Employee Retirement Income Plan

Summary Plan Description
2006 Edition/Hourly West Employees/IAM 725; IBEW 2295; IUOE 501–Weldors; DASO; AFSO 1/SPFPA; IBT 848–Firefighters; UAW 148 and 1482; SPFPA 159 and 160

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

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

This booklet is a summary of the Employee Retirement Income Plan of McDonnell Douglas Corporation—Hourly West Plan (Plan 002), which is referred to as the “Plan” in this booklet. You may be eligible to participate in this Plan if you are an eligible employee of the Company who is represented by one of the following unions:

- International Association of Machinists and Aerospace Workers (IAM), AFL-CIO
  District Lodge No. 725

- International Brotherhood of Electrical Workers (IBEW), AFL-CIO
  Local No. 2295

- International Union of Security, Police and Fire Professionals of America (SPFPA) and Certain Affiliated Amalgamated Locals
  Local No. 159
  Local No. 160

- American Federation of Security Officers (AFSO)
  Local No. 1/International Union of Security, Police and Fire Professionals of America (SPFPA)

- International Union of Operating Engineers (IUOE)
  Local No. 501—Weldors

- International Union, United Automobile, Aerospace and Agricultural Implement Workers of America (UAW)
  Local No. 148
  Local No. 1482

- International Brotherhood of Teamsters (IBT)
  Local No. 848 (Firefighters Unit)

- Douglas Association of Security Officers (DASO)

Since the Plan was initiated in 1955, it has been changed. The provisions described in this booklet are effective March 1, 2006, unless otherwise noted. If you retired or ended your employment before March 1, 2006, your benefits may differ from the benefits described in this booklet.

The Plan may be an important source of income for your future. It is intended to work with The Boeing Company Voluntary Investment Plan (VIP) and the Social Security program to provide retirement income. You are encouraged to build on this base through your own personal savings and investments.

"Company," as used throughout this booklet, refers to McDonnell Douglas Corporation, a wholly owned subsidiary of The Boeing Company. "Boeing," as used throughout this booklet, refers to The Boeing Company or any affiliate or subsidiary of The Boeing Company.
Notice of Company Rights

The Company intends to continue this Plan; however, the Company reserves the right to suspend, amend, change, modify, or terminate 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.

Currently, the Company has delegated the authority to amend and administer the Plan to the Employee Benefit Plans Committee, appointed by The Boeing Company Board of Directors. As Plan Administrator, the Committee will apply the terms of the Plan and will, as appropriate, use its discretion in interpreting terms of the Plan when reviewing claims for benefits.

The summary plan description booklet is not a guarantee of 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.

If you have questions about the information in this booklet, please call the Boeing Pension Service Center through Boeing TotalAccess at the telephone number listed in Exhibit 18, on page 48.

This booklet summarizes the terms of the Employee Retirement Income Plan of McDonnell Douglas Corporation—Hourly West Plan. Every effort has been made to provide an accurate summary of the Plan, but in the event of a conflict between this summary and the official Plan document, the terms of the Plan will control. Copies of the Plan document are available at the cost of reproduction by sending a written request to The Boeing Company, 100 North Riverside, MC 5002-8421, Chicago, IL 60606-1596.
Contacting the Boeing Pension Service Center Through Boeing TotalAccess

Boeing TotalAccess is your gateway to benefits information. You can access the Boeing Pension Service Center through Boeing TotalAccess at any time for many services. (See page 48 for a detailed description.) Boeing TotalAccess is available 24 hours a day, seven days a week on line and by telephone.

On the Boeing Web, log on to https://my.boeing.com and click the TotalAccess tab. Then follow the links.


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 when you use the World Wide Web or telephone.
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Eligibility and Participation

To become eligible to participate in the Plan, you must be an employee at an employing company. In addition, you must be a member of a covered group under that employing company.

Employing Company

“Employing company” means the Company and any affiliates or subsidiaries of the Company that have adopted the Plan. The status of any company as an employing company may be subject to change.

Covered Group

In addition to being employed by an employing company, you must be a member of a covered group under that company. See page 1 for a list of covered groups.

Eligibility Requirements

In general, if you were hired on or after January 1, 2001, you become a Plan participant on the day after the first anniversary of your hire date if you completed 1,000 hours of vesting service during that period (also known as your 12-month eligibility waiting period). If you do not complete 1,000 hours of vesting service during your first 12 months with Boeing, you will become a Plan member on the first day of the Plan year (January 1 through December 31) following the Plan year in which you complete 1,000 hours of vesting service.

Eligibility Example

Assume you were hired on February 1, 2004, and completed 1,000 hours of vesting service by September 1, 2004. You became a Plan participant on February 2, 2005 (the first day following the first anniversary of your hire date).

If you were hired before January 1, 2001, you may have been subject to different eligibility requirements under the Plan, including special eligibility rules if you were hired between November 29, 1999, and January 1, 2001. Contact the Boeing Pension Service Center through Boeing TotalAccess for more information.

Rehired Employees

If your employment with Boeing ends and you are rehired to a covered group within one year, you automatically will become a Plan participant on your rehire date. However, you will be required to satisfy the eligibility requirements by completing 1,000 hours of vesting service during your first 12 months of reemployment with Boeing, if either of the following applies to you:

• You were not a Plan participant during your prior employment.
• You had five or more consecutive one-year breaks in service when you were reemployed and were not previously vested.

Transferred Employees

This information applies to you if you transfer to or from a group that does not participate in the Plan.
If you transfer into a covered group from a group that does not participate in the Plan, and you completed the Plan’s eligibility service requirements before your transfer, you may begin participating in the Plan on your transfer date. If you have not completed the Plan’s eligibility requirements by your one-year anniversary, you will become a participant on the first day of the Plan year following the Plan year in which you complete 1,000 hours of vesting service.

### Eligibility Example for Transferred Employees

Assume you worked for Boeing since September 1, 2003, but were not a member of a covered group, and you completed 1,000 hours of vesting service during the 2004 Plan year (January 1, 2004, through December 31, 2004). If you became a member of a covered group on January 1, 2005, you automatically became a Plan participant on that date because you completed the Plan’s eligibility service requirements in 2004.

If you have earned benefits under another plan, those benefits will remain under that plan and will be paid separately according to the provisions of that plan. Those benefits will not be included in the benefit you earn under this Plan.

If you are participating in the Plan and transfer to an ineligible group, you stop earning benefit service on your transfer date. However, you will continue earning vesting service.

### Who May Not Participate

You are *not* eligible to participate in the Plan if any of the following apply to you:

- You are not part of a covered group.
- You are a nonresident alien working for the Company, and you have no earned income from the Company for work performed in the United States.
- You are working in a capacity that, at the sole discretion of the Plan Administrator, is considered a nonemployee, even if a court or administrative agency later determines you are an employee. Nonemployees include independent contractors, contract labor, consultants or advisers, leased employees, directors, or any person not paid directly through the payroll department.

### Your Responsibilities as a Plan Participant

As a Plan participant, you have certain responsibilities, including keeping Boeing informed of your latest address and understanding how to apply for benefits. The Boeing Pension Service Center is available to help you by answering your questions and providing you with Plan materials, such as a benefit commencement package.

**Boeing Pension Service Center**

You may call the Boeing Pension Service Center by calling Boeing TotalAccess and follow the prompts to

- Ask questions about Plan benefits.
- Request an estimate of your benefit.
- Request a benefit commencement package, which includes the Commencement Election form you will need to begin your benefit payments.
Service center representatives can provide you with confidential information about your pension benefits. If they cannot answer your question immediately, they will research the issue and contact you when they have an accurate answer. Representatives are available to talk with you Monday through Friday from 9 a.m. to 8 p.m. Eastern time (8 a.m. to 7 p.m. Central time; 7 a.m. to 6 p.m. Mountain time; 6 a.m. to 5 p.m. Pacific time).

To use the automated phone system, you may call Sunday through Friday from 7 a.m. to 3 a.m. and Saturday from 7 a.m. to midnight Eastern time.

To use Boeing TotalAccess, you need your BEMS ID number (or Social Security Number) and your Boeing TotalAccess password.

Your Ongoing Responsibilities

You must keep Boeing informed of your current address at all times. It may be necessary for Boeing to contact you from time to time on matters relating to your pension benefit.

You need to know your password, and you need to keep it secure. Your password is necessary whenever you want to access information about your pension benefit, whether you are an active employee, a retiree, or a terminated employee. If you lose your password, call Boeing TotalAccess and follow the prompts.

If you leave Boeing and are eligible to receive a pension benefit at a later date, you will be responsible for contacting the Pension Service Center through Boeing TotalAccess to request the forms to begin your benefit payments.

Your Responsibilities When Applying for Plan Benefits

It is your responsibility to apply for Plan benefits. Follow these steps to apply:

1. **Request your benefit commencement package.** Call the Boeing Pension Service Center by calling Boeing TotalAccess and following the prompts to request your benefit commencement package 60 to 90 days before you want your pension benefits to begin. A representative will provide you with the forms you must complete and answer any questions you may have about the retirement election process. You must call no later than the first of the month before the month in which you want your pension benefits to begin. When you call, you will need to provide
   - Your BEMS ID number or Social Security number.
   - Your Boeing TotalAccess password.
   - The names, Social Security numbers, and dates of birth of your spouse and dependent children, if applicable.

   You also may request your benefit commencement package through the automated phone system; however, you should call during business hours if you need to talk with a Boeing Pension Service Center representative. For example, if you use the automated system, you will be transferred to a representative to provide any spouse and dependent information.

2. **Review your benefit commencement package.** The Boeing Pension Service Center will mail your benefit commencement package to your home. Carefully read through the materials in the benefit commencement package as soon as possible. You may need to allow time to gather documentation, such as your marriage certificate and birth certificates for you and your spouse. Depending on the form of payment you choose, you may need your spouse’s consent, which will require your spouse’s signature to be notarized by a notary public. If you have any questions, call the Boeing Pension Service Center immediately to avoid processing delays.
3. **Return your completed forms and documentation.** Complete the required forms and return them, along with any requested documentation, according to the instructions in your benefit commencement package. The Boeing Pension Service Center must receive the forms before the benefit commencement date for payments to begin as scheduled. *You must return the completed forms and documentation before the date you requested your pension benefits to begin (for example, by June 30 for a July 1 benefit commencement date), or your benefits may be affected.*

*If you retire directly from Boeing, you must submit your completed forms no later than the day before you want your benefits to begin. If your forms are not received by the deadline and you elect early retirement, your benefit will be reduced by the deferred vested benefit reduction factors. These reduction factors are more substantial than other early retirement factors for the Plan. See Exhibit 10, on page 23.*

If you change your mind after submitting your form and want to delay receiving your pension payments, you must notify the Boeing Pension Service Center in writing. The written notification must be received before your benefit commencement date. When you are ready for payments to begin, you must call the Boeing Pension Service Center to begin the process again.

4. **Process your termination.** If you are an active employee, you must process your termination before pension payments can begin. Active employees should process their own termination by going to [https://my.boeing.com](https://my.boeing.com) and searching for “voluntary termination” for directions. If you need assistance, call Boeing TotalAccess at the number listed on page 48. If you are on a leave of absence, coordinate with your leave of absence focal, who will assist you.

**Service**

How long you work for Boeing is important in determining both your eligibility for benefits and the amount of your benefits. In general terms, this section explains how your service affects your pension benefits. Your actual service under the Plan will depend on several factors, such as whether you have been employed with one or more covered groups over the course of your career and whether you participated in certain other Boeing-sponsored retirement plans during that time.

**Vesting Service**

In addition to determining when you can participate in the Plan, vesting service also is used to determine whether you are eligible to receive benefits. This is known as becoming “vested.” When you become vested, you have a nonforfeitable right to your Plan benefits. This means you cannot lose your right to receive benefits, even if you end your employment with Boeing before you retire under the Plan. For more information, see “When You May Retire,” on page 20.

In general, you start earning vesting service when you begin working for Boeing. You earn one year of vesting service for each Plan year (as defined in “Eligibility Requirements,” on page 7) in which you complete at least 1,000 hours of vesting service. However, you earned one additional year of vesting service if you were a member of a covered group and an active employee on November 27, 2000, the beginning of the short Plan year. Any period of service will be counted only once when calculating your years of vesting service.
Change to the Calculation of Vesting Service

In 2000, the Plan changed the way your vesting service was calculated. The date when this change applied to you depended on your covered group at that time, as shown in Exhibit 2.

### Exhibit 2

<table>
<thead>
<tr>
<th>If you are (or were) a member of the following covered group . . .</th>
<th>How your vesting service is calculated has changed for the service you earned on or after . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>• UAW Local Nos. 148 and 1482</td>
<td>October 1, 2000</td>
</tr>
<tr>
<td>• DASO</td>
<td></td>
</tr>
<tr>
<td>• IAM District Lodge No. 725</td>
<td></td>
</tr>
<tr>
<td>• IUOE Local No. 501—Weldors</td>
<td></td>
</tr>
<tr>
<td>• IBT Local No. 848 (Firefighter Unit)</td>
<td></td>
</tr>
<tr>
<td>• SPFPA Local Nos. 159 and 160</td>
<td>November 27, 2000</td>
</tr>
<tr>
<td>• IBEW Local No. 2295</td>
<td></td>
</tr>
<tr>
<td>• AFSO Local No. 1/SPFPA</td>
<td></td>
</tr>
</tbody>
</table>

### Vesting Service Before the Change in Calculation

Before the date your vesting calculation changed (as shown in Exhibit 2), you earned vesting service as follows:

- One hour of vesting service for each hour in which you were paid (directly or indirectly), including straight time and overtime hours, vacation, holidays, sick leave, and other paid time off.
- 1.23 hours of vesting service for each hour you were regularly scheduled to work if you were scheduled to receive eight hours of pay for fewer than eight hours of work (the third-shift equivalent).
- 45 hours of vesting service for each week of the first 12 months of any approved leave of absence that is not credited as benefit service.
- All benefit service you earned under this Plan.
- Vesting service recognized under any other pension plan sponsored by Boeing.

