initial 45-day period that an additional period of up to 45 days is necessary.

The Committee will provide you with its written decision and explain the specific plan provisions for the denial (if applicable). The Committee has the sole discretionary authority to determine eligibility questions arising under the disability plan. The decisions of the Committee are final and binding. In reviewing eligibility questions, the Committee will apply the terms of the plan and will use its discretion in interpreting the terms of the plan. Benefits will be paid under the plan only if the Committee decides in its discretion that you have met the eligibility and participation requirements and the service representative has determined that you are entitled to the benefits.

If your appeal is denied, you may pursue legal remedies under ERISA. Before you may pursue these legal remedies, however, you must exhaust this claim appeal process. If you do take legal action, you must file suit within two years after the date of the event upon which the claim is based.

Life and Accident Benefits

Claim Review and Appeal

You or your beneficiary may send life and accident claims to the service representative (claim administrator), which is listed in Table 1 on page 7. The service representative will process the claim within 90 days of receipt. If the service representative requires more time, you or your beneficiary will be notified in writing before the end of the initial 90-day period of the need for an extension of up to 90 days.

If the claim is denied, you or your beneficiary will be notified in writing of the reasons for the denial, the right to appeal, and the right to obtain copies of all documents related to the claim that were reviewed by the service representative in making its determination.

If you or your beneficiary disagrees with the claim denial, you, your beneficiary, or a designated representative has the option of attempting to resolve any misunderstanding by calling the service representative and providing additional information. If you prefer to communicate in writing or the issue is not resolved with a telephone call, you, your beneficiary, or your designated representative may file an
appeal in writing with the service representative. You, your beneficiary, or your designated representative has 60 days after receiving notification of the claim denial to file a written appeal. Please include the reasons for the appeal and any information or documentation that will be helpful to the review of the claim.

The service representative will review the written appeal and notify you, your beneficiary, or your designated representative of its decision within 60 days after the appeal is received. If the service representative requires additional time to consider the appeal, you, your beneficiary, or your designated representative will be notified in writing before the end of the initial 60-day period that an additional period of up to 60 days is necessary.

The service representative will provide you, your beneficiary, or your designated representative with its written decision and explain the specific plan provisions for the denial (if applicable). The service representative has the sole discretionary authority to determine payment of benefits under the life and accident plans. The decisions of the service representative are final and binding. In reviewing your claim, the service representative will apply the terms of the plan and will use its discretion in interpreting the terms of the plan. Benefits will be paid under the plan only if you have met the eligibility and participation requirements and the service representative has determined that you are entitled to the benefits.

If the appeal is denied, legal remedies may be pursued under ERISA. Before pursuing these legal remedies, however, you, your beneficiary, or your designated representative must exhaust this claim appeal process. If legal action is taken, the suit must be filed within two years after the date of the event upon which the claim is based.

Eligibility Review and Appeal

If you, your dependent, or your legal representative believes that you or your dependent has been improperly denied participation in a life or accident plan or the opportunity to make an election change due to a qualified change in status, follow the appeal procedures previously described. However, instead of contacting the service representative, contact the Boeing Service Center for Health and Welfare Plans at 100 Half Day Road, P.O. Box 1466, Lincolnshire, IL 60069-1466, telephone 1-888-747-2016 (hearing impaired: 1-800-855-2880; from overseas: 847-883-0746). Any appeal must be made within 60 days of the date you or your dependent is denied participation or the opportunity to make an election change due to a qualified change in status. If the denial is upheld, you, your beneficiary, or your designated representative may file an appeal with the Committee. Appeals must be sent to the Employee Benefit Plans Committee, The Boeing Company, 100 North Riverside Plaza, MC 5002-8421, Chicago, IL 60606-1596.

The appeal to the Committee must be in writing and must be filed within 60 days after receiving notification of the denial of the initial appeal. The Committee will advise you, your beneficiary, or your designated representative of its decision no later than 60 days after the appeal is received. If the Committee requires additional time to consider the appeal, you, your beneficiary, or your designated representative will be notified in writing before the end of the initial 60-day period that an additional period of up to 60 days is necessary.

The Committee will provide you, your beneficiary, or your designated representative with its written
decision and explain the specific plan provisions for the denial (if applicable). The Committee has the sole discretionary authority to determine eligibility questions arising under the life and accident plans. The decisions of the Committee are final and binding. In reviewing eligibility questions, the Committee will apply the terms of the plan and will use its discretion in interpreting the terms of the plan. Benefits will be paid under the plan only if the Committee decides in its discretion that you have met the eligibility and participation requirements and the service representative has determined that you are entitled to the benefits.

If the appeal is denied, you, your beneficiary, or your designated representative may pursue legal remedies under ERISA. Before pursuing these legal remedies, however, you, your beneficiary, or your designated representative must exhaust this claim appeal process. If legal action is taken, the suit must be filed within two years after the date of the event upon which the claim is based.

**Medical and Surgical Benefits After a Mastectomy**

Federal law requires medical plans that provide mastectomy benefits also to provide certain postmastectomy benefits and to tell participants that these benefits are available. The Plan affected by this requirement is The Boeing Company Employee Health Benefit Plan (Plan 626).

Covered individuals receiving benefits for a mastectomy may elect breast reconstruction in connection with the mastectomy in a manner determined in consultation with the patient and the attending physician. Covered services include the following:

- 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 and treatment of physical complications of all stages of mastectomy, including lymphedema.

These reconstructive benefits are subject to annual deductibles, copayments, and coinsurance provisions as are other medical and surgical benefits covered under the medical plans.

### Table 1

**Service Representatives for Life and Accident Coverages**

<table>
<thead>
<tr>
<th>Life Insurance Service Representative</th>
<th>Accident Insurance Service Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Address and Telephone Number</strong></td>
<td><strong>Address and Telephone Number</strong></td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Basic life insurance:</td>
<td>Basic accidental death and dismemberment insurance, supplemental accidental death and dismemberment insurance, voluntary personal accident insurance, and business travel accident insurance:</td>
</tr>
<tr>
<td>Aetna Life Insurance Company</td>
<td>AIG Life Insurance Company</td>
</tr>
<tr>
<td>10 State House Square, SH21</td>
<td>P.O. Box 15701</td>
</tr>
<tr>
<td>Hartford, CT 06103</td>
<td>Wilmington, DE 19850-5701</td>
</tr>
<tr>
<td>1-800-523-5065</td>
<td>1-800-551-0824</td>
</tr>
<tr>
<td>Supplemental life insurance:</td>
<td></td>
</tr>
<tr>
<td>Metropolitan Life Insurance Company</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 3016</td>
<td></td>
</tr>
<tr>
<td>Utica, NY 13504</td>
<td></td>
</tr>
<tr>
<td>1-800-638-6420</td>
<td></td>
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</tbody>
</table>
New Address for Employee Benefit Plans Committee

The address of the Committee has changed to Boeing World Headquarters. This change applies to all benefit plans sponsored by The Boeing Company and any of its affiliates or subsidiaries (the “Company”), including plans subject to ERISA. You may contact the Committee at Employee Benefit Plans Committee, The Boeing Company, 100 North Riverside Plaza, MC 5002-8421, Chicago, IL 60606-1596, telephone 312-544-2297.

For More Information

If you have questions, call the Boeing Service Center for Health and Welfare Plans at 1-888-747-2016 (hearing impaired: 1-800-855-2880; from overseas: 847-883-0746).
Benefits Update

April 2003

Summary of Benefit Plan Changes and Clarifications

Employees Represented by IAFF I-17 and I-66; IAM 24, 44, 70, 86, 751, and 2766; IBEW 271; IUOE 286 and 286W; Pilots Association; SPEEA; SPEEA WTPU; SPFPA 2, 5, 255, and 506; and UAW 1069

This Benefits Update summarizes the changes and clarifications that affect your benefit plans and updates your summary plan descriptions. The effective date of each change and clarification is January 1, 2003, unless otherwise noted.

This Benefits Update is for your information and is being provided to you as required by Federal law. No action on your part is required.

How to Obtain a Provider Directory

Many of the Boeing health care plans offer benefits through a network of providers. Generally, you receive a higher level of benefits when you use the services of a network provider.

Network provider directories identify providers who have participation agreements with particular health care plans. You may obtain provider directories (free of charge) for your plans as follows:

- Access Your Benefits Resources web site (http://resources.hewitt.com/boeing) to obtain a personalized provider list, which shows network providers in your area by plan.
- Call the Boeing Service Center for Health and Welfare Plans at 1-888-747-2016 (hearing impaired: 1-800-855-2880; from overseas: 847-883-0746) and request a list of providers in your area.
- Contact your health care plan service representative (claim administrator) directly and request a provider directory.

Note: You must have your Social Security number and Boeing Service Center for Health and Welfare Plans password/personal identification number (PIN) available when you access Your Benefits Resources web site or call the Boeing Service Center automated phone system.

Because provider changes occur periodically, confirm with the provider or the health care plan service representative that your provider is participating in the plan’s network before receiving services.

Enrollment Due to Certain Changes in Status

If you are enrolled in the health care plans and you have a new dependent as a result of an event such as marriage, entering into a same-gender domestic partner relationship, birth, adoption, or placement for adoption, you may enroll the new dependent as long as enrollment is requested within 120 days after the event.
If you are not enrolled in the health care plans and you have a new dependent as a result of an event such as marriage, entering into a same-gender domestic partner relationship, birth, adoption, or placement for adoption, you may enroll yourself, your spouse or same-gender domestic partner, and any dependent children during the year as long as enrollment is requested within 60 days after the event.

If you enroll within the time frames specified above, coverage will be retroactive to the date of the change in status.

**New Health Care Plan Coverage Effective Date During Hospitalization**

If you elect a new health care plan during annual enrollment or special enrollment or as a result of a qualified change in status and are confined to a hospital when coverage becomes effective, the new health care plan will take effect as scheduled for you and your eligible dependents. However, if your previous health care plan (including a Company-sponsored health care plan) provides continued coverage during the hospitalization period, the previous plan will be the primary plan and the new plan secondary under the coordination of benefits rules until the hospitalization ends.

**Merger Under The Boeing Company Cafeteria Plan**

Effective December 31, 2002, the Dependent Care Expense Account Plan merged into and is part of the Dependent Care Reimbursement Account Plan. Both plans are part of The Boeing Company Cafeteria Plan (Plan 576). This merger does not affect your benefits or elections under the Plan.

**Dependent Care Reimbursement Account Changes**

Under the Dependent Care Reimbursement Account Plan, an employee may make pretax contributions and receive tax-free reimbursement of qualified dependent care expenses. Under Federal tax rules, an employee’s participation is limited to the least of the employee’s income for the year, the spouse’s income for the year, or $5,000 ($2,500 if married and filing separate tax returns).

Currently, if the spouse is disabled or a student, the spouse’s assumed income is $250 if one dependent is in day care and $500 a month if two or more dependents are in day care. Because Congress updates these amounts periodically, the Dependent Care Reimbursement Account Plan, which is part of The Boeing Company Cafeteria Plan (Plan 576), was amended to remove the assumed income dollar amounts for a disabled spouse or a spouse who is a full-time student.

For future reference, the Internal Revenue Service (IRS) periodically publishes updated rules for dependent care expenses in IRS Publication 503. This publication is available by calling 1-800-TAX-FORM or on line (http://www.irs.gov/formspubs).

**Medical and Surgical Benefits After a Mastectomy**

Federal law requires that medical plans which provide mastectomy benefits must also provide certain postmastectomy benefits and notify participants that these benefits are available.
Covered individuals receiving benefits for a mastectomy may elect breast reconstruction in connection with the mastectomy in a manner determined in consultation with the patient and the attending physician. Covered services include the following:

- 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 and treatment of physical complications of all stages of mastectomy, including lymphedema.

These reconstructive benefits are subject to annual deductibles, copayments, and coinsurance provisions consistent with other medical and surgical benefits covered under the medical plans.

**Where to Get Information About Qualified Medical Child Support Orders**

For information regarding qualified medical child support orders, please refer to the information provided in your summary plan description or contact the Service Center. You may obtain a copy of the Plan procedures governing medical child support orders without charge by sending a written request to the Employee Benefit Plans Committee, The Boeing Company, 100 North Riverside, MC 5002-8421, Chicago, IL 60606-1596.

**Information About Distribution of Plan Assets if the Plan is Terminated**

Although the Company currently intends to continue the Plan(s), it reserves the right to change, modify, amend, or terminate it (them) at any time. If (any of) the Plan(s) is (are) terminated and if there are any Plan assets, the assets will be used to pay Plan benefits and administrative expenses. Any Plan assets remaining after all Plan obligations have been met will revert to the Company to the extent permitted under the applicable insurance contract or trust agreement. To the extent the insurance contract or trust agreement provides that Plan assets may not revert to the Company, the remaining assets will be used to pay other benefits as permitted under applicable law.

