Health Care Plans

Summary Plan Description
2009 Edition/Union-Represented Employees IBCJA 721; IBEW 2295; IBPATA 36; IBT 578 and 952; UAW 864, 887, 952, 1519, and 1558; SMWIA 461

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 Information and Notice

The Boeing Company provides a variety of medical and dental plan options. You are eligible for coverage under these plans if you meet the conditions described in this booklet and you are represented by one of the union groups listed in Section 1.

All benefits are provided through The Boeing Company Master Welfare Plan and its component benefit programs. The benefits in this booklet are provided under the Boeing North American Employee Health Plan (Plan 602) (the “Plan”).

Through this Plan, The Boeing Company (the “Company”) also provides different benefit plans to other groups. Because they have different benefits, those groups receive separate summary plan description booklets. (See “Other Groups That the Plan Covers,” in Section 6.)

Summary Plan Description and Plan Document

The summary plan description for the Dental PPO Plan is this booklet, any summaries of material modifications (Updates), and the applicable provider directories.

For the 80/20 PPO, PPO+Account, and Dental Premier Plan, the summary plan description is this booklet, any summaries of material modifications (Updates), the applicable coverage-specific brochure, and the applicable provider directories.

For the Point-of-Service Plan, health maintenance organization (HMO) plans, vision care program, and prepaid dental plans, the summary plan description is this booklet, any summaries of material modifications (Updates), the applicable certificates of coverage (issued by the service representative), and the applicable provider directories.

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

The contents and delivery of this booklet are intended to comply with the Employee Retirement Income Security Act of 1974, as amended (ERISA). If there is any conflict between the information in this booklet and the official Plan document, the official Plan document will govern. Any representations contrary to the Plan are not binding.

Network Provider Directory

You can obtain a network provider directory or a list of network providers at no cost to you by
• Connecting to the Your Benefits Resources web site and searching the online provider directory.
• Calling the service representative directly or through Boeing TotalAccess.
• Visiting the web site of your service representative.

Providers move in and out of networks periodically. Before you receive services, be sure to confirm with your provider or the service representative that your provider still is participating in the plan’s network.

Updates

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

Notice of Company Rights

The Company fully intends to continue the Plan. However, the Company reserves the right to terminate, suspend, or modify any benefits described in this booklet, in whole or in part, at any time, and for any reason for employees, former employees, retirees, and their dependents. The Plan Administrator, the Boeing Service Center for Health and Insurance Plans (the “Boeing Service Center”), and the service representatives have the right to recover overpayments, regardless of the cause, nature, or source of the overpayments.
This summary plan description booklet does not guarantee current or future employment or benefits. Receiving benefits under this Plan does not restrict the Company’s rights to discharge any employee at any time.

For important terms used in this booklet, please see Section 7.

Effective Date

This booklet highlights the benefits available to eligible employees and their eligible dependents under the Boeing North American Employee Health Plan as of January 1, 2009.

Definition of Terms

Key terms used throughout this booklet are in bold the first time the term is used under each heading. You can find the definitions for these terms in Section 7, “Definitions.”

What This Booklet Does Not Include

This booklet does not describe the specific benefits of the 80/20 PPO, Point-of-Service Plan, PPO+Account, HMO plans, Dental Premier Plan, or the prepaid dental plans. If you enroll in one of those plans, the Company or the service representative will send you a booklet that describes the features and benefits of that plan.

Whom do I contact with questions?

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

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

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

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

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

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

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

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

**Service representatives**: The Company has engaged third-party organizations, called service representatives, to administer the plans, make benefit determinations, and pay claims. Each service representative answers benefit and claim questions by telephone, and many provide web sites. Connect to a service representative by

- Calling Boeing TotalAccess.
- Connecting to the service representative’s web site directly. (Web sites are shown in Section 8.)
- Calling the number on your health care identification card.

Refer to “Where to Get More Information,” in Section 8, for telephone numbers, addresses, and web sites.
# Table of Contents

## Section 1—Eligibility and Enrollment

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who Is Eligible:</td>
<td>1-1</td>
</tr>
<tr>
<td>You</td>
<td>1-1</td>
</tr>
<tr>
<td>Part-Time Employees</td>
<td>1-1</td>
</tr>
<tr>
<td>Your Dependents</td>
<td>1-2</td>
</tr>
<tr>
<td>Your Spouse or Same-Gender Domestic Partner</td>
<td>1-2</td>
</tr>
<tr>
<td>Your Dependent Children</td>
<td>1-2</td>
</tr>
<tr>
<td>Disabled Children</td>
<td>1-2</td>
</tr>
<tr>
<td>When You and Your Spouse or Same-Gender Domestic Partner Both Work for the Company</td>
<td>1-3</td>
</tr>
<tr>
<td>Coverage for Your Spouse or Same-Gender Domestic Partner</td>
<td>1-3</td>
</tr>
<tr>
<td>Coverage for Your Dependent Children</td>
<td>1-3</td>
</tr>
<tr>
<td>How to Choose Your Medical and Dental Plans</td>
<td>1-3</td>
</tr>
<tr>
<td>Medical Plan Options</td>
<td>1-3</td>
</tr>
<tr>
<td>Where to Find Detailed Plan Information</td>
<td>1-3</td>
</tr>
<tr>
<td>Dental Plan Options</td>
<td>1-4</td>
</tr>
<tr>
<td>When to Enroll or Make Changes</td>
<td>1-5</td>
</tr>
<tr>
<td>If You Are Newly Eligible</td>
<td>1-5</td>
</tr>
<tr>
<td>During the Annual Enrollment Period</td>
<td>1-5</td>
</tr>
<tr>
<td>During the Year When Certain Life Events Occur</td>
<td>1-5</td>
</tr>
<tr>
<td>Special Enrollment Events</td>
<td>1-5</td>
</tr>
<tr>
<td>Qualified Status Changes</td>
<td>1-6</td>
</tr>
<tr>
<td>How to Enroll</td>
<td>1-7</td>
</tr>
<tr>
<td>When Additional Documentation Is Required</td>
<td>1-8</td>
</tr>
<tr>
<td>Application for Disabled Children</td>
<td>1-8</td>
</tr>
<tr>
<td>Documentation for QMCSOs, Legal Custody, and Guardianship</td>
<td>1-8</td>
</tr>
<tr>
<td>Proof of Marriage or Qualifying Domestic Partnership</td>
<td>1-8</td>
</tr>
<tr>
<td>Evidence of Loss of Other Coverage</td>
<td>1-8</td>
</tr>
<tr>
<td>When Coverage Begins</td>
<td>1-9</td>
</tr>
<tr>
<td>Coverage for You</td>
<td>1-9</td>
</tr>
<tr>
<td>Coverage for Your Dependents</td>
<td>1-10</td>
</tr>
<tr>
<td>What Coverage Costs</td>
<td>1-10</td>
</tr>
<tr>
<td>How Much You Pay for Coverage</td>
<td>1-10</td>
</tr>
<tr>
<td>How Much You Pay if Your Spouse or Same-Gender Domestic Partner Works</td>
<td>1-10</td>
</tr>
<tr>
<td>Court-Ordered Child Support</td>
<td>1-11</td>
</tr>
<tr>
<td>Medical Child Support Order</td>
<td>1-11</td>
</tr>
<tr>
<td>Qualified Medical Child Support Order</td>
<td>1-11</td>
</tr>
<tr>
<td>How the Company Notifies You of a Medical Child Support Order</td>
<td>1-12</td>
</tr>
<tr>
<td>How Same-Gender Domestic Partner Coverage Affects Taxes</td>
<td>1-12</td>
</tr>
</tbody>
</table>

## Section 2—Vision Care Program

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>How the Vision Care Program Works</td>
<td>2-1</td>
</tr>
<tr>
<td>Who Administers the Benefits</td>
<td>2-1</td>
</tr>
<tr>
<td>Save Money by Using a Network Provider</td>
<td>2-1</td>
</tr>
</tbody>
</table>
## Section 3—Dental PPO Plan

### How the Dental PPO Plan Works
- Who Administers the Benefits ........................................... 3-1
- Save Money by Using a Network Provider ............................... 3-1

### How the Dental PPO Plan Pays Benefits
- Annual Deductible ................................................................ 3-1
- Coinsurance Percentages ...................................................... 3-2

### What the Dental PPO Plan Covers
- Class I Covered Services and Supplies .................................. 3-3
- Class II Covered Services and Supplies .................................. 3-3
- Class III Covered Services and Supplies ............................... 3-4
- Class IV Covered Services and Supplies ............................... 3-5

### What the Dental PPO Plan Does Not Cover .............................. 3-5

### How to Submit a Dental Claim .............................................. 3-6

### How Dental Coverage May Be Extended ................................. 3-6

## Section 4—Claims and Appeals

### How to Submit a Claim or File an Appeal ................................. 4-1

### Medical and Dental Benefit Claims Process .............................. 4-1
- How to File a Claim for Benefits ........................................... 4-1
- Time Limits for Decisions on Benefit Claims .......................... 4-2
- If Your Benefit Claim Is Denied ............................................ 4-3
- How to Appeal if Your Benefit Claim Is Denied ....................... 4-3
- Time Limits for Decisions on Benefit Appeals .......................... 4-4
- If Your Benefit Appeal Is Denied ........................................... 4-4
- Whom to Contact for Benefit Claim and Appeal Procedures ...... 4-4

### Eligibility Claims Process ..................................................... 4-5
- How to File a Claim for Eligibility .......................................... 4-5
- Time Limits for Decisions on Eligibility Claims ...................... 4-5
- If Your Eligibility Claim Is Denied .......................................... 4-6
- How to Appeal if Your Eligibility Claim Is Denied .................... 4-6
- Time Limits for Decisions on Eligibility Appeals ..................... 4-7
- If Your Eligibility Appeal Is Denied ........................................ 4-7
- Whom to Contact for Eligibility Claim and Appeal Procedures .... 4-7

### What You Can Do if Your Appeal Is Denied ............................. 4-7

### How Claims Are Paid When You Have Duplicate Coverage .......... 4-7
- Determine Whether the Plan Is Primary or Secondary ............... 4-8
- If You Are Covered by Two Boeing-Sponsored Plans ............... 4-9
- If You Are Covered by Medicare and This Plan ..................... 4-9
- Claim Administration ......................................................... 4-9

### When an Injury or Illness Is Caused by the Negligence of Another 4-9
### Section 5—Coverage End Dates and Continuation of Coverage

<table>
<thead>
<tr>
<th>How Coverage Can End</th>
<th>5-1</th>
</tr>
</thead>
<tbody>
<tr>
<td>How You and Your Dependents Can Lose Eligibility for Coverage</td>
<td>5-1</td>
</tr>
<tr>
<td>When Coverage Ends</td>
<td>5-2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Continue Coverage Through COBRA</th>
<th>5-3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who Is Eligible for COBRA Coverage</td>
<td>5-3</td>
</tr>
<tr>
<td>Your Right to COBRA Coverage</td>
<td>5-3</td>
</tr>
<tr>
<td>Your Spouse’s or Same-Gender Domestic Partner’s Right to COBRA Coverage</td>
<td>5-3</td>
</tr>
<tr>
<td>Your Child’s Right to COBRA Coverage</td>
<td>5-4</td>
</tr>
<tr>
<td>How to Enroll for COBRA Coverage</td>
<td>5-4</td>
</tr>
<tr>
<td>Notify the Boeing Service Center When Coverage Ends</td>
<td>5-4</td>
</tr>
<tr>
<td>Watch Your Mail for COBRA Election Forms</td>
<td>5-4</td>
</tr>
<tr>
<td>Elect COBRA Coverage</td>
<td>5-4</td>
</tr>
<tr>
<td>Pay for COBRA Coverage</td>
<td>5-5</td>
</tr>
<tr>
<td>When COBRA Coverage Begins</td>
<td>5-5</td>
</tr>
<tr>
<td>When You Can Change COBRA Coverage</td>
<td>5-5</td>
</tr>
<tr>
<td>How Long COBRA Coverage Can Continue and How Much It Costs</td>
<td>5-5</td>
</tr>
<tr>
<td>Secondary COBRA Qualifying Events</td>
<td>5-8</td>
</tr>
<tr>
<td>When COBRA Coverage Ends</td>
<td>5-8</td>
</tr>
</tbody>
</table>

| Convert Your Coverage to an Individual Policy | 5-8 |

### Section 6—Plan Administration and Legal Rights

<table>
<thead>
<tr>
<th>Your Rights and Responsibilities</th>
<th>6-1</th>
</tr>
</thead>
<tbody>
<tr>
<td>What Rights You Have Under Federal Law</td>
<td>6-1</td>
</tr>
<tr>
<td>Receive Information About Your Plan and Benefits</td>
<td>6-1</td>
</tr>
<tr>
<td>Continue Group Health Plan Coverage</td>
<td>6-1</td>
</tr>
<tr>
<td>Prudent Actions by Plan Fiduciaries</td>
<td>6-1</td>
</tr>
<tr>
<td>Enforce Your Rights</td>
<td>6-1</td>
</tr>
<tr>
<td>Receive Assistance With Your Questions</td>
<td>6-2</td>
</tr>
<tr>
<td>Your Responsibilities Under the Plan</td>
<td>6-2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How the Plan Is Administered</th>
<th>6-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Administrator’s Rights</td>
<td>6-2</td>
</tr>
<tr>
<td>Company’s Right to Amend, Modify, and Terminate the Plan</td>
<td>6-3</td>
</tr>
<tr>
<td>Who Pays for This Plan</td>
<td>6-3</td>
</tr>
<tr>
<td>How the VEBA Trust Fund Works</td>
<td>6-3</td>
</tr>
<tr>
<td>How Benefits Are Paid</td>
<td>6-3</td>
</tr>
<tr>
<td>Right to Recover Overpayments</td>
<td>6-4</td>
</tr>
<tr>
<td>No Contract of Employment</td>
<td>6-4</td>
</tr>
<tr>
<td>Plan Information</td>
<td>6-4</td>
</tr>
</tbody>
</table>

| Other Groups That the Plan Covers | 6-5 |

### Section 7—Definitions

### Section 8—Contacts
Who Is Eligible

These plans are intended to cover you and your **dependents** who meet the eligibility requirements described in this section. Generally, if you meet these conditions, you are eligible to enroll yourself, your spouse or same-gender domestic partner, and your children as described in “When to Enroll or Make Changes,” in this section. To enroll your **eligible dependents**, you must enroll yourself in the plans.