You were credited with a full year of vesting service when you completed 1,000 or more hours of vesting service during a Plan year.

A period of time will only be counted once for purposes of vesting service, even if it could be considered under more than one provision. You cannot earn more than one year of vesting service in one Plan year.
Vesting Service After the Change in Calculation
On or after the date your vesting calculation changed (as shown in Exhibit 2), you earn 45 hours of vesting service for each week for which you are paid. You earn a year of vesting service for each Plan year in which you complete 1,000 or more hours of vesting service. You will receive a partial year of vesting service for Plan years in which you complete fewer than 1,000 hours of vesting service. Your partial year of vesting service will be determined by dividing your total hours of vesting service earned during the Plan year by 1,000. For example, if you earn 900 hours of vesting service in a Plan year, you will receive partial credit for the Plan year of 0.9 (900 ÷ 1,000 = 0.9).

In addition, you earned one year of vesting service during the short Plan year (November 27, 2000, through December 31, 2000) if you were on the active payroll of a covered group (or on a paid leave of absence) as of November 27, 2000.

In most instances, the Plan counts all your active service as part of a covered group as vesting service. This includes periods you are on sick leave, vacation, or an authorized period of absence, as described in “Authorized Periods of Absence,” beginning on page 14.

Although leased employees are not eligible to participate in the Plan, if you are a leased employee, and you later become eligible to participate in the Plan, your service as a leased employee with a covered group will count as vesting service. If this applies to you, contact the Boeing Pension Service Center for more information.

When You Become Vested
You become vested in the Plan after you complete five years of vesting service or attain age 65 while employed and a member of the Plan, whichever occurs first. If you leave Boeing after becoming vested, at age 65 you will be entitled to 100 percent of the benefit you earned up to the time you left Boeing.

Benefit Service
Benefit service is part of the formula used to calculate the amount of your pension. You earn one year of benefit service for each Plan year in which you complete 1,800 hours of benefit service. If you complete fewer than 1,800 hours of benefit service in any Plan year, you receive one-twelfth of a year of benefit service for every 150 hours of benefit service you performed and for any remaining hours totaling 75 or more.

In most instances, the Plan counts all your active service as part of a covered group as benefit service. This includes periods you are on sick leave, vacation, or an authorized period of absence, as described in “Authorized Periods of Absence,” beginning on page 14.

In certain situations your benefit service may be lost. For instance, if you have a break in service, as described on page 15, you may lose benefit service.

Any period of service will be counted only once for the purposes of calculating years of benefit service.

Change to the Calculation of Benefit Service
In 2000, the Plan changed the way your benefit service was calculated. The date when this change applied to you depended on your covered group at that time, as shown in Exhibit 3.
Exhibit 3

Change in Benefit Service Calculation

<table>
<thead>
<tr>
<th>If you are (or were) a member of the following covered group . . .</th>
<th>How your benefit service is calculated has changed for the service you earned on or after . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>• UAW Local Nos. 148 and 1482</td>
<td>October 1, 2000</td>
</tr>
<tr>
<td>• DASO</td>
<td></td>
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<td>• IAM District Lodge No. 725</td>
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</tr>
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<td>• IUOE Local No. 501—Weldors</td>
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<tr>
<td>• IBT Local No. 848 (Firefighter Unit)</td>
<td></td>
</tr>
<tr>
<td>• IBEW Local No. 2295</td>
<td>November 27, 2000</td>
</tr>
<tr>
<td>• SPFPA Local Nos. 159 and 160</td>
<td></td>
</tr>
<tr>
<td>• AFSO Local No. 1/SPFPA</td>
<td></td>
</tr>
</tbody>
</table>

For service you earned before the date your benefit service calculation changed, you earned one hour of benefit service for each hour of work that you were directly or indirectly entitled to receive compensation. This was provided if you were regularly scheduled to work a 40-hour workweek, the third-shift equivalent, or any other work schedule deemed by the Company to be full-time employment. For service you earned on or after the date your benefit service calculation changed, you earn 45 hours of benefit service for each week for which you are paid.

**Aggregate Benefit Service**

Your eligibility for 50/30 early retirement (as described in Exhibit 8, on page 21) and certain early retirement supplements will be based on your “aggregate benefit service.” In general, your aggregate benefit service equals your years of benefit service earned under this Plan, plus any years of benefit service you may have completed as a participant in certain other Boeing-sponsored retirement plans.

For the purposes of this Plan, your aggregate benefit service will include any or all of the following:

- Your years of benefit service earned under this Plan.
- Your years of benefit service earned under The Pension Value Plan for Employees of The Boeing Company.
- Your years of benefit service earned under the Employee Retirement Income Plan of McDonnell Douglas Corporation—Hourly East Plan (“Hourly East Plan”) or the Salaried Plan (“Salaried Plan”).
- Your years of service completed under the Employee Retirement Income Plan of McDonnell Douglas Corporation—Defined Contribution and Hourly Defined Contribution Plans (“Defined Contribution Plan” and “Hourly Defined Contribution Plan”). Your years of service will be included, provided those years of service would have counted as benefit service if you had been a member of a covered group under this Plan, the Hourly East Plan, or the Salaried Plan during the same period.
• Your years of contributory service under the McDonnell Douglas Helicopter Company Retirement Plan for Salaried Employees (“Salaried Helicopter Plan”), before the date that plan merged with the Salaried Plan, or your years of contributory service under the McDonnell Douglas Helicopter Company Retirement Plan for Hourly Employees (“Hourly Helicopter Plan”).

• Your years of benefit service under the Employee Retirement Income Plan of McDonnell Douglas Corporation—ISG Plan (“ISG Plan”).

**Authorized Periods of Absence**

If you are on a leave of absence, your vesting service and benefit service may continue for a period of time, as shown in Exhibit 4 on page 15.

If you return to work for at least one day and subsequently take the same or different leave of absence, you may earn another period of benefit service and vesting service as shown in Exhibit 4 for your second leave of absence.

Two leaves of absence are considered to be consecutive if you do not return to work between the date the first leave ends and the second leave begins. Consecutive leaves of absence will be treated as a single leave. That means you earn the maximum amount of vesting service and benefit service allowed by the Plan for the leave of absence that allows you to earn the greatest amount of vesting service and benefit service. Your service is counted from the first day of your first leave of absence.

If your employment ends during a leave of absence, your vesting service and benefit service will stop on your termination date.

Vesting service and benefit service begin accumulating again according to Plan rules on the date you return from a leave of absence.

You also earn benefit service for either of the following:

• Time for which you are entitled to back pay as awarded or agreed to by the Company.
• Approved vacation, holiday, or jury duty.
<table>
<thead>
<tr>
<th>Type of leave</th>
<th>Effect on vesting service</th>
<th>Effect on benefit service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work-related medical¹</td>
<td>Continues for duration of leave</td>
<td>Continues for duration of leave</td>
</tr>
<tr>
<td>Non-work-related medical (including maternity)</td>
<td>Continues for up to two years (104 weeks)</td>
<td>Continues for up to one year (52 weeks)</td>
</tr>
<tr>
<td>Other leaves of absence such as personal, family, educational, disciplinary, or public service</td>
<td>Continues for up to one year (52 weeks)</td>
<td>Benefit service stops</td>
</tr>
<tr>
<td>Layoffs</td>
<td>Continues for up to one year (52 weeks)</td>
<td>Continues for up to one year (52 weeks)</td>
</tr>
<tr>
<td>Union business²</td>
<td>Continues for duration of leave</td>
<td>Continues for duration of leave</td>
</tr>
<tr>
<td>Subsidiary</td>
<td>Continues for duration of leave</td>
<td>Benefit service stops</td>
</tr>
<tr>
<td>Uniformed services leave</td>
<td>See “Uniformed Service,” on page 17.³</td>
<td></td>
</tr>
</tbody>
</table>

¹ To qualify for a work-related medical leave of absence, you must have sustained your disability while at work for an employing company and receive disability payments under workers’ compensation or a similar law.

² To qualify for this leave of absence, union business must be related to employees in a covered group.

³ If you entered uniformed service as a result of terrorist attacks on September 11, 2001, you will be credited with up to 180 days of benefit service regardless of whether you are hired by an employing company upon your return.

To determine your hours of vesting service and benefit service while you are on a leave of absence (or working for a company that is not an employing company, as applicable), you will be credited with 45 hours of vesting service and/or benefit service for each week during these periods.

If you took a leave of absence before the date your vesting service or your benefit service calculation changed, different rules may have applied to you. Call the Boeing Pension Service Center for details.

**Break in Service**

If you are vested, you cannot experience a break in service. You are vested in a Plan benefit after you complete five years of vesting service or you attain age 65 while employed with one year of vesting service, whichever occurs first. If you are vested, this section and “Reemployment and Service Restoration,” on page 17 do not apply to you.

If you end your employment with Boeing and you have a break in service before you are vested, you could lose your vesting service and benefit service.

Not every termination of employment results in a break in service. You will not have a break in service if your employment terminated, and you were later reemployed under one of the situations shown in Exhibit 5 on page 16.
If you did not return to employment with Boeing as described in Exhibit 5, you generally have a break in service for each Plan year that ended after your employment terminated in which you earned fewer than 501 hours of vesting service, except as described under “Break in Service During the 2001 Plan Year,” on page 17. You did not have a break in service for the Plan year in which your employment ended if you earned 501 or more hours of vesting service during that Plan year before your date of termination. (If your employment ended before December 1, 1976, a break in service generally occurred on the date your employment ended, regardless of how many hours of service you completed during the Plan year.)

You may be credited with up to 501 hours of vesting service if you terminate employment because of one of the following reasons: pregnancy, childbirth, adoption or placement for adoption of a child, caring for a child immediately following birth or adoption, or a leave under the Family and Medical Leave Act of 1993. You will be credited with these hours of vesting service in the Plan year in which your absence begins unless they are not needed to avoid a break in service for that year. In this situation, these hours of vesting service will be credited to you in the following Plan year, if needed.

If you had five or more consecutive one-year breaks in service, you may have experienced a “disqualifying break in service.” A disqualifying break in service would cause you to lose all rights to benefits in which you are not vested. For more information, see “Reemployment and Service Restoration,” on page 17.

### Restoration-of-Service Example

Assume you are laid off on February 1, 2004, with fewer than 501 hours of vesting service for the year. Because you have fewer than 501 hours, a break in service occurs for that year. If you return to work for Boeing within three years, your prior vesting service and benefit service will be restored as soon as you return to work.

### Break-in-Service Example

Assume you quit your job on February 1, 2004, with fewer than 501 hours of vesting service for the year. Because you have fewer than 501 hours, a break in service occurs for that year. If you do not return to work for Boeing before December 31, 2008 (five plan years with fewer than 501 hours), you experience a disqualifying break in service; your prior vesting service and benefit service will be lost.

If you are not vested when your employment ends and you incur a break in service, your vesting service and benefit service may be restored if you are reemployed, as explained in “Reemployment and Service Restoration,” on page 17.
Break in Service During the 2001 Plan Year

If you were credited with fewer than 501 combined hours of vesting service during the short Plan year (November 27, 2000, through December 31, 2000) and the Plan year beginning January 1, 2001, you will incur a break in service for the 2001 Plan year (January 1, 2001, through December 31, 2001).

Reemployment and Service Restoration

If you experience a break in service and your vesting service and benefit service are lost, your prior vesting service and benefit service may be restored if you are rehired by Boeing and work at least one year. Vesting service and benefit service may be restored within 90 days if you are rehired by the Company. You must be rehired as a full-time employee for benefit restoration.

If you experience a disqualifying break in service and your vesting service and benefit service are lost, your prior vesting service and benefit service may be restored within 90 days if you are rehired by the Company. You must be rehired as a full-time employee for benefit restoration.

Uniformed Service

If you take a leave because you enter the U.S. uniformed services (including the military, National Guard, and the Commission Corps of the Public Health Service) and have reemployment rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA), the time you spend in the U.S. uniformed services will be used to calculate vesting and benefit service under the Plan, in accordance with applicable law. You must meet the requirements of USERRA, including notice to Boeing, and return to employment within the prescribed time periods. For more information about how service in the uniformed services affects your pension benefit, call the Boeing Pension Service Center through Boeing TotalAccess. (See Exhibit 18, on page 48.)

Reemployment and Your Benefits

In general, if you return to work for Boeing after retiring, your monthly pension benefits (including early retirement supplement [ERS], level income special allowance [LISA], or any other supplements) will be discontinued for your period of reemployment. However, your benefit payments will not be suspended if you were employed by Boeing on August 1, 1997, and continued to be employed with Boeing until you retired.

In general, any additional Plan benefit you earn following your rehire date will depend on how long you are reemployed and whether you were receiving benefits when you were reemployed, as shown in Exhibit 6.
### Exhibit 6

#### Benefits if You Are Reemployed

<table>
<thead>
<tr>
<th>If you retire or end your employment but are later reemployed on a full-time basis (or the third-shift equivalent) for . . .</th>
<th>If you were receiving benefits when you were reemployed, your benefit when you retire again generally will be . . .</th>
<th>If you were not receiving benefits when you were reemployed, your benefit when you retire again generally will be . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer than 365 days(^1)</td>
<td>The benefit you were eligible to receive when you originally retired, plus an additional amount based on the benefit service you earned while you were reemployed(^2)</td>
<td>The benefit you were eligible to receive when you originally terminated, plus an additional amount based on the benefit service you earned while you were reemployed</td>
</tr>
<tr>
<td>365 days or more(^3), (^4), (^5)</td>
<td>The benefit calculated when your reemployment ends based on your service for both periods of employment (^2)</td>
<td>The benefit calculated when your reemployment ends based on your service for both periods of employment (^6)</td>
</tr>
</tbody>
</table>

\(^1\) In general, if you are reemployed for fewer than 365 days, the Plan provisions in effect on your latest retirement date only will apply to the benefits earned during your reemployment. The same reduction factors will apply to the benefits accrued before your reemployment. The reduction factors that apply to any additional benefits you accrued during your reemployment depend on your situation when you subsequently retire. In addition, you may elect a new form of payment when you subsequently retire. Special cases may apply when determining the 365-day period in the event of layoff or death. For more information on how your benefits will be calculated after reemployment, call the Boeing Pension Service Center.