**New Name and Address for the Reimbursement Account Service Representative**

HRM, the reimbursement account service representative, merged operations with CBCA Inc. Reimbursement account participants may contact CBCA at the following address and telephone and fax numbers:

CBCA Inc.
FSA Claims Division
P.O. Box 358
Minneapolis, MN 55440-0358
Telephone: 1-888-871-4108
Fax: 1-866-292-2554
Medical Plan Lifetime Maximum Update

If you transfer from one Company-sponsored medical plan to another, the lifetime maximum benefit under the old medical plan will not be transferred to your new medical plan. A new lifetime maximum benefit will apply under the new medical plan.

Claim and Eligibility Review and Appeal Procedures for Health Care Plans

Plans that offer health care (medical and dental) benefits are required by Federal law to implement the following new procedures for review and appeal of claims and eligibility determinations.

You may obtain a complete copy of the benefit claim review and appeal procedures for a Plan by calling the service representative (claim administrator) at the telephone numbers listed in your Health Care Plans summary plan description booklet. You may obtain a complete copy of the eligibility review and appeal procedures for a Plan by contacting the Boeing Service Center at 100 Half Day Road, P.O. Box 1466, Lincolnshire, IL 60069-1466, telephone 1-888-747-2016 (hearing impaired: 1-800-855-2880; from overseas: 847-883-0746).

Benefit Claim Review and Appeal

This section describes claim review and appeal procedures for the Traditional Medical Plan and as applicable the Incentive Dental Plan, the Preferred Dental Plan, the Scheduled Dental Plan, and the Dental Plan. Claim review and appeal procedures for the prepaid dental plans, coordinated care plans, and, as applicable, health maintenance organization (HMO) plans are described in their respective member handbooks.

Your medical or dental claims should be sent to the appropriate service representative (claim administrator). The addresses and telephone numbers for the service representatives are listed in your Health Care Plans summary plan description booklet.

Your claim will fall within one of the following categories:

- Your request for health benefits before a service or supply is received where the Plan requires you to obtain approval of the benefit in advance of receiving medical care as a condition of receiving benefits (such as benefits requiring authorization or precertification) is considered a preservice claim.
- A request for coverage for continuation of services previously approved by the health plan as an ongoing course of treatment or to be provided over a certain period of time is considered a concurrent care claim.
- An urgent request for coverage for medically necessary services is considered an urgent claim.
- A request for coverage for health benefits that is not a preservice, concurrent care, or urgent claim is considered a postservice claim.

When you submit a postservice claim, the service representative will notify you of its decision within 30 days of receiving your claim for benefits. When you submit a preservice claim, the service representative will notify you of its decision within 15 days. If matters beyond the control of the Plan require more time, the review period may be extended up to an additional 15 days. You will be notified of this extension before the end of the initial 15-day review period. For concurrent claims, the service
representative will notify you of its decision within 24 hours provided you notify the Plan at least 24 hours prior to the expiration of the previously approved services. If your claim for benefits has been filed improperly, the health plan service representative will notify you within five days (24 hours in the case of an urgent claim). If additional information is required in order to review your claim, the service representative will notify you of the specific information needed and allow you at least 45 days to provide that information.

If your benefit claim is denied, the service representative will notify you in writing of the specific reasons for the denial; a description and explanation of any additional information needed to process your claim; the specific Plan provisions, rules, protocols, or guidelines on which the claim determination was based; your right to appeal; and your right to obtain copies of documentation related to the decision, without charge. If your claim is denied based on a medical necessity, experimental treatment, or other similar exclusion or limitation, an explanation of the scientific or clinical judgment used in the claim determination will be provided free of charge on request.

An expedited claim process is available. It applies when

- The timing of the regular review process described above could jeopardize your life, health, or ability to regain maximum function, or
- A physician familiar with you and your medical condition believes that the timing of the regular review process described above would subject you to severe pain that could not be controlled adequately without the care that is being considered, or otherwise determines that your claim is “a claim involving urgent care.”

The expedited claim process that would apply in either of these situations would make the claim an urgent claim. In the case of an urgent claim, the service representative will notify you of its decision within 72 hours.

If your claim is denied, you may be able to resolve the denied claim without a formal appeal by calling the service representative and discussing the situation. If the claim is not resolved with a telephone call (an informal review process), you may file a formal appeal. You (or your legal representative) may file an appeal within 180 days after receiving notification of the claim denial. Your appeal to the service representative must be in writing except in the case of an urgent appeal, which can be made orally by calling the service representative. You must include the reasons for your appeal and may include any information or documentation that will be relevant to the review.

The service representative will review the appeal and render a decision. In reviewing your appeal, the service representative will apply the terms of the Plan and will use its discretion in interpreting the terms of the Plan. Generally, the service representative will decide your appeal within 60 days after receiving your postservice appeal if using one level of appeal or within 30 days if using two levels of appeal. For preservice or concurrent appeals, the service representative will decide your appeal within 30 days if using one level of appeal or 15 days if using two levels of appeal. The service representative will provide you with its decision in writing. In the case of an urgent appeal, you will be notified of the appeal determination within 72 hours.

If your benefit claim appeal is denied, the service representative will notify you in writing of the specific reasons for the denial; the specific Plan provisions, rules, protocols, or guidelines on which the claim
Eligibility Claim Review and Appeal

If you have eligibility questions or believe you have been improperly denied participation in a medical or dental plan or the opportunity to make an election as a result of a qualified change in status, follow the claim procedures previously described. However, instead of contacting the service representative, contact the Boeing Service Center for Health and Welfare Plans at 100 Half Day Road, P.O. Box 1466, Lincolnshire, IL 60069-1466, telephone 1-888-747-2016 (hearing impaired: 1-800-855-2880; from overseas: 847-883-0746).

You may be able to resolve questions about eligibility for health plan benefits without filing a formal eligibility claim by calling the Boeing Service Center. If your question is not resolved, you may file a formal eligibility claim by requesting a claim form from the Boeing Service Center. *(Urgent claims can be submitted by calling the Boeing Service Center at 1-888-747-2016. The Boeing Service Center may require you to provide information from your provider to substantiate your urgent eligibility claim.)*

The Boeing Service Center will review your eligibility claim and notify you of its decision within the same time frames as outlined in “Benefit Claim Review and Appeal.” If your eligibility claim is denied, the Boeing Service Center will notify you in writing of the specific reasons for the denial; a description and explanation of any additional information needed to process your eligibility claim; the specific Plan provisions, rules, protocols, or guidelines on which the eligibility claim determination was based; your right to appeal; and your right to obtain copies of documentation related to the decision, without charge.

If your eligibility claim is denied, you (or your legal representative) may file an appeal with the Employee Benefit Plans Committee (“the Committee”) or its delegate if the Boeing Service Center denies your eligibility. Appeals must be sent to the Employee Benefit Plans Committee, The Boeing Company, 100 North Riverside, MC 5002-8421, Chicago, IL 60606-1596. The telephone number for urgent appeals is 312-544-2799. You also may send a fax to the Committee at 312-544-2077. The Committee may require you to provide information from your provider to substantiate your urgent appeal. It is the Committee’s exclusive right to interpret and apply the terms of the Plan and exercise its discretion to determine all questions arising under the Plan. The decisions of the Committee are final and binding. Benefits will be paid under the Plan only if the Committee decides in its discretion that you have met the eligibility and participation requirements and the service representative has determined you are entitled to the benefits.

Your appeal to the Committee must be written (or oral or faxed for an urgent appeal) and must be filed within 180 days after receiving notification of the Boeing Service Center’s denial. You must indicate the reason for your appeal and may include any information or documents that you believe are relevant.
The Committee will notify you of its decision within 60 days after receiving your *postservice appeal* or within 30 days after receiving your *preservice or concurrent appeal*. The Committee will notify you of its decision in writing. If your eligibility appeal is denied, the notification will include the specific reasons for the denial; the specific Plan provisions, rules, protocols, or guidelines on which the determination was based; your right to bring legal action; and your right to obtain copies of documentation related to the decision, without charge. In the case of an *urgent appeal*, you will be notified of the appeal determination within 72 hours.

**Legal Action**

If the service representative (claim administrator) or the Employee Benefit Plans Committee makes an adverse benefit determination on appeal, you may bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. However, you must bring any legal action within two years after the rendering of the services on which the claim is based, or within two years of the date you or your dependent initially is denied participation in the Plan.

**Plan Funding Information**

The Company has established a Voluntary Employees’ Beneficiary Association (VEBA) trust for The Boeing Company Employee Health Benefit Plan (Plan 626). The VEBA trust is a tax-exempt trust established solely for the purpose of providing benefits to plan participants as allowed under Federal law. All or part of your medical and dental benefits may now be provided through this trust. The VEBA trust holds Plan contributions, funds medical and dental benefits, and pays administrative expenses that are authorized by the Plan Administrator. Assets held in the VEBA trust are considered Plan assets and are protected under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The name of the trust is The Boeing Company VEBA Master Trust. The Chase Manhattan Bank is the Trustee and can be contacted at The Chase Manhattan Bank, 3 Chase MetroTech Center—7th floor, Brooklyn, NY 11245.

The Company may establish a minimum contribution that will be made under the Plan for each year. The minimum contribution requires that employer contributions to a VEBA trust will never be less than the specified minimum amount. The Company has established a minimum contribution for 2003; however, there is no assurance that the Company will establish a minimum contribution in future years. This minimum contribution will be used to provide benefits and pay expenses under the Plan and Trust.

**Plan Amendment Information**

This *Benefits Update* is your summary of material modifications and an amendment to the following benefit plans:

- The Boeing Company Employee Health Benefit Plan (Plan 626).
- The Boeing Company Employee Health and Welfare Plan (Plan 503).
- The Boeing Company Cafeteria Plan (Plan 576).
The Plan documents for Plan 626 and Plan 503 include this and other Benefits Updates, your summary plan descriptions, and any applicable provider directories and health and welfare insurance contracts. If there is a discrepancy between this Benefits Update and applicable insured health and welfare contracts, the insured health and welfare contracts will control.

If there is any discrepancy between this Benefits Update and the Plan document for Plan 576, the Plan document will control.

**For More Information**

If you have questions, call the Boeing Service Center for Health and Welfare Plans at 1-888-747-2016 (hearing impaired: 1-800-855-2880; from overseas: 847-883-0746).
Summary of Benefit Plan Changes
Employees Represented by SPEEA, SPEEA WTPU, and Pilots Association

This Benefits Update clarifies certain administrative procedures and describes changes that affect your health and insurance benefits. It also updates the following summary plan description booklets for union-represented employees, as applicable:

- Health Care Plans.
- Disability, Life, and Accident Plans.
- Reimbursement Account Plans.

The effective date of each change is noted within each section.

This Benefits Update is for your information and is provided to you as required by Federal law. No action on your part is required.

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Clariication of Where to Get Benefits Information

The following clarification applies to the Health Care Plans; Disability, Life, and Accident Plans; and Reimbursement Account Plans summary plan description booklets.

Boeing TotalAccess is your gateway to benefits, payroll, and human resources information—on line or by telephone. This means that Boeing TotalAccess connects you directly with the Boeing Service Center for Health and Insurance Plans, many of the service representatives, and other benefits resources. These resources, and how to reach them through Boeing TotalAccess, are explained on page 2.
**Boeing TotalAccess**

Boeing TotalAccess is available 24 hours a day, seven days each week—on line and by telephone.

- At work, log on to [http://my.boeing.com](http://my.boeing.com) on the Boeing Web. Click the TotalAccess tab and follow the links.
- From home, log on to [https://my-ext.boeing.com](https://my-ext.boeing.com) on the World Wide Web.

Boeing TotalAccess directs you to the resources you need. You must have your BEMS ID number (or Social Security number) and Boeing TotalAccess password when you call or use the World Wide Web.

**Boeing Service Center for Health and Insurance Plans**

The Boeing Service Center for Health and Insurance Plans provides information about your medical, dental, life, disability, and reimbursement account plans. Its web site, Your Benefits Resources, offers detailed information about your plans, options, and costs. Boeing TotalAccess connects you to Your Benefits Resources, where you can compare medical and dental plans; enroll for coverage; change your coverage; find a physician, hospital, or dentist; research quality ratings for physicians, hospitals, and nursing homes; file reimbursement account claims; and designate your beneficiaries. You can access Your Benefits Resources anytime—at work or at home—through Boeing TotalAccess (see this page).

If you do not have web access, you can call the Boeing Service Center for Health and Insurance Plans through Boeing TotalAccess (see this page). Choose health and insurance from the menu and follow the prompts. Representatives are available Monday through Friday from 7 a.m. to 8 p.m. Central time (8 a.m. to 9 p.m. Eastern time; 6 a.m. to 7 p.m. Mountain time; 5 a.m. to 6 p.m. Pacific time).

**Service Representatives**

The Company has engaged third-party service representatives to administer the plans, make benefit determinations, and pay claims. Each service representative answers benefit and claim questions by telephone. The service representatives for the medical and dental plans also may supply duplicate identification cards and provide the names of and contact information for providers in the plan networks.

To contact the service representative for your plan, call Boeing TotalAccess, choose health and insurance from the menu, and follow the prompts (see this page), or see the directory in your summary plan description booklet for a list of service representatives and telephone numbers. You also can call your medical or dental plan service representative at the telephone number on the back of your health care identification card or go directly to the service representative’s web site.