**You**

You are eligible for coverage under the health care plans described in this booklet if you are

- On the active payroll and paid through the Company payroll system.
- Represented by one of the following unions:
  - International Brotherhood of Carpenters & Joiners of America
  - Local No. 721
  - International Brotherhood of Electrical Workers
  - Local No. 2295
  - International Brotherhood of Painters & Allied Trades of America
  - District Council 36
  - International Brotherhood of Teamsters
  - Local No. 578
  - Local No. 952
  - International Union, United Automobile, Aerospace and Agricultural Implement Workers of America
  - Local No. 864
  - Local No. 887
  - Local No. 952
  - Local No. 1519
  - Local No. 1558
  - Sheet Metal Workers International Association
  - Local No. 461

**Part-Time Employees**

If you are a part-time employee, you may be eligible for coverage under the medical and dental plans offered at your location. To be eligible, you must work a fixed weekly schedule of more than 19 hours.

**Who is not eligible for the health care plans?**

You are not eligible for health care coverage if you are

- On a part-time work schedule and are regularly scheduled to work 19 or fewer hours each week.
- Working in a capacity that, at the Plan Administrator’s sole discretion, is considered contract labor or independent contracting.
- Not represented by one of the union groups listed under “Who Is Eligible,” above.
Your Dependents

If you are enrolled in the plans as an employee, you also may cover your eligible dependents. Dependents who are eligible include your spouse or same-gender domestic partner and children, as described below. Proof of dependent eligibility will be required.

Your Spouse or Same-Gender Domestic Partner

Under these plans, “spouse” and “same-gender domestic partner” mean
- Your legal spouse (as recognized under both applicable state law and the Internal Revenue Code).
- Your opposite-gender common-law spouse if your relationship meets the common-law requirements for the state where you entered the common-law relationship.
- Your same-gender domestic partner if
  - You and your partner live in the same permanent residence in a permanent, exclusive, emotionally committed, and financially responsible relationship similar to a marriage.
  - Your partner is at least 18 years old, is not related to you by blood, is not married to or separated from another person, and is not a domestic partner to anyone else.
  - Your domestic partner relationship does not exist solely to obtain coverage under the Plan.

Covering your same-gender domestic partner may affect your Federal and/or state income taxes, and you will be required to provide proof of your same-gender relationship. For more information, see “How Same-Gender Domestic Partner Coverage Affects Taxes,” later in this section.

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

Your Dependent Children

Your dependent children are your natural children, adopted children, children legally placed with you for adoption, and stepchildren who are, in each case, under age 25, unmarried, and dependent on you for principal support. You also may cover unmarried children under age 25 who are dependent on you for principal support and are one of the following:
- Related to you either directly or through marriage (for example, grandchildren, nieces, and nephews).
- Under your legal custody or guardianship (or for whom you have a pending application for legal custody or guardianship) and are living with you.
- Dependents of your eligible same-gender domestic partner.
- Children for whom the Company receives a qualified medical child support order. (QMCSOs are described later in this section.)

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

Disabled 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 disabled 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 disability as long as you continue to be eligible and enrolled in the plans and the child continues to meet these eligibility requirements.

Special applications for coverage are required for disabled dependent children age 25 or older.
What is principal support?
Principal support means that you and/or your current or former spouse provide more than half the financial support for your child. (In determining this, you can exclude any scholarships for study at a regular educational institution unless the child is not your natural child, adopted child, or stepchild.) In most cases, if you claim the child as a dependent on your annual Federal taxes, then you provide principal support for the purposes of eligibility for these plans.

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

When You and Your Spouse or Same-Gender Domestic Partner Both Work for the Company

If you and your spouse or same-gender domestic partner both work for the Company, special coverage provisions will apply. Generally, no person may be covered both as an employee (active or retired) and as a dependent under any type of plan offered by the Company. Certain exceptions apply, as follows.

Coverage for Your Spouse or Same-Gender Domestic Partner

If you and your spouse or same-gender domestic partner both work for the Company, generally you each must choose your own plans. That is, you cannot cover your spouse or same-gender domestic partner as a dependent under your plans, and he or she cannot cover you.

In certain circumstances, special rules may apply unless your spouse or same-gender domestic partner is not eligible for coverage under this plan; for details, contact the Boeing Service Center through Boeing TotalAccess.

Coverage for Your Dependent Children

When you and your spouse or same-gender domestic partner both work for the Company, you must enroll all dependent children in the same medical plan and the same dental plan (except as required by a QMCSO). For details, contact the Boeing Service Center through Boeing TotalAccess.

How to Choose Your Medical and Dental Plans

The Company provides a variety of medical and dental plan options.

Medical Plan Options

Generally, your home zip code determines which medical plans are available to you. However, other plans may be available to you based on your work location and if permitted under the service representative’s policy. Medical plan options include the

• 80/20 PPO.
• Point-of-Service Plan.
• PPO+Account.
• HMO plans available in your area.

For details, see the “Compare Medical Plan Features” table, later in this section.

Where to Find Detailed Plan Information

During your initial enrollment or later during annual enrollment, you can get information about your medical plan options, including detailed comparisons of covered services, costs, and a list of network providers for each plan option by

• Visiting the Your Benefits Resources web site.
• Calling the Boeing Service Center through Boeing TotalAccess.
**Compare Medical Plan Features**

This summary compares the basic differences among the primary types of medical plans: the 80/20 PPO, Point-of-Service Plan, PPO+Account, and HMO plans. Consider the type of care you and your family typically need; then check to see how the plan options meet your health care needs.

<table>
<thead>
<tr>
<th></th>
<th>80/20 PPO</th>
<th>Point-of-Service Plan</th>
<th>PPO+Account</th>
<th>HMO Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Network of providers</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>PCP must coordinate all care</strong></td>
<td>No; any provider may be used</td>
<td>Yes, for Select 1 No, for Select 2, Select 3, and the Flex Net Plan</td>
<td>No</td>
<td>Yes; PCP generally must coordinate care to receive the maximum benefit</td>
</tr>
<tr>
<td><strong>PCP referral required to visit a specialist</strong></td>
<td>No; visit any specialist</td>
<td>Yes, for Select 1 No, for Select 2, Select 3, and the Flex Net Plan</td>
<td>No</td>
<td>Yes; PCP generally must provide referral for services to be covered</td>
</tr>
<tr>
<td><strong>Annual deductible</strong></td>
<td>Yes; however, many services, including network office visits, preventive care, prescriptions, and routine vision care are not subject to an annual deductible</td>
<td>No, for Select 1 Yes, for Select 2, Select 3, and the Flex Net Plan; however, certain services, including prescription drugs, are not subject to an annual deductible</td>
<td>Yes; however, some services, including preventive care, certain preventive care medications, and routine vision care, are not subject to an annual deductible</td>
<td>No</td>
</tr>
<tr>
<td><strong>Prescription drug copayment/coinsurance</strong></td>
<td>Yes; copayments for retail participating pharmacies and mail order</td>
<td>Yes; copayments for retail participating pharmacies and mail order</td>
<td>Yes; coinsurance for retail participating pharmacies and mail order</td>
<td>Yes; copayments for retail participating pharmacies and mail order</td>
</tr>
<tr>
<td><strong>Preventive care</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Routine vision care</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Annual out-of-pocket maximum</strong></td>
<td>Yes; separate maximums for network and nonnetwork services</td>
<td>Yes; separate maximums for network and nonnetwork services</td>
<td>Yes; separate maximums for network and nonnetwork services</td>
<td>Varies by plan</td>
</tr>
<tr>
<td><strong>Health Savings Account</strong></td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Dental Plan Options**

The Company dental plans are designed to provide you and your **covered dependents** with quality, comprehensive dental benefits. Your dental plan helps you pay for certain treatments such as preventive care and routine examinations to help you maintain good dental health. Depending on your location, you may have a choice of the following types of dental plans:

- Dental PPO Plan.
- Dental Premier Plan.
- Prepaid dental plans.
When to Enroll or Make Changes

When you become eligible for coverage in the medical and dental plans, you generally may enroll
• By the date printed on the enrollment worksheet you receive as a newly eligible employee.
• During the annual enrollment period designated by the Company.
• Within the specified time frames for a special enrollment event or qualified status change during the year.
   (See the table, “How and When to Enroll,” later in this section.)

Each of these enrollment periods is explained here.

If You Are Newly Eligible

If you are a newly eligible employee, you will receive an enrollment worksheet by mail that shows
your available health and insurance plan options, coverage levels, and costs. You also can find enrollment
information on line at the Your Benefits Resources web site. Medical and dental coverage is optional;
you may elect medical coverage, dental coverage, both, or neither. However, if you do not want
coverage, you must decline it; otherwise, you may be enrolled automatically.

During the Annual Enrollment Period

The Company establishes an annual enrollment period each year. During annual enrollment, you can add
or drop coverage for yourself or your eligible dependents in accordance with the eligibility rules. The
Company will send you information about the annual enrollment dates and when your coverage changes
will be effective.

During the Year When Certain Life Events Occur

After you enroll, you generally may change or drop coverage only during the annual enrollment period
designated by the Company. However, Federal rules allow you to add, change, or drop coverage during the
year as a result of certain special enrollment events or qualified status changes, as described below.

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

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

Special Enrollment Events

If you declined coverage in the medical or dental plans for yourself and/or your eligible dependents when
you were first eligible because you or your dependents had other health care coverage, you may enroll
yourself and/or your eligible dependents if you or your dependent experiences one of these special
enrollment events:
• You or your dependent loses or becomes ineligible for other health care coverage because of an
event such as loss of dependent status under another health care plan (through divorce, legal separation,
termination of a same-gender domestic partnership, or dependent child reaching the limiting age),
death, termination of employment, reduction in hours of employment, termination of employer
contributions toward the coverage, elimination of coverage for the class of similarly situated employees
or dependents, moving out of the plan’s service area with no other coverage available from the other
health care plan, or reaching the lifetime limit on all benefits under the other health care plan. If you or
your dependent reaches the lifetime limit under a Company plan, and you are eligible for another
Company plan in your area, you and your dependents may enroll in that other plan.
• You or your dependent exhausts any continuation coverage from another employer; that is,
   coverage provided under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended
   (COBRA), ends.
• You gain a new dependent because of marriage, entering a same-gender domestic partnership, birth,
adoption, or placement for adoption.
Note: For this purpose, “other health care coverage” does not include coverage through Medicare, Medicaid, or the TRICARE Supplement Plan.

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

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

**Qualified Status Changes**

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

Qualified status changes are the following events:

**Legal marital status (or qualifying same-gender domestic partnership).** You marry, enter into a same-gender domestic partnership, divorce, legally separate, or dissolve a same-gender domestic partnership or your marriage is annulled or your spouse or same-gender domestic partner dies.

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

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

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

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

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

**Significant change in coverage.** You or your dependent experiences a significant curtailment of employer-sponsored health care coverage or that coverage ends, including expiration of coverage under another employer’s COBRA plan. Examples of curtailment include a significant increase in the annual deductible or copayments or a loss of access to a significant portion of a provider network.

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

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

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

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

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

**Family and Medical Leave Act leave of absence.** You take an approved leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA).
How to Enroll

Soon after you become an eligible employee, you will receive a Boeing TotalAccess password and an enrollment worksheet for your health and insurance benefits. You also can find an enrollment worksheet online at the Your Benefits Resources web site. You can use your enrollment worksheet as a guide when you enroll; you will not need to submit it to enroll.

After you enroll, you can use the Your Benefits Resources web site to review your elections and see your costs for coverage.

To do so, you will need
• Your Boeing TotalAccess password.
• Your BEMS ID number (or Social Security number) and birth date.
• Social Security numbers and birth dates for the dependents you are enrolling.
• Information about your spouse’s 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 certain coverage levels of the Point-of-Service Plan, an HMO plan, or a prepaid dental plan. You and your covered dependents can choose the same or different primary care providers for your medical plan. However, under some prepaid dental plans, you must name the same dental primary care provider for all covered dependents.