\(^2\) If you originally elected the accelerated income option or level income option (if available) when you retired, your monthly payment will be reduced by the value at your subsequent retirement date of the accelerated income amount or level income amount paid to you from your original retirement date until the date you were rehired, based on your life expectancy determination.

\(^3\) In general, if you are reemployed for 365 days or more, your benefits will be determined based on the Plan provisions in effect on your latest retirement date without regard to your original retirement. In addition, any early retirement reduction factor applied to your benefit earned during your reemployment (as explained in “Reductions for Early Retirement,” beginning on page 22) will be based on your age when your period of reemployment ends. For more information on how your benefits will be calculated after reemployment, call the Boeing Pension Service Center.

\(^4\) You will have satisfied the continuous 365-day reemployment requirement if you were reemployed on or after November 29, 1999, and before November 27, 2000, and you remained on the active payroll of a covered group as of November 27, 2000.

\(^5\) If you meet the requirements for a different type of benefit (that is, early, normal, or late retirement instead of deferred vested), you will be eligible for that new type of benefit.

\(^6\) If you were reemployed under the circumstances described in Exhibit 5, on page 16, and you were not receiving a benefit when reemployed, your benefit will be recalculated when you subsequently terminate as if you had not originally terminated your employment.

If you were receiving ERS or LISA (as described beginning on page 23) when you were reemployed, it will stop during your period of reemployment. When you retire again, you may continue receiving ERS or LISA if you continue to meet the age and service requirements and subsequently retire from a covered group. If you are reemployed for fewer than 365 days, your ERS or LISA will be based on Plan provisions in effect when you originally retired.

If you were not receiving benefits when you were reemployed, you will not be eligible to receive ERS or LISA if you worked fewer than 365 days, even if you meet the age and service requirements when your reemployment ends. However, if you worked more than 365 days or were reemployed under the circumstances described in Exhibit 5, on page 16, and were not receiving benefits, you may receive ERS or LISA if you qualify for an early retirement supplement.
Regardless of whether you were receiving benefits when you were reemployed, if you work 365 days or more or if your reemployment ends due to layoff, your ERS or LISA will be the greater of either of the following:

- The benefit based on Plan provisions in effect when you originally retired.
- The benefit based on Plan provisions in effect when you retire.

If you die while you are reemployed, your spouse may be eligible for a preretirement survivor benefit. (See page 39.)

Benefits

Your Plan benefit is based on a flat dollar amount per month per year of benefit service earned while you were employed with a covered group. This flat dollar amount will vary depending on your covered group and the date your employment ends, as shown in Exhibit 7. If you are vested and ended your employment before the date shown for your covered group, the flat dollar amount you are entitled to receive from the Plan may be different. Contact the Boeing Pension Service Center for more information.

<table>
<thead>
<tr>
<th>Covered group</th>
<th>For terminations on or after</th>
<th>Flat dollar amount per year of benefit service</th>
</tr>
</thead>
<tbody>
<tr>
<td>IAM District Lodge No. 725</td>
<td>March 1, 2006</td>
<td>$68 per month</td>
</tr>
<tr>
<td>DASO</td>
<td>March 1, 2006</td>
<td>$68 per month</td>
</tr>
<tr>
<td>IUOE Local No. 501—Weldors</td>
<td>March 1, 2006</td>
<td>$68 per month</td>
</tr>
<tr>
<td>UAW Local Nos. 148 and 1482</td>
<td>June 1, 2004</td>
<td>$60 per month</td>
</tr>
<tr>
<td>IBT Local No. 848</td>
<td>March 1, 2006</td>
<td>$68 per month</td>
</tr>
<tr>
<td>IBEW Local No. 2295</td>
<td>December 1, 2002</td>
<td>$58 per month</td>
</tr>
<tr>
<td>SPFPA Local No. 159</td>
<td>March 1, 2006</td>
<td>$68 per month</td>
</tr>
<tr>
<td>SPFPA Local No. 160</td>
<td>January 1, 2002</td>
<td>$50 per month</td>
</tr>
<tr>
<td>AFSO Local No. 1/SPFPA</td>
<td>January 1, 2002</td>
<td>$50 per month</td>
</tr>
</tbody>
</table>

Example

Assume you were born on August 1, 1940. You retire at age 65 on August 1, 2005, and are entitled to a flat dollar amount of $58 per month per year of benefit service. You have 30 years of benefit service. You choose a single life annuity as the payment option. Your pension benefit under the Plan’s benefit formula would be calculated as follows:

\[
\text{Years of benefit service} \\times \frac{30}{\text{Flat dollar amount (varies by covered group) \times $58}} = \text{Monthly benefit*}
\]

* This amount will be reduced if you retire before age 62, if you retire with fewer than 30 years of aggregate benefit service, or if you choose a payment option other than single life annuity.

Note: Effective for terminations on or after March 1, 2006, the nonrepresented benefit rate is $70 for pension payments received on or after July 1, 2006.
If you are currently a member of a covered group, and you stop being eligible because you transfer to an affiliate or subsidiary of Boeing that has not adopted the Plan, you still will be eligible for any future increases to the flat dollar amount for the covered group in which you most recently worked. However, you will not be eligible for any future increases to the flat dollar amount after you end your employment with Boeing.

**Maximum Plan Benefit**

The Internal Revenue Service (IRS) establishes the maximum annual benefits payable under this Plan. For 2006, the maximum annual benefit is $210,000. This benefit may be reduced for early retirement and the payment option you elect. In addition, contributions to other plans can affect certain limits. If the limits are exceeded, benefits under the plans may be reduced.

**When You May Retire**

**Normal Retirement—Age 65**

Normal retirement age is 65. You are eligible for normal retirement benefits on the first day of the month coinciding with or following your 65th birthday. For example, if your 65th birthday is March 1, you are eligible for normal retirement benefits on March 1. However, if your birthday is March 20, you will be eligible for normal retirement benefits on April 1.

You may retire before or after your normal retirement date, depending on your age and years of service, as described in the following sections.

**Early Retirement—Ages 50 to 65**

In general, you may retire as early as age 55 under the Plan if you have at least 10 years of vesting service. However, you may retire as early as age 50 if you have 30 or more years of aggregate benefit service and you are a member of certain covered groups, as described on page 21. If you are eligible for early retirement but are laid off before you elect to retire, you may be eligible for a more favorable early retirement benefit if you begin receiving payments within certain time periods following your layoff date. See “Retirement From Layoff Status,” on page 28 for details.

If you elect to retire early on your 50th or 55th birthday, and that birthday falls on the first day of any month, you will be deemed to have attained age 50 or age 55 (as applicable) on the last working day of the prior month. In general, your early retirement benefits will begin on the first day of the month following the month in which you filed the Commencement Election form. For example, if you file your written election for benefits on February 10, your retirement will take effect on March 1.

If you do not elect early retirement by the first day of the month following the date your employment ends, you will not be eligible for early retirement unless you were laid off. (See “Retirement From Layoff Status,” on page 28.) If this applies to you, you will become eligible for a deferred vested benefit. For more information, see “Deferred Vested Retirement Reduction Factors,” on page 22.

In general, if you retire directly from Boeing and begin receiving your Plan benefit before age 65, your payment will be reduced using the early retirement reduction factor appropriate for your situation. This adjustment is made to your early retirement benefit because payments are expected to continue over a longer period of time. The amount of the Plan benefit you receive will be reduced for each year (or partial year) your retirement date precedes your attainment of age 62, as shown in Exhibit 9, on page 22.
### Exhibit 8

**Early Retirement Benefits**

<table>
<thead>
<tr>
<th>If your age is between . . .</th>
<th>And you have . . .</th>
<th>And you were . . .</th>
<th>Then your monthly benefit payable at retirement will be . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>50–62</td>
<td>30 or more years of aggregate benefit service</td>
<td>A member of IAM Local No. 725, SPFPA Local No. 159, SPFPA Local No. 160 or AFSO Local No. 1/SPFPA*</td>
<td>An immediate benefit based on your years of benefit service. You may qualify for Early Retirement Supplement (ERS) of $550 per month ($500 for SPFPA Local No. 160) if you retire as an active employee of this plan. Your payments will not be reduced to reflect your age at the time benefits begin.</td>
</tr>
<tr>
<td>55–62</td>
<td>30 or more years of aggregate benefit service</td>
<td>A member of IUOE Local No. 501—Weldors, IBEW Local No. 2295, UAW Local No. 148, UAW Local No. 1482, IBT Local No. 848, or DASO</td>
<td>An immediate benefit based on your years of benefit service, but may be reduced to reflect your age at the time benefits begin (see “Reductions for Early Retirement,” in the following section).</td>
</tr>
<tr>
<td>55–65</td>
<td>10 or more years of vesting service</td>
<td>A plan member</td>
<td>An immediate benefit based on your years of benefit service. You may be eligible for a Level Income Special Allowance (LISA) benefit if you retire as an active employee of the Plan. Your payments will be reduced to reflect your age at the time benefits begin, based on the LISA reductions (see Exhibit 12, on page 26, for details).</td>
</tr>
<tr>
<td>60–62</td>
<td>20 but fewer than 30 years of aggregate benefit service</td>
<td>All covered groups</td>
<td>An immediate benefit based on your years of benefit service. You may be eligible for a Level Income Special Allowance (LISA) benefit if you retire as an active employee of the Plan. Your payments will be reduced to reflect your age at the time benefits begin, based on the LISA reductions (see Exhibit 12, on page 26, for details).</td>
</tr>
</tbody>
</table>

* If you formerly were a member of one of these covered groups and earned a benefit under the Plan, but later transferred to a covered group that does not offer 50/30 early retirement, you still may qualify to retire under this section. If you retire before age 55, your monthly payment will be based on the benefit you earned with the applicable covered group offering 50/30 early retirement. On or after your attainment of age 55, your benefit will be based on your entire benefit under the Plan, as adjusted for the form of payment you select.

**Note:** Hourly nonrepresented participants may be eligible for 50/30 but not for ERS or LISA.
Reductions for Early Retirement

In general, if you elect to retire early, your accrued benefit may be reduced. The reduction factor that applies depends on whether you retire from Boeing or terminate your employment and defer receiving retirement benefits until a later date.

Early Retirement Reduction Factors. If you retire from Boeing, your benefit reduction will be determined based on your age at retirement, as shown in Exhibit 9.

<table>
<thead>
<tr>
<th>Age at Retirement</th>
<th>Reduction Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>55</td>
<td>58.00</td>
</tr>
<tr>
<td>56</td>
<td>64.00</td>
</tr>
<tr>
<td>57</td>
<td>70.00</td>
</tr>
<tr>
<td>58</td>
<td>76.00</td>
</tr>
<tr>
<td>59</td>
<td>82.00</td>
</tr>
<tr>
<td>60</td>
<td>88.00</td>
</tr>
<tr>
<td>61</td>
<td>94.00</td>
</tr>
<tr>
<td>62</td>
<td>100.00</td>
</tr>
<tr>
<td>63</td>
<td>100.00</td>
</tr>
<tr>
<td>64</td>
<td>100.00</td>
</tr>
<tr>
<td>65</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Example

Assume you were born on August 1, 1945. You retire from Boeing at age 60 on August 1, 2005, and you have a flat dollar amount of $58 per month per year of benefit service. You have 15 years of benefit service. Your accrued monthly benefit under the Plan is $870. You choose a single life annuity as the payment option. Your monthly early retirement benefit under the Plan would be calculated as follows:

Flat dollar amount (varies by covered group) $58
Years of benefit service in the Hourly West Plan $ \times 15$
Monthly benefit $870
Early retirement reduction factor $ \times 0.88$

Monthly Early Retirement Benefit** $766$

* The percentages shown here are based on whole ages. Your benefit will be based on your age in years and completed months.

** This amount will be reduced further if you choose a payment option other than a single life annuity.

Deferred Vested Retirement Reduction Factors. If you end your employment with Boeing before electing early retirement, your deferred vested benefit will be reduced using the reduction factors shown in Exhibit 10 on page 23. These reductions are more substantial than the early retirement reduction factors.
**Exhibit 10**

### Deferred Vested Retirement Reduction Factors

The following chart shows the percentage of your benefit payable based on your age when your benefits begin.

<table>
<thead>
<tr>
<th>Age at Retirement *</th>
<th>55</th>
<th>56</th>
<th>57</th>
<th>58</th>
<th>59</th>
<th>60</th>
<th>61</th>
<th>62</th>
<th>63</th>
<th>64</th>
<th>65</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>45.73</td>
<td>48.98</td>
<td>52.55</td>
<td>56.48</td>
<td>60.83</td>
<td>65.66</td>
<td>71.04</td>
<td>77.05</td>
<td>83.80</td>
<td>91.40</td>
<td>100.00</td>
</tr>
</tbody>
</table>

**Example**

Assume you were born on August 1, 1960. You end your employment with Boeing at age 45 on August 1, 2005, and you have a flat dollar amount of $58 per month per year of benefit service. You have 15 years of benefit service. Your accrued monthly benefit under the Plan is $870. If you elect to start receiving your Plan benefits at age 62 and choose a single life annuity as the payment option, your monthly early retirement benefit under the Plan would be calculated as follows:

- Flat dollar amount (varies by covered group) $58
- Years of benefit service in the Hourly West Plan $15
- Monthly benefit $870
- Deferred vested retirement reduction factor $0.7705
- **Monthly Early Retirement Benefit** = $670

* The percentages shown here are based on whole ages. Your benefit will be based on your age in years and completed months.