**Change in the Short-Term Disability Claim Process**

The following changes apply to the *Disability, Life, and Accident Plans* summary plan description booklet and are effective for employees who take a medical leave of absence on or after February 14, 2004. Some or all of these changes do not apply to the groups listed in “Exceptions to the Claim Payment Process,” on page 4.
How to Submit a Claim for Short-Term Disability Benefits

This section amends the information for submitting short-term disability claims described in the February 2002 Benefits Update, “Summary of Benefit Plan Changes and Clarifications,” and the Disability, Life, and Accident Plans summary plan description booklet.

The process for filing short-term disability claims has been improved. Employees who begin a short-term disability period on or after February 14, 2004, now can file for short-term disability benefits by telephone instead of filing paper claim forms.

If you experience a disability and you expect that it will last for more than seven consecutive days, you may be eligible for short-term disability benefits. To file a claim, call Boeing TotalAccess (see page 2), select leave of absence from the menu, and follow the prompts. You should call within (but not more than) 14 calendar days before the date on which you plan to begin your disability leave, or in cases where the absence is unexpected, you should call as soon as possible before your leave begins. After you speak with a Boeing TotalAccess representative, you will be transferred to the service representative (Aetna, Inc.) to provide the following information:

- The reason for your disability.
- The dates that you expect to be absent.
- The name and telephone number of your physician or physicians.

You also should notify your physician’s office that Aetna will be requesting your information. Be sure to complete any release of information forms that your physician requires.

Claim Payment Process

After Aetna receives all of the necessary information from you and your physician and you have begun your disability leave, Aetna will review your claim and contact you with a decision.

If your claim is approved, Aetna will notify the Company Payroll Department. You will begin to receive short-term disability benefits as part of your regularly scheduled payroll check or direct deposit from the Company. Previously, short-term disability benefits were paid weekly by Aetna.

If you are a full-time or part-time employee, the amount of your short-term disability benefit will be determined by using your weekly salary as of the date your disability first begins. After disability payments begin, any change in your weekly salary will be reflected in your short-term disability benefit payments.

Your short-term disability benefits are reported to the Federal Government and are considered taxable income to you. Your regular payroll tax rate will apply to your short-term disability benefit payments. Any regular payroll deductions, such as health care contributions, life insurance contributions, or loan repayments, also will apply and will be deducted automatically from your short-term disability payments. Contributions to the Voluntary Investment Plan, however, can be deducted only from regular pay, sick leave pay, or vacation pay; they cannot be deducted from short-term disability benefits.

If your claim is not approved, Aetna will notify you in writing of the reasons for the denial, your right to appeal, and your right to obtain copies of all documents related to your claim that were reviewed in making the decision.
The process and time periods for short-term disability claim reviews and appeals are described in your February 2002 Benefits Update, “Summary of Benefit Plan Changes and Clarifications.”

Exceptions to the Claim Payment Process

Exceptions to these changes apply to the following groups:

- **Employees in Wichita.** All nonunion and union-represented employees in Wichita continue to file paper claim forms. However, any short-term disability benefits are paid through Boeing payroll (as just described) by check or direct deposit.

- **Employees in Hawaii.** Because of certain state requirements, employees in Hawaii continue to coordinate short-term disability benefits through local leave of absence contacts, and Aetna continues to send short-term disability payments.

- **Employees on foreign assignment.** The new claim payment process does not apply to employees who are on foreign assignments. Those employees continue to submit paper claims to Aetna, and Aetna continues to send short-term disability payments.

Clarification of the Enrollment Process

The following clarification applies to the *Health Care Plans; Disability, Life, and Accident Plans; and Reimbursement Account Plans* summary plan description booklets and replaces the section “Boeing Service Center for Health and Welfare Plans” in each booklet.

How to Enroll as a Newly Eligible Employee

Soon after you are hired, you will receive a Boeing TotalAccess password and an enrollment worksheet for your health and insurance benefits. Your can use your enrollment worksheet as a guide when you enroll; you will not need to submit it for enrollment. You also will need the following information:

- Your BEMS ID number (or your Social Security number) and birth date.
- Social Security numbers and birth dates for dependents that you are enrolling.
- Information about your spouse’s or same-gender domestic partner’s employment and health care coverage, if any.
- The name and identification number of your primary care provider if you enroll in a coordinated care plan, health maintenance organization (HMO) plan, or prepaid dental plan. You and your family members can choose the same or different primary care providers. To find the identification number for a provider, view the network provider directories on Your Benefits Resources (see page 2) or contact the service representative for the plan.

If you enroll in the Traditional Medical Plan and the Incentive Dental Plan, you will not need to select primary care providers for either of those plans.

Enrolling On Line or by Telephone

The Boeing Service Center for Health and Insurance Plans provides two ways for you to enroll: on line or by telephone. Both ways are easy, and you can find or request the information you need to make informed choices about your health and insurance coverage.
• To enroll online, connect to Your Benefits Resources through Boeing TotalAccess (see page 2). Once you reach Your Benefits Resources, follow the links to enroll.
• To enroll by telephone, call the Boeing Service Center for Health and Insurance Plans through Boeing TotalAccess (see page 2). Follow the voice prompts to enroll for coverage.

After you enroll, you can use the online system to review your elections, add new dependents, request certain forms, or connect directly to your selected medical or dental plans.

### Your Benefits Resources
The Your Benefits Resources web site provides many tools to help you make informed decisions about health care and insurance. You can

- See which plans are available to you.
- Compare medical and dental plan features and costs when enrolling for coverage.
- Enroll or add new dependents.
- Review your choices.
- Designate a beneficiary.
- Find physicians and dentists in your plans.
- Estimate reimbursement account expenses.
- File reimbursement account claims.
- Research the quality of physicians, hospitals, and nursing homes.

### How to Enroll or Change Coverage During the Year
Generally, you may not make any changes to your coverage during the year unless you experience a special enrollment event or qualified status change (such as a marriage, birth, or adoption) or the Company offers an annual enrollment opportunity.

To add or drop coverage during the year because of a special enrollment event or a qualified status change, you can make the change online through Your Benefits Resources or speak to a representative at the Boeing Service Center for Health and Insurance Plans.

To enroll during an annual enrollment period, make your changes online through Your Benefits Resources during the time period specified by the Company.

### Changing Coverage During the Year
During the year, if you gain a dependent or your dependent’s eligibility changes, you must notify the Boeing Service Center within 60 days. If you already are enrolled for coverage and gain a new dependent as a result of marriage, same-gender domestic partnership, birth, adoption, or placement for adoption, you will have an additional 60 days, for a total of 120 days, to request enrollment in a medical and/or dental plan for your dependent.
Change in the Beneficiary Designation Process

The following amends the section “Beneficiary Designation” in your Disability, Life, and Accident Plans summary plan description booklet.

Effective January 1, 2004, the Boeing Service Center maintains records of beneficiaries for all life and accident insurance plans. You can view your beneficiary information at any time on Your Benefits Resources. If no beneficiary is listed or if your designation is not current, you must update your information on Your Benefits Resources or by speaking to a customer service representative at the Boeing Service Center for Health and Insurance Plans (see page 2).

If you do not have a beneficiary on file with the Boeing Service Center for Health and Insurance Plans, claims will be paid according to the terms of the summary plan description for the Plan.

Change in the Reimbursement Account Service Representative

The following amends the Reimbursement Account Plans summary plan description booklet.

Effective January 1, 2004, administration of the health care and dependent care reimbursement accounts transferred from CBCA Inc. to Your Spending Account, a division of the Boeing Service Center for Health and Insurance Plans. The process for filing reimbursement account claims also has changed.

How to File a Reimbursement Account Claim

Claims for qualifying expenses that you incur on or after January 1, 2004, may be submitted to Your Spending Accounts in three ways: on line, by mail, or by fax.

To submit a reimbursement claim on line, log on to Your Benefits Resources through Boeing TotalAccess (see page 2) and click the link for Your Spending Account. Once you complete the online claim process, you still will need to print a copy of your completed claim form and mail or fax it with your receipts to Your Spending Account (see below).

To submit a reimbursement claim by mail or fax, call the Boeing Service Center for Health and Insurance Plans through Boeing TotalAccess and request the Your Spending Account claim form. Be sure to submit both the form and your receipts to YSA, P.O. Box 785040, Orlando, FL 32878-5040, or fax them to 1-888-211-9900.

Clarification of How to Convert to Individual Coverage

The following clarifies the section “Conversion of Your Medical Plan Coverage” in your Health Care Plans summary plan description. That section is changed to read as follows:

If medical coverage terminates for you or a covered dependent, you or your dependent may be able to enroll in an individual group medical policy if the medical plan service representative offers one. No evidence of insurability will be required. Benefits under the individual policy will not necessarily be the same as those provided under your group medical plan.

To convert to an individual policy, you must contact the service representative and complete the application process within 31 days of the date your coverage in this plan ended. The service representative will send you a monthly bill for your premium payments, which generally are larger than those at the group rate.
Medical and Surgical Benefits After a Mastectomy

Federal law requires that medical plans that provide mastectomy benefits also must provide certain postmastectomy benefits and notify participants annually that these benefits are available.

When a covered individual is receiving benefits for a mastectomy, the patient may elect breast reconstruction in connection with the mastectomy in a manner determined in consultation with the attending physician. Covered services include the following:

- 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 and treatment of physical complications of all stages of mastectomy, including lymphedema.

These reconstructive benefits are subject to any annual deductible, copayments, and coinsurance provisions consistent with other medical and surgical benefits covered under the medical plans.

For More Information

If you have questions about eligibility for or enrollment in your benefits, connect to the Boeing Service Center for Health and Insurance Plans through Boeing TotalAccess—on line or by telephone (see page 2).

If you have questions about these changes or specific plan benefits, call the applicable service representative, either through Boeing TotalAccess or at the telephone number shown in your summary plan description or in a later Update. For health care plans, call the telephone number shown on the back of your health care identification card.

Plan Amendment Information

This Benefits Update is your summary of material modifications to the summary plan descriptions listed on page 1 and is an amendment to the following benefit plans:

- The Boeing Company Employee Health and Welfare Benefit Plan (Plan 503).
- The Boeing Company Employee Health Benefit Plan (Plan 626).
- The Boeing Company Cafeteria Plan (Plan 576).

This Benefits Update is being provided to you in accordance with the Employee Retirement Income Security Act of 1974, as amended.

The official Plan documents for Plans 503 and 626 are composed of the summary plan description booklets (including this and any other summaries of material modifications), the insurance contracts, and any network provider directories. If there is a discrepancy between this Benefits Update and applicable insured health and welfare contracts, the insured health and welfare contracts will control. The Boeing Company Cafeteria Plan is the official plan document for Plan No. 576. Although the Company fully intends to continue the Plans described here, the Company reserves the right to change, modify, amend, or terminate them at any time and for any reason for employees, former employees, retirees, and their dependents.
September 2004

Summary of Benefit Plan Changes

Employees and Retired Employees Represented by SPEEA WTPU

This Update summarizes the collectively bargained changes and clarifications that will affect your benefit plans and updates your summary plan descriptions. The effective date of each change is October 1, 2004, unless otherwise noted.

The changes and clarifications described in this Update will apply to you if you are an active employee of The Boeing Company (the “Company”) or a retired employee of the Company represented by the Society of Professional Engineering Employees in Aerospace, Wichita Technical and Professional Unit (SPEEA WTPU).

This Update is for your information and is being provided to you as required by Federal law. No action on your part is required.

VOLUNTARY INVESTMENT PLAN

Effective October 1, 2004, the following changes will apply to The Boeing Company Voluntary Investment Plan (VIP):

- The maximum salary deferral percentage will be raised from 15 percent to 20 percent of base pay. You may contribute on a pretax basis, an aftertax basis, or a combination of both up to 20 percent. Internal Revenue Service rules, which limit the maximum annual contribution amounts to the VIP, still will apply.

- A new dividend payout program will allow you to choose how you want to receive your quarterly dividends if you have a balance in the Boeing Stock Fund:
  - **Reinvest in the Boeing Stock Fund**—You can continue to have your dividends reinvested in the fund. The dividends will purchase additional Boeing Stock Fund units.
  - **Request a cash payment**—You can choose to have your dividends paid to you in cash. A check will be mailed to you as soon as administratively possible after the dividend payment date. Your payment will be taxable as ordinary income but will not be subject to the early withdrawal penalty. Taxes will not be withheld from cash dividend payments.

  **Note:** The new dividend payout program also will apply to terminated employees with a balance in the Boeing Stock Fund.

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When and How to Make Dividend Elections

You may elect how you want your dividend paid—either reinvested in the Boeing Stock Fund or paid in cash—any time before 4 p.m. Eastern time on the day before the ex-date. The ex-date is the date on which the owner/seller, and not the buyer, of a stock will be entitled to a recently announced dividend.

The ex-date will be posted each quarter on the Boeing Savings Plans Online web site (https://my-ext.boeing.com). Your balance in the Boeing Stock Fund on the day before the ex-date will determine the amount of your dividend. Stock fund units acquired on or after the ex-date will not receive a dividend in the current quarter. You can make your election online or by telephone (1-866-473-2016).