If you enroll in the 80/20 PPO, certain coverage levels of the Point-of-Service Plan, PPO+Account, Dental PPO Plan, or Dental Premier Plan, you will not need to select primary care providers.

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

If you are rehired, you automatically may be enrolled in your prior coverage, depending on the length of your lapse in service, the availability of the plan, and other factors. Contact the Boeing Service Center through Boeing TotalAccess for information or to verify or change your coverage.

<table>
<thead>
<tr>
<th>How and When to Enroll</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>To enroll . . .</strong></td>
</tr>
<tr>
<td>As a newly eligible employee</td>
</tr>
<tr>
<td>During an annual enrollment period</td>
</tr>
<tr>
<td>Yourself and your dependents because of a special enrollment event or a qualified status change (as defined in “During the Year When Certain Life Events Occur”)</td>
</tr>
<tr>
<td>A new dependent midyear because of marriage, entering into a same-gender domestic partnership, birth, adoption, or placement for adoption when you already are enrolled in the plan</td>
</tr>
</tbody>
</table>
How and When to Enroll (continued)

<table>
<thead>
<tr>
<th>To enroll . . .</th>
<th>Enroll through the . . .</th>
<th>By the . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you experience a change in work site that results in a change in the medical and/or dental plans available to you</td>
<td>Your Benefits Resources web site</td>
<td>31st day after the event</td>
</tr>
</tbody>
</table>

Note: If loss of coverage is due to reaching another plan’s lifetime limit on all benefits, the event date is the day the claim exceeding the lifetime limit is incurred; the 60-day enrollment period starts when the other plan denies the claim, in whole or in part, because of reaching the lifetime limit.

* You will find links for enrollment on the Your Benefits Resources web site only when enrollment is available to you as a new employee or during the annual enrollment periods specified by the Company.

** To enroll a new dependent after the 60th day, you must call the Boeing Service Center through Boeing TotalAccess and speak with a representative.

When Additional Documentation Is Required

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

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

Application for Disabled Children

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

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

Documentation for QMCSOs, Legal Custody, and Guardianship

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

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

Proof of Marriage or Qualifying Domestic Partnership

If you enroll your spouse, you will be required to document your marriage or common-law marriage. If you enroll your eligible same-gender domestic partner or his or her eligible children, you will be required to submit proof of your qualifying domestic partnership. For additional information, contact the Boeing Service Center through Boeing TotalAccess.

Evidence of Loss of Other Coverage

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

The effective date of your coverage depends on when you enroll and what event initiates your enrollment. The following tables explain when coverage begins for you and your dependents. In all cases, you must be on the active payroll on the effective date for coverage to begin.

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

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

If the previous health care plan (including a Company-sponsored health care plan) provides continued coverage during the hospitalization, the previous plan will be primary and the new plan will be secondary until hospitalization ends. (See Section 4.)

Coverage for You

<table>
<thead>
<tr>
<th>If you . . .</th>
<th>Your coverage will begin on the . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are a newly hired employee (and you make your election by the date indicated on your enrollment worksheet)</td>
<td>First day of the month after your first day of employment</td>
</tr>
<tr>
<td>Enroll or change your coverage during an annual enrollment period</td>
<td>First day of the new benefit year</td>
</tr>
<tr>
<td>Enroll or change your coverage because of a special enrollment event (see “Special Enrollment Events,” in this section)</td>
<td>Special enrollment event date</td>
</tr>
<tr>
<td>Enroll or change your coverage because of a qualified status change (see “Qualified Status Changes,” in this section)</td>
<td>Qualified status change date</td>
</tr>
</tbody>
</table>
| Enroll in a new medical or dental plan if your current plan is no longer available following a change of address | • First day of the month after or coinciding with the date of the move, if Boeing TotalAccess receives your address change within 60 days of the move date  
  • First day of the month after the date you notify Boeing TotalAccess, if Boeing TotalAccess receives your address change after 60 days from the move date |
| Are recalled from a layoff within your recall rights period                 | Date you are reinstated to the active payroll                              |
| Are reemployed after uniformed service (and return to work promptly in accordance with Federal law) | Date you are reinstated to the active payroll                              |
| Return to work from an approved leave of absence                            | Date you are reinstated to the active payroll                              |
| Are rehired                                                                | First day of the month after the date you are reinstated to the active payroll |
| Transfer from one payroll to another                                         | First day of the month after or coinciding with your transfer date        |
## Coverage for Your Dependents

<table>
<thead>
<tr>
<th>If you enroll your dependents or change their coverage . . .</th>
<th>Their coverage will begin on the . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>When you are a newly hired employee</td>
<td>Same day that your coverage begins (if applied for at the same time)</td>
</tr>
<tr>
<td>During an annual enrollment period</td>
<td>First day of the new benefit year</td>
</tr>
<tr>
<td>As a result of a special enrollment event (see “Special Enrollment Events,” in this section)</td>
<td>Special enrollment event date</td>
</tr>
<tr>
<td>As a result of a qualified status change (see “Qualified Status Changes,” in this section)</td>
<td>Qualified status change date</td>
</tr>
<tr>
<td>Following receipt of a QMCSO</td>
<td>First of the month the QMCSO is received or on the date specified in the QMCSO</td>
</tr>
</tbody>
</table>

## What Coverage Costs

### How Much You Pay for Coverage

Generally, you and the Company share the cost of health care coverage. The amount you pay from each paycheck toward the cost of your health care coverage is called a contribution. The amount you pay out of your own pocket depends on which plan you choose (for a comparison of the basic differences among the medical plans, see the table, “Compare Medical Plan Features,” earlier in this section).

Contribution amounts are governed by your collective bargaining agreement and published each year during the annual enrollment period. You can find your contribution amount on the information that will be mailed to you, or you can find out more through the Your Benefits Resources web site or by calling the Boeing Service Center through Boeing TotalAccess. A working spouse contribution also may be required, as explained in “How Much You Pay if Your Spouse or Same-Gender Domestic Partner Works,” in this section.

Your enrollment in health care coverage authorizes the Company to deduct your contributions (if any) on a pretax basis from your paycheck each pay period.

Contributions for coverage are deducted beginning with the first paycheck of the month after the month in which you enroll. Contributions for a partial month of coverage are taken retroactively on an aftertax basis. Increased contributions due to a special enrollment event or qualified status change are taken on an aftertax basis for retroactive periods of coverage.

### How Much You Pay if Your Spouse or Same-Gender Domestic Partner Works

If your spouse or same-gender domestic partner has not enrolled in a medical plan available through his or her employer and enrolls in your plan, you must pay an additional monthly contribution (called a working spouse contribution).

You will not be required to pay this contribution if your spouse or same-gender domestic partner is

- Not employed full time through an employer other than the Company.
- Currently covered by his or her employer’s medical plan.
- Currently covered by other group health coverage as a retired employee and not by his or her employer.
- Not offered medical coverage by his or her employer.
- Retired and not employed, or employed but regularly scheduled to work less than 36 hours per week.
- Employed by the Company.
- Not enrolled in his or her employer’s medical plan but commits to join at the next annual enrollment period or other opportunity, and within one year. You will be required to verify this information.
If your spouse no longer meets one of these conditions during the year, you must notify the Boeing Service Center through Boeing TotalAccess. You may be required to pay any working spouse contributions that you have missed.

If you are not sure whether this contribution applies to you, call the Boeing Service Center through Boeing TotalAccess.

**Can I stop the working spouse contribution during the year?**

Yes. If your spouse or same-gender domestic partner becomes covered under another employer’s medical plan or meets one of the conditions listed above, you will have 60 days to stop the working spouse contribution retroactively. After 60 days, a change can be made prospectively only. Call the Boeing Service Center through Boeing TotalAccess.

---

**Court-Ordered Child Support**

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

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

**Medical Child Support Order**

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

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

**Qualified Medical Child Support Order**

Not all medical child support orders are qualified. A QMCSO

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

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

The health plans pay network providers directly for covered services. When a covered charge has been paid by you, an alternate recipient, a custodial parent, or a legal guardian, the plan will reimburse the person who paid the expense. You must file a claim for reimbursement. For claim-filing instructions, see Section 4.
How the Company Notifies You of a Medical Child Support Order

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

If the order is a QMCSO, the Company will

• Notify you and the alternate recipient of the plan’s procedures for adding the alternate recipient to your coverage.

• Allow the alternate recipient an opportunity to designate a representative to receive copies of any notices due under the QMCSO.

• Begin coverage for the alternate recipient on the date specified in the QMCSO (which is not necessarily the first of the month).

• Begin deducting any required contributions from your paycheck, including any contributions for coverage retroactive to the coverage effective date specified in the QMCSO.

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

How can I learn more about QMCSOs?

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

How Same-Gender Domestic Partner Coverage Affects Taxes

If you enroll your same-gender domestic partner or his or her eligible children in a Company-sponsored health care plan, the benefit value may be taxable to you as ordinary income. The taxability of benefits depends on whether your same-gender domestic partner (and his or her children) qualifies as a dependent under Internal Revenue Code Section 105.

For additional information about domestic partner benefit tax implications, you should consult a tax adviser.
How the Vision Care Program Works

You and your covered dependents are automatically enrolled in the vision care program described in this section if you are enrolled in the following medical plans:

- Aetna HMO.
- Aetna PPO+Account.
- Health Net HMO.
- Health Net Point-of-Service Plan.
- Kaiser Permanente HMO.
- Regence 80/20 PPO.

Who Administers the Benefits

The Company has contracted a service representative to handle the day-to-day administration of the program. Vision Service Plan (VSP) administers the vision care program and is the service representative.

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

Save Money by Using a Network Provider

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 table, “Vision Care Program Schedule of Benefits,” later in this section.

You can access network provider lists on the VSP web site or by calling the service representative. See Section 8 for contact information.

Once you select a network provider, call the provider’s office to make an appointment. Identification cards are not required.

What if I live in an area that has no network providers?

The plan may pay your benefits at the network level if you are enrolled in this plan and the plan determines that you live outside of a network service area. Contact the service representative if you believe that you live outside a network service area.

What the Vision Care Program Covers

The program covers the following vision care services and hardware:

- A complete examination of visual function performed by a licensed ophthalmologist or optometrist.
- Contact lenses when chosen instead of conventional lenses and frames.
- Frames required for prescription lenses.
- Prescription lenses.

Expenses for vision care services not listed above might be covered as part of the other medical benefits under your medical plan.
Benefit Payment Levels

The vision care program pays benefits according to the following table. All claims are administered by VSP, the service representative.

<table>
<thead>
<tr>
<th>Covered Services and Supplies</th>
<th>Network Provider*</th>
<th>Nonnetwork Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100% after a $15 copayment (annual deductible does not apply)</td>
<td>100% up to $50 (annual deductible does not apply)</td>
</tr>
<tr>
<td></td>
<td>Limited to one eye examination per benefit year (network and nonnetwork combined)</td>
<td>Limited to one eye examination per benefit year (network and nonnetwork combined)</td>
</tr>
<tr>
<td>Lenses</td>
<td>Limited to two sets of lenses every two benefit years (network and nonnetwork combined) and subject to the following benefit maximums (annual deductible does not apply):</td>
<td>Limited to two sets of lenses every two benefit years (network and nonnetwork combined) and subject to the following benefit maximums (annual deductible does not apply):</td>
</tr>
<tr>
<td>Single vision</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$80</td>
<td>$80</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$95</td>
<td>$95</td>
</tr>
<tr>
<td>Lenticular</td>
<td>$155</td>
<td>$155</td>
</tr>
<tr>
<td>Contact lenses (in place of allowance for conventional lenses and frames)</td>
<td>$120 (annual deductible does not apply; network and nonnetwork combined)</td>
<td>$120 (annual deductible does not apply; network and nonnetwork combined)</td>
</tr>
<tr>
<td></td>
<td>15% discount on contact lens fitting and evaluation examination</td>
<td>No discount applies</td>
</tr>
<tr>
<td>Frames</td>
<td>$90</td>
<td>$90</td>
</tr>
<tr>
<td></td>
<td>Limited to two frames every two benefit years (annual deductible does not apply; network and nonnetwork combined)</td>
<td>Limited to two frames every two benefit years (annual deductible does not apply; network and nonnetwork combined)</td>
</tr>
<tr>
<td></td>
<td>20% discount on complete pairs of prescription glasses</td>
<td>No discount applies</td>
</tr>
</tbody>
</table>

* The network payment level is based on the approved fees that the service representative negotiated for specific providers and services covered by the plan.

What the Vision Care Program Does Not Cover

The vision care program does not cover the following vision services or hardware:

- Antireflective coatings or tintings.
- Charges for sunglasses or light-sensitive glasses in excess of the amounts covered for nontinted glasses.
- Corrective experimental vision treatment. This means a procedure or lens that is not used universally or accepted by the vision care profession, as determined by the service representative.
- Costs in excess of the maximum covered charges.
- Dyslexia, visual analysis therapy, or training related to muscular imbalance of the eye or for orthoptics.
- Lenses or frames that are furnished or ordered before coverage begins.
- Medical or surgical treatment of the eyes. (However, VSP network providers do offer discounts for refractive surgery, and the medical plan covers treatment of diseases of the eye.)
- Nonprescription (over-the-counter) glasses.
• Orthoptics or vision training or any associated supplemental testing. (However, the medical plan may cover this for children under age 12.)
• Plano lenses (less than a ±0.38 dioptr power), two pair of glasses instead of bifocals, or extra charges for progressive lenses in excess of the bifocal allowance.
• Services or supplies that are not listed as covered.
• Services or supplies received from network providers more than 30 days after the service representative authorizes the patient’s vision care benefits.
• Services or supplies received while the patient is not covered by the plan.
• Solutions or cleaning products for spectacle glasses or contact lenses.
• Special supplies such as nonprescription sunglasses or subnormal vision aids.