** This amount will be reduced further if you choose a payment option other than a single life annuity.

### Early Retirement Supplement (ERS)

You may retire early and receive ERS in addition to your Plan benefit if one of the following applies to you:

- You are between the ages of 55 and 62 (if you are represented by UAW Local No. 148, UAW Local No. 1482, IBT Local No. 848, DASO, IBEW 2295, or IUOE Local No. 501—Weldors).
- You are between the ages of 50 and 62 (if you are represented by IAM District Lodge No. 725, SPFPA Local No. 159, SPFPA Local No. 160, or AFSO Local No. 1/SPFPA).

In addition, to be eligible for ERS, both of the following must apply to you:

- You have 30 or more years of aggregate benefit service.
- You are a member of a covered group under the Plan.

The amount of your ERS depends on the covered group from which you retire as shown in Exhibit 11 on page 24. This amount is provided in addition to the early retirement benefits you are eligible to receive under the Plan. If you retired before the effective date shown in Exhibit 11, your ERS payment may be different.
Early Retirement Supplement (ERS) Effective Dates

<table>
<thead>
<tr>
<th>Covered group</th>
<th>Effective for early retirements beginning on or after</th>
<th>ERS amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>• AFSO Local No. 1/SPFPA • SPFPA Local No. 160</td>
<td>February 1, 2002</td>
<td>$500</td>
</tr>
<tr>
<td>• IBEW Local No. 2295 • IAM District Lodge Local No. 725 • DASO • IUOE Local No. 501—Weldors • SPFPA Local No. 159</td>
<td>January 1, 2003</td>
<td>$550</td>
</tr>
<tr>
<td>• UAW Local Nos. 148 and 1482 • IBT Local No. 848</td>
<td>May 1, 2000</td>
<td>$550</td>
</tr>
</tbody>
</table>

In general, you will continue to receive a monthly ERS payment from the date of retirement to the earliest of the following:

- The date you attain age 62. (The ERS supplement can be extended up to age 62 and two months if you retire from a covered group represented by IBT Local No 848, and age 62 and six months if you retire from UAW Local No. 148 or UAW Local No. 1482. You must provide the Plan Administrator with a notarized certification that you are not receiving Social Security benefits reduced for age to extend beyond age 62.)
- The date you die.
- The date you are rehired by Boeing.

Once you are no longer eligible to receive ERS payments, the Plan will pay only the early retirement benefit you have earned, in the form you selected when you retired.

The following example shows how your benefit will be paid if you qualify to receive ERS when you retire.
Early Retirement Benefit Example
With an Early Retirement Supplement (ERS)

Assume you were born on August 1, 1950. You retire from a covered group at age 55, on August 1, 2005. You have 30 years of benefit service in the Hourly West Plan. You are entitled to a flat dollar amount of $58 per year of benefit service, and ERS payments of $550 per month. You choose a single life annuity as the payment option. Your monthly pension benefit under the Plan’s benefit formula with an ERS would be calculated as follows:

| Years of benefit service in the Hourly West Plan | 30 |
| Flat dollar amount (varies by covered group) | x | $58 |
| Early retirement benefit | $1,740 |
| Early retirement supplement (varies by covered group) | + | $550 |
| **Monthly early retirement payment** | **$2,290** |
| (generally payable until age 62)* |
| **Monthly early retirement payment** | **$1,740** |
| (generally payable after age 62)* |

* This amount will be reduced further if you choose a payment option other than single life annuity. You may not elect the accelerated income option when you retire with an ERS.

You may not receive LISA, as described in the following section, if you qualify to receive ERS payments. In addition, you may not receive ERS if you elect the accelerated income option, as described on page 37, or if you elect disability retirement.

Generally, if you retired early with ERS and you became eligible for Social Security disability benefits before January 1, 2001, your ERS payments will cease effective on the first day of the month in which you became eligible for Social Security disability benefits. If your disability is determined to be retroactive, you will be required to repay the ERS payments made to you after your disability date. You can repay your ERS payments in a single, lump-sum payment, or your disability benefit payments may be reduced to account for the ERS payments already received.

**Level Income Special Allowance (LISA)**

You may retire early and receive LISA in addition to your Plan benefit if all of the following apply to you:

- You are between the ages of 60 and 62.
- You have 20 years, but fewer than 30 years, of aggregate benefit service.
- You are a member of a covered group under the Plan.

The amount of your LISA depends on the covered group from which you retire. This amount is provided in addition to the early retirement benefits you are eligible to receive under the Plan. In addition, the early retirement reduction that applies to your Plan benefit is shown in Exhibit 12, on page 26, under “Reductions for Early Retirement With LISA.” If you retired before the effective date shown in Exhibit 12, your LISA payment and the reductions that apply to your monthly benefit payment may be different.
Exhibit 12

Level Income Special Allowance (LISA) Effective Dates

<table>
<thead>
<tr>
<th>Covered group</th>
<th>Effective for early retirements beginning on or after</th>
<th>LISA amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>• AFSO Local No. 1/SPFPA</td>
<td>February 1, 2002</td>
<td>$500</td>
</tr>
<tr>
<td>• SPFPA Local No. 160</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• IBEW Local No. 2295</td>
<td>January 1, 2003</td>
<td>$550</td>
</tr>
<tr>
<td>• IAM District Lodge No. 725</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• DASO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• IUOE Local No. 501—Weldors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• SPFPA Local No. 159</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• IBEW Local No. 2295</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• IAM District Lodge No. 725</td>
<td></td>
<td></td>
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<tr>
<td>• DASO</td>
<td></td>
<td></td>
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<tr>
<td>• IUOE Local No. 501—Weldors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• SPFPA Local No. 159</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• UAW Local Nos. 148 and 1482</td>
<td>May 1, 2000</td>
<td>$550</td>
</tr>
<tr>
<td>• IBT Local No. 848</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reductions for Early Retirement With LISA

If you elect to retire with LISA, your accrued benefits are reduced to reflect your age at the time payments begin. The following percentages generally will determine the amount of your payment.

<table>
<thead>
<tr>
<th>Age at Retirement*</th>
<th>Percentage of Earned Benefit Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>62</td>
<td>100.00</td>
</tr>
<tr>
<td>61</td>
<td>96.00</td>
</tr>
<tr>
<td>60</td>
<td>92.00</td>
</tr>
</tbody>
</table>

* The percentages shown here are based on whole ages. Your benefit will be based on your age in years and full months at the time of your retirement.

In general, you will receive a monthly LISA from your date of retirement to the earliest of the following:

- The date you attain age 62. (The LISA supplement can be extended up to age 62 and two months if you retire from a covered group represented by IBT Local No 848, and age 62 and six months if you retire from UAW Local No. 148 or UAW Local No. 1482. You must provide the Plan Administrator with a notarized certification that you are not receiving Social Security benefits reduced for age to extend beyond age 62.)
- The date you die.
- The date you are rehired by Boeing.

Once you are no longer eligible to receive LISA payments, the Plan will pay only the early retirement benefit you have earned, in the form you selected when you retired.

The following example shows how your benefit will be paid if you qualify to receive LISA when you retire.
Early Retirement Benefit Example
With Level Income Special Allowance (LISA)

Assume you were born on August 1, 1945. You retire from a covered group at age 60, on August 1, 2005. You have 20 years of benefit service in the Hourly West Plan. You are entitled to a flat dollar amount of $58 per year of benefit service, and LISA payments of $550 per month. You choose a single life annuity as the payment option. Your monthly pension benefit under the Plan’s benefit formula with LISA would be calculated as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>Calculation</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years of benefit service in the Hourly West Plan</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Flat dollar amount (varies by covered group)</td>
<td>× $58</td>
<td></td>
</tr>
<tr>
<td>Monthly benefit</td>
<td></td>
<td>$1,160</td>
</tr>
<tr>
<td>Early retirement adjustment</td>
<td>× 0.92</td>
<td></td>
</tr>
<tr>
<td>Early retirement benefit</td>
<td></td>
<td>$1,067</td>
</tr>
<tr>
<td>Level income special allowance (varies by covered group)</td>
<td>+ $550</td>
<td></td>
</tr>
</tbody>
</table>

**Monthly Early Retirement Payment (generally payable until age 62)**

$1,617

**Monthly Early Retirement Payment (generally payable after age 62)**

$1,067

* This amount will be reduced further if you choose a payment option other than single life annuity. You may not elect the accelerated income option when you retire with LISA.

You may not receive LISA with your early retirement benefit if you receive an ERS, as described in the prior section. In addition, you may not receive LISA if you elect the accelerated income option, as described on page 37, or if you elect disability retirement.

Generally, if you retired early with LISA and you became eligible for Social Security disability benefits before January 1, 2001, your LISA payments will cease effective on the first day of the month in which you became eligible for Social Security disability benefits. If your disability is determined to be retroactive, you will be required to repay the LISA payments made to you after your disability date. You can repay your LISA payments in a single, lump-sum payment, or your disability benefit payments may be reduced to account for the LISA payments already received.

**Late Retirement—After Age 65**

The Plan provides for a late retirement benefit if you continue to work after the end of the month in which you reach age 65. You may elect to retire at any time thereafter. Your benefit will be calculated in the same manner as a normal retirement benefit. If you terminate employment after age 65, you will be eligible to start receiving benefits immediately. Contact the Boeing Pension Service Center to start receiving your benefits.

**If You Continue Working After Age 65**

If you continue working for the Company in a covered group after age 65, you will continue to earn years of benefit service under the Plan. You will not begin to receive benefit payments until the earlier of the first day of the month on or after the date you retire from Boeing or your age 70½ distribution date, as described in the following section.

If you work for Boeing after age 65, you will experience what the U.S. Department of Labor considers a “suspension of benefits” and will receive a notice from Boeing regarding this suspension. This means that during the period you work between the ages of 65 and your age 70½ distribution date, you will not receive pension benefits even though you will still be
eligible to retire and could elect to receive your benefits if you did. In general, your benefits will not begin before your age 70½ distribution date unless you end your employment with Boeing.

**Age 70½ Distribution Date**

Effective January 1, 2001, under the terms of the Plan, benefits under the Plan must begin as of April 1 following the calendar year in which you reach age 70½, even if you are still working for Boeing. This is your age 70½ distribution date. For example, if you reached age 70½ in November 2000, you would have started receiving your benefits on April 1, 2001 (the year this provision took effect).

If you are an active employee on your age 70½ distribution date, you will begin receiving a monthly benefit equal to your accrued benefit under the Plan, payable in the form of a single life annuity. However, you may elect the life and 10-year period certain option. Under this option, your payments will be made in the form of a single life annuity while you are working. In the event you die while actively employed, your beneficiary will receive adjusted payments based on the period certain you elected.

If you continue to work past your age 70½ distribution date, you will continue to earn benefit service until the last day of the Plan year before you retire. At the end of each Plan year (and when you terminate your employment), your benefit will be recalculated to reflect the benefit service you earned during the prior Plan year and the payments you have received since your age 70½ distribution date. If your benefit increases because of this annual recalculation, you will receive the greater benefit on January 1 of the following year (or the first day of the month next following your termination). If the net effect of this recalculation would reduce your benefit, there will be no change in your benefit payment amount. When you retire, you may elect to receive your benefit in any form of payment available under the Plan.

If you die after age 70½ but while actively employed by Boeing, your spouse (if you have one) automatically will receive a monthly benefit equal to a 55 percent surviving spouse option, calculated as if you had ended your employment and commenced benefits as of the first day of the month following the date of your death. However, if you originally elected the life and 10-year period certain option when you attained age 70½, your beneficiary will receive adjusted monthly payments beginning on the first of the month following your date of death, and ending at the end of the period certain you elect.

Before you become eligible for an age 70½ distribution, the Plan Administrator will notify you about the forms of payment for which you are eligible and the amount of your benefit. If you attained age 70½ before January 1, 2001, different rules regarding your age 70½ distribution date applied to you. For more information, contact the Boeing Pension Service Center.

**Retirement From Layoff Status**

If you are laid off by Boeing and meet certain requirements, you may retire and be treated as if you retired directly from Boeing. The Plan provisions that apply to you depend on your age and years of service when you are laid off.

**Layoff After Age 50 or 55**

You may elect early retirement anytime within five years of your layoff date, unless you become eligible for and elect normal or late retirement benefits, if you

- Are at least age 55 and have 10 or more years of vesting service on your layoff date.
- Are at least age 50 and have 30 or more years of aggregate benefit service, and you are a member of certain covered groups, as described on page 21.
Your benefits will begin on the first day of the month following the month in which you elect early retirement benefits. If you do not elect to retire within five years of your layoff date and you are not eligible for normal or late retirement benefits, you will be eligible for a deferred vested benefit.

If you are age 60 or older and have 10 or more years of vesting service on your layoff date, you may retire from layoff status with a normal retirement benefit when you attain age 65, unless you elect early retirement benefits. If you retire with a normal retirement benefit, your benefit will begin on the first day of the month coinciding with or next following your 65th birthday.

If your layoff occurs on or after the date you reach age 65, or you reach age 65 within five years of your layoff date, contact the Pension Service Center through Boeing TotalAccess for more information.

**Early Retirement Supplements During Layoff**

If you are laid off, you may be eligible to receive an early retirement supplement in addition to your monthly early retirement benefit. To be eligible for ERS, you must satisfy the age and service eligibility requirements on the date you are laid off. You also may defer your early retirement, but not later than five years from your layoff date.

You may become eligible for LISA if all of the following apply to you:

- You are eligible for retirement at the time of your layoff.
- You have completed at least 20 years of aggregate benefit service when you begin your benefit payments.
- You elect early retirement between the ages of 60 and 62, and you do so within five years of your layoff date.

See “Early Retirement Supplement (ERS),” on page 23, and “Level Income Special Allowance (LISA),” on page 25, for more information.

**Special Layoff Provisions for Certain Participants**

In certain situations if you have a nonrepresented benefit in this Plan, you may become eligible for early retirement from a layoff. To qualify for the special Plan layoff provisions, you must meet three criteria: age and service requirements, the date of your layoff, and your membership in certain other covered groups at the time of your layoff. However, regardless of your age when you qualify for this special layoff, you may not begin receiving monthly benefit payments before you attain age 55.