Once you have made an election, it will remain in place until you change it, so it is not necessary for you to make an election each quarter. You can change your election anytime, but to be effective for the current quarter dividend, you must make the change before the ex-date. If you do not make any election regarding dividends, your dividends automatically will be reinvested in the Boeing Stock Fund. If you transfer your balance out of the Boeing Stock Fund after the ex-date but before the dividend payment date for a given quarter, you still will receive that quarter’s dividend, either to be reinvested in the Boeing Stock Fund or paid in cash, as you elect.

RETIREMENT PLAN

The Company will continue to provide The Boeing Company Employee Retirement Plan for employees covered under the SPEEA WTPU contract. If you are an active employee, on an authorized leave of absence, or within your six-year layoff period and start your pension benefit on or after the following dates, the rate used to calculate your basic benefit will increase as follows:

- $59 per month per year of service effective October 1, 2004.
- $60 per month per year of service effective January 1, 2005.

MEDICAL BENEFITS FOR EMPLOYEES

The changes in this section will apply to The Boeing Company Employee Health Benefit Plan.

Plan Choices

Effective October 1, 2004, the Company will offer the following medical plans:

- Traditional Medical Plan.
- Preferred Plus coordinated care plan.
- Selections Plus coordinated care plan.
Contributions
The current contributions for the Traditional Medical Plan will continue through September 30, 2004.

- **Effective October 1, 2004**, in regions where you may choose between the Traditional Medical Plan and a coordinated care plan, the Company will pay the full cost of the lowest cost plan in the applicable region for you and your eligible dependents. If you (or your dependents) elect coverage under a higher cost plan, you will contribute—on a pretax basis—12 percent of the cost of the plan you choose, subject to limits described in the collective bargaining agreement.

- **Effective July 1, 2005**, in regions where you may choose between the Traditional Medical Plan and a coordinated care plan, the Company will pay the full cost of the lowest cost plan in the applicable region for you and your eligible dependents. If you (or your dependents) elect coverage under a higher cost plan, you will contribute—on a pretax basis—18 percent of the cost of the plan you choose, subject to limits described in the collective bargaining agreement.

- **Effective July 1, 2006**, in regions where you may choose between the Traditional Medical Plan and a coordinated care plan, the Company will pay the full cost of the lowest cost plan in the applicable region for you and your eligible dependents. If you (or your dependents) elect coverage under a higher cost plan, you will contribute—on a pretax basis—18 percent of the cost of the plan you choose, subject to limits described in the collective bargaining agreement.

- **Effective July 1, 2007**, in regions where you may choose between the Traditional Medical Plan and a coordinated care plan, the Company will pay the full cost of the lowest cost plan in the applicable region for you and your eligible dependents. If you (or your dependents) elect coverage under a higher cost plan, you will contribute—on a pretax basis—18 percent of the cost of the plan you choose; no limits will apply.

- The additional $100 working spouse contribution will continue for spouses or same-gender domestic partners who decline enrollment in another employer-sponsored medical plan.

Traditional Medical Plan
All changes to the Traditional Medical Plan will be effective October 1, 2004, except as noted.

Annual Deductible and Copayment
The individual annual deductible will increase from the greater of $125 or 0.2 percent of your base annual wage to $200 or 0.2 percent of base annual wage. For families of three or more, the annual deductible maximum will increase from the greater of $375 or 0.6 percent of your base annual wage to $600 or 0.6 percent of base annual wage.

The deductible no longer will apply to network office, home, or hospital outpatient physician visits. Instead, a $15 copayment will apply to each office, home, or hospital outpatient visit to a network provider (except for covered preventive care and smoking cessation services). Allowed charges in excess of the copayment will be paid in full.
Hospital Charges and Patient Safety Standards

Covered inpatient and outpatient hospital charges will be paid after the deductible as follows:

- Through September 30, 2004, services will be paid in full when received from a network provider.
- Effective October 1, 2004, services will be paid in full when received from a network hospital that meets the patient safety standards described below.
- Effective October 1, 2004, services will be paid at 95 percent when received from a network hospital that does not meet the patient safety standards described below.
- Services will continue to be paid at 60 percent of usual and customary charges when received from a nonnetwork hospital.

Patient safety standards refer to nationally recognized criteria for making hospital services safer. A hospital meets patient safety standards if it meets established criteria such as those listed here. The hospital must publicly certify upon request that it meets all criteria and the statements pertaining to standards are accurate and reflect normal operating procedures at the hospital. The criteria include the following:

- **Criteria for Network Hospital Admissions for Complex Procedures**

  Evidence-based hospital referrals: For patients admitted for one of several complex procedures (for example, coronary artery bypass grafts, percutaneous coronary intervention, abdominal aortic aneurysm repair, pancreatic resection, esophagectomy, and high-risk deliveries), network hospitals must meet experience criteria, consisting of process, volume, and/or outcome measures, for the performance of the specific procedure.

  If complex procedures—as identified by national standards—change in the future, the Company and union will meet and discuss the changes.

- **Criteria for Other Network Hospital Admissions**

  For patients admitted for all other procedures or conditions, network hospitals must meet the following standards:

  - **Computerized physician order entry:** Prior to October 1, 2004, the hospital must publicly assure that by January 1, 2005, physicians will enter at least 75 percent of inpatient medication orders via a computer linked to error-prevention software. The software must be capable of alerting physicians to at least 50 percent of common, serious prescribing errors. On and after January 1, 2005, the hospital must publicly assure that it actually fulfills these capabilities.

  - **Intensive care unit staffing:** On and after October 1, 2004, the hospital publicly assures that its adult and/or pediatric intensive care unit is managed or co-managed by critical care specialists who:

    1. Are present during daytime hours and exclusively provide clinical care in the ICU, and
    2. At all other times, can return urgent ICU paging calls within five minutes and arrange for a physician or FCCS-certified nonphysician specialist to reach ICU patients within five minutes at least 95 percent of the time.

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

Effective October 1, 2004, other covered services currently paid in full will be paid at 95 percent after the deductible. However, hospital alternatives (Christian Science sanatorium, hospice agency, and skilled nursing facility) will continue to be paid at 100 percent. Nonnetwork services will continue to be paid at 60 percent. Covered services for preventive care and smoking cessation treatment will continue to be paid in full to the applicable benefit limits.

Durable Medical Equipment

In a region where there is a durable medical equipment network, covered durable medical equipment will be paid at 95 percent when received from a network provider and 60 percent when received from a nonnetwork provider. In a region where there is no durable medical equipment network, as determined by the service representative, covered durable medical equipment will be paid at 80 percent.

Lifetime Maximum Benefit

The lifetime maximum benefit will increase from $1.25 million to $1.5 million.

Maternity Care

Maternity care will be covered for eligible spouses and dependent children.

Prescription Drug and Medicine Coverage

These benefits are administered by Medco Health Solutions, Inc. (the service representative). The Company may change the service representative at any time.

The program offers two coverage options for prescription drugs and medicines. You may use the preferred pharmacy card program to obtain covered prescriptions from any retail pharmacy. As an alternative, you may use the mail service program, called Medco By Mail, to order covered prescription drugs.

A formulary will apply to all retail pharmacy and mail order purchases. A formulary is a list of drugs determined to be effective in both cost and treatment. 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.

Effective October 1, 2004, there will be three 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.
Traditional Medical Plan Preferred Pharmacy Card Program

The preferred pharmacy card 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, antigen, allergy serum, and insulin as well as needles, syringes, chem strips, chem pads, and lancets when prescribed along with insulin. The program also covers legend drugs for smoking cessation.

The program restricts each prescription or refill to a 34-day supply.

The preferred pharmacy card program will continue to be offered with the addition of a formulary. Covered prescription drugs will be reimbursed as follows:

<table>
<thead>
<tr>
<th>Preferred Pharmacy Card Benefit Levels</th>
<th>GENERIC</th>
<th>BRAND-NAME FORMULARY</th>
<th>BRAND-NAME NONFORMULARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating Pharmacy</td>
<td>90% of discounted, allowed charges</td>
<td>80% of discounted, allowed charges</td>
<td>70% of discounted, allowed charges</td>
</tr>
<tr>
<td>Nonparticipating Pharmacy (or participating pharmacy without identification card)</td>
<td>90% of allowed charges</td>
<td>80% of allowed charges</td>
<td>70% of allowed charges</td>
</tr>
</tbody>
</table>

If you use your health identification card at a participating pharmacy, you will be responsible for paying the pharmacist the full discounted price for the prescription. The pharmacist then will file a prescription drug claim for you electronically.

If you use a nonparticipating pharmacy or do not use your identification card when purchasing a prescription at a participating pharmacy, you will be responsible for paying the pharmacist the full price for the prescription; no discount will apply. You then must file a special claim form to receive reimbursement for covered expenses. Your reimbursement will be based on the discounted charge applicable to a participating pharmacy.

Traditional Medical Plan Mail Service Program

The Medco By Mail program is provided as an alternative to the preferred pharmacy card program.

As with the preferred pharmacy card program, Medco By Mail 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 and insulin as well as needles, syringes, chem strips, chem pads, and lancets when prescribed along with insulin. The program also covers legend drugs for smoking cessation.

This program covers up to a 90-day supply per prescription or refill if prescribed by the physician. Authorized refills are covered only after the initial order has been used. Certain controlled substances are subject to quantity limitations.

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.
Medco By Mail also will continue to be offered with the addition of a formulary. New copayments will be:

<table>
<thead>
<tr>
<th></th>
<th>Mail Service Copayments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Generic</td>
</tr>
<tr>
<td><strong>Mail Service Program</strong></td>
<td>$10</td>
</tr>
<tr>
<td>(Medco By Mail)</td>
<td></td>
</tr>
<tr>
<td><strong>Nonnetwork Mail Service</strong></td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**Prescription Drug and Medicine Exclusions**

The following items are excluded under both the preferred pharmacy card program and the mail service program:

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

- Any charges for the administration or injection of any drug.

- 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 prescription filled in excess of the number prescribed by the physician or any refill after one year from the date of the physician’s order.

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

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

- Fertility agents, unless approved by the service representative.

- Obesity drugs, unless approved by the service representative.

- Drugs dispensed during an inpatient admission by a hospital, skilled nursing facility, sanatorium, or other facility.

- Experimental drugs or drugs used for investigational purposes.

- Drugs that are not medically necessary for the treatment of an illness, injury, or other covered condition, including vitamins, except as specifically provided by the program.

- Over-the-counter drugs that can be purchased without a prescription, except insulin.

- Infusion therapy drugs, except as described in the home health care benefit.

- Delivery or handling charges.

- Any service or supply otherwise excluded by the program.
Vision Care Program

The Company will introduce a new, national network vision program. The program is administered by Vision Service Plan (VSP, the service representative). The Company may change the service representative at any time.

**Accessing the VSP Network**

VSP features a national network of licensed optometrists and ophthalmologists. These providers have contracted with VSP to provide vision care services and supplies. Although you may receive care from any covered licensed provider, the program offers certain advantages when using a network provider.

Network providers offer discounts on complete pairs of prescription glasses and on contact lens examinations (evaluation and fitting). The program pays the network provider the amounts shown in the Schedule of Covered Vision Care Expenses on the next page. You pay the excess of such amounts. Network providers also submit claims to the service representative.

You can access network provider lists on the VSP web site (http://www.vsp.com) or by calling 1-800-877-7195.

**Making an Appointment With a Network Provider**

Once you select a network provider, you call the provider’s office to make an appointment. Identification cards are not required.

**Covered Services and Supplies**

The program will cover the following vision care services and supplies (up to the amounts shown in the schedule below):

- A complete eye examination of visual function, performed by a licensed ophthalmologist or optometrist.
- Prescription lenses.
- Frames required for prescription lenses.
- Contact lenses if elected in place of conventional lenses and frames.
### Benefit Payment Levels

The program pays benefits according to the following schedule:

<table>
<thead>
<tr>
<th>Services and Supplies</th>
<th>Maximum Covered Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eye Examination</strong></td>
<td>Paid in full after $15 copayment for VSP network provider services; paid up to $50 for nonnetwork provider services</td>
</tr>
<tr>
<td><strong>Lenses:</strong></td>
<td></td>
</tr>
<tr>
<td>Single vision (2 lenses)</td>
<td>$50*</td>
</tr>
<tr>
<td>Bifocal (2 lenses)</td>
<td>$80*</td>
</tr>
<tr>
<td>Trifocal (2 lenses)</td>
<td>$95*</td>
</tr>
<tr>
<td>Lenticular (2 lenses)</td>
<td>$155*</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td>$70*</td>
</tr>
<tr>
<td><strong>Contact Lenses, in place of allowances for conventional lenses and frames above</strong></td>
<td>$105*</td>
</tr>
</tbody>
</table>

* VSP network providers offer a 20 percent discount on complete pairs of prescription glasses and a 15 percent discount on contact lens examinations (evaluation and fitting); you pay the VSP network provider only the excess over the amounts shown in the schedule above. Nonnetwork provider charges for lenses, frames, and contact lenses are reimbursed up to the amounts shown in the schedule above; no discount applies.