How to Submit a Vision Care Claim

When you receive services or supplies from a network provider, the provider will verify eligibility and will bill the service representative directly. You are responsible for meeting your copayments, if any, before the plan pays a benefit on your behalf.

When you receive services or supplies from a nonnetwork provider, claims must be submitted to the VSP service representative for reimbursement. Nonnetwork providers may require full payment at the time you receive the care; in this instance, the service representative will reimburse you according to plan payment levels.

For more information about claim-filing instructions, see Section 4.
How the Dental PPO Plan Works

The Dental PPO Plan is available in many locations. If you receive dental care from a dentist who participates in the network, you and your dependents will receive a higher level of benefits.

Who Administers the Benefits

The Company has contracted a service representative to handle the day-to-day administration of the plan. The service representative answers benefit questions, makes benefit decisions, pays claims, processes claim appeals, and accounts for premiums, service fees, and claim costs. The current service representative is Washington Dental Service (WDS), a Delta Dental organization.

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

What is a service representative?

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

Save Money by Using a Network Provider

Under the Dental PPO Plan, you can use any licensed dentist. However, the plan generally pays a higher level of benefits if you use a dentist who participates in the PPO network (network dentist). For a list of network dentists, contact the service representative (see Section 8).

You also can go to a dentist outside the network (a nonnetwork dentist). There are two types of nonnetwork dentists. For both types of nonnetwork dentists, the plan generally pays a lower level of benefits.

- Nonnetwork WDS dentists—WDS dentists who do not participate in the PPO network.
- Nonmember dentists—Dentists who are not members of WDS.

What if I live in an area that has no network providers?

The plan will pay the network level of benefits if there are no network providers in your area.

How the Dental PPO Plan Pays Benefits

For most services and supplies covered by this plan, you and the plan each pay a portion of your dental care costs as described below and shown in the table, “How the Dental PPO Plan Pays Benefits.”

Annual Deductible

Generally, the annual deductible is the amount you must pay out of your own pocket each benefit year before the plan begins to pay benefits. The Dental PPO Plan has separate deductibles for network and nonnetwork services. Nonnetwork deductible expenses apply toward the network deductible.

The annual deductible applies to most covered services except:

- Class I services and supplies received from network providers.
- Class IV services and supplies received from network or nonnetwork providers.

Once you satisfy the annual deductible, the plan pays a percentage of the charges that are subject to the annual deductible.
## How the Dental PPO Plan Pays Benefits

<table>
<thead>
<tr>
<th>Covered Services and Supplies</th>
<th>Payment Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network Provider</td>
</tr>
</tbody>
</table>
| Annual deductible (applies to all covered services and supplies, except as noted) | • $50 per individual  
• $150 per family of three or more, but not more than $50 for any individual | • $75 per individual  
• $225 per family of three or more, but not more than $75 for any individual  
• Nonnetwork charges apply toward the network deductible |
| Class I (diagnostic and preventive services) | 100% (annual deductible does not apply) | 80% |
| Class II (minor restorations) | 80% | 50% |
| Class III (major restorations) | 60% bridges and dentures | 50% |
| Class IV (orthodontia) | 50% (network and nonnetwork combined; annual deductible does not apply) | |
| Annual maximum benefit (for Classes I, II, and III)** | $1,800 per individual (network and nonnetwork combined) | |
| Lifetime maximum benefit (for Class IV)† | $1,800 per individual (network and nonnetwork combined) | |

* If your provider is not a WDS member, you pay any amounts that exceed the maximum allowable fees recognized by the plan.

** When multiple treatment dates are required, the charges apply toward the annual maximum benefit for the benefit year in which the procedure is completed. (A prosthesis or crown is considered complete on the date it is seated or delivered.)

† This lifetime maximum benefit for orthodontia applies to all periods during which the person is covered under any Company-sponsored dental plan.

### What will happen if I reach my annual maximum?

You are responsible for paying any charges over the maximum benefit.
What are recognized fees?

This plan pays benefits based on the recognized fees. A recognized fee is the provider’s charge for a covered service, up to the plan’s maximum allowance. The amount of the recognized fee depends on whether you see a network or nonnetwork provider.

Under this plan, recognized fees are determined as follows:
• For a network dentist, recognized fees are network-allowed charges.
• For a member dentist who is a nonnetwork dentist, recognized fees are the fees that the dentist filed with the service representative for specific dental services and supplies. The service representative approves these fees and agrees to pay the plan’s nonnetwork benefit based on them.
• For a nonmember dentist, recognized fees are the lesser of either
  − The amount charged by the dentist.
  − The maximum fee that the service representative approved for member dentists in the state where services are performed.

When alternative procedures are available, the plan covers the least expensive procedure. However, if your dentist submits satisfactory evidence to the service representative that a more expensive procedure is the only one professionally adequate for you, the plan will cover the more expensive procedure according to the appropriate benefit payment level.

What the Dental PPO Plan Covers

The Dental PPO Plan covers the following services and supplies in accordance with the benefit payment levels and maximums shown in the previous table, “How the Dental PPO Plan Pays Benefits.”

Class I Covered Services and Supplies

The plan covers the following Class I services and supplies:
• Diagnostic services and supplies, including
  − Oral examinations, covered twice in a benefit year.
  − Full-mouth X-rays, covered once in a five-year period.
  − Bitewing X-rays, covered once each benefit year.
  − Study models.
  − Examination of a tissue biopsy (also called a histopathic examination). Surgery for a biopsy is covered as an oral surgery procedure.
  − Examinations by a specialist for consultation if the dentist is in a specialty field recognized by the American Dental Association and if the patient is not receiving treatment from the specialist.
  − Emergency examinations.
• Preventive care services and supplies, including
  − Prophylaxis (cleaning) or procedures that include cleanings, covered twice in a benefit year. Topical application of fluoride treatment is covered twice in a benefit year.
  − Space maintainers for dependent children through age 11.

Class II Covered Services and Supplies

The plan covers the following Class II services and supplies:
• Endodontics for the following procedures:
  − Pulpal and root canal treatment.
  − Pulpotomy and apicoectomy.
• General anesthesia or intravenous sedation, but not both, when administered by a licensed dentist in connection with covered endodontic, oral, or periodontic surgery.
• Oral surgery, including
  − Surgical and nonsurgical extractions.
  − Preparation of the alveolar ridge and soft tissues of the mouth for the insertion of dentures.
– Treatment of pathological conditions and traumatic facial injuries.
– General anesthesia when administered by a licensed dentist in connection with a covered oral surgery procedure.

• Periodontics—surgical and nonsurgical procedures to treat tissues that support the teeth, including
  – Prophylaxis (cleaning) covered up to two times in a benefit year for two years following periodontal surgery or for participants with a history of periodontal disease (in addition to cleanings covered under Class I services).
  – Periodontal scaling and root planing, covered once per area every two years.
  – Gingivectomy.
  – Limited adjustments to occlusion (eight or fewer teeth), such as the smoothing of teeth or reduction of cusps.
  – Osseous surgery, once in each three-year period per area.

• Restorative services and supplies including
  – Amalgam, composite, or filled resin restorations or fillings (placed in the front surface of bicuspids) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp).
  – Pit and fissure sealants for dependent children through age 13, or beyond age 13 for late-erupting molars. Fissure sealants are topically applied acrylic, plastic, or composite materials 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.
  – Stainless steel crowns. (See below for limitations.)
Restorations on the same surface or surfaces of a tooth are covered once in a two-year period. Crowns, inlays, and onlays (whether porcelain, plastic, gold substitute casting, or a combination of these) are covered on the same tooth once in a five-year period. (Gold restorations, crowns, and jackets will be covered when teeth cannot be restored using other materials.) Stainless steel crowns are covered once in a five-year period (once in a two-year period for primary teeth).
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.

Class III Covered Services and Supplies
The plan covers the following Class III services and supplies:

• Prosthodontic services and supplies, including
  – Standard full or partial dentures. A standard full or partial denture is made from accepted materials and by conventional methods. If any other procedure is provided (such as personalized restorations or specialized treatment), the plan will apply the appropriate amount for a standard full or partial denture toward the cost.
  – Cast chrome or acrylic dentures. If a more elaborate or precise device is used, the plan will apply the appropriate amount for covered partial dentures toward the cost.
  – Denture adjustments and relines when these services are provided more than six months after the initial placement occurs. Denture adjustments are covered twice in a 12-month period. Later relines are covered twice in a 12-month period. Jump rebases are covered once in a 24-month period.
  – Stayplate dentures for replacing anterior teeth during the healing period, or for children age 16 or younger, for missing anterior permanent teeth.
  – Fixed bridges.
  – Inlays (only when used as an abutment for a fixed bridge), covered once in a five-year period.
  – Removable partial dentures.
  – The adjustment or repair of an existing prosthetic device. Replacement of an existing prosthetic device is covered once in a five-year period only when it is not serviceable and cannot be made serviceable. Expenses related to making the device serviceable are covered.
Class IV Covered Services and Supplies

Orthodontic services and supplies are in Class IV. The plan covers straightening of teeth, including correction or prevention of malocclusion.

To facilitate benefit payments, your orthodontist or you should submit the treatment plan to the service representative before treatment starts.

How can I obtain a pretreatment estimate?

If your dental care will be extensive, you may ask your dentist to submit a request for a pretreatment estimate, called a “predetermination of benefits.” This predetermination will allow you to know in advance what procedures are covered, the amount the service representative will pay toward the treatment, and your financial responsibility.

What the Dental PPO Plan Does Not Cover

The Dental PPO Plan does not cover the following services and supplies:

• All services not specifically included in this plan as covered dental benefits.
• Analgesics such as nitrous oxide, conscious sedation, euphoric drugs, injections, or prescription drugs.
• Any orthodontia treatment received before you or your dependents were eligible for dental coverage.
• Any single procedure or bridge, denture, or other prosthodontic service that was started before you or your dependents were eligible for dental coverage.
• Application of desensitizing agents.
• Charges for replacement or repair of an orthodontic appliance paid in part or in full by this plan.
• Dental services covered under a Company-sponsored medical plan or any other dental plan.
• Dentistry for cosmetic purposes or for conditions resulting from hereditary or developmental defects, such as a cleft palate, upper and lower jaw malformations, congenitally missing teeth, and teeth that are discolored or lacking enamel.
• Duplicate dentures, personalized dentures, cleaning of prosthetic appliances, temporary dentures, porcelain or resin inlay bridges, or crowns and copings provided in conjunction with overdentures. The plan also does not cover fixed prosthodontics for children under age 16.
• Experimental services or supplies.
• Fees for broken appointments.
• Fees for completing insurance forms.
• General anesthesia, except as specified for oral surgery procedures.
• Grafting tissues from outside the mouth to tissue inside the mouth (extraoral grafts).
• Habit-breaking appliances.
• Home fluoride kits, cleaning of prosthetic appliances, replacement of space maintainers previously paid for by the plan, plaque control programs, oral hygiene instructions, or dietary instruction.
• Hospitalization charges and any additional fees charged by the dentist for hospital treatment.
• Iliac crest or rib grafts to alveolar ridges.
• Implants (materials implanted into or on bone or soft tissue) or the removal of implants, except as provided under covered prosthodontic services and supplies.
• Intentionally self-inflicted injury, unless resulting from a medical condition.
• Intravenous sedation.
• Patient management problems.
• Periodontal splinting or any crown or bridgework provided with periodontal splinting, crowns as part of periodontal therapy and periodontal appliances, or major (complete) occlusal adjustment.
• Restorations or appliances necessary to correct vertical dimension or to restore the occlusion. Such procedures include restorations for malalignment of teeth and restoration of tooth structure lost from attrition, abrasion, or erosion.
• Posterior direct composite (resin) restorations. These restorations are optional services, and payment will be limited to the cost of an equivalent amalgam restoration. Direct composite (resin) restorations are covered on anterior teeth and the facial surface of bicuspids.

• Services for any disturbances of the jaw joint (temporomandibular joints or TMJ) or associated muscles, nerves, or tissues.

• Services for injuries or conditions that are compensable under workers’ compensation or employer’s liability laws.

• Services provided by any federal, state, or provincial government agency or provided without cost by any municipality, county, or other political subdivision.

• Services or supplies for which benefits are payable under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection, commercial liability, homeowner’s policy, or other similar type of coverage.

• Services specifically excluded in this dental coverage description.

• Surgical procedures for correction of malalignment of teeth and/or jaws.

---

**How to Submit a Dental Claim**

Washington Dental Service is the service representative for the Dental PPO Plan.