1. **Age and Service Requirements**

   To qualify for the special Plan layoff provisions, you must meet one of the following age and service requirements:
   - You must be at least age 50, but not yet age 55, on your layoff date, and you must have 10 or more years of vesting service.
   - You may be under age 50 on your layoff date, but your age plus your years of vesting service under the Plan must equal 75 or greater at layoff.

2. **Date of Layoff**

   In addition to meeting the age and service requirements for the special Plan layoff provisions, your layoff date must be on or after January 1, 1990.

3. **Membership in Certain Other Covered Groups on Your Layoff Date**

   In addition to meeting Plan requirements regarding age and service and the date of your layoff, your benefit under this plan must be a nonrepresented benefit.
You can postpone receiving retirement benefits. However, retirement benefits must begin no later than age 65.

**Disability Retirement**

You may qualify for disability retirement benefits if you become permanently and totally disabled while an active employee of Boeing or while on an approved leave of absence. Permanent and total disability means you have an illness or injury that is expected to prevent you from engaging in regular employment for compensation or profit for the rest of your life. You may be eligible to receive disability retirement benefits if you meet all of the following conditions:

- You have not yet attained age 65.
- You have a permanent and total disability that began before your termination.
- You have been unable to work for medical reasons for six consecutive months. (A return to active employment for fewer than 10 regularly scheduled workdays will not interrupt this period.)
- You have 10 or more years of vesting service under the Plan.
- Effective as of the applicable dates in Exhibit 13, you must receive a Social Security Disability Award.
- You terminate your employment with Boeing.
- You apply for Disability Retirement within 365 days of your termination date.
Exhibit 13

Determination of Disability

To receive a disability retirement benefit under the Plan, hourly nonrepresented members and members of all other covered groups must receive a determination from the Social Security Administration that their disability is permanent and total in addition to meeting the other requirements to receive a disability benefit. If your disability leave began before the dates listed in this exhibit, a determination of your total and permanent disability may be made by either the Company’s group insurance carrier or the Social Security Administration.

<table>
<thead>
<tr>
<th>Covered group</th>
<th>Effective for disability leaves beginning on or after</th>
</tr>
</thead>
<tbody>
<tr>
<td>IAM District Lodge No. 725</td>
<td>October 25, 1999</td>
</tr>
<tr>
<td>• DASO</td>
<td></td>
</tr>
<tr>
<td>• IUOE Local No. 501—Weldors</td>
<td>October 1, 2000</td>
</tr>
<tr>
<td>IBEW Local No. 2295</td>
<td>November 27, 2000</td>
</tr>
<tr>
<td>• SPFPA Local No. 159</td>
<td></td>
</tr>
<tr>
<td>• SPFPA Local No. 160</td>
<td>January 1, 2002</td>
</tr>
<tr>
<td>• AFSO Local No. 1/SPFPA</td>
<td></td>
</tr>
<tr>
<td>IBT Local No. 848</td>
<td>January 1, 2003</td>
</tr>
<tr>
<td>UAW Local 148 and Local 1482</td>
<td>June 1, 2004</td>
</tr>
</tbody>
</table>

You generally must apply for disability retirement benefits within 365 days following the date your employment ended due to the disability. You may apply for disability benefits more than 365 days following the date your employment ended if your disability is due to a mental incapacity that a doctor determines to have prevented you from applying within the 365-day application period.

Your disability retirement benefits begin on the first of the month after the later of one of the following events:

• You have not worked for six months for medical reasons.
• You have applied for disability retirement.

Disability retirement payments consist of your accrued benefits. If you are single, your disability benefit will be paid as a single life annuity. If you are married, your disability benefit generally will be paid as a 55 percent surviving spouse annuity, unless you elect otherwise. (You may not receive your disability retirement benefit under the life and 10-year period certain option or the accelerated income option.) Payments are not reduced based on your age when benefits begin, although the surviving spouse annuity payments will be actuarially reduced based on your age and your spouse’s age.
While you are receiving disability retirement benefits, the Company may ask you to provide proof that you are receiving Social Security disability benefits. Your disability retirement benefits may be forfeited if you do not submit the proof requested. You will receive monthly disability payments until the earliest of the following:

- Your disability ceases to be permanent and total.
- You become gainfully employed (other than for the purposes of rehabilitation).
- You elect early retirement benefits.
- You fail to provide proof that you are receiving Social Security disability benefits.
- You attain age 65.

Once you attain age 65, your monthly disability benefit will be converted to a normal retirement benefit. You will continue to be paid in accordance with the payment method you elected for your disability retirement benefit.

**Conditional Early Retirement**

If you are eligible to retire when your employment ends because of disability and have filed for Social Security disability benefits, you may request conditional early retirement benefits, not including an ERS or LISA, until your disability retirement benefits begin. Also, you may not elect the accelerated income option or the life and period certain option forms of payment.

If you subsequently are determined to be permanently and totally disabled, your benefit will be converted from an early retirement benefit to a disability retirement benefit, payable retroactive to the date you first met the conditions for disability retirement. This means your benefit payments will no longer be reduced based on your age. The total amount of conditional early retirement benefits paid to you will be subtracted from the total amount of retroactive disability benefits due to you. The difference will be paid to you in a lump-sum payment, and you will receive your monthly disability benefit thereafter as long as you remain eligible. If your application for disability retirement benefits is not approved, you will continue to receive early retirement benefits.

**If Your Disability Retirement Benefits End**

If you are eligible to elect early retirement because your disability retirement benefits end, your application for early retirement benefits must be received within 60 days after the date of notice informing you your disability retirement benefits will end. However, after you begin receiving your early retirement benefits, you will receive disability retirement benefits retroactive to the date they stopped if both of the following apply to you:

- You subsequently become disabled from the same condition that caused your earlier disability.
- The Plan determines your disability has been continuous. In this case, the amount payable will be reduced by the amount of early retirement benefits paid to you.

If your disability retirement benefits end after you reach age 55, but before you reach age 65, you may apply for a deferred vested benefit if either of the following applies to you:

- You were not eligible for early retirement benefits when you retired.
- You were eligible for, but did not elect, early retirement benefits within 60 days after receiving notice that your disability retirement benefits would end.

Deferred vested benefits begin on the first day of the month after your written application is received, but not before your disability retirement benefits end.
If you begin receiving deferred vested benefits and the Plan again determines you have been continuously disabled from the same conditions that caused the initial disability, you will receive disability retirement benefits. Your benefits will be retroactive to the date they stopped. The amount payable will be reduced by the amount of the deferred vested benefit paid to you. If your disability payments end before or after you attain age 55, but you do not elect early retirement or deferred vested benefits at that time, you will continue to be eligible for deferred vested benefits. See “If You Leave Before Retirement,” next.

If you return to work at Boeing after your disability ends and you subsequently terminate or retire, your retirement benefits will be calculated as if no disability retirement benefits had been paid to you.

**If You Leave Before Retirement**

If you stop working for Boeing before you become eligible to retire, but after you become vested, you may claim the vested benefits you have earned once you reach early or normal retirement age. If you ended your employment on or after November 27, 2000, you may choose from the same payment options listed under “Benefit Payments,” next. If you ended your employment before November 27, 2000, the payment options available to you may be different. The Boeing Pension Service Center must receive your completed Commencement Election form before your intended benefit commencement date.

You may claim vested benefits before normal retirement (age 65), but the benefits will be reduced according to the reductions shown in Exhibit 10, on page 23, to account for the longer time over which your Plan benefit may be paid. This reduction for deferred vested benefits is substantially greater than the reduction applied to benefits of active employees retiring from Boeing. For more information about these benefit reductions, contact the Boeing Pension Service Center through Boeing TotalAccess.

Because important information about the Plan and your vested benefits may be mailed to you from time to time, you must notify Boeing TotalAccess whenever your address changes, even if you are not yet receiving benefits.

**Benefit Payments**

The payment methods available under the Plan include

- A single life annuity.
- A 55 percent surviving spouse annuity, if you are married.
- A life and 10-year period certain option.
- An accelerated income option.

If you do not choose a payment method, the Plan automatically will pay your benefit as a single life annuity if you are single or as a 55 percent surviving spouse annuity if you are married.

In general, you may not change the method of payment following your benefit commencement date.

If you are a former participant in the Employee Savings Plan of McDonnell Douglas Company—Hourly West Plan (“Savings Plan”) whose benefit merged into this Plan on November 18, 1996, the forms of payment you may select for your Fund E savings benefit may be different than as described in this section. See “Payment of Your Fund E Savings Benefit” in the Appendix, on page 49, for more details.
Single Life Annuity
Under this payment method, you will receive a monthly benefit payment for the rest of your lifetime. No benefit payments are made after your death.

If you are married and want to elect this option, you must have your spouse’s written consent on your Commencement Election form and have it witnessed by a notary public.

If you elect this option and later marry (or remarry) after benefit payments have begun, you may change your form of payment from a single life annuity to the 55 percent surviving spouse annuity option. For more information, see “Postretirement Surviving Spouse Option,” below.

55 Percent Surviving Spouse Option
You must be married to receive the 55 percent surviving spouse option, which also is known as a “joint and survivor annuity.” Under this payment method, you will receive a monthly benefit payment for the rest of your life. If you die before your spouse dies, your surviving spouse will receive 55 percent of your monthly benefit for life.

Because the Plan is paying a benefit over the lifetimes of two people, the initial monthly benefit amount is smaller than it would be if it were paid as a single life annuity, as shown in Exhibit 16, on page 36. This reduction is in addition to any other type of reduction that may apply to your monthly benefit payment, such as an early retirement reduction or deferred vested retirement reduction. The reduction is based on the difference between your age and your spouse’s age, as shown in Exhibit 14.

<table>
<thead>
<tr>
<th>Exhibit 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Reductions for the 55 Percent Surviving Spouse Option</td>
</tr>
<tr>
<td>If your spouse is . . .</td>
</tr>
<tr>
<td>Within five years of your age</td>
</tr>
<tr>
<td>More than five years younger than you</td>
</tr>
<tr>
<td>More than five years older than you</td>
</tr>
</tbody>
</table>

If your spouse dies before you do, the benefit will revert to the higher single life annuity for the rest of your life, beginning on the first day of the month after your spouse’s death. You will be required to furnish the Boeing Pension Service Center with a copy of your spouse’s death certificate for this payment adjustment to be made.

Postretirement Surviving Spouse Option
If you marry (or in some cases, remarry) after retirement, you may be able to change your payment method to a 55 percent surviving spouse option with your new spouse as beneficiary. You must file your request within two years following the date of your marriage (or remarriage).
If your election is made
• In the first year following the date of your marriage (or remarriage), the election will be effective as of the first day of the month following your anniversary date.
• In the second year following the date of your marriage (or remarriage), the election will be effective as of the first day of the second month following your election.

No election may be made after the second anniversary of your marriage. If you elect the postretirement 55 percent surviving spouse annuity, your benefit will be reduced as described in “55 Percent Surviving Spouse Option,” on page 34.

For example, if you get married on June 15, 2005, and you elect a postretirement surviving spouse option on July 1, 2005, your election will take effect on July 1, 2006 (the first of the month following your first anniversary). If you wait to elect this option until October 1, 2006, your election will be effective on December 1, 2006 (the first date of the month following your election).

If you die before your election takes effect, your spouse will not be eligible for the postretirement surviving spouse option.

**Life and 10-Year Period Certain Option**

If you participate in one of the covered groups listed below and commence your benefits on or after the date shown, you may elect the life and 10-year period certain option.

<table>
<thead>
<tr>
<th>Exhibit 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility for the Life and 10-Year Period Certain Option</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Covered group</th>
<th>You are eligible for this option if you commence your benefits on or after . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>• DASO</td>
<td>October 1, 2000</td>
</tr>
<tr>
<td>• IAM Local No. 725</td>
<td></td>
</tr>
<tr>
<td>• IBT Local No. 848</td>
<td></td>
</tr>
<tr>
<td>• IUOE Local No. 501—Weldors</td>
<td></td>
</tr>
<tr>
<td>• UAW Local Nos. 148 and 1482</td>
<td></td>
</tr>
</tbody>
</table>

| • AFSO Local No. 1  | December 1, 2000                                                                 |
| • SPFPA Local No. 159 |                                                                               |
| • SPFPA Local No. 160 |                                                                               |
| • IBEW Local No. 2295 |                                                                               |

This form of payment guarantees a monthly pension for your entire life. In addition, if you die before benefits have been paid for the 10-year period, your beneficiary will receive the same monthly benefit amount for the remainder of the 10-year period. For example, if you elect this option and die two years after your benefit payments begin, your beneficiary will receive the same monthly benefit amount for the remaining 8 years of the 10-year period.

Because of this arrangement, the monthly benefit amount will be less than it would be if it were paid as a single life annuity. The amount of the benefit reduction depends on your age at retirement.

If you are married and want to elect this option, you must have your spouse’s written consent on your Commencement Election form and have it witnessed by a notary public.
If you are married and elect this option, your spouse automatically is your beneficiary. If you want to designate someone other than your spouse as your beneficiary, you must have your spouse’s written consent. Your spouse must sign the spousal consent section of the Commencement Election form and have his or her signature witnessed by a notary public. If you are single, you may designate anyone as your beneficiary.

If your beneficiary dies before the end of the period certain, you may name another beneficiary. If your beneficiary dies while receiving payments, the remaining payments will be made to his or her named beneficiary. If your beneficiary dies before you and you do not name a new beneficiary, your remaining benefits will be paid to a beneficiary determined by the Plan. See “Beneficiary Designations,” on page 39, for more information.

This payment option is not available for

- Disability retirements.
- Participants who ended their employment before November 27, 2000.
- Participants whose life expectancy is less than 10 years.