Patients will 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 will not be covered under this program, but some may be covered as a medical condition under the Traditional Medical Plan.

### Benefit Limitations

Benefits will be provided for one eye examination every benefit year and two sets of lenses and two frames every two benefit years (network and nonnetwork combined). The program will cover contact lenses when purchased in place of conventional lenses and frames. Any replacement of lost, stolen, or broken lenses and/or frames will be subject to the two-set limit.

### Vision Care Program Exclusions

The following vision care expenses will not be covered:

- Special supplies, such as nonprescription sunglasses or subnormal vision aids.
- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (less than a ± 0.38 diopter power), two pair of glasses in place of bifocals, or extra charges for progressive lenses in excess of the bifocal allowance.
- Medical or surgical treatment of the eyes. (However, VSP network providers offer discounts for refractive surgery.)
• Corrective vision treatment of an experimental nature. Experimental nature means a procedure or lens that is not used universally or accepted by the vision care profession, as determined by the service representative.

• Solutions and/or cleaning products for spectacle glasses or contact lenses.

• Costs above the maximum covered expenses.

• Services or supplies not listed as covered expenses.

• Services or supplies received while the individual was not covered under the program or charges for lenses and frames furnished or ordered before the individual became covered under the program.

• Services or supplies received more than 60 days after the service representative authorizes the patient’s vision care benefits.

Coordination of Vision Benefits

The plan under which the patient is the employee (or retired employee) is the primary plan. The plan under which the patient is the dependent is the secondary plan. When another plan is the primary plan for vision coverage, this Company-sponsored plan pays the difference between the benefits paid by the primary plan and what would have been paid if this Company-sponsored plan had been primary. Generally, if you and your spouse have dual coverage, your plan is primary for your expenses and secondary for your spouse’s expenses. For children covered under the plans of both parents, the plan of the parent whose birthday occurs earlier in the year is primary, and the other parent’s plan is secondary.

Coordinated Care Plans

All changes to the coordinated care plans will be effective October 1, 2004.

• The office visit copayment will increase from $5 to $10.

• The lifetime maximum benefit will increase from $1.25 million to $1.5 million.

• Maternity care will be covered for eligible spouses and dependent children.

• The retail pharmacy program will continue to be offered with the addition of a formulary. New copayments will be
  • $5 for generic drugs.
  • $15 for brand-name formulary drugs.
  • $30 for brand-name nonformulary drugs.

  The program will cover a 34-day supply per prescription or refill.

• The mail service program will continue to be offered with the addition of a formulary. New copayments will be
  • $10 for generic drugs.
  • $30 for brand-name formulary drugs.
  • $60 for brand-name nonformulary drugs.

  The program will continue to provide up to a 90-day supply for these copayment amounts.

• If a coordinated care plan does not offer the negotiated plan design, the Company will substitute the closest available plan design.
OTHER HEALTH AND INSURANCE CHANGES

Health Care Spending Account

This change will apply to The Boeing Company Cafeteria Plan.

Effective January 1, 2005, the Company will offer a health care spending account to all employees regularly scheduled to work more than 19 hours each week. You will be able to contribute on a pretax basis between $250 and $3,000. The plan is administered by Your Spending Account (a division of Hewitt Associates, LLC, the service representative). The Company may change the service representative at any time.

Overview

A health care spending account allows you to set aside pretax contributions from your pay to use for reimbursement of qualified out-of-pocket health care expenses during the year. Federal tax laws limit the type of expenses that can be reimbursed from this account. The law also requires that all money not used to reimburse qualified health care expenses incurred during the covered period be forfeited.

Starting January 1, 2005, the health care spending account coverage period will be January 1 through December 31 of each year.

Contributions

You may contribute on a pretax basis between $250 and $3,000.

By opening a health care spending account, you authorize the Company to reduce compensation in an amount equal to your contributions. You may not change contribution amounts during the year unless you experience a qualified change in status.

Qualified Expenses

Examples of reimbursable expenses include

- Expenses not paid by a health care plan, such as
  - Deductibles.
  - Copayments.
  - Out-of-pocket expenses.
  - Charges above usual and customary limits.
  - Charges above the health care plan benefit maximums.
  - The cost of prescription lenses, frames, or contacts (including solutions and cleaners) above the plan’s scheduled allowances.
  - Prescription drugs not covered, or covered only in part, by the plan.
  - Orthodontia treatment above the dental plan lifetime maximum.
  - Weight loss programs prescribed by a physician to treat an existing disease, including obesity.
  - The cost of smoking cessation programs in excess of the plan maximum.
• Most expenses not covered by a health care plan but considered tax deductible by the IRS; for example
  • Alternative treatments, such as experimental therapies.
  • Refractive surgery.
  
  A complete list of tax-deductible health care expenses appears in IRS Publication 502 (1-800-TAX-FORM; http://www.irs.gov). Most, but not all, of the tax-deductible expenses in Publication 502 are reimbursable through the health care spending account.

• The cost of over-the-counter (OTC) drugs, provided that all of the following conditions are met (as determined by the service representative):
  • The OTC drug primarily is for medical care and not for cosmetic procedures.
  • The OTC drug is purchased to treat an existing medical condition.
  • The quantity of OTC drug purchased is reasonable for the treatment of the condition. (Generally, no more than a 30-day supply would be considered reasonable.)
  • The OTC drug is not purchased just to benefit general health.
  • The OTC drug is purchased for your treatment or that of your covered dependents.
  • A dated receipt is provided for the purchase that includes the name and cost of the OTC drug for which you are seeking reimbursement.

The following types of OTC drugs are likely to qualify for reimbursement. This list of reimbursable expenses is not exhaustive and is intended to give examples of some of the most common OTC drugs.

<table>
<thead>
<tr>
<th>Type of OTC Drug</th>
<th>Type of OTC Drug</th>
<th>Type of OTC Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy medications</td>
<td>Cold remedies</td>
<td>Menstrual cycle medications</td>
</tr>
<tr>
<td>Antacids and acid reducers</td>
<td>Contraceptives</td>
<td>Migraine medications</td>
</tr>
<tr>
<td>Anticandidal medications (such as Femstat 3®, Gyne-Lotrimin, Mycelex-7®, Monistat 3®, and Vagistat-1®)</td>
<td>Cough suppressants</td>
<td>Motion sickness medications</td>
</tr>
<tr>
<td>Antidiarrheal medications and laxatives</td>
<td>Decongestants and nasal decongestants</td>
<td>Nicotine gum or patches and smoking cessation aids</td>
</tr>
<tr>
<td>Antifungal products</td>
<td>Diaper rash ointments</td>
<td>Pediculicides (head lice treatments)</td>
</tr>
<tr>
<td>Antihistamines</td>
<td>Dietary supplements and weight reduction aids*</td>
<td>Poison ivy protection</td>
</tr>
<tr>
<td>Anti-itch lotions and creams</td>
<td>Eye drops for allergy and cold relief</td>
<td>Prenatal vitamins*</td>
</tr>
<tr>
<td>Bandages (such as Band-Aid® and Ace® bandages)</td>
<td>Hemorrhoid treatments</td>
<td>Sleep aids, such as oral medications and snoring strips*</td>
</tr>
<tr>
<td>Internal analgesics and antipyretics (such as Advil®, Aleve®, Children’s Motrin®, Nuprin®, Excedrin®, Tylenol®, and aspirin)</td>
<td>Motion sickness medications</td>
<td>Toothache and teething pain relievers</td>
</tr>
<tr>
<td></td>
<td>* Purchased at the direction of a physician to treat a specific existing medical condition</td>
<td></td>
</tr>
</tbody>
</table>
Nonreimbursable Expenses

Examples of nonreimbursable expenses include

- Contributions for medical plan coverage or other health insurance premiums.
- Your cost for long-term care or premiums for long-term care insurance.
- Items paid or payable by any health care coverage.
- Cosmetic expenses, including cosmetic surgery, cosmetic dental treatment such as teeth bleaching, treatments for baldness such as Rogaine® or hair transplants, skin treatments such as Retin-A® (unless prescribed for the treatment of acne), prescription drugs used for cosmetic purposes, or electrolysis.
- OTC drugs that are cosmetic in nature or are merely beneficial to general health such as
  - Cosmetics (such as face creams, moisturizers, eye creams, or wrinkle reducers).
  - Deodorants.
  - Drugs that are obtained illegally.
  - Hair removal treatments or waxes.
  - Mouthwashes, antiseptics, or oral anesthetics.
  - Teeth whitening kits or powders.
  - Toiletries (such as toothpaste).
  - Vitamins or dietary supplements taken to improve overall health.
- Physician access fees.
- Expenses incurred for special treatment programs (unless prescribed to treat a medical condition and documented by a letter of medical necessity from a physician) such as health club memberships, spas, or weight-loss programs or weight-loss drugs for general health.

Eligibility

The changes in this section will apply to the following plans:

- The Boeing Company Employee Health Benefit Plan.
- The Boeing Company Employee Health and Welfare Benefit Plan.
- The Boeing Company Retiree Health and Welfare Benefit Plan.
- The Boeing Company Cafeteria Plan.

The following changes will be effective October 1, 2004:

- For newly hired employees who are eligible for coverage, health and insurance coverage will become effective on the first day of the month following the first day of employment.
• Coverage for dependent children under age 25 will be modified to conform to IRS rules for providing tax-free health care coverage to dependent children, as follows:
  • Children who are under age 25, unmarried, and dependent on you for principal support (including children attending school) may be covered under the medical and dental plans. These criteria will apply to natural children, adopted children, children legally placed with you for adoption, stepchildren, and children related to you directly or through marriage.
  • Children for whom you have legal custody or guardianship (or a pending application for legal custody or guardianship) may be covered under the medical and dental plans if they are under age 25, unmarried, dependent on you for principal support (including children attending school), and living with you.

Voluntary Long-Term Disability Benefits
Effective October 1, 2004, the Company will modify the voluntary Long-Term Disability Plan, under The Boeing Company Employee Health and Welfare Benefit Plan, as follows:
• The waiting period for long-term disability benefits will be revised to 26 weeks (previously six months) to eliminate the potential gap between short-term and long-term disability.
• You will be eligible for long-term disability benefits for up to 24 months if you are unable to perform the duties of your own occupation.
• You will be eligible for long-term disability benefits related to mental illness and substance abuse disabilities for up to 24 months unless you are confined in an inpatient facility (previously unlimited).

Part-Time Benefits
The changes in this section will apply to the following plans:
• The Boeing Company Employee Health Benefit Plan.
• The Boeing Company Employee Health and Welfare Benefit Plan.
• The Boeing Company Cafeteria Plan.

Benefits will be provided in accordance with standard Company policy, PRO-522, which addresses coverage of all health and insurance benefits as well as participation in savings and pension plans, as summarized below.

Health and Insurance Benefits
If you are on a part-time schedule (as defined below) and scheduled to work more than 19 hours each week, you will be eligible for all health and insurance plans.

Contributions
As a part-time employee, your cost for medical coverage will be based on a percentage of the cost, determined by scheduled weekly hours:

<table>
<thead>
<tr>
<th>Part-Time Scheduled Hours</th>
<th>Employee Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 19</td>
<td>Not eligible</td>
</tr>
<tr>
<td>19.1 – 32</td>
<td>30%</td>
</tr>
<tr>
<td>32.1 or more</td>
<td>Same as full-time employees</td>
</tr>
</tbody>
</table>

If you are required to pay the $100 working spouse contribution for medical coverage, that contribution will be in addition to any other contributions you make for medical plans.
Salary-Related Benefits
Benefits for the following plans will be adjusted to reflect your part-time schedule:

- Basic Life Insurance Plan.
- Supplemental Life Insurance Plan.
- Short-Term Disability Plan.
- Long-Term Disability Plan.

Business Travel Accident Plan
As an active employee, you will be eligible for business travel accident benefits while traveling on Company business, regardless of your number of scheduled hours. Coverage will be based on annualized salary at your number of scheduled hours. The minimum benefit will be $50,000.

Part-Time Schedule
A part-time schedule consists of:

- A seven-day cycle with fixed days and less than 40 hours of work over one regular workweek, or
- A 14-day cycle with fixed days and less than 80 hours of work over two regular workweeks.

RETIREE MEDICAL BENEFITS
The changes in this section will apply to The Boeing Company Retiree Health and Welfare Benefit Plan. Retiree medical benefits are only available to employees who were hired or rehired prior to January 1, 1999. Eligibility provisions shown in the collective bargaining agreement will continue to apply.

Retiree Medical Plan Choices
Effective October 1, 2004, the Company will offer the following medical plans:

- Traditional Medical Plan.
- Preferred Plus coordinated care plan.
- Selections Plus coordinated care plan.

Plan Benefits
Plan changes and revisions for active employees will apply to retiree medical coverage as well. See Medical Benefits for Employees on page 2.