Claim forms generally are not required under the Dental PPO Plan as long as you receive services from a member dentist. Present your Dental PPO Plan identification card to identify yourself as covered under the plan. 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 as well as care received from nonmember dentists. Claim forms are available from the service representative; see Section 8, “Contacts.”

Claims must be submitted to the service representative within 12 months from the date you received dental services or supplies. For more information about submitting claims and appeals, see Section 4.

---

**How Dental Coverage May Be Extended**

The plan generally does not cover services or supplies that you receive while you are not covered under the plan. However, the plan will cover certain services and supplies after the date coverage would otherwise end. These services and supplies and the conditions for extending care are described below if the dentist started the course of treatment before your coverage ends:

• A crown that is required to restore a tooth (independent of the crown’s use in connection with a partial denture) if the tooth is prepared for the crown while you are covered and the crown is installed during the 31 days after your coverage ends.

• A prosthetic device (including abutment crowns of a partial denture), if the impressions are taken while you are covered, and the device is installed or delivered within 31 days after your coverage ends.

• Orthodontia care that is provided within three calendar months after coverage ends.

• Restorative, endodontic, periodontic, and oral surgical procedures completed within 31 days after your coverage ends.
How to Submit a Claim or File an Appeal

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

1. Medical (including the vision care program) and dental benefit claims and appeals for the vision and dental plans described in this booklet, as well as the Company-sponsored 80/20 PPO and Dental Premier Plan.

2. Eligibility claims and appeals for all medical, vision, and dental plans available to the groups listed in “Who Is Eligible,” in Section 1.

The benefit claim review and appeal procedures described in this booklet do not apply to the Point-of-Service Plan, PPO+Account, HMO plans, and 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. Concurrent care claims are either urgent care claims or fall into one of the other claim categories: preservice or postservice.

3. Postservice claim: a request for coverage of health care benefits that is not a preservice, concurrent care, or urgent care claim. Generally, postservice claims are filed for payment or reimbursement of benefits for care that already has been received.

4. Urgent care claim: a request for a claim determination needed quickly due to medical exigencies. An urgent care claim is any claim for medical care or treatment with respect to which the application of the time period that otherwise applies to nonurgent claim determinations could seriously jeopardize the life, health, or ability of a patient to regain maximum function, or which—in the opinion of the attending physician—would subject the patient to severe pain that could not be managed adequately without the care or treatment that is the subject of the claim. In addition, if a physician with knowledge of the patient’s medical condition determines that a claim is an urgent care claim, the claim shall automatically be treated as an urgent care claim for the purposes of this provision.

How to File a Claim for Benefits

Generally, whenever you receive services from a 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 is ultimately your responsibility to ensure that your claim for benefits is filed.

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

### How do I expedite an urgent care claim?

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

### Time Limits for Decisions on Benefit Claims

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

#### Time Limits for Receiving Benefit Claim Decisions

<table>
<thead>
<tr>
<th>Type of claim</th>
<th>You will receive notification of the decision within . . .</th>
<th>But it may be extended for an additional . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postservice care claim</td>
<td>30 days after your claim is received</td>
<td>15 days because of matters beyond the control of the service representative**</td>
</tr>
<tr>
<td>Preservice care claim*</td>
<td>15 days after your claim is received</td>
<td>15 days because of matters beyond the control of the service representative**</td>
</tr>
<tr>
<td>Concurrent urgent 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 information†</td>
</tr>
<tr>
<td>Concurrent preservice or postservice care claim</td>
<td>Same as preservice or postservice claims, depending on medical circumstances</td>
<td>15 days because of matters beyond the control of the service representative**</td>
</tr>
<tr>
<td>Urgent care claim*</td>
<td>72 hours after your claim is received</td>
<td>Not applicable if you provide enough information†</td>
</tr>
</tbody>
</table>

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

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

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

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

- Specific reasons for the denial.
- Reference to the specific Plan provisions on which the claim determination was based.
- Description and explanation of any additional information that is needed to process your claim.
- Description of the Plan’s appeal procedures and the applicable time limits, as well as your right to bring legal action if your claim is denied on appeal.
- Statement that you can request, free of charge, copies of documentation related to the decision.
- Description of any rule, protocol, or other criterion that was relied on in determining your claim, and your right to obtain a copy, free of charge, upon request.
- Statement that you can request, free of charge, an explanation of the scientific or clinical judgment that was used if your claim was denied based on a medical necessity, an experimental treatment, or another similar exclusion or limitation.
- For an urgent care claim, a description of the expedited review process applicable to such claims.

How can I avoid claim delays?

In many cases, your physician or other health care provider will send a bill directly to the service representative. If you are covered under the 80/20 PPO, simply present your medical ID card to your provider. If you are covered under the Dental PPO Plan or Dental Premier Plan, present your dental plan ID card. You also may be asked to provide your Social Security number.

If you are required to submit a claim, use the following tips to prevent delays and other claim-filing problems:

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

How to Appeal if Your Benefit Claim Is Denied

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

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

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

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

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

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

How can I expedite an appeal for urgent care?

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

Time Limits for Decisions on Benefit Appeals

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

<table>
<thead>
<tr>
<th>Time Limits for Receiving Benefit Appeal Decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>You will receive notification of the decision on your . . .</td>
</tr>
<tr>
<td>Postservice care appeal</td>
</tr>
<tr>
<td>Preservice care appeal</td>
</tr>
<tr>
<td>Concurrent care appeal</td>
</tr>
<tr>
<td>Urgent care appeal</td>
</tr>
</tbody>
</table>

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

If Your Benefit Appeal Is Denied

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

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

Whom to Contact for Benefit Claim and Appeal Procedures

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

Call the Boeing 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.

See Section 8 for the telephone number.

How to File a Claim for Eligibility

You may be able to resolve questions about eligibility for health plan benefits by calling the Boeing 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.

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

Time Limits for Decisions on Eligibility Claims

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

<table>
<thead>
<tr>
<th>Time Limits for Receiving Eligibility Claim Decisions</th>
<th>But it may be extended for an additional . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your claim for eligibility involves . . .</td>
<td>You will receive notification of the decision within . . .</td>
</tr>
<tr>
<td>A preservice care claim*</td>
<td>15 days after your claim is received</td>
</tr>
<tr>
<td>A concurrent urgent 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>
</tr>
<tr>
<td>A concurrent preservice or postservice care claim</td>
<td>Same as preservice or postservice claims, depending on medical circumstances</td>
</tr>
<tr>
<td>An urgent care claim*</td>
<td>72 hours after your claim is received</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>
</tr>
</tbody>
</table>

* 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.

** 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.

† 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 the following information:

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

How to Appeal if Your Eligibility Claim Is Denied

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

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

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

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

  **Fax:**
  312-544-2077

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

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

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

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

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

### Time Limits for Receiving Eligibility Appeal Decisions

<table>
<thead>
<tr>
<th>You will receive notification of the decision on your . . .</th>
<th>Within . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preservice care appeal</td>
<td>30 days after receipt of your appeal</td>
</tr>
<tr>
<td>Concurrent care appeal</td>
<td>Same as preservice, postservice, or urgent care appeals, depending on medical circumstances</td>
</tr>
<tr>
<td>Urgent care appeal</td>
<td>72 hours* after receipt of your appeal</td>
</tr>
<tr>
<td>Other appeal, including a postservice 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 fax, telephone, other electronic means, or orally.

### If Your Eligibility Appeal Is Denied

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

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

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

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

### What You Can Do if Your Appeal Is Denied

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

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

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

### How Claims Are Paid When You Have Duplicate Coverage

This section describes coordination of benefit rules for the 80/20 PPO, vision care program, Dental PPO Plan, and Dental Premier Plan. Coordination of benefit rules for the Point-of-Service Plan, PPO+Account, HMO plans, and prepaid dental plans are described in their respective member handbooks.

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

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

When the 80/20 PPO, Dental PPO Plan, or Dental Premier Plan is primary, this plan will pay its benefits first and without regard to any benefits that may be payable under the secondary plan.

When the 80/20 PPO, Dental PPO Plan, or Dental Premier Plan is secondary, this plan will pay the difference between the benefits paid by the primary plan and what this plan would have paid had it been primary.

Determine Whether the Plan Is Primary or Secondary

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

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

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

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

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

If You Are Covered by Medicare and This Plan

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

Treatment of end-stage renal disease is covered by the 80/20 PPO 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 80/20 PPO provides secondary coverage.

Claim Administration

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

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

The following information applies to all eligible groups, except IBT 578 and IBT 952.

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

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

• Complete a claim and submit all bills related to the injury or illness to the responsible party or insurer.
• Complete and submit all of the necessary information requested by the service representative.
• Reimburse the plan if he or she recovers payment from the responsible party or any other source.
• Allow the plan to be subrogated to all rights of recovery a covered person has against the responsible party or any other source and to cooperate with the service representative’s efforts to recover from the responsible party or any other source any amounts this plan pays in benefits related to the injury or illness, including any lawsuit brought against the responsible party or insurer.

This provision applies whenever you or a covered dependent is entitled to or receives benefits under this plan and is also entitled to or receives compensation or any other funds from another party in connection with that same medical condition, whether by insurance, litigation, settlement, or otherwise. The plan is entitled to such funds to the extent of plan benefits paid to or on behalf of the individual as a first priority right, whether or not the individual has been “made whole,” and without regard to any common fund doctrine. The plan is entitled to such funds regardless of whether the plan’s benefits are identified as being included in the funds and regardless of whether liability for payment of the funds is admitted by the responsible party or any other source of the funds. This plan may recover such funds by constructive trust, equitable lien, right of subrogation, reimbursement, or any other remedy allowed under applicable law.

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

The following information applies only to IBT 578 and IBT 952.

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

If a person covered by this plan is injured by another party who is legally liable for the medical or dental bills, he or she may request this plan to pay its regular benefit on his or her behalf. In exchange, the covered person agrees to:
• Notify the plan within 30 days of giving notice to any party, including an insurance company or attorney, of the covered person’s intention to pursue a claim.
• Complete a claim and submit all bills related to the injury or illness to the responsible party or any insurer.
• Complete and submit all of the necessary information requested by the service representative.
• Reimburse the plan from any payment he or she receives from the responsible party or any other source.
• Allow the plan to be subrogated to all rights of recovery a covered person has against the responsible party or any other source and to cooperate with the service representative’s efforts to recover from the responsible party or any other source any amounts this plan pays in benefits related to the injury or illness, including any lawsuit brought against the responsible party or insurer.
• Grant the plan a lien in the amount of benefits paid that can be enforced against any source of funds available to compensate the covered person for injury or illness caused by another party.

This provision applies whenever you or a covered dependent is entitled to or receives benefits under this plan and is also entitled to or receives compensation or any other funds from another party in connection with that same medical condition, whether by insurance, litigation, settlement, or otherwise. The plan is entitled to such funds to the extent of plan benefits paid to or on behalf of the individual as a first-priority right, whether or not the individual has been “made whole,” and without regard to any common fund doctrine. The plan is entitled to such funds regardless of whether the plan’s benefits are identified as being included in the funds and regardless of whether liability for payment of the funds is admitted by the responsible party or any other source of the funds. This plan may recover such funds by constructive trust, equitable lien, right of subrogation, reimbursement, or any other remedy allowed under applicable law.

The covered person shall do nothing to prejudice the plan’s subrogation or recovery interest, including, but not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan. If an individual fails, refuses, or neglects to reimburse the plan or otherwise comply with the requirements of this provision, or if payments are made under the plan based on fraudulent information or otherwise in excess of the amount necessary to satisfy the provisions of the plan, then, in addition to all other remedies and rights of recovery that the plan may have, the plan has the right to terminate or suspend benefit payments and/or recover the reimbursement due to the plan by withholding, offsetting, and recovering such amount out of any future plan benefits or amounts otherwise due from the plan to or with respect to such individual. The plan also has the right in any proceeding at law or equity to assert a constructive trust, equitable lien, or any other remedy or recovery allowed under applicable law, against any and all persons or entities who have assets that the plan can claim rights to. The plan has a first-priority right of recovery from any judgment, settlement or other payment, regardless of whether the individual has been “made whole,” and without regard to any common fund doctrine.

In the event that any claim is made that any part of this subrogation and recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the plan or service representative shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.
Coverage End Dates and Continuation of Coverage

How Coverage Can End

Once you and your eligible dependents enroll, health care coverage stays in effect until

- You cancel coverage during an annual enrollment period or after a qualified status change or event.
- You lose eligibility for coverage.
- You fail to make timely payments of required premium contributions while on an approved leave of absence.
- The Company ends this Plan or changes the Plan provisions so you are no longer eligible.

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

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

If you take a leave of absence, your coverage may end. For when and how COBRA applies, see “Continue Coverage During a Leave of Absence,” in this section.

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

How You and Your Dependents Can Lose Eligibility for Coverage

Health care coverage for you and your covered dependents will end if you and/or your dependent become ineligible for participation in the plan for one of the following reasons:

- You quit.
- You are discharged or laid off.
- You experience a change in your job situation that causes you to become ineligible for coverage. (For example, your position is reclassified to a part-time position of 19 or fewer regularly scheduled hours per week.)
- You retire.
- You are not actively at work as a result of a labor dispute.
- You die.
- The Company ends this Plan.
- You fail to make timely payments of your required contribution while on an approved leave of absence.
- You cancel coverage.
- You incur a claim that exceeds the plan’s lifetime maximum benefit.