### Exhibit 16

<table>
<thead>
<tr>
<th>Comparison of Payment Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following are sample monthly payments for you and your spouse. These sample payments assume you commence your benefits at age 65. These amounts are for illustration only, have been rounded to the nearest dollar, and may not reflect your actual payment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Method</th>
<th>Monthly amount to retiree for life</th>
<th>Monthly amount to spouse after retiree’s death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single life annuity</td>
<td>$1,000</td>
<td>$0</td>
</tr>
<tr>
<td>55% surviving spouse option</td>
<td>$950</td>
<td>$523</td>
</tr>
<tr>
<td>Life and 10-year period certain</td>
<td>$911</td>
<td>$911*</td>
</tr>
</tbody>
</table>

* This assumes you die within 10 years after your benefit payments begin, and your spouse is your beneficiary.
Accelerated Income Option

If you participate in one of the covered groups listed below and commence your benefits on or after the date shown, you may elect the accelerated income option.

<table>
<thead>
<tr>
<th>Covered group</th>
<th>You are eligible for this option if you commence your benefits on or after . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>• DASO</td>
<td>October 1, 2000</td>
</tr>
<tr>
<td>• IAM Local No. 725</td>
<td></td>
</tr>
<tr>
<td>• IBT Local No. 848</td>
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<td>• IUOE Local No. 501—Weldors</td>
<td></td>
</tr>
<tr>
<td>• UAW Locals Nos. 148 and 1482</td>
<td></td>
</tr>
<tr>
<td>• AFSO Local No. 1/SPFPA</td>
<td>December 1, 2000</td>
</tr>
<tr>
<td>• SPFPA Local No. 159</td>
<td></td>
</tr>
<tr>
<td>• SPFPA Local No. 160</td>
<td></td>
</tr>
<tr>
<td>• IBEW Local No. 2295</td>
<td></td>
</tr>
</tbody>
</table>

If you retire before age 62 and two months, you may choose the accelerated income option. You may elect this option along with a single life annuity, the 55 percent surviving spouse option, or the life and 10-year period certain option. If you are married and want to elect this option, you must have your spouse’s written consent on the Benefit Commencement form and have it witnessed by a notary public.

The accelerated income option allows you to collect a larger than normal portion of your pension benefit until age 62 and two months and a smaller benefit afterward. Your single life annuity is reduced to pay for this option. For most employees who elect this option, the temporary supplement is $700 per month and is offered until you reach age 62 and two months. If your benefit is not large enough to pay for the $700 temporary supplement, you will receive a smaller temporary supplement, and you no longer receive any retirement benefits after age 62 and two months.

If you are married, elect the 55 percent surviving spouse annuity with the accelerated income option, and die before reaching age 62 and two months, 55 percent of the temporary supplement will be paid to your spouse until the date you would have reached age 62 and two months.

When you reach age 62 and two months (or would have reached age 62 and two months), the temporary supplement will end, and your benefit will be reduced. This reduced benefit will be payable for life. If you are married, elect the 55 percent surviving spouse option, and die before your spouse, benefits will continue to your spouse.

If you elect the accelerated income option and life and 10-year period certain option, and then die before age 62 and two months, your beneficiary will continue to receive the temporary supplement until the earlier of when you would have been age 62 and two months or the end of the 10-year period. If the period extends beyond the date you would have reached age 62 and two months, your beneficiary will receive the reduced amount for the balance of the 10-year period.
This payment option is not available if any of the following apply to you:
• You are retiring with ERS.
• You are retiring with LISA.
• You are electing a disability retirement.
• You ended your employment with the Company before November 27, 2000.

**Spousal Consent**
If you are married and choose any payment option other than the 55 percent surviving spouse option, you must have your spouse’s written, notarized consent.
You must have your spouse’s written, notarized consent on the Commencement Election form to elect the following options:
• Single life annuity.
• Life and 10-year period certain option.
• Accelerated income option.

**Payment of Small Benefits**
If the total value of your benefit (or your surviving spouse’s preretirement survivor benefit) is less than $5,000 when you (or your surviving spouse) are eligible to receive it, the Plan automatically will pay you a lump sum. You may elect to roll over this lump-sum payment. See “Direct Rollovers,” next, for more information.

**Direct Rollovers**
You, your surviving spouse, or a former spouse under a qualified domestic relations order may roll over all or a portion of the following benefits into an eligible retirement plan:
• A lump-sum payment for small benefits.
• Equal payments over a period of less than 10 years.

In general, eligible retirement plans include individual retirement accounts (IRA), individual retirement annuities, qualified trusts, and annuity plans. However, your surviving spouse can only make a rollover into an IRA or individual retirement annuity. For more information about direct rollovers, call the Boeing Pension Service Center.

**Qualified Domestic Relations Order**
Federal law protects your benefits under the Plan from assignment and transfer to others. However, the Retirement Equity Act of 1984 specifically provides that this protection does not apply to a qualified domestic relations order (QDRO). A QDRO is a judgment, decree, or order that relates to divorce decrees, property settlements, and child support orders. If a court order of this type is received, you will be advised in writing.
For additional information regarding QDROs, please contact the Boeing Pension Service Center through Boeing TotalAccess. You may obtain a copy of the Plan’s general procedures governing QDROs without charge by contacting the Employee Benefit Plans Committee, which may be reached at The Boeing Company, 100 North Riverside, MC 5002-8421, Chicago, IL 60606-1596.
Beneficiary Designations
The Plan pays a benefit to your surviving spouse or other beneficiary in the following situations:

- You choose the life and 10-year period certain payment option and die before the end of the 10-year period (see page 35).
- You are eligible for Fund E savings benefits when you die (see the Appendix, beginning on page 49).

If you do not designate a beneficiary, the benefits mentioned above will be paid in the following priority:

- To your surviving spouse, if you are married.
- To your estate, if you are single and did not designate a beneficiary.

If you are married, you must have your spouse’s signed and notarized consent on the Commencement Election form to designate someone else as your beneficiary.

Preretirement Survivor Benefits
If you are vested and die before your benefit payments begin, your surviving spouse (if any) may be eligible for a lifetime benefit under the Plan. The amount payable to your spouse will be based on a number of elements, including your age at death and whether you are an active or vested former employee when you died. Your spouse may elect to receive preretirement survivor benefits immediately or defer payments to a later date (but no later than the date you would have reached age 65).

Your spouse must provide copies of your birth, marriage, and death certificates to the Boeing Pension Service Center to claim a survivor benefit.

If you are a former participant in the Savings Plan whose benefit merged into this Plan on November 18, 1996, the surviving spouse benefit available for your Fund E savings benefit may be different than as described in this section. See “Preretirement Survivor Benefits” in the Appendix, beginning on page 50, for more details.

If You Die While Employed by Boeing
If you are vested and die while employed by Boeing, your spouse’s benefits will be determined based on your age at death and the difference between your age and your spouse’s age.

Your spouse’s survivor benefit will be paid as if all of the following applied to you:

- You ended your employment with Boeing on the date of your death.
- You elected to retire with a 55 percent surviving spouse annuity.
- You died before benefit payments began.

This means you will be considered to have retired directly from Boeing. A 55 percent surviving spouse annuity will become payable to your spouse on the first day of the month that follows the date of your death.

If your spouse chooses to begin payments before the time you would have reached age 65, your spouse’s benefits will be further reduced by early retirement reduction factors. For benefits that begin after the time you would have reached early retirement age, the reduction factors that apply are shown in Exhibit 9, on page 22. For benefits that begin before the time you would have reached early retirement age, additional reduction factors will apply.
Your spouse may elect to defer payments until a later date, up to the date you would have reached age 65. If benefits are deferred to the time you would have reached age 65, your surviving spouse’s benefits will not be further reduced for early commencement. Benefits will be paid for your surviving spouse’s lifetime.

**Preretirement Survivor Benefit Example**

This example assumes that you are vested, have eight years of benefit service, and die at age 55. Your surviving spouse is the same age as you and elects to receive the surviving spouse benefit immediately upon your death.

<table>
<thead>
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<th>Description</th>
<th>Calculation</th>
<th>Amount</th>
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<tr>
<td>Monthly accrued benefits as of date of death</td>
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<td>Age 55 reduction factor (see Exhibit 9, on page 22)</td>
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<td>Reduced monthly benefit</td>
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<td>55 percent surviving spouse option factor</td>
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<td>Reduced monthly benefit</td>
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<tr>
<td>Benefit payable to survivor</td>
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<td>$227</td>
</tr>
</tbody>
</table>

**If You Die After Age 70½**

See “Age 70½ Distribution Date,” on page 28.

**If You Die After Terminating Your Employment**

If you are vested, end your employment with Boeing, and die before you begin receiving benefits, you are considered a vested former employee, and your spouse will be eligible to receive a deferred vested survivor benefit.

If you die as a vested former employee, your spouse’s survivor benefit will be paid as if all of the following applied to you:

- You lived to age 65.
- You elected a 55 percent surviving spouse annuity.
- You died before benefit payments began.

A 55 percent surviving spouse annuity will become payable to your spouse on the first day of the month following the date of your death or notification of death, whichever is later.

If your spouse chooses to begin payments before the time you would have reached age 65, your spouse’s benefits will be reduced further by deferred vested retirement reduction factors. For benefits that begin after the time you would have reached age 55, the deferred vested reduction factors that apply are shown in Exhibit 10, on page 23. For benefits that begin before the time you would have reached age 55, additional reduction factors will apply.

Your spouse may elect to defer payments until a later date, though not later than the first day of the month following the month you would have reached age 65. If benefits are deferred to age 65, your surviving spouse’s benefits will not be further reduced for early commencement. Benefits will be paid for your surviving spouse’s lifetime.
If You Die After Layoff

If you were laid off while eligible for retirement benefits and you die before benefits commence, your surviving spouse’s benefit would be subject to the formula described under “If You Die While Employed by Boeing” on page 39.

Postretirement Death Benefit

If you retire with a benefit from this Plan, your beneficiary is eligible to receive a $2,000 death benefit under the Plan. Following your death, this benefit will be paid as a single, lump-sum payment to the person designated as your beneficiary on the Commencement Election form provided by the Boeing Pension Service Center. If you did not designate a beneficiary, your postretirement death benefit will be paid to your surviving spouse, or to your estate if not married.

The postretirement death benefit is in addition to any survivor benefit available to your spouse based on the form of payment you elected when you retired.

The spouse of a vested former employee is not eligible for the postretirement death benefit.

Circumstances That May Affect Your Benefits

Under certain conditions, you may not receive pension benefits, or you may receive smaller payments than you expected. Here are some examples of such cases.

- If you do not meet the eligibility requirements of the Plan, you will not earn benefits.
- If your employment terminates before you are vested, no benefits will be payable.
- If you do not use the designated forms from the Boeing Pension Service Center or do not complete them in a timely manner, benefits could be postponed.
- If you do not meet retirement age requirements, no vested benefits will be payable until you do.
- If you experience a layoff or your employment terminates, your benefits could be affected.
- If you receive benefits as a single life annuity, benefits will stop when you die.
- If you (or your beneficiary) fail to make a timely appeal of denied benefits, no benefits will be payable.
- If you are subject to a qualified domestic relations order, a portion of your benefit could be paid to an alternate payee.
- If you are not eligible for a particular benefit because you retired before that benefit became effective, or because you are a vested terminated participant, that benefit will not be payable.
- If your employment ends, and you do not return to work, or you are rehired after a break in service but do not meet the necessary requirements for restoration of service, benefits in which you are not vested will not be payable.
- If the Plan terminates, your benefits will be guaranteed by the Pension Benefit Guaranty Corporation (PBGC) up to certain limits. If your Plan benefit exceeds PBGC limits, you may not receive the entire benefit you have earned. The Company does not guarantee any of the benefits payable under the Plan.

If you have any questions concerning your application or would like additional information, please call the Boeing Pension Service Center through Boeing TotalAccess. In addition, if
you have an issue regarding your benefit or your right to receive a benefit under the Plan, this often can be resolved by calling the Boeing Pension Service Center and discussing the situation with a representative. If the issue is not resolved through an informal process, you may file a formal claim.

**Claim and Appeal Procedure**

In general, if you have an issue regarding your benefit or your right to receive a benefit under this plan, this often can be resolved by calling the Boeing Pension Service Center through Boeing TotalAccess and discussing the situation with a representative. If the issue cannot be resolved through an informal process, you may file a formal claim.

The Plan has established the following procedures for initiating a formal claim and appeal of denied benefits under the Plan described in this booklet. Copies of the claim and appeal procedures for the Plan are available by sending a written request to the Employee Benefit Plans Committee at The Boeing Company, 100 North Riverside, MC 5002-8421, Chicago, IL 60606-1596.

A formal claim for benefits should be sent to Boeing Pension Operations at The Boeing Company, P.O. Box 3707, MC 11-59, Seattle, WA 98124-2207. Boeing Pension Operations will respond in writing within 90 days of receiving the claim. If special circumstances require more time, the review period may be extended up to an additional 90 days. You will be notified in writing of this extension.

If your claim is denied, you will be notified in writing. This notice will include

- The specific reasons for the denial.
- A reference to the specific Plan provisions on which the claim determination was based.
- A description and explanation of any additional information that is needed to process your claim.
- A description of the Plan’s review procedures and the applicable time limits.
- A summary of your rights to take legal action.

You or a person you appoint may appeal a denial of benefits by writing to the Employee Benefit Plans Committee at The Boeing Company, 100 North Riverside, MC 5002-8421, Chicago, IL 60606-1596, within 60 days of receiving notice of the denial or partial denial of Plan benefits. If an appeal of an adverse benefit determination is not made within 60 days of receipt of such benefit determination notice, the claimant will be deemed to have waived his or her right for review. Upon request, you will be provided with reasonable access to any information that was relevant to your claim.

In your appeal, you must

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

The Committee will review your appeal, render a decision, and notify you of its decision within 60 days of receipt of your appeal. If special circumstances require more time, the review period may be extended up to an additional 60 days. You will be notified in writing of this extension.
If your appeal is denied, in whole or in part, the Committee will send you a notice that will include
• The specific reasons for the denial.
• A reference to the specific Plan provision on which the determination was based.
• A summary of your right to additional appeals or legal action.
• A statement of your right to obtain, free of charge, copies of documentation relevant to the decision.