Contributions
Effective October 1, 2004, monthly contributions for retiree medical coverage will be as follows:

- Contributions for each medical plan will be the greater of the retired employee contributions required under the 3-1/3 percent formula for employees hired on or after January 1, 1993 [cost of selected medical coverage \textit{minus} (3-1/3 percent \textit{times} years of service \textit{times} cost of selected medical coverage)], or the monthly amounts shown in the collective bargaining agreement. There is no coverage for employees hired January 1, 1999, or later.

- The additional $100 working spouse contribution will continue for spouses who decline enrollment in another employer-sponsored medical plan.
Eligibility

The following changes will be effective October 1, 2004:

- The Company will amend the eligibility provisions to require an employee to be age 55 and have 10 or more years of vesting service under a Company-sponsored retirement plan. Currently, the Company requires age 55 with 10 or more years of credited service under a Company-sponsored retirement plan or 11 or more years of Company service.

FOR MORE INFORMATION

Contact the Boeing service centers through Boeing TotalAccess.

- On the Boeing Web: Log on to http://my.boeing.com and click the TotalAccess tab.
- On the World Wide Web: Log on to https://my-ext.boeing.com using your BEMS ID number (or your Social Security number) and your Boeing TotalAccess password.
- Call Boeing TotalAccess toll free at 1-866-473-2016 (TTY/TDD: 1-800-755-6363) and follow the prompts. You must have your BEMS ID number (or your Social Security number) and your Boeing TotalAccess password. Customer service hours vary by service center; representatives generally are available during regular business hours.

PLAN AMENDMENT INFORMATION

This Update is a summary of material modifications to your summary plan descriptions for the following Company benefit plans:

- The Boeing Company Employee Health Benefit Plan (Plan 626).
- The Boeing Company Employee Health and Welfare Benefit Plan (Plan 503).
- The Boeing Company Retiree Health and Welfare Benefit Plan (Plan 502).
- The Boeing Company Employee Retirement Plan (Plan 001).
- The Boeing Company Voluntary Investment Plan (Plan 002).
- The Boeing Company Cafeteria Plan (Plan 576).

This document is provided to you in accordance with the Employee Retirement Income Security Act of 1974, as amended.

If there is any discrepancy between this Update and the Plan documents listed above, the Plan documents will control. Although the Company fully intends to continue the Plans described here, the Company reserves the right to change, modify, amend, or terminate them at any time and for any reason for employees, former employees, retirees, and their dependents.
Summary of Health and Insurance Benefit Plan Changes and Clarifications

Employees Represented by Pilots Association, SPEEA, and SPEEA-WTPU

This Update summarizes the administrative changes and clarifications that affect your benefit plans and updates your summary plan descriptions. The effective date of each change is January 1, 2005, unless otherwise noted.

The changes in this Update apply to the following plans:

- The Boeing Company Employee Health and Welfare Benefit Plan (Plan 503).
- The Boeing Company Cafeteria Plan (Plan 576).
- The Boeing Company Employee Health Benefit Plan (Plan 626).

HEALTH AND INSURANCE CHANGES AND CLARIFICATIONS

The changes in this section will apply to:

- The Boeing Company Employee Health and Welfare Benefit Plan (Plan 503).
- The Boeing Company Employee Health Benefit Plan (Plan 626).

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Incapacitated Children

A disabled child age 25 or older may continue to be eligible (or enrolled if the child of a newly eligible employee) if he or she is incapable of self-support because of any mental or physical condition and the child became incapacitated before age 25. 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 eligible under the plans and the child continues to meet these eligibility requirements.

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

Enrollment and Default Coverage Clarifications

When you become eligible for coverage, the Boeing Service Center for Health and Insurance Plans will send you an enrollment worksheet that outlines the health care options available to you. If you do not enroll by the date printed on your enrollment worksheet, you will be enrolled automatically in the Traditional Medical Plan and Scheduled Dental Plan. Your family will not be enrolled and will not have any coverage. If you work part time, you do not enroll, and you would be required to make a contribution towards the cost of your coverage, you will not be automatically enrolled and will not have coverage.

If you are returning to active employment after an approved leave of absence, uniformed service, or layoff (within your recall period), your prior health and insurance plan coverage will be reinstated on the day you return to work for one full day. If your prior plan or coverage is not available, you will be allowed to elect a new plan. If you do not elect a new plan by the deadline, you will be enrolled automatically in the Traditional Medical Plan and Scheduled Dental Plan. Your family will not be enrolled and will not have any coverage.

If you are rehired from retirement or after termination, your coverage will be effective as of the first of the month after you return. If your rehire date is less than 90 days from your termination date, your prior benefits will be reinstated. If more than 90 days have passed since your termination date, you will be required to elect new plans and coverages. If you participate in the dependent care or health care spending account plans, you will be allowed to elect new coverage amounts.

Medical and Surgical Benefits After a Mastectomy

If you have had or are going to have a mastectomy, you 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 will be provided subject to the same deductible, copayment, and coinsurance applicable to other medical and surgical benefits provided under this plan.
Clarification of Work Hours for Eligible Employees

The following clarifies “Eligible Employees” in the Health Care Plans; Disability, Life, and Accident Plans; and Reimbursement Account Plans summary plan description booklets. In each booklet, the first paragraph of “Eligible Employees” is replaced by the following.

You are eligible for coverage under the plans described in this booklet if you are all of the following:

- A union-represented Boeing employee who is regularly scheduled to work 19.1 or more hours a week.
- On the active payroll.
- Paid through the Company Payroll Department.

Change in the Beneficiary Designation Process

The following amends “Beneficiary Designation” in your Disability, Life, and Accident Plans summary plan description booklet.

Effective January 1, 2004, the Boeing Service Center maintains records of beneficiaries for all life and accident insurance plans. You can view or modify your beneficiary information at any time on the Your Benefits Resources web site. If no beneficiary is listed or if your designation is not current, you must update your information on Your Benefits Resources or by speaking to a customer service representative at the Boeing Service Center.

If you do not have a beneficiary on file with the Boeing Service Center, claims will be paid according to the terms of the summary plan description for the Plan.

Clarification of How to Convert to Individual Coverage

The following clarifies “Conversion of Your Medical Plan Coverage” in your Health Care Plans summary plan description. That section is changed to read as follows:

If medical coverage terminates for you or a covered dependent, you or your dependent may be able to enroll in an individual group medical policy if the medical plan service representative offers one.

No evidence of insurability will be required. Benefits under the individual policy will not necessarily be the same as those provided under your group medical plan.

To convert to an individual policy, you must contact the service representative and complete the application process within 31 days of the date you are notified your coverage in this plan ended, but not later than 90 days after the date your coverage ended. The service representative will send you monthly bills for your premium payments, which generally are larger than those at the group rate.

Change in the Short-Term Disability Claim Process

The following changes apply to the Disability, Life, and Accident Plans summary plan description booklet and are effective for employees who take a medical leave of absence on or after February 14, 2004. Some or all of these changes do not apply to the groups listed in “Exceptions to the Claim Payment Process,” on page 4.

How to Submit a Claim for Short-Term Disability Benefits

This section amends the information for submitting short-term disability claims described in the February 2002 Benefits Update, “Summary of Benefit Plan Changes and Clarifications,” and the Disability, Life, and Accident Plans summary plan description booklet.

The process for filing short-term disability claims has been improved. Employees who begin a short-term disability period on or after February 14, 2004, can file for short-term disability benefits by telephone instead of filing paper claim forms.
If you experience a disability and you expect that it will last for more than seven consecutive days, you may be eligible for short-term disability benefits. To file a claim, call Boeing TotalAccess, select leave of absence from the menu, and follow the prompts. You should call within (but not more than) 14 calendar days before the date on which you plan to begin your disability leave, or in cases where the absence is unexpected, you should call as soon as possible before your leave begins. After you speak with a Boeing TotalAccess representative, you will be transferred to the service representative (Aetna, Inc.) to provide the following information:

- The reason for your disability.
- The dates that you expect to be absent.
- The name and telephone number of your physician or physicians.

You also should notify your physician’s office that Aetna will be requesting your information. Be sure to complete any release of information forms that your physician requires.

**Claim Payment Process**

After Aetna receives all of the necessary information from you and your physician and you have begun your disability leave, Aetna will review your claim and contact you with a decision.

If your claim is approved, Aetna will notify the Company Payroll Department. You will begin to receive short-term disability benefits as part of your regularly scheduled payroll check or direct deposit from the Company. (Previously, short-term disability benefits were paid weekly by Aetna.)

If you are a full-time or part-time employee, the amount of your short-term disability benefit will be determined by using your weekly salary as of the date your disability first begins. After disability payments begin, any change in your weekly salary will be reflected in your short-term disability benefit payments.

Your short-term disability benefits are reported to the Federal Government and are considered taxable income to you. Your regular payroll tax rate will apply to your short-term disability benefit payments. Any regular payroll deductions, such as health care contributions, life insurance contributions, or loan repayments, also will apply and will be deducted automatically from your short-term disability payments. Contributions to the Voluntary Investment Plan, however, can be deducted only from regular pay, sick leave pay, or vacation pay; they cannot be deducted from short-term disability benefits. In addition, you may be entitled to receive other income benefits that will reduce your short term disability benefit under the terms of the Plan. See your summary plan description booklet for a specific listing of other income benefits that would reduce your short term disability benefit.

If your claim is not approved, Aetna will notify you in writing of the reasons for the denial, your right to appeal, and your right to obtain copies of all documents related to your claim that were reviewed in making the decision.

The process and time periods for short-term disability claim reviews and appeals are described in your February 2002 Benefits Update, “Summary of Benefit Plan Changes and Clarifications.”

**Exceptions to the Claim Payment Process**

Exceptions to this claim payment process are as follows:

- **Employees in Wichita.** All union-represented employees in Wichita continue to file paper claim forms. However, any short-term disability benefits are paid through Boeing payroll (as just described) by check or direct deposit.

- **Employees in Hawaii.** Because of certain state requirements, employees in Hawaii continue to coordinate short-term disability benefits through local leave of absence contacts, and Aetna continues to send short-term disability payments.

- **Employees on foreign assignment.** The claim payment process just described does not apply to employees who are on foreign assignments. Those employees continue to submit paper claims to Aetna, and Aetna continues to send short-term disability payments.
CLARIFICATIONS ABOUT COBRA COVERAGE

The changes in this section will apply to:

- The Boeing Company Employee Health Benefit Plan (Plan 626).
- The Boeing Company Cafeteria Plan (Plan 576).

Continue Coverage Through COBRA

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

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

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

The Boeing Service Center administers COBRA coverage.

Who Is Eligible for COBRA Coverage

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

Certain trade-displaced employees may have additional COBRA rights and possible tax credits if they have been certified by the Department of Labor or state labor agencies as eligible for trade adjustment assistance under the Trade Act of 2002. Qualifying individuals receive information from the Federal Government, which describes a special enrollment period for trade-displaced workers who have not become covered under COBRA coverage, a 65 percent tax credit for qualified health insurance premiums, an advance payment program, and procedures for participating in the program.

You can obtain information about trade adjustment assistance by calling the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282 (TDD/TTY: 1-866-626-4282) or visiting the Department of Labor web site (http://www.doleta.gov/tradeact/).

Special rules may apply if you retire or are offered other medical coverage as an alternative to COBRA. Information about coverage during an approved leave of absence appears in the chart beginning on page 8.

Your Right to COBRA Coverage

You will have a right to elect COBRA coverage if you are covered by a Company-sponsored health care plan and you lose coverage because either

- Your employment ends, or
- Your hours decrease.

Your Spouse’s or Same-Gender Domestic Partner’s Right to COBRA Coverage

Your covered spouse or same-gender domestic partner has a right to elect COBRA coverage if he or she is covered by a Company-sponsored health care plan and loses coverage because of

- Your death.
- Your employment ending.
• Your work hours decreasing.
• Your divorce, legal separation from you, or dissolution of the domestic partnership.

Your Child’s Right to COBRA Coverage
Your covered dependent child has a right to elect COBRA coverage if he or she is covered by a Company-sponsored health care plan and loses coverage because of
• Your death.
• Your employment ending.
• Your work hours decreasing.
• Your divorce, legal separation, or dissolution of the domestic partnership.
• His or her loss of eligibility for coverage.

How to Enroll for COBRA Coverage
You are responsible for
• Notifying the Boeing Service Center when your dependent’s coverage ends.
• Enrolling for COBRA coverage.
• Paying any required contributions in a timely manner.
• Notifying Boeing TotalAccess if your address changes.

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

If your coverage ends because of your termination, death, or reduction in work hours, the Company will notify the Boeing Service Center within 30 days from the date your coverage ends.

Notify the Boeing Service Center When Coverage Ends
You or your covered dependents must notify the Boeing Service Center, in writing or by telephone, if your covered dependent loses coverage because of divorce, legal separation, or dissolution of domestic partnership or if your child loses his or her eligibility for coverage.

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

Watch Your Mail for COBRA Election Forms
The Boeing Service Center will send you a notice of your COBRA rights and enrollment materials within 14 days of the date it is notified that your coverage will end or has ended.