Your spouse or same-gender domestic partner will become ineligible for coverage if

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

Your child will become ineligible for coverage if

- You become ineligible for coverage, as described above.
- Your child reaches age 25 and he or she is not eligible to be covered as a disabled child.
- Your child marries.
• Your child no longer depends on you for principal support.
• Your child becomes an employee covered by this or any other Company-sponsored health care plan.
• Your child otherwise no longer meets the eligibility requirements described in Section 1.

When Coverage Ends

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

If you are eligible for retiree medical coverage through The Boeing Company and terminate your employment, your active coverage will continue until the end of the month after the month you terminate. Special rules apply if you terminate from a leave of absence. See “Continue Coverage During a Leave of Absence,” below.

If you or your dependents incur a claim that exceeds the plan’s lifetime maximum benefit, your coverage ends on the day the medical service is rendered or supply is purchased, resulting in a claim that exceeds the plan’s overall lifetime maximum benefit. If another Boeing plan is available in your area, you may be able to enroll yourself and your dependents in that plan at this time; see “Special Enrollment Events,” in Section 1.

You and your dependents may be able to continue coverage through COBRA in certain circumstances. You and your dependents cannot continue coverage through COBRA if
• The Company ends all its health care plans, or
• You or your dependents reach the lifetime maximum benefit provided by a medical plan and are not eligible to enroll in another Company plan in your area.

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

Will I receive evidence of my Boeing coverage?

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

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

Can I continue my active coverage for a disabled child age 25 or older?

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

Continue Coverage During a Leave of Absence

You and your eligible dependents may continue to be covered by your active coverage during certain approved leaves of absence. To continue your active coverage, you must pay your active contribution amount while you are on an approved leave of absence. You can make payments through payroll deduction or by aftertax payments if you stop receiving a paycheck. The Company may continue to pay its portion of your coverage for some or all of the duration of your leave. See the table, “COBRA Coverage Periods and Qualifying Events” in this section or call the Boeing Service Center through Boeing TotalAccess for details.

For details about periods of active coverage, see the table, “COBRA Coverage Periods and Qualifying Events,” in this section.
If you remain on an approved leave of absence after your active coverage continuation period ends, you may enroll in COBRA coverage. If you enroll and pay the required contribution amounts, your COBRA coverage will begin during the next full calendar month of your leave and continue as shown in the table, “COBRA Coverage Periods and Qualifying Events,” in this section.

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

**Continue Coverage Through COBRA**

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), is a Federal law that entitles you and your covered dependents to continue 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.

**Your Right to COBRA Coverage**

You have a right to elect COBRA coverage if you are covered by a Company-sponsored health care plan and you lose coverage because

- Your employment ends.
- 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 domestic partnership.
• His or her loss of eligibility for coverage. (See “Who Is Eligible,” in Section 1.)

Are the medical benefits under COBRA coverage different from benefits under my active coverage?
No. Your COBRA coverage will be identical to the coverage provided to similarly situated active employees or dependents. However, costs may differ, as described in this section.

How to Enroll for COBRA Coverage

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

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

If your coverage ends because of your 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 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.

During the 60-day election period, you may change your mind about enrolling for coverage. That is, you may decline enrollment and then decide to elect COBRA coverage within the same 60-day period. You may do this as long as you contact the Boeing Service Center and elect COBRA coverage before the end of the 60 days.
If you decline COBRA enrollment, then change your mind and elect COBRA coverage before the end of the 60-day enrollment period, your COBRA coverage will start the day you contact the Boeing Service Center and enroll in COBRA. Your coverage period will be measured from the date of your qualifying event. For example, assume you terminate employment on December 31 and decline COBRA enrollment on January 15. Then, on February 20, you enroll in COBRA. In this case, your COBRA coverage will be effective February 20, but your COBRA coverage period will be measured from December 31, the date of your COBRA qualifying event.

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.

**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, entering a same-gender domestic partnership, birth, or adoption.)

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

**Can I add a new dependent to my COBRA coverage?**

Yes. You may add a child born to you or placed with you for adoption while you are covered through COBRA. That child will have all of the COBRA rights as if he or she had been a covered dependent under your active coverage. Any other dependent you add to your COBRA coverage will have only the rights to your then-current COBRA coverage period; the new dependent will not be able to extend coverage if a secondary qualifying event occurs.

**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 continuation 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.

### 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>
</table>
| Your employment ends, except layoff | • You  
• Your spouse or same-gender domestic partner*  
• Your dependent child* | 18 months at 102% |
| Your hours are reduced | • You  
• Your spouse or same-gender domestic partner*  
• Your dependent child* | 18 months at 102% |
| You are laid off | • You  
• Your spouse or same-gender domestic partner*  
• Your dependent child* | 18 months; for medical coverage, the active contribution amount for the first month, plus an additional period based on seniority, then 102%; for dental coverage, 102% |
| You die | • Your spouse or same-gender domestic partner*  
• Your dependent child* | 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 |
| Divorce, legal separation, or dissolution of domestic partnership | • Your spouse or same-gender domestic partner*  
• Your dependent child* | 36 months at 102% |
| A dependent child loses eligibility | Your dependent child* | 36 months at 102% |
| A covered individual becomes disabled and | | |
| • Is determined by the Social Security Administration to have been disabled for the purposes of Social Security at any time during the first 60 days of COBRA coverage, and  
• Provides notification of the determination within 60 days after it is granted and during the first 18 months of COBRA coverage | • You  
• Your spouse or same-gender domestic partner*  
• Your dependent child* | 29 months; 18 months at 102%, then 150% for you and your dependents if the disabled person is covered; if the disabled person is not covered, 102% |
| You go on an approved medical leave of absence**,**†,**†† | • You  
• Your spouse or same-gender domestic partner*  
• Your dependent child* | Your medical and dental coverage continue for the duration of your leave at active contribution amounts |
### COBRA Coverage Periods and Qualifying Events (continued)

<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 medical leave of absence and you</td>
<td>• You</td>
<td>29 months; 18 months at 102%, then 150%</td>
</tr>
<tr>
<td>• Are determined by the Social Security Administration to have been disabled</td>
<td>• Your spouse or same-gender domestic partner*</td>
<td></td>
</tr>
<tr>
<td>for the purposes of Social Security at any time during the first 60 days of</td>
<td>• Your dependent child*</td>
<td></td>
</tr>
<tr>
<td>COBRA coverage, and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provide notification of the determination within 60 days after it is granted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and during the first 18 months of COBRA coverage**,**†,††</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You go on an approved nonmedical leave of absence†,††</td>
<td>• You</td>
<td>24 months; active contribution continues for 6 months, then 18 months of COBRA coverage at 100%</td>
</tr>
<tr>
<td>• Your spouse or same-gender domestic partner*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Your dependent child*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You go on an approved Uniformed Services Employment and Reemployment Rights</td>
<td>• You</td>
<td>USERRA Continuation Coverage: 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</td>
</tr>
<tr>
<td>Act (USERRA) leave†</td>
<td>• Your spouse or same-gender domestic partner*</td>
<td></td>
</tr>
<tr>
<td>Note: Coverage continuation during an USERRA leave is not considered</td>
<td>• Your dependent child*</td>
<td></td>
</tr>
<tr>
<td>COBRA coverage. However, your COBRA continuation period runs concurrently with</td>
<td></td>
<td></td>
</tr>
<tr>
<td>your USERRA continuation period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You go on an approved union-related leave of absence†</td>
<td>• You</td>
<td>Active contribution for the duration of your union-related leave</td>
</tr>
<tr>
<td>• Your spouse or same-gender domestic partner*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Your dependent child*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* For more information, see “Secondary COBRA Qualifying Events,” in this section.

** A medical leave of absence is a leave that is due to an illness, an accidental injury (on or off the job), or a pregnancy-related condition. Two medical leaves of absence that are separated by fewer than 30 days of continuous work are considered one leave of absence, unless the second leave is entirely due to unrelated conditions.

† The Family and Medical Leave Act of 1993 (FMLA) applies to family and medical leaves at locations with 50 or more employees within a 75-mile radius. This Federal law requires that employees on family or medical leave have the same rights and privileges as do active employees. The continuation rules and employee contributions generally are more generous than required by the law. However, in a situation where these rules do not provide the required coverage, the Company will comply with Federal law.

†† Contact the Boeing Service Center through Boeing TotalAccess for information about medical, nonmedical, USERRA, and union leaves.

** 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 may continue until 36 months after the date of your Medicare entitlement.

In addition, note that different rules apply when more than one qualifying event occurs. Contact the Boeing Service Center through 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

COBRA coverage ends on the earliest date 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.
• The last day of the month following the month in which you receive a Social Security determination that you no longer are disabled after your COBRA coverage has been extended beyond 18 months (but not less than 31 days after you receive the determination).
• The last day of the month in which your dependent who is not a qualified beneficiary ceases to be an eligible dependent as defined by the plan.
• You or your dependent becomes covered by Medicare (under Part A or Part B, with or without Part D) or a Medicare Advantage plan after the date COBRA coverage is elected.

Once COBRA coverage ends, it cannot be reinstated.

What events must be reported?

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

Convert Your Coverage to an Individual Policy

If medical coverage ends, you or your covered dependents may convert coverage to an individual group medical conversion policy offered by the service representative for your medical plan, if available. Individual policy benefits will not be the same as under this plan, however, so be sure to read the application materials carefully.
To convert to an individual policy, complete a conversion application and submit it to the service representative by the later of the following:

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

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

No evidence of insurability will be required.

You or your covered dependents may be able to convert your COBRA coverage at the end of the 18-, 29-, or 36-month COBRA coverage period.
Your Rights and Responsibilities

What Rights You Have Under Federal Law

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

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator’s office and other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain copies of documents governing Plan operation, including insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and updated summary plan descriptions by writing to the Plan Administrator. The Plan Administrator may charge you a reasonable fee for copies.

- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

The fiduciaries have a duty to operate the Plan prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

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

- Know why this was done.

- Obtain copies of documents relating to the decision without charge.

- Appeal any denial—all within certain time schedules. (See Section 4, “Claims and Appeals.”)

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

- If you request a copy of Plan documents or the latest annual report and you do not receive it within 30 days, you may file suit in Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive them, unless the materials were not sent because of reasons beyond the Plan Administrator’s control.

- If your eligibility or Plan benefit claim is denied or ignored, in whole or in part, you may file suit in state or Federal court after you exhaust your appeal rights.
• In addition, if you disagree with the Plan’s decision or lack of decision concerning the qualified status of a medical child support order, you may file suit in Federal court.
• If Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the Department of Labor or you may file suit in Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees; if you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

Receive Assistance With Your Questions

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

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

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

Your Responsibilities Under the Plan

As a participant in the Plan, you must
• Submit any claim for Plan benefits in accordance with Plan rules.
• Inform the Boeing Service Center through Boeing TotalAccess of any change in
  – Your marital or domestic partner relationship status.
  – The status of your eligible children, as defined by Plan rules.
  – Your address or the address of your eligible dependents.
• Provide any information or documentation requested by the Boeing Service Center, health plan service representative, or Plan Administrator.
• Abide by Plan rules.

How the Plan Is Administered

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

Plan Administrator’s Rights

Notwithstanding any other provision in the Plan, and to the full extent permitted under ERISA and the Internal Revenue Code, the Plan Administrator has the exclusive right, power, and authority, in its sole and absolute discretion, to
• Administer, apply, construe, and interpret the Plan and all related Plan documents.
• Decide all matters and questions arising in connection with entitlement to benefits and the nature, type, form, amount, and duration of benefits.
• Amend the Plan.
• Establish rules and procedures to be followed by participants and beneficiaries in filing applications for benefits and in other matters required to administer the Plan.
• Prescribe forms for filing benefit claims and for annual and other enrollment materials.
• Receive all applications for benefits and make all determinations of fact necessary to establish the right of the applicant to benefits under the provisions of the Plan, including the amount of such benefits.
• Appoint accountants, attorneys, actuaries, consultants, and other persons (who may be employees of the Company) for advice, counsel, and reports to make determinations of benefits or eligibility.
• Delegate its administrative duties and responsibilities to persons or entities of its choice such as the Boeing Service Center, the service representatives, and employees of the Company.

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

Company’s Right to Amend, Modify, and Terminate the Plan

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

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

Who Pays for This Plan

Company contributions primarily pay the cost of coverage under this Plan. Employee contributions, if any, pay a small portion of the cost of coverage and are published each year during the annual enrollment period. Employee contributions are fixed for each benefit year. You may obtain current employee contribution information by visiting the Your Benefits Resources web site or calling the Boeing Service Center through Boeing TotalAccess.

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

How the VEBA Trust Fund Works

The Company has established a Voluntary Employees’ Beneficiary Association (VEBA) trust for the Boeing North American Employee Health Plan (Plan 602). The VEBA trust is a tax-exempt trust that was established solely to provide benefits to Plan participants as allowed under Federal law. All or part of your health care benefits may be provided through this trust.