If the Committee makes an adverse benefit determination on appeal, you may bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Any action must be commenced within 180 days following the decision on appeal of your initial claim for benefits (or following the last date for filing an appeal, if no appeal is taken.) For initial claims filed before January 1, 2005, any action must instead be commenced within two years of the date of your initial claim for benefits.

Benefits will be paid under the plan only if the Committee decides in its discretion that you are entitled to them.

It is the Committee’s exclusive right to interpret the terms of the Plan, to resolve eligibility for benefits, and exercising its discretion, to resolve all questions arising under the Plan. The decision of the Committee is final and binding.

Plan Amendment or Termination

The Company intends to continue the Plan. However, the Company may, at its sole discretion, change, modify, amend, or terminate the Plan at any time, subject to the provisions of any collective bargaining agreement. The McDonnell Douglas Corporation Board of Directors has delegated the right to change, modify, and amend the Plan to the Employee Benefit Plans Committee, which is appointed by The Boeing Company Board of Directors. If the Plan is terminated, you will have a vested, nonforfeitable right to the benefit you have earned. The amount of your benefit, if any, will depend on Plan assets, the terms of the Plan, and the benefit guarantee of the Pension Benefit Guaranty Corporation (PBGC), a Federal insurance agency.

Plan assets will be shared among Plan participants and beneficiaries according to Federal regulations under the Employee Retirement Income Security Act of 1974 (ERISA), as amended, and related regulations.

Your pension benefits under this Plan are insured by the PBGC. If the Plan terminates without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers
• Normal and early retirement benefits.
• Disability benefits if you become disabled before the Plan terminates.
• Certain benefits for your survivors.

The PBGC guarantee generally does not cover
• Benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates.
• Some or all of benefit increases and new benefits based on Plan provisions that have been in place for fewer than five years at the time the Plan terminates.
• Benefits that are not vested because you have not worked long enough for the Company.
• Benefits for which you have not met all of the requirements at the time the Plan terminates.
• Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Plan’s normal retirement age.
• Nonpension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money your Plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, ask the Plan Administrator or contact the PBGC Technical Assistance Division, 1200 K Street NW, Suite 930, Washington, DC 20005-4026 or call 202-326-4000 (hearing impaired: 1-800-877-8339 and ask to be connected to 202-326-4000). Additional information about the PBGC pension insurance program is available through the PBGC web site (http://www.pbgc.gov).

Employing Companies

The status of any company as an employing company is subject to change. The authority to designate or remove companies as employing companies under the Plan has been delegated by McDonnell Douglas Corporation to the Employee Benefit Plans Committee, appointed by The Boeing Company Board of Directors. For a current list of employing companies, please contact the Plan Administrator at the address listed in the following section.

Special Disclosure Information

Plan Name

The name of the Plan is the Employee Retirement Income Plan of McDonnell Douglas Corporation—Hourly West Plan. It is commonly referred to as the “Hourly West Plan.”

Plan Sponsor

The Plan is sponsored by McDonnell Douglas Corporation, a wholly owned subsidiary of The Boeing Company. The mailing address is 100 North Riverside, MC 5002-8421, Chicago, IL 60606-1596.

Plan Administrator and Agent for Service of Legal Process;
Limitations on Actions

The Plan Administrator is the Employee Benefit Plans Committee, The Boeing Company, 100 North Riverside, MC 5002-8421, Chicago, IL 60606. Legal process may be served upon the Committee at Employee Benefit Plans Committee, The Boeing Company, c/o United States Corporation Company of Illinois, 33 North LaSalle Street, Chicago, IL 60602.

Legal process also may be served upon the Plan Trustee at the address listed below. If you would like to commence a lawsuit against the Plan with respect to a denied benefit, you must do so within 180 days following the decision on appeal of your initial claim for benefits (or following the last date for filing an appeal, if no appeal is taken.) If your initial claim was filed before January 1, 2005, your lawsuit must instead be filed within two years of the time that you made your initial claim for benefits. A lawsuit that does not meet these deadlines will be considered untimely.
Type of Administration
The Plan is administered in accordance with the provisions of the official Plan document, collective bargaining agreements, and the master trust agreement.

Type of Plan
The Plan is a defined benefit pension plan.

Funding and Contributions
The Plan Sponsor funds the entire cost of the Plan by contributing actuarially determined amounts into a master trust, from which benefits are paid. No employee contributions are required or permitted.

Top-Heavy Plan Provisions
Federal regulations require that the Plan include provisions that would take effect in the event the Plan was ever to become top heavy. The Plan will be considered top heavy if a large percentage of benefits have accrued in favor of key employees. The Company does not expect the Plan to become top heavy.

Plan Records
Effective January 1, 2001, Plan records are kept on a calendar-year basis (January 1 through December 31). Before January 1, 2001, a Plan year was the period commencing on the Monday following the last Sunday in November, and ending with the last Sunday of the following November. There was a short Plan year for the period commencing November 27, 2000, to December 31, 2000.

Plan Number and Employer Identification Number
The Plan number is 002. The employer identification number for Plan reporting purposes is 43-0400674.

Plan Trustee
The Plan Trustee is the JP Morgan Chase Bank, Master Custody Department, Chase MetroTech Center, Brooklyn, NY 11245.

Unions
The Plan is provided according to agreements with the following unions:

- International Association of Machinists and Aerospace Workers (IAM), AFL-CIO
  - District Lodge No. 725

- International Brotherhood of Electrical Workers (IBEW), AFL-CIO
  - Local No. 2295

- International Union of Security, Police and Fire Professionals of America (SPFPA) and Certain Affiliated Amalgamated Locals
  - Local No. 159
  - Local No. 160

- American Federation of Security Officers (AFSO)
  - Local No. 1/International Union of Security, Police and Fire Professionals of America (SPFPA)
Participant Rights and Protections Under ERISA

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

Receive Information About Your Plan and Benefits

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

• If you want a personal copy of these documents or related material, send a written request to the Plan Administrator. You can obtain copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and updated summary plan description. You will be charged a reasonable cost.

• You may 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.

• You may obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and, if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide this statement free of charge.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so 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 pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in Federal court.

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

**Assistance With Your Questions**

If you have any questions about your Plan, contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You also may obtain certain publications about your rights and responsibilities from the Employee Benefits Security Administration (EBSA) on the World Wide Web ([http://askebsa.dol.gov](http://askebsa.dol.gov)) or by calling the EBSA hotline at 1-866-444-EBSA (1-800-998-7542.)
Exhibit 18

Where to Get Information

Boeing Pension Service Center, through Boeing TotalAccess

Telephone:* Seven days a week, 24 hours a day**
1-866-473-2016
1-800-755-6363 (TTY/TDD service)

Representatives available:

Boeing TotalAccess representatives:
Monday through Friday
8 a.m. to 9 p.m. Eastern time
7 a.m. to 8 p.m. Central time
6 a.m. to 7 p.m. Mountain time
5 a.m. to 6 p.m. Pacific time

Boeing Pension Service representatives:
Monday through Friday
9 a.m. to 8 p.m. Eastern time
8 a.m. to 7 p.m. Central time
7 a.m. to 6 p.m. Mountain time
6 a.m. to 5 p.m. Pacific time

Automated Pension Service telephone hours:
Monday through Friday, 7 a.m. to 3 a.m., Eastern time
Saturday, 7 a.m. to midnight, Eastern time

Boeing Web:**
https://my.boeing.com
Log on to Boeing TotalAccess, click the My Savings & Pension tab, and follow the links.

World Wide Web:**
https://my-ext.boeing.com
Log on to Boeing TotalAccess and follow the links.

Mailing address:
P.O. Box 7833
Ocala, FL 34478-7833

Fax: 856-770-3437

* Subject to minimum scheduled maintenance or downtime.
** BEMS ID number (or Social Security number) and Boeing TotalAccess password required to receive information about your plan benefit.
Appendix
Employee Savings Plan of McDonnell Douglas Company—Hourly West Plan

This is a general overview of the provisions that apply to members whose benefits under the Employee Savings Plan of McDonnell Douglas Company—Hourly West Plan (“Savings Plan”) merged into this Plan effective November 18, 1996. Merged benefits may be referred to as your “Fund E savings benefit.” Refer to the Savings Plan summary plan description or call the Boeing Pension Service Center through Boeing TotalAccess for more information.

Your Fund E Savings Benefit
Your benefit under the Savings Plan merged into this Plan if either of the following applied to you on November 18, 1996:

• You were a member of a covered group under this Plan, and you were an active employee, on a leave of absence, or on layoff.
• You had ended your employment with a covered group under this Plan, but you had not yet begun receiving your Savings benefit.

You keep your Fund E savings benefit that merged into this Plan. You may elect to receive your Fund E savings benefit at any time after you end your employment with Boeing. If you wait to receive your Fund E savings benefit until you retire, you will receive it in addition to benefits you earn under this Plan.

Your Fund E savings benefit consists of your employer accrued benefit earned through November 18, 1996. Your “employer accrued benefit” equals the lump-sum dollar amount contributed by your employer to the Savings Plan on your behalf before November 18, 1996.

In general, your Fund E savings benefit will be paid in accordance with the terms and provisions of this Plan, except as described in the following sections.

Payment of Your Fund E Savings Benefit
When you elect to receive your Fund E savings benefit, you may select from the following forms of payment for your Fund E savings benefit even if you are not yet eligible for retirement benefits under this Plan:

• A single, lump-sum cash payment. Under a lump-sum cash payment, the Plan will pay you a single sum equal to your entire Fund E savings benefit. No further payments will be made.
• A single life annuity.
• A 55 percent surviving spouse annuity, if you are married.

If you leave Boeing due to layoff, retirement, or termination and you qualify to receive a voluntary severance benefit as the result of ending your employment, you can elect to defer payment of your Fund E savings benefit for up to 12 months following your separation from service. However, under no circumstances can you delay payment of your Fund E savings benefit beyond the date you would have attained age 70½.

If you do not specify a payment method when you elect to receive your Fund E savings benefit, it will be paid as described on page 33.

Spousal Consent
If you are married and choose to elect any payment option other than the 55 percent surviving spouse annuity for your Fund E savings benefit, you must have your spouse’s written, notarized consent.
You must have spousal consent witnessed by a notary public to select the single life annuity or the single, lump-sum cash payment.

**Preretirement Survivor Benefits**

If you are vested in your Fund E savings benefit and die before benefit payments begin, your beneficiary may be eligible to receive your Fund E savings benefit. This benefit is in addition to any preretirement survivor benefit available for the remainder of your Plan benefit, as described on page 39. How this preretirement survivor benefit is paid will depend on whom you have named as the beneficiary for your Fund E savings benefit, as outlined in the following sections.

For the beneficiaries of members who died before January 1, 2002, the preretirement survivor benefits that apply to your Fund E savings benefit may be different. Please contact the Boeing Pension Service Center for more details.

**If Your Beneficiary Is Your Spouse**

If you are married at the time of your death and have named your spouse as your beneficiary, the portion of his or her survivor benefit attributable to your Fund E savings benefit will be paid as a single life annuity, payable over your spouse’s lifetime. Your spouse may begin receiving benefits immediately. However, he or she may elect to defer payments until a later date, up to the latest of the following:

- The date you would have reached age 65.
- 120 days following your date of death.
- 60 days following the date your spouse provides information to the Boeing Pension Service Center regarding your death, including a Commencement Election form and documentation such as of birth, marriage, and death certificates.

Alternatively, your surviving spouse may elect to receive your entire Fund E savings benefit as a single, lump-sum cash payment within 90 days following your date of death. If he or she elects to receive this amount as a lump sum, no further payments of your Fund E savings benefit will be made from the Plan.

If you die after attaining age 59½, payment of your Fund E savings benefit to your surviving spouse may be deferred for up to 12 months following your date of death. This deferral of payment will apply to your spouse only if you filed a written notice with the Boeing Pension Service Center before your date of death, and that notice had your spouse’s written, notarized consent. However, deferring payment of your Fund E savings benefit may not extend beyond the date you would have attained age 70½.

**If You Are Not Married or Your Beneficiary Is Not Your Spouse**

If you are not married when you die, or if you are married but named someone other than your spouse as the beneficiary for your Fund E savings benefit, your benefit will be paid to your beneficiary as a single, lump-sum cash payment within 90 days following your date of death. To name someone other than your spouse as beneficiary, you must provide your spouse’s written, notarized consent of your selection.

If you have not named a beneficiary or if no beneficiary survives you at the time of your death, your Fund E savings benefit will be paid according to the method of determining benefit payments under “Beneficiary Designations,” on page 39.
If you die after attaining age 59½, payment of your Fund E savings benefit to your beneficiary may be deferred for up to 12 months following your date of death. This deferral of payment will apply to your spouse only if you filed a written notice with the Boeing Pension Service Center before your date of death, and that notice had your spouse’s written, notarized consent. However, deferring payment of your Fund E savings benefit may not extend beyond the date you would have attained age 70½.
Summary of Benefit Plan Changes and Clarifications

Employees Represented by UAW 148

This Update summarizes the collectively bargained and administrative changes and clarifications that will affect your benefit plans and updates your summary plan descriptions. The effective date of each change is January 1, 2008, unless otherwise noted.

The changes and clarifications in this Update will apply to you if you are an active employee of The Boeing Company (the “Company”) who is represented by the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America (UAW) Local No. 148.

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

Eligibility

The changes and clarifications in this section will apply to the McDonnell Douglas Group Life, Disability & Health Benefits Plan (Plan 529). Contact the Boeing Service Center through Boeing TotalAccess for details.

Eligible Dependents

For the medical and dental plans, a same-gender domestic partner will be eligible if you and your same-gender domestic partner meet all of the following requirements:

- 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 is not solely to obtain coverage under the Plan.