Elect COBRA Coverage
You and/or any dependent who has lost coverage has an independent right to elect COBRA coverage. For example, your spouse may elect COBRA coverage, but you or your spouse may decline COBRA coverage for your dependent children.

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

If the Boeing Service Center determines that you or your dependent is not eligible for COBRA coverage, you will receive a notice stating the reasons for ineligibility.
Pay for COBRA Coverage

The Boeing Service Center will notify you of the amount you and your covered dependents must pay for COBRA coverage.

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

You have an initial 45-day grace period from the date of your election to pay the first premium. You also must pay for any months of continued health care coverage since the date your active coverage ended. After the first payment, your COBRA coverage payments are due by the first of each month. (You have a 31-day grace period, beginning on the first day of the month, in which to make each payment. Payments must be postmarked within the 31-day grace period.)

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

It is important that you make timely payments for your COBRA coverage. If you fail to make a payment as described above, coverage will end automatically on the last day of the month for which coverage was paid. You will not be allowed to reinstate coverage that has been terminated because timely payments were not made.

When COBRA Coverage Begins

Generally, COBRA coverage begins when your active coverage ends. However, if you decline enrollment when you are first offered COBRA coverage and then later choose to enroll for coverage within the applicable time period, your coverage will begin on the date you contact the Boeing Service Center to elect COBRA coverage, so you will have a break in the continuity of your coverage.

When You Can Change COBRA Coverage

As a COBRA participant, you have the same opportunity as an active employee to

- Choose different health care plans during annual enrollment.
- Add or drop covered dependents during annual enrollment.
- Enroll eligible dependents under special enrollment and qualified status change rules. (For example, you may add a new dependent acquired through marriage, same-gender domestic partnership, birth, or adoption.)

How Long COBRA Coverage Can Continue and How Much It Costs

Generally, COBRA coverage may last for up to 18 or 36 months, depending on the event that caused you or your dependent to lose coverage and whether or not any secondary event occurs during the COBRA coverage period. These COBRA coverage periods and the events that determine them are shown here.

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

If the cost of coverage changes for similarly situated active employees or dependents, the cost of COBRA coverage will change.
<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Qualified Beneficiaries</th>
<th>Maximum Length of COBRA Coverage and Cost of COBRA Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your employment ends, except layoff</td>
<td>• You</td>
<td>18 months at 102%</td>
</tr>
<tr>
<td></td>
<td>• Your spouse or same-gender domestic partner*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Your dependent child*</td>
<td></td>
</tr>
<tr>
<td>Your hours are reduced</td>
<td>• You</td>
<td>18 months at 102%</td>
</tr>
<tr>
<td></td>
<td>• Your spouse or same-gender domestic partner*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Your dependent child*</td>
<td></td>
</tr>
<tr>
<td>You are laid off</td>
<td>• You</td>
<td>18 months; for medical, the active contribution amount for the first 3 months, then 102%; for dental, 102%</td>
</tr>
<tr>
<td></td>
<td>• Your spouse or same-gender domestic partner*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Your dependent child*</td>
<td></td>
</tr>
<tr>
<td>You die</td>
<td>• Your spouse or same-gender domestic partner*</td>
<td>36 months; for nonoccupational death, the active contribution amount for the first 12 months, then 102%; for occupational death, the active contribution amount for 36 months</td>
</tr>
<tr>
<td></td>
<td>• Your dependent child*</td>
<td></td>
</tr>
<tr>
<td>Divorce, legal separation, or dissolution of domestic partnership</td>
<td>• Your spouse or same-gender domestic partner*</td>
<td>36 months at 102%</td>
</tr>
<tr>
<td></td>
<td>• Your dependent child*</td>
<td></td>
</tr>
<tr>
<td>A dependent child loses eligibility</td>
<td>• Your dependent child*</td>
<td>36 months at 102%</td>
</tr>
<tr>
<td>A covered individual becomes disabled before active coverage ends or within 60 days of COBRA coverage beginning, and he or she</td>
<td>• You</td>
<td>29 months; 18 months at 102%, then 150%</td>
</tr>
<tr>
<td>• Receives a Social Security disability award within the first 18 months of COBRA coverage, and</td>
<td>• Your spouse or same-gender domestic partner*</td>
<td></td>
</tr>
<tr>
<td>• Provides notification of the award within 60 days after it is granted and during the first 18 months of COBRA</td>
<td>• Your dependent child*</td>
<td></td>
</tr>
<tr>
<td>You go on an approved medical leave of absence</td>
<td>• You</td>
<td>6 months of continued active coverage, then 29 months of COBRA coverage; for the first 24 months of COBRA coverage, you contribute the active medical contribution for you only and 100% for your covered dependents, as well as 100% for your and your dependents’ dental coverage; for the last 5 months, you contribute 150% for medical and dental</td>
</tr>
<tr>
<td></td>
<td>• Your spouse or same-gender domestic partner*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Your dependent child*</td>
<td></td>
</tr>
</tbody>
</table>
COBRA Coverage Periods and Qualifying Events

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Qualified Beneficiaries</th>
<th>Maximum Length of COBRA Coverage and Cost of COBRA Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>You go on an approved nonmedical leave of absence</td>
<td>• You</td>
<td>3 months of continued active coverage, then 21 months of COBRA coverage at 100%</td>
</tr>
<tr>
<td></td>
<td>• Your spouse or same-gender domestic partner*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Your dependent child*</td>
<td></td>
</tr>
<tr>
<td>You go on an approved Uniformed Services Employment and Reemployment Rights Act</td>
<td>• You</td>
<td>24 months provided your uniformed services leave continues in accordance with USERRA; the first 3 months of coverage are provided at the active contribution amount, with the remaining 21 months at 100% of the active rate. For up to 60 months during a temporary period, this coverage will be continued at the active contribution level for the duration of your uniformed services leave. This is provided that your 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 with Iraq.</td>
</tr>
<tr>
<td>(USERRA) leave</td>
<td>• Your spouse or same-gender domestic partner*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Your dependent child*</td>
<td></td>
</tr>
</tbody>
</table>

* For more information, see “Secondary COBRA Qualifying Events,” in this section.

Note: If your qualifying event is the end of employment or a reduction of your hours of employment, and you become entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for your dependents who lose coverage as a result of the qualifying event will last until 36 months after the date of your Medicare entitlement.

In addition, please note that different rules apply when more than one qualifying event occurs. Contact Boeing TotalAccess for additional information.

Secondary COBRA Qualifying Events

If your spouse or same-gender domestic partner or dependent child experiences a secondary COBRA qualifying event during your 18- or 29-month COBRA period, he or she may continue COBRA coverage for up to a total of 36 months from the date you lost active coverage because of termination of employment or a reduction in your hours. During this extension period, COBRA coverage will cost 102 percent of the cost of coverage.

A secondary COBRA qualifying event occurs when your dependent loses coverage because one of these events occurs during your 18- or 29-month COBRA period:

- You die.
- You divorce, you become legally separated, or your domestic partnership is dissolved.
- Your dependent child reaches age 25, marries, is no longer dependent on you for principal support, or otherwise loses eligibility under plan rules.

To qualify for this extended COBRA coverage, your dependent must be a “qualified beneficiary.” That is, your dependent must have been covered while you were an active employee and continuously enrolled under your COBRA coverage. If your child is born, adopted, or placed with you for adoption during your period of COBRA coverage, he or she must have been enrolled within 120 days and continuously covered since birth, adoption, or placement for adoption.
When COBRA Coverage Ends

Generally, COBRA coverage ends on the last day of the month in which any of the following events occurs:

- The 18-, 29-, or 36-month COBRA period expires.
- The Company no longer provides group health coverage to any employees.
- The COBRA coverage premium is not paid within 31 days of the due date (except during the initial 45-day grace period).
- You become covered, after electing COBRA coverage, under another group health plan that contains no applicable exclusion or preexisting condition limit.
- You enroll in Medicare after electing COBRA coverage.
- You receive a Social Security determination that you no longer are disabled after your COBRA coverage has been extended beyond 18 months, but not more than 29 months. In that case, coverage ends on the first of the month that is more than 30 days after the determination and after the initial 18-month COBRA coverage period ends.
- Your dependent who is not a qualified beneficiary ceases to be an eligible dependent as defined by the Plan.

Once COBRA coverage ends, it cannot be reinstated.

COBRA coverage under your health care spending account will end on the earlier of:

- The dates noted in the bullets above, or
- The last day of the plan year in which the initial qualifying event occurs.

Converting Your COBRA Coverage

At the end of the 18-, 29-, or 36-month COBRA coverage period, you or your covered dependents may convert to an individual policy, if available, that is offered by the Boeing group health plan service representative.

To convert to an individual policy, complete a conversion application and submit it to the service representative within 31 days of when your Company-sponsored coverage ends. You will be billed for the applicable rate, which generally is higher than the group rate. Conversion applications are available from the service representative. No evidence of insurability will be required.

For More Information, to Enroll, or to Report a Qualifying Event

If you have questions, to enroll in COBRA coverage, or to report a qualifying event, contact the Boeing Service Center through Boeing TotalAccess.

- On the World Wide Web: Visit https://my-ext.boeing.com and log on with your Social Security number (or BEMS ID number, if you retired recently and you have one) and your Boeing TotalAccess password. Click the button for health and insurance plans to go to Your Benefits Resources, the web site for the Boeing Service Center.
- By telephone: Call 1-866-473-2016. Hearing-impaired callers can access TTY/TDD services at 1-800-755-6363. Choose health and insurance from the menu. Boeing Service Center representatives are available to assist you weekdays between 8 a.m. and 7 p.m. Central time. You must have your BEMS ID number (or Social Security number) and Boeing TotalAccess password when you call.
In writing: Send your report of a qualifying event or other information to:

The Boeing Service Center for Health and Insurance Plans
100 Half Day Road
P.O. Box 1466
Lincolnshire, IL 60069-1466

SPENDING ACCOUNT CHANGES AND CLARIFICATIONS
The changes in this section will apply to The Boeing Company Cafeteria Plan (Plan 576).

Change in the Spending Account Service Representative
The following paragraph amends the Reimbursement Account Plans summary plan description booklet.

Effective January 1, 2004, administration of the health care and dependent care spending accounts transferred from CBCA Inc. to Your Spending Account™ (YSA). The process for filing spending account claims also changed.

How to File a Spending Account Claim
Claims for qualifying expenses may be submitted to Your Spending Account in three ways: on line, by mail, and by fax.

To submit a spending account claim on line, log on to the Your Benefits Resources web site through Boeing TotalAccess, click the link for Your Spending Account, and follow the instructions. Once you complete the on line claim process, you still will need to print a copy of your completed claim form and mail or fax it with your receipts to Your Spending Account. (See below for contact information.)

To submit a spending account claim by mail or fax, call the Boeing Service Center through Boeing TotalAccess and request the Your Spending Account claim form. Be sure to submit both the form and your receipts to YSA, P.O. Box 785040, Orlando, FL 32878-5040, or fax them to 1-888-211-9900.

CLARIFICATION ABOUT LEGAL ACTION
The following clarification applies to:

- The Boeing Company Employee Health and Welfare Benefit Plan (Plan 503).
- The Boeing Company Cafeteria Plan (Plan 576).
- The Boeing Company Employee Health Benefit Plan (Plan 626).

If the service representative (claim administrator) or the Employee Benefit Plans Committee makes an adverse benefit or eligibility determination on appeal, you or your beneficiary may bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. For claims filed on or after January 1, 2004, any legal action must be commenced within 180 days following the decision on appeal of your initial claim for benefits or eligibility (or following the last day for filing an appeal if no appeal is taken).
FOR MORE INFORMATION

Contact the Boeing Service Center through Boeing TotalAccess.

- On the Boeing Web: Log on to https://my.boeing.com and click the TotalAccess tab.
- On the World Wide Web: Log on to https://my-ext.boeing.com using your BEMS ID number (or your Social Security number) and your Boeing TotalAccess password.
- By telephone: Call Boeing TotalAccess toll-free at 1-866-473-2016. Hearing-impaired callers can access TTY/TDD services at 1-800-755-6363. You must have your BEMS ID number (or your Social Security number) and Boeing TotalAccess password available when you call. Boeing Service Center representatives are available between 8 a.m. and 7 p.m. Central time.

PLAN AMENDMENT INFORMATION

This *Update* is a summary of material modifications to your summary plan descriptions for the following Company benefit plans:

- The Boeing Company Employee Health and Welfare Benefit Plan (Plan 503).
- The Boeing Company Cafeteria Plan (Plan 576).
- The Boeing Company Employee Health Benefit Plan (Plan 626).

This document is provided to you in accordance with the Employee Retirement Income Security Act of 1974, as amended.

If there is any discrepancy between this *Update* and the Plan documents listed above, the Plan documents will control. Although the Company fully intends to continue the Plans described here, the Company reserves the right to change, modify, amend, or terminate them at any time and for any reason for employees, former employees, retirees, and their dependents.
Summary of Health and Insurance Benefit Plan Changes and Clarifications

July 2006

Employees Represented by SPEEA-WTPU

This Update summarizes the administrative changes and clarifications that affect your benefit plans and updates your summary plan descriptions. The effective date of each change is January 1, 2006, unless otherwise noted.