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

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

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

How Benefits Are Paid

The service representatives administer benefit payments in accordance with the provisions of the applicable administrative agreements and insurance contracts.

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

**Right to Recover Overpayments**

If an incorrect amount is paid to you or on your behalf, any remaining payments may be adjusted, including withholding funds from future reimbursements, to correct the error. The Plan Administrator, Boeing Service Center, and service representatives also may take other action that they determine 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 Plan reserves the right to recover from employees any overpayment of claims or costs of coverage.

**No Contract of Employment**

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 Information**

<table>
<thead>
<tr>
<th>Plan Document</th>
<th>The Boeing Company Master Welfare Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Name and Number</td>
<td>Boeing North American Employee Health Plan (602)</td>
</tr>
</tbody>
</table>
| Plan Sponsor | The Boeing Company  
100 North Riverside  
MC 5002-8421  
Chicago, IL 60606-1596 |
| Employer Identification Number | 91-0425694 |
| Plan Year | Calendar-year basis (January 1 through December 31) |
| Plan Administrator | Employee Benefit Plans Committee  
100 North Riverside  
MC 5002-8421  
Chicago, IL 60606-1596  
312-544-2297 |
| Agent for Service of Legal Process | Employee Benefit Plans Committee  
The Boeing Company  
c/o United States Corporation Company of Illinois  
33 North La Salle Street  
Chicago, IL 60602  
Legal process also may be served on the Plan Trustee or Plan Administrator |
| Type of Plan | Welfare benefit plan that provides medical and dental benefits |
| Type of Administration | This Plan is administered according to the terms of the applicable administrative agreements and insurance contracts with the service representatives for each benefit coverage |
| Collective Bargaining Agreement | The Plan is maintained pursuant to collective bargaining agreements; a copy of any such agreement or agreements may be obtained by participants and beneficiaries upon written request to the Plan Administrator and is available for examination by participants and beneficiaries |
| Contributions | Employer and employee contributions, as applicable, based on the collective bargaining agreements |
Other Groups That the Plan Covers

The Boeing North American Employee Health Plan (Plan 602) includes other medical and dental plans. Those plans provide benefits—which differ from those described in this booklet—for the following employee and retiree groups:

Certain nonunion retirees of the Company

Eligible union-represented retirees of the Company who were represented by

- International Association of Machinists and Aerospace Workers, AFL-CIO
  District Lodge No. 281
- International Brotherhood of Electrical Workers, AFL-CIO
  Local No. 2088 (Key West and Puerto Rico)
- International Union of Operating Engineers
  Local No. 501

The employee groups participating in Plan 602 change from time to time. You may obtain an updated list by contacting the Plan Administrator.
annual deductible
The amount of money that you pay for covered services and supplies before your plan begins to pay for covered expenses. The annual deductible does not apply to some services and supplies, as described in applicable sections.

annual enrollment period
A period of time designated by the Company each year when you may add or change your benefit elections for yourself and/or your eligible dependents.

benefit year
The 12-month period that each plan uses to calculate the annual deductible, annual out-of-pocket or coinsurance maximum, and other benefit limits. The benefit year for this health care plan is January 1 through December 31.

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

coinsurance
The percentage of the covered charge that you and the plan each pay.

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

copayment
A fixed dollar amount that you pay toward the cost of a particular covered service such as a network office visit. You generally pay the copayment at the time the service is received.

covered charge
The provider’s charge for a covered service or supply, up to the service representative’s maximum allowance. The amount of the covered charge depends on whether you see a network provider or nonnetwork provider.

• For a network provider, the service representative determines the amount of the covered charge for a particular service or supply under any applicable agreement between the service representative and the provider.
• For a nonnetwork provider, the covered charge is based on the usual and customary charge for the covered service or supply. This plan does not recognize any portion of a provider’s charge that exceeds the usual and customary charge; you are responsible for these excess charges.

covered dependent
Your spouse, same-gender domestic partner, or child who has met the eligibility conditions for the plan and who is currently enrolled in the plan.

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

dentist
A legally qualified dentist who is practicing within the scope of his or her license.
dependent
See eligible dependent and covered dependent.

dependent
Your spouse, same-gender domestic partner, or child who has met the eligibility conditions for enrollment in this plan, as described in Section 1.

eligible dependent
An employee who qualifies for benefits under the plan by meeting the conditions described in Section 1.

ERISA

experimental or investigational service or supply
A service or supply that meets at least one of these criteria. The service or supply
• Requires approval by the U.S. Food and Drug Administration or other government agency that has not been granted when the service or supply is ordered.
• Has been classified as experimental or investigational.
• Is under clinical investigation by health professionals.
• 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 all criteria in either Category 1 or 2.

Category 1:
The trial has been approved by the National Institutes of Health, Food and Drug Administration, 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.
• 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.

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

health care
A general term that means both medical and dental care (for purposes of the descriptions in this booklet).

health maintenance organization (HMO)
A type of medical plan, as described in “Medical Plan Options,” in Section 1.

HMO
See health maintenance organization (HMO).
licensed professional
For the Dental PPO Plan, an individual legally authorized to perform services as defined in his or her license, including, but not limited to, denturist, hygienist, and radiology technician.

medically necessary service or supply
A service or supply that meets the following criteria in accordance with the plan and as determined by the service representative. A service or supply is medically necessary if it is

- Required to diagnose or treat the patient’s illness, injury, or condition and the condition could not have been diagnosed or treated without it.
- Consistent with the symptom or diagnosis and the treatment of the condition.
- The most appropriate service or supply that is essential to the patient’s needs.
- Appropriate as good medical practice.
- Professionally and broadly accepted as the usual, customary, and effective means of diagnosing or treating the illness, injury, or condition.
- Unable to be provided safely to the patient as an outpatient (for an inpatient service or supply).

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.

network provider
Any health care professional, institution, facility, agency, or other provider that has a contract with a service representative to provide services at negotiated rates.

nonnetwork provider
Any health care professional, institution, facility, agency, or other provider that does not have a contract with a service representative to provide services at negotiated rates.

nonparticipating pharmacy
A retail pharmacy that does not have a contract with the service representative to provide prescription drugs at discounted prices.

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

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

PCP
See primary care provider (PCP).

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

plan benefit
The portion of the covered charge that the plan pays.

prepaid dental plan
A Company-sponsored dental plan that provides dental care through a network of dentists. These plans require participants to select a primary care provider in advance and receive covered services (other than orthodontia) through that dentist.
primary care provider (PCP)
A physician or other medical professional who serves as a first point of contact within the plan’s network of contracted physicians, hospitals, and other medical specialists. This physician or medical professional is referred to as a primary care provider, and he or she coordinates all care and referrals for you within a plan’s network.

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

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

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

service area
The geographical area designated by the Plan that determines eligibility for a health care plan and the network level of coverage.

service representative
An agent that the Company has contracted with to make benefit determinations and administer benefit payments under the plans described in this booklet. See Section 8 for a list of service representatives. The Company may change a service representative at any time.
# Contacts