This Update is for your information and is being provided to you as required by Federal law. No action on your part is required.

The changes in this Update apply to the following plans:

- The Boeing Company Employee Health and Welfare Benefit Plan (Plan 503).
- The Boeing Company Employee Health Benefit Plan (Plan 626).
- The Boeing Company Cafeteria Plan (Plan 576).

Health and Insurance Changes and Clarifications

The changes in this section will apply to:

- The Boeing Company Employee Health and Welfare Benefit Plan (Plan 503).
- The Boeing Company Employee Health Benefit Plan (Plan 626).

Availability of HIPAA Privacy Notice

The Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), provides certain protections with respect to the confidentiality of your health information. The Boeing Group Health Plans maintain a Notice of Privacy Practices that provides information to individuals whose protected health information will be used or maintained by the Plans. As a participant in one of the Plans, you have the right to obtain the HIPAA Privacy Notice upon request.

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If you would like a copy of the Notice of Privacy Practices, please contact the Boeing Health and Insurance Service Center through Boeing TotalAccess.

**Special Enrollment Events**

If you declined coverage in the medical or dental plans for yourself and/or your 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 one of these special enrollment events occurs:

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

If you are enrolled in the medical or dental plans and you gain a new dependent because of marriage, entering a same-gender domestic partnership, birth, adoption, or placement for adoption, you may enroll your new dependent and any other eligible dependents in these plans.

When you enroll yourself and/or your dependents as a result of a special enrollment event, you can enroll in any family status tier and any other 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 making a fraudulent claim).

**Medical and Surgical Benefits After a Mastectomy**

If you have had or are going to have a mastectomy, you 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 will be provided subject to the same deductible, copayment, and coinsurance applicable to other medical and surgical benefits provided under this plan.
Changing Coverage During the Year
If you have a change to your work site that results in a change to the health care plans available to you, you can change your health care plan within 31 days of the date in which your work site changed.

How to Submit a Claim or File an Appeal
This section describes two types of claim review and appeal procedures for the health care plans:
1. Medical and dental benefit claims and appeals for the medical and dental plans.
2. Eligibility claims and appeals for all medical and dental plans available to eligible groups.
The benefit claim review and appeal procedures described in this booklet do not apply to the coordinated care plans, HMO plans, or prepaid dental plans. If you are enrolled in one of those plans, refer to the member handbook for information about medical and dental claims and appeals.

Medical and Dental Benefit Claims Process
Each service representative is responsible for evaluating benefit claims in accordance with the terms of the Plan and using a reasonable claims procedure in accordance with Federal rules. The service representatives have the right to obtain independent health care advice and to request additional information as necessary to decide your claims.

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

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

How to File a Claim for Benefits
Generally, whenever you receive services from a network provider, participating pharmacy, or member dentist, that provider submits your claim to the appropriate service representative for review and payment; you do not need to file a claim for yourself.
If you do need to file your own claim, which may be the case when you receive services from a nonnetwork provider, nonparticipating pharmacy, or nonmember dentist, you must submit a written claim form to the appropriate service representative. You can obtain claim forms by calling the service representative or, in some cases, from the service representative’s web site.

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

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

**Time Limits for Decisions on Benefit Claims**

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

<table>
<thead>
<tr>
<th>Type of claim</th>
<th>You will receive notification within . . .</th>
<th>But it may be extended for an additional . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postservice claim</td>
<td>30 days after your claim is received</td>
<td>15 days because of matters beyond the control of the service representative²</td>
</tr>
<tr>
<td>Preservice claim¹</td>
<td>15 days after your claim is received</td>
<td>15 days because of matters beyond the control of the service representative²</td>
</tr>
<tr>
<td>Concurrent care claim</td>
<td>24 hours after your claim is received, provided that a request to extend an ongoing course of treatment is made at least 24 hours before the previous approval expires</td>
<td>Not applicable if you provide enough information³</td>
</tr>
<tr>
<td>Urgent care claim¹</td>
<td>72 hours after your claim is received</td>
<td>Not applicable if you provide enough information³</td>
</tr>
</tbody>
</table>

¹ If you or your authorized representative fails to follow the Plan’s procedures for filing a preservice or urgent care claim, within 5 days (24 hours for an urgent care claim) the service representative will notify you or your authorized representative of the failure and explain the proper procedures.

² If more information is required to review your claim, the service representative will notify you before the end of the initial review period (or within 5 days for a preservice claim) of the specific information needed and will allow you at least 45 days to provide that information. The review time periods for preservice and postservice claims will be suspended until the date that you respond to the request for more information.

³ If more information is required to review your claim, the service representative will notify you within 24 hours of the specific information needed and will allow you at least 48 hours to provide that information. The review time periods for concurrent care and urgent care claims may be extended for as long as 48 hours from the earlier of (1) the date that the service representative receives the additional information or (2) the end of the time period that you were given to provide the additional information.
If Your Benefit Claim Is Denied

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

- Specific reasons for the denial.
- Reference to the specific Plan provisions on which the claim determination was based.
- Description and explanation of any additional information that is needed to process your claim.
- Description of the Plan’s appeal procedures and the applicable time limits, as well as your right to bring legal action if your claim is denied on appeal.
- Statement that you can request, free of charge, copies of documentation related to the decision.
- Description of any rule, protocol, or other criterion that was relied on in determining your claim, and your right to obtain a copy free of charge, upon request.
- Statement that you can request, free of charge, an explanation of the scientific or clinical judgment that was used if your claim was denied based on a medical necessity, an experimental treatment, or another similar exclusion or limitation.
- For an urgent care claim, a description of the expedited review process applicable to such claims.

How to Appeal if Your Benefit Claim Is Denied

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

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

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

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

The service representative will review your appeal and make a decision. The review will be conducted by a person who did not make the decision on your initial claim and is not the subordinate of that person. The review will include all information you submit and will not give deference to the initial claim decision.

If deciding the appeal involves medical judgment, such as determining medical necessity or if treatment was experimental, a qualified health care professional will be consulted. That health care professional will not be one who was consulted in determining your initial claim and will not be a subordinate of such person. In reviewing your appeal, the service representative will use its discretion in interpreting the terms of the Plan and will apply them accordingly.

The decisions of the service representative are final and binding. Benefits will be paid under the Plan only if the Plan Administrator decides in its discretion that you have met the eligibility and participation requirements, and the service representative has determined that you are entitled to benefits.
Time Limits for Decisions on Benefit Appeals

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

<table>
<thead>
<tr>
<th>Time Limits for Receiving a Benefit Appeal Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>You will receive notification of the decision on your . . .</td>
</tr>
<tr>
<td>Postservice claim appeal</td>
</tr>
<tr>
<td>Preservice claim appeal</td>
</tr>
<tr>
<td>Concurrent care claim appeal</td>
</tr>
<tr>
<td>Urgent care claim appeal</td>
</tr>
</tbody>
</table>

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

If Your Benefit Appeal Is Denied

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

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

Whom to Contact for Benefit Claim and Appeal Procedures

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

Eligibility Claims Process

Call the Boeing Service Center through Boeing TotalAccess if

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

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

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

**Time Limits for Decisions on Eligibility Claims**

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

<table>
<thead>
<tr>
<th>If your claim for eligibility involves . . .</th>
<th>You will receive notification within . . .</th>
<th>But it may be extended for an additional . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>A preservice claim¹</td>
<td>15 days after your claim is received</td>
<td>15 days because of matters beyond the control of the Boeing Service Center²</td>
</tr>
<tr>
<td>A concurrent care claim</td>
<td>24 hours after your claim is received, provided that a request to extend an ongoing course of treatment is made at least 24 hours before the previous approval expires</td>
<td>Not applicable if you provide enough information³</td>
</tr>
<tr>
<td>An urgent care claim¹</td>
<td>72 hours after your claim is received</td>
<td>Not applicable if you provide enough information³</td>
</tr>
<tr>
<td>Another claim, including a postservice claim or eligibility claim that does not involve medical or dental services</td>
<td>30 days after your claim is received</td>
<td>15 days because of matters beyond the control of the Boeing Service Center²</td>
</tr>
</tbody>
</table>

¹ If you or your authorized representative fails to follow the Plan’s procedures for filing a preservice or urgent care eligibility claim, within 5 days (24 hours for an urgent care claim) the Boeing Service Center will notify you or your authorized representative of the failure and explain the proper procedures.

² If more information is required to review your claim, the Boeing Service Center will notify you before the end of the initial review period (or within 5 days for a preservice claim) of the specific information needed and will allow you at least 45 days to provide that information. The review time periods for preservice and postservice claims will be suspended until the date that you respond to the request for more information.

³ If more information is required to review your claim, the Boeing Service Center will notify you within 24 hours of the specific information needed and will allow you at least 48 hours to provide that information. The review time periods for concurrent care and urgent care claims may be extended for as long as 48 hours from the earlier of (1) the date that the Boeing Service Center receives the additional information or (2) the end of the time period that you were given to provide the additional information.
If Your Eligibility Claim Is Denied

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

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

How to Appeal if Your Eligibility Claim Is Denied

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

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

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

  Address: Employee Benefit Plans Committee
  The Boeing Company
  100 North Riverside
  MC 5002-8421
  Chicago, IL 60606-1596
  Fax: 312-544-2077
  Telephone (for urgent appeals): 312-544-2799

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

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

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

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

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

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

**If Your Eligibility Appeal Is Denied**

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

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

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

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

**What You Can Do if Your Appeal Is Denied**

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

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

For initial claims filed before January 1, 2004, any legal action must be commenced within two years after the rendering of the services on which the claim is based, or within two years of the date you or your dependent was initially denied participation in the plan.
Coverage for Dependent Children Under the Supplemental Life Insurance and Supplemental Accidental Death and Dismemberment Plans

The changes in this section will apply to The Boeing Company Employee Health and Welfare Benefit Plan (Plan 503).

Your Dependent Children

Your dependent children are your natural children, adopted children, children legally placed with you for adoption, and stepchildren, who are under age 25, unmarried, and dependent on you for principal support. This includes children:

- Who are attending school.
- Who are related to you either directly or through marriage (for example, grandchildren, nieces, and nephews).
- Of your eligible same-gender domestic partner.
- For whom the Company receives a qualified medical child support order (QMCSO).

You also may cover unmarried children under age 25 who are under your legal custody or guardianship (or for whom you have a pending application for legal custody or guardianship) who are solely dependent on you for support and are living with you.

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

You may cover unmarried children described above who are age 25 or older, disabled, and incapable of self-support because of any mental or physical condition that began before age 25. Coverage may continue under the Supplemental Life Insurance and Supplemental Accidental Death and Dismemberment 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.

You cannot cover your dependent children while they are serving in the armed forces of any country or subdivision of a country for more than 30 days.

To participate in the Supplemental Life Insurance Plan, a dependent must reside in the United States or Canada.

Spending Account Changes and Clarifications

The changes in this section apply to The Boeing Company Cafeteria Plan (Plan 576).

Change in the Spending Account Service Representative

Effective January 1, 2006, administration of the health care and dependent care spending accounts transferred from Your Spending Account to Aetna. The process for filing spending account claims also changed.
How to File a Spending Account Claim

Claims for qualifying expenses may be submitted to Aetna by mail or by fax.

To obtain a spending account claim form on line, log on to https://my.boeing.com, click the TotalAccess tab, and then click My Health and Wellness. Under Things You Can Do, click Get a Spending Account Claim Form. You also may call Aetna through Boeing TotalAccess to request the Aetna claim form.

Once you have completed your spending account claim form, send the form and a copy of your receipts to Aetna FSA, P.O. Box 4000, Richmond, KY 40476-4000, or fax them to 1-888-AET-FLEX (1-888-238-3539). You should keep copies of claim forms and receipts for your records.

For More Information

Contact the Boeing Service Center through Boeing TotalAccess.

- **On the Boeing Web:** Log on to https://my.boeing.com and click the TotalAccess tab.
- **On the World Wide Web:** Log on to https://my-ext.boeing.com using your BEMS ID number (or Social Security number) and your Boeing TotalAccess password.
- **By telephone:** Call 1-866-473-2016. TTY/TDD services are available at 1-800-755-6363. You must have your BEMS ID number (or Social Security number) and your Boeing TotalAccess password. Boeing Service Center representatives are available between 8 a.m. and 7 p.m. Central time.

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Plan Amendment Information

This *Update* is a summary of material modifications to your summary plan descriptions for the following Company benefit plans:

- The Boeing Company Employee Health and Welfare Benefit Plan (Plan 503).
- The Boeing Company Employee Health Benefit Plan (Plan 626).
- The Boeing Company Cafeteria Plan (Plan 576).

This document is provided to you in accordance with the Employee Retirement Income Security Act of 1974, as amended (ERISA).

If there is any discrepancy between this *Update* and the Plan documents listed above, the Plan documents will control. Although the Company fully intends to continue the Plans described here, the Company reserves the right to change, modify, amend, or terminate them at any time and for any reason for employees, former employees, retirees, and their dependents.