## Where to Get More Information

<table>
<thead>
<tr>
<th>If you have questions about . . .</th>
<th>Contact . . .</th>
<th>At . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligibility and enrollment</strong> for all medical and dental plans&lt;br&gt;• Medical and dental plan options&lt;br&gt;• Plan comparisons&lt;br&gt;• Cost of coverage&lt;br&gt;• Enrollment&lt;br&gt;• Network providers</td>
<td><strong>Boeing Service Center for Health and Insurance Plans</strong></td>
<td>Web site: Your Benefits Resources, through Boeing TotalAccess&lt;br&gt;• Boeing Web: <a href="https://my.boeing.com">https://my.boeing.com</a>&lt;br&gt;• World Wide Web: <a href="http://www.boeing.com/express">www.boeing.com/express</a>&lt;br&gt;Telephone: through Boeing TotalAccess&lt;br&gt;• General: 1-866-473-2016&lt;br&gt;• TTY/TDD: 1-800-755-6363&lt;br&gt;• Boeing TotalAccess hours of service&lt;br&gt;− Automated telephone system: self-service applications are available 24 hours a day, seven days a week&lt;br&gt;− Representatives available Monday through Friday from 7 a.m. to 8 p.m. Central time&lt;br&gt;You must have your BEMS ID number (or Social Security number) and Boeing TotalAccess password to use Boeing TotalAccess on the World Wide Web or by telephone&lt;br&gt;Mailing address: 100 Half Day Road P.O. Box 1466 Lincolnshire, IL 60069-1466</td>
</tr>
<tr>
<td><strong>COBRA</strong> information for all medical and dental plans&lt;br&gt;• Notification of COBRA event&lt;br&gt;• Enrollment in COBRA coverage&lt;br&gt;• COBRA payments</td>
<td><strong>Boeing Service Center for Health and Insurance Plans</strong></td>
<td>Same as for eligibility and enrollment, above</td>
</tr>
<tr>
<td><strong>Health and wellness</strong> information&lt;br&gt;• Resources for medical conditions and treatments&lt;br&gt;• Information on drugs and supplements&lt;br&gt;• Health programs&lt;br&gt;• Work site programs</td>
<td><strong>BoeingWellness, the Boeing-Mayo Clinic site</strong></td>
<td>Web site: <a href="http://www.boeingwellness.com">www.boeingwellness.com</a></td>
</tr>
<tr>
<td><strong>80/20 PPO</strong>&lt;br&gt;• Medical coverage&lt;br&gt;• Precertification&lt;br&gt;• Medical claims&lt;br&gt;• Customer service&lt;br&gt;• Medical cards and replacement cards&lt;br&gt;• Retail pharmacy claims</td>
<td><strong>Regence BlueShield Available in Oklahoma and Texas</strong></td>
<td>Telephone:&lt;br&gt;• Through Boeing TotalAccess (above) or direct: 1-800-422-7713&lt;br&gt;• Network provider information: 1-800-810-2583&lt;br&gt;• Medical review program: 1-800-423-6884&lt;br&gt;Mailing address: P.O. Box 91015 Seattle, WA 98111-9115&lt;br&gt;Web site: <a href="http://www.regence.com/boeing">www.regence.com/boeing</a></td>
</tr>
<tr>
<td>If you have questions about . . .</td>
<td>Contact . . .</td>
<td>At . . .</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------</td>
<td>----------</td>
</tr>
<tr>
<td><strong>Point-of-Service Plan</strong>&lt;br&gt;• Medical coverage&lt;br&gt;• Precertification&lt;br&gt;• Medical claims&lt;br&gt;• Customer service&lt;br&gt;• Medical cards and replacement cards&lt;br&gt;• Retail pharmacy claims&lt;br&gt;• Participating pharmacies&lt;br&gt;• Mail-order prescriptions</td>
<td><strong>Health Net</strong>&lt;br&gt;Available in California</td>
<td>Telephone:&lt;br&gt;• Network provider information: 1-800-676-6976&lt;br&gt;• Treatment review program: 1-800-977-7282&lt;br&gt;• Claim questions: 1-800-676-6976&lt;br&gt;Mailing addresses:&lt;br&gt;• Claims: Health Net Commercial Claims&lt;br&gt;  P.O. Box 14702&lt;br&gt;  Lexington, KY 40512&lt;br&gt;• Appeals: Health Net of California&lt;br&gt;  Appeals &amp; Grievances Dept.&lt;br&gt;  P.O. Box 10348&lt;br&gt;  Van Nuys, CA 91410-0348&lt;br&gt;Web site: <a href="http://www.healthnet.com">www.healthnet.com</a></td>
</tr>
<tr>
<td><strong>PPO+Account</strong>&lt;br&gt;• Medical coverage&lt;br&gt;• Mental health and substance abuse coverage&lt;br&gt;• Precertification&lt;br&gt;• Prescription drug coverage&lt;br&gt;• Medical claims&lt;br&gt;• Customer service&lt;br&gt;• Medical cards and replacement cards&lt;br&gt;• Health Savings Account</td>
<td><strong>Aetna</strong>&lt;br&gt;Available in all locations</td>
<td>Telephone: 1-800-221-7371&lt;br&gt;Mailing addresses:&lt;br&gt;• Claims: Aetna Claims&lt;br&gt;  P.O. Box 14089&lt;br&gt;  Lexington, KY 40512-4089&lt;br&gt;• Appeals: Aetna&lt;br&gt;  Attn: National Account CRT&lt;br&gt;  P.O. Box 14463&lt;br&gt;  Lexington, KY 40512-4463&lt;br&gt;Web site: <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td><strong>Prescription drug program</strong> for&lt;br&gt;80/20 PPO and PPO+Account participants&lt;br&gt;• Participating pharmacies&lt;br&gt;• Refills&lt;br&gt;• Claims</td>
<td><strong>Medco Health Solutions, Inc.</strong>&lt;br&gt;<strong>Vision Service Plan (VSP)</strong>&lt;br&gt;• Coverage&lt;br&gt;• Claims&lt;br&gt;• Customer service</td>
<td>Telephone: 1-800-841-2797&lt;br&gt;Mailing addresses:&lt;br&gt;• Appeals: Medco Health Appeals&lt;br&gt;  Attn: Appeals&lt;br&gt;  8111 Royal Ridge Parkway&lt;br&gt;  Irving, TX 75063&lt;br&gt;• Retail pharmacy:&lt;br&gt;  P.O. Box 14711&lt;br&gt;  Lexington, KY 40512&lt;br&gt;• Mail order (Medco By Mail):&lt;br&gt;  P.O. Box 650022&lt;br&gt;  Dallas, TX 75265-0022&lt;br&gt;Web site: <a href="http://www.medco.com">www.medco.com</a></td>
</tr>
<tr>
<td><strong>Vision care program</strong> for&lt;br&gt;80/20 PPO, Aetna HMO, Health Net HMO, Kaiser Permanente HMO, Point-of-Service Plan, and PPO+Account participants&lt;br&gt;• Coverage&lt;br&gt;• Claims&lt;br&gt;• Customer service</td>
<td><strong>Vision Service Plan (VSP)</strong>&lt;br&gt;• Coverage&lt;br&gt;• Claims&lt;br&gt;• Customer service</td>
<td>Telephone: 1-800-877-7195&lt;br&gt;Mailing addresses:&lt;br&gt;• Claims: P.O. Box 997105&lt;br&gt;  Sacramento, CA 95899-7105&lt;br&gt;• Appeals: VSP Member Appeals&lt;br&gt;  3333 Quality Drive&lt;br&gt;  Rancho Cordova, CA 95670&lt;br&gt;Web site: <a href="http://www.vsp.com">www.vsp.com</a></td>
</tr>
<tr>
<td>If you have questions about...</td>
<td>Contact...</td>
<td>At...</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mental health and substance abuse program</td>
<td><strong>ValueOptions (Boeing Helpline)</strong> for 80/20 PPO participants</td>
<td>Telephone: 1-800-892-1411</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TTY/TDD: 1-800-855-2880</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mailing address: P.O. Box 6065</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cypress, CA 90630</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mailing address (claims): P.O. Box 1290</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Latham, NY 12110</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Web site: <a href="http://www.valueoptions.com">www.valueoptions.com</a></td>
</tr>
<tr>
<td></td>
<td><strong>Aetna</strong> for PPO+ Account participants</td>
<td>Telephone: 1-800-221-7371</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mailing addresses:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Claims: Aetna Claims</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P.O. Box 14089</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lexington, KY 40512-4089</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Appeals: Aetna</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Attn: National Account CRT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P.O. Box 14463</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lexington, KY 40512-4463</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Web site: <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td></td>
<td><strong>Managed Health Network (MHN)</strong> for Point-of-Service Plan participants</td>
<td>Telephone: 1-800-509-4646</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mailing addresses:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Claims: Managed Health Network</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P.O. Box 14621</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lexington, KY 40512-4621</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Appeals: Managed Health Network</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Attn: Health Net Team</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1600 Los Gamos Drive, Suite 300</td>
</tr>
<tr>
<td></td>
<td></td>
<td>San Rafael, CA 94903</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Web site: <a href="http://www.mhn.com">www.mhn.com</a></td>
</tr>
<tr>
<td>HMO plans</td>
<td><strong>Aetna HMO</strong></td>
<td>Telephone: 1-800-421-6819</td>
</tr>
<tr>
<td></td>
<td>Available in Texas</td>
<td>Mailing address: P.O. Box 14089</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lexington, KY 40512</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Web site: <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td></td>
<td><strong>Health First HMO</strong></td>
<td>Telephone: 1-800-716-7737</td>
</tr>
<tr>
<td></td>
<td>Available in Florida</td>
<td>Mailing address: 6450 US Highway 1</td>
</tr>
<tr>
<td></td>
<td>(Brevard County area)</td>
<td>Rockledge, FL 32955</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Web site: <a href="http://www.health-first.org">www.health-first.org</a></td>
</tr>
<tr>
<td></td>
<td><strong>Health Net HMO</strong></td>
<td>Telephone: 1-800-522-0088</td>
</tr>
<tr>
<td></td>
<td>Available in California</td>
<td>Mailing addresses:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Claims: P.O. Box 14702</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lexington, KY 40512</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Appeals: P.O. Box 10348</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Van Nuys, CA 91410-0348</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Web site: <a href="http://www.healthnet.com">www.healthnet.com</a></td>
</tr>
<tr>
<td></td>
<td><strong>Kaiser Permanente HMO</strong></td>
<td>Telephone: 1-800-464-4000</td>
</tr>
<tr>
<td></td>
<td>Available in California</td>
<td>Mailing address: P.O. Box 7102</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pasadena, CA 91109-7102</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Web site: <a href="http://www.kaiserpermanente.org">www.kaiserpermanente.org</a></td>
</tr>
<tr>
<td>If you have questions about . . .</td>
<td>Contact . . .</td>
<td>At . . .</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>---------------</td>
<td>---------</td>
</tr>
</tbody>
</table>
| PacifiCare HMO                  | Telephone: 1-800-624-8822 | ***PacifiCare HMO***
| Available in Oklahoma           | Mailing address: P.O. Box 6006 Cypress, CA 90630 | Web site: [www.pacificare.com](http://www.pacificare.com) |
| **Dental PPO Plan**             | **Washington Dental Service** | Telephone: 1-877-521-2101
| • Dental coverage               | Available in California, Oklahoma, and Texas | For dental care outside the United States: 1-800-523-6586 or 215-942-8226 (call collect)
| • Predetermination              | Mailing address: P.O. Box 75983 Seattle, WA 98175-0983 | Web site: [www.deltadentalwa.com](http://www.deltadentalwa.com) |
| • Dental claims                 | **Dental Premier Plan**        | Telephone: 1-877-521-2101
| • Customer service              | Available in Oklahoma          | For dental care outside the United States: 1-800-523-6586 or 215-942-8226 (call collect)
| • Dental cards and replacement cards | Mailing address: P.O. Box 75983 Seattle, WA 98175-0983 | Web site: [www.deltadentalwa.com](http://www.deltadentalwa.com) |
| **Prepaid dental plans**        | **CompDent**                  | Telephone: 1-800-342-5209
| • Dental coverage               | Available in Texas             | Mailing address: P.O. Box 8236 Chicago, IL 60680-8236 Web site: [www.compdent.com](http://www.compdent.com) |
| • Predetermination              | **SafeGuard**                 | Telephone: 1-800-422-4234
| • Dental claims                 | Available in California       | Mailing address: Washington Dental Service P.O. Box 75983 Seattle, WA 98175-0983 Web site: [www.deltadentalins.com](http://www.deltadentalins.com) |
| • Customer service              | **Washington Dental Service (WDS)/DeltaCare® USA** | Telephone: 1-800-880-1800
| • Dental cards and replacement cards | Available in California        | Mailing address: SafeGuard P.O. Box 30930 Laguna Hills, CA 92654-0930 Web site: [www.safeguard.net](http://www.safeguard.net) |
Summary of Benefit Plan Changes and Clarifications

Employees Represented by IBC&JA 721; IBEW 2295; IBPATA 36; IBT 578 and 952; IUOE 501; SMWIA 461; UAW 864, 887, 952, 1519, 1558

The changes and/or clarifications in this Update affect the health care plans, disability, life and accident plans; and health care flexible spending account. In addition annual reminders are included.

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 and clarification is January 1, 2009, 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 and clarifications in this Update apply to:

- Boeing North American Employee Health Plan (Plan 602).
- The Boeing Company Employee Health and Welfare Benefit Plan (Plan 503).
- The Boeing Company Cafeteria Plan (Plan 576).

Eligibility and Enrollment

The changes and clarifications in this section apply to both the Boeing North American Employee Health Plan (Plan 602) and The Boeing Company Employee Health and Welfare Benefit Plan (Plan 503).

Same-Gender Spouse

Effective June 26, 2008, an individual who is recognized under state law as your same-gender spouse qualifies as a same-gender domestic partner under the plans.

If you enroll your same-gender spouse or his or her eligible children in a Company-sponsored health care plan, the benefit value may be taxable to you as ordinary income. The taxability of benefits depends on whether your same-gender spouse (and his or her children) qualifies as a dependent under Internal Revenue Code Section 105.

For additional information about domestic partner benefit tax implications, you should consult a tax adviser.

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 this notice upon request.

If you would like a copy of the Notice of Privacy Practices, please contact the Boeing Service Center for Health and Insurance Plans through Boeing TotalAccess.
When Coverage Begins

The effective date of your coverage for health care, disability, life, or accident benefits depends on when you enroll and what event initiates your enrollment. The following table explains when your coverage begins.

<table>
<thead>
<tr>
<th>If you . . .</th>
<th>Your coverage will begin on the . . .</th>
</tr>
</thead>
</table>
| Are a newly hired employee (and you make your election by the date indicated on your enrollment worksheet) | *Business travel accident:* First day of active employment  
*All other coverages:* First day of the month after your first day of active employment |
| Enroll or change your coverage during an annual enrollment period             | First day of the new benefit year, unless evidence of insurability is required for the Supplemental Life Insurance Plan |
| Enroll or change your health care coverage because of a special enrollment event (see “Special Enrollment Events,” in your summary plan description) | Special enrollment event date                                                                      |
| Enroll or change your coverage because of a qualified status change or status change (see “Qualified Status Changes” or “Status Changes,” in your summary plan description) | Qualified status change date or status change date, unless evidence of insurability is required for the Supplemental Life Insurance Plan |
| Enroll in a new health care plan if your current plan is no longer available following a change of address | Date Boeing TotalAccess receives your address change (if you call Boeing TotalAccess within 60 days of your address change, coverage will begin on the date of your address change) |
| Are recalled from a layoff within your recall rights period                  | Date you are reinstated to the active payroll                                                       |
| Are reemployed after uniformed service (and return to work promptly in accordance with Federal law) | Date you are reinstated to the active payroll                                                       |
| Return to work from an approved leave of absence                             | Date you are reinstated to the active payroll                                                       |
| Are rehired (this includes returning from retirement)                       | *Business travel accident:* Date you are reinstated to the active payroll  
*All other coverages:* First day of the month after the date you are reinstated to the active payroll |
| Transfer from one payroll to another                                         | *Business travel accident:* Date of transfer  
*All other coverages:* First day of the month after or coinciding with your transfer date |

**Note:** For the disability, life, and accident plans, you must be actively at work on the effective date of coverage for coverage to begin.
Medical Plans
The changes and reminder in this section apply to the Boeing North American Employee Health Plan (Plan 602).

Prescription Drug Formulary
You can obtain the prescription drug formulary (a list of generic and preferred brand-name drugs) for your medical plan at no cost to you by
- Calling the service representative (health care plan) directly or through Boeing TotalAccess.
- Visiting the web site of your service representative.

Reconstructive Breast Surgery (annual reminder)
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 your plan.

Disability, Life, and Accident Plans
The change and clarification in this section apply to the Boeing North American Employee Health Plan (Plan 602).

Short-Term Disability Claims
To initiate a short-term disability claim or if you have questions about eligibility, call Boeing TotalAccess and ask for a leave of absence. Your call will be transferred to the Boeing Leave Service Center administered by Aetna Disability and Absence Management. Claim information will be taken over the telephone; the service representative will advise you if any additional information is required. If possible, have your physician’s contact information available.

Life Insurance Coverage During a Uniformed Services (Military) Leave of Absence
During a temporary period after September 11, 2001, your basic life insurance will be continued for the duration of your leave for up to a total of 60 months, 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. Supplemental life insurance can continue for 24 months; you pay the full cost of coverage.
Supplemental Life Insurance Plan

If you cover your spouse, same-gender domestic partner, or dependent children under the Supplemental Life Insurance Plan and want to designate a beneficiary other than yourself, you, as the employee, must designate another beneficiary. If you do not specifically designate a beneficiary, you automatically will be the designated beneficiary.

You can designate a beneficiary through the Boeing Service Center on line or by telephone. If you designate your beneficiary on line, you will need to provide your beneficiary's full name, relationship, gender, Social Security number, and birth date. If you do not utilize the online tool and designate your beneficiary by calling the Boeing Service Center through Boeing TotalAccess, beneficiary Social Security numbers will not be required.

Health Care Flexible Spending Account (FSA)

*The change in this section applies to The Boeing Company Cafeteria Plan (Plan 576).*

If you perform military service for more than 179 consecutive days, you may take your health care FSA balance as a taxable cash distribution before the FSA plan year ends in which you perform the service. Contact the Boeing Service Center through Boeing TotalAccess for details.

For More Information

Contact the Boeing Service Center through Boeing TotalAccess. For short-term disability questions, contact the Boeing Leave 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 www.boeing.com/express using your BEMS ID number (or Social Security number) and your Boeing TotalAccess password.
- **By telephone:** Call 1-866-473-2016. TTY/TDD services are available at 1-800-755-6363. You must have your BEMS ID number (or Social Security number) and your Boeing TotalAccess password. Customer service 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:

- Boeing North American Employee Health Plan (Plan 602).
- The Boeing Company Employee Health and Welfare Benefit Plan (Plan 503).
- 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).

Every effort has been made to provide accurate information in this Update. In the event of a conflict between this Update and The Boeing Company Master Welfare Plan document and/or Plan document listed above, the terms of The Boeing Company Master Welfare Plan document and/or Plan document listed above will control. Copies of the summary plan descriptions may be obtained by contacting the Boeing service centers through Boeing TotalAccess.

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 and/or beneficiaries.