A same-gender domestic partner is considered a spouse for the purpose of the medical and dental plans. Covering your same-gender domestic partner may affect your Federal and/or state income taxes, and you may be required to provide proof of your same-gender relationship.

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.
Supplemental Life Insurance Plan
The change in this section will apply to the McDonnell Douglas Group Life, Disability & Health Benefits Plan (Plan 529). Contact the Boeing Service Center through Boeing TotalAccess for details.

Same-gender domestic partners who meet the eligibility requirements and their children may be enrolled in the Supplemental Life Insurance Plan.

Disability Plans
The clarifications in this section will apply to the McDonnell Douglas Group Life, Disability & Health Benefits Plan (Plan 529). Contact the Boeing Service Center through Boeing TotalAccess for details.

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

If a person covered by this plan is injured by another party who is legally liable for the disability income replacement, 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 also is entitled to or receives compensation or any other funds from another party in connection with that same disability, 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.
Short-Term Disability Plan

The service representative is responsible for evaluating benefit claims in accordance with the terms of the Plan and using a reasonable claim procedure in accordance with Federal rules. The service representative has the right to request additional information as necessary to decide your claims.

Definitions

Disabled

Disabled means you are unable to perform the material duties of your regular occupation or other appropriate work Boeing makes available as a result of an illness, accidental injury (on or off the job), or a pregnancy-related condition.

Physician

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

Medical Plans

The changes and clarifications in this section will apply to the McDonnell Douglas Group Life, Disability & Health Benefits Plan (Plan 529). Contact the Boeing Service Center through Boeing TotalAccess for details.

Medical Plan Choices

Medical plan choices will be as follows:

California
- Regence Traditional PPO
- Aetna PPO+Account
- Health Net HMO
- Kaiser Permanente HMO

All Other Locations
- Regence Traditional PPO
- Aetna PPO+Account

Regence Traditional PPO

Summary of Changes

The following changes will apply to the Regence Traditional PPO:

Annual Deductible
The nonnetwork annual deductible will have a $1,800 maximum per family of three or more.

Annual Out-of-Pocket Maximum
The network annual out-of-pocket maximum will be $6,000 per family of three or more, but not more than $2,000 for any one person.

The nonnetwork annual out-of-pocket maximum will be $12,000 per family of three or more, but not more than $4,000 for any one person.

Lifetime Maximum Benefit
The lifetime maximum benefit will be $2 million per individual.
**Preventive Care**

Network preventive care services and supplies will be covered as follows:

- Preventive care services, including covered examinations, well child benefits, related laboratory and X-ray charges, and immunizations will be covered at 100 percent (deductible does not apply) up to a $500 annual maximum.

- Routine Pap tests, mammograms, prostate screenings, and colorectal screenings (including colonoscopies) will be covered at 100 percent (deductible does not apply) with no annual maximum (subject to applicable standards of the appropriate medical associations and agencies).

**Copayment**

The emergency room copayment will be $75 per visit.

**Covered Services and Supplies**

The following services and supplies will be revised as described below.

**Ambulance**

The Traditional PPO will cover professional ambulance services, including air ambulance, to transport you from the place where you are injured or become ill to the first hospital where you receive treatment. These services also will be covered when a physician requires an ambulance to transport you to a hospital, including from one hospital to another, but only to the nearest hospital with appropriate regional specialized treatment facilities, equipment, or staff physicians.

No other costs in connection with travel will be considered.

**Prescription Drug Program**

Prescription drugs will be covered as follows:

<table>
<thead>
<tr>
<th>Traditional PPO Prescription Drug Program Schedule of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Traditional PPO prescription drug program is administered by Medco By Mail (the service representative).</td>
</tr>
<tr>
<td>Retail pharmacy card program</td>
</tr>
<tr>
<td>Generic</td>
</tr>
<tr>
<td>Brand formulary</td>
</tr>
<tr>
<td>Brand nonformulary</td>
</tr>
<tr>
<td>Mail-order pharmacy program</td>
</tr>
<tr>
<td>Generic</td>
</tr>
<tr>
<td>Brand formulary</td>
</tr>
<tr>
<td>Brand nonformulary</td>
</tr>
</tbody>
</table>

**Prescription Drug Program Exclusions**

The following exclusion will be added under both the retail pharmacy card program and the mail-order pharmacy program:

- Any prescription drug for which the person is covered or eligible to receive benefits under another employer's group benefit plan or a workers' compensation law or from any municipality, state, or Federal program, including a Medicare prescription drug plan, except as required by law.
Vision Care Program
The vision care program, administered through Vision Service Plan (VSP), will be revised as follows:

- The frame allowance will be $90.
- The contact lens allowance will be $120.

Definitions
The following definitions will be revised:

Emergency
A sudden, unexpected onset of serious illness or severe injury that could result in (or that a prudent person would have reason to believe could result in) death, permanent damage or impairment of bodily function, or loss of limb use if not treated immediately.

For mental health and substance abuse coverage, a situation also is considered an emergency when there is imminent danger to yourself or others or you are medically compromised as a result of mental illness or substance abuse.

Substance Abuse
An alcohol- or drug-related disorder that exhibits signs, symptoms, history, and other characteristics congruent with those required for substance-related disorder diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV).

Usual and Customary
The maximum charge for a covered service or supply the service representative will consider for reimbursement from a nonnetwork provider. The service representative may refer to this as the “maximum reimbursable charge,” “maximum allowable charge,” “reasonable and customary charge,” “allowed amount,” or a similar term.

The usual and customary charge is the least of

- The provider’s actual charge for the service or supply,
- The provider’s normal charge for a similar service or supply, or
- A predetermined percentile (negotiated between each carrier and plan sponsor) of charges made by providers of a comparable service or supply in the geographic area where it is received.

To determine if a charge exceeds the usual and customary charge for medical services or supplies in situations involving unusual or complicated services or supplies, the nature and severity of the injury or sickness may be considered.

The service representative uses a database of provider charges to determine the usual and customary charge in an area. Information about the database and percentile used to determine the usual and customary charge can be obtained by contacting the service representative.

Aetna PPO+Account
The current PPO+Account with a Health Reimbursement Account (HRA) will be replaced with the Aetna PPO+Account with a Health Savings Account (HSA). The PPO+Account medical plan is a high-deductible health plan. This means it meets Federal requirements that allow the plan to offer an HSA. If you enroll in PPO+Account medical coverage, you may be eligible to set up an HSA through Aetna. With the PPO+Account you may see any physician you choose. However, your out-of-pocket costs will be lower when you see a network provider for services covered by this plan.

You can obtain a network provider directory or list of network providers by visiting Your Benefits Resources web site or Aetna’s web site, or by calling Boeing TotalAccess or Aetna. Providers move in and out of networks periodically. Before you receive services, be sure to confirm with your provider or Aetna that your provider is still in the Aetna network.
## Schedule of Benefits

The PPO+Account is administered by Aetna (the service representative).

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Network*</th>
<th>Nonnetwork**,**†</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual deductible</strong></td>
<td>$1,500 for employee only</td>
<td>$2,625 for employee + spouse or child(ren)</td>
</tr>
<tr>
<td></td>
<td>$2,625 for employee + spouse or child(ren)</td>
<td>$3,750 for employee + spouse and child(ren)</td>
</tr>
<tr>
<td></td>
<td>The deductible may be met by one person or a combination of family members</td>
<td>Network and nonnetwork expenses apply to the deductible</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>90%; limits for specific treatments are listed in “Covered Services and Supplies,” section of this table</td>
<td>60%; limits for specific treatments are listed in “Covered Services and Supplies,” section of this table</td>
</tr>
<tr>
<td><strong>Annual coinsurance maximum</strong></td>
<td>$1,600 for employee only</td>
<td>$3,200 for employee only</td>
</tr>
<tr>
<td></td>
<td>$2,800 for employee + spouse or child(ren)</td>
<td>$5,600 for employee + spouse or child(ren)</td>
</tr>
<tr>
<td></td>
<td>$4,000 for employee + spouse and child(ren)</td>
<td>$8,000 for employee + spouse and child(ren)</td>
</tr>
<tr>
<td></td>
<td>Annual coinsurance maximum is in addition to the annual deductible and combined for all family members</td>
<td></td>
</tr>
<tr>
<td><strong>Lifetime maximum benefit</strong></td>
<td>$2 million per individual (network and nonnetwork combined)</td>
<td></td>
</tr>
</tbody>
</table>

### Covered Services and Supplies

<table>
<thead>
<tr>
<th>Service</th>
<th>Network*</th>
<th>Nonnetwork**,**†</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulance</strong></td>
<td>90%</td>
<td>90% (if true medical emergency as defined under “Emergency Room” in “Covered Services and Supplies” beginning on page 10); otherwise, 60%</td>
</tr>
<tr>
<td><strong>Christian Science sanatorium</strong></td>
<td>90%; limits apply</td>
<td></td>
</tr>
<tr>
<td><strong>Cosmetic surgery</strong></td>
<td>90% for limited conditions</td>
<td>60% for limited conditions</td>
</tr>
<tr>
<td><strong>Emergency room</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical emergency</td>
<td>90% (if true medical emergency as defined under “Emergency Room” in “Covered Services and Supplies” on page 10)</td>
<td></td>
</tr>
<tr>
<td>All other treatment</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Hearing aids</strong></td>
<td>90% up to $800 per ear</td>
<td></td>
</tr>
<tr>
<td>Limited to one aid per ear every three benefit years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing aid overhaul in place of new hearing aid after three benefit years</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hemodialysis</strong></td>
<td>90% for the first 30 months of Medicare entitlement due to end stage renal disease; thereafter, Medicare is primary and this plan is secondary</td>
<td>60%</td>
</tr>
<tr>
<td><strong>PPO+Account Schedule of Benefits (continued)</strong>&lt;br&gt;The PPO+Account is administered by Aetna (the service representative).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>Network*</td>
<td>Nonnetwork**,†</td>
</tr>
<tr>
<td>Hospice care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
|  | ▪ 90%; six-month maximum  
▪ Skilled care of four or more hours per day by a registered nurse, licensed practical nurse, or home health aide  
▪ Respite care visits of two or more hours per day up to 120 hours per three months |  |
| Mental health treatment (including eating disorders) | See “Mental Health and Substance Abuse Program,” on page 20 |  |
| Covered inpatient, residential, or intensive outpatient services | 90% when obtained from a provider referred by Aetna | 60% when obtained from a provider not referred by Aetna; limited to 20 days per year |
| Covered outpatient or partial hospital services | 90%; no precertification required for first eight outpatient visits with a network provider; subsequent visits must be approved by Aetna or will be paid at nonnetwork level | 60% when obtained from a provider not referred by Aetna; limited to 20 visits per year |
| Orthoptic therapy | 90% for children through age 11; limits apply | 60% for children through age 11; limits apply |
| Preventive care |  |  |
| Routine physical examinations (for employees, spouses, and children) | ▪ 100% (deductible does not apply) up to a $500 annual maximum for all preventive care services, including covered examinations, well child benefits, related laboratory and X-ray charges, and immunizations  
▪ 100% (deductible does not apply) with no annual maximum for routine Pap tests, mammograms, prostate screenings, and colorectal screenings (including colonoscopies) (subject to applicable standards of the appropriate medical associations and agencies) | Not covered when received in a network service area |
| Prostheses | 90%; $500 annual limit for hair prostheses if undergoing chemotherapy or radiation therapy (network and nonnetwork combined) | 60%; $500 annual limit for hair prostheses if undergoing chemotherapy or radiation therapy (network and nonnetwork combined) |
| Smoking cessation | ▪ 100% (deductible does not apply)  
▪ $500 lifetime maximum benefit |  |
| Spinal and extremity manipulations | 90%; limited to 26 visits for spinal and extremity manipulations combined per year (network and nonnetwork combined) | 60%; limited to 26 visits for spinal and extremity manipulations combined per year (network and nonnetwork combined) |
### PPO+Account Schedule of Benefits (continued)

The PPO+Account is administered by Aetna (the service representative).

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Network*</th>
<th>Nonnetwork**,†</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Substance abuse treatment</strong></td>
<td>90% when obtained from a provider referred by Aetna</td>
<td>60% when obtained from a provider not referred by Aetna</td>
</tr>
<tr>
<td></td>
<td>No precertification required for first eight outpatient visits with a network provider; subsequent visits must be preapproved by Aetna or will be paid at the nonnetwork level</td>
<td>Up to $2,500 per course of treatment; maximum will count toward $7,500 network maximum</td>
</tr>
<tr>
<td></td>
<td>Up to $7,500 per course of treatment</td>
<td>Limited to two courses of treatment lifetime maximum (network and nonnetwork combined)</td>
</tr>
<tr>
<td></td>
<td>Limited to two courses of treatment lifetime maximum (network and nonnetwork combined)</td>
<td></td>
</tr>
<tr>
<td><strong>Temporomandibular joint dysfunction and myofascial pain dysfunction syndrome (TMJ/MPDS) treatment</strong></td>
<td>50% up to a lifetime maximum of $3,500</td>
<td></td>
</tr>
<tr>
<td><strong>Therapies</strong></td>
<td>90%; limited to $1,000 each benefit year (network and nonnetwork combined)</td>
<td>60%; limited to $1,000 each benefit year (network and nonnetwork combined)</td>
</tr>
<tr>
<td>Neurodevelopmental therapy (for children 6 and younger)</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>Occupational, physical, and speech therapy</td>
<td>90%</td>
<td>60%</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.

** The nonnetwork payment level is based on the usual and customary charge (as defined by this plan). You are responsible for paying any charges in excess of the amount the service representative determines to be the usual and customary charge.

† For certain benefits, the plan will pay 90% of usual and customary charges if the service representative does not maintain a network of providers in a particular license category in a certain area.

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**Medical Review Program**

Under the PPO+Account, the medical review program encourages the appropriate use of health care services. This program is designed to let you and your physician know whether or not the plan will cover certain procedures before you incur the expense.

Before you receive medical care, you may be required to request one or both of the following types of prior approval from the service representative:

- **Preadmission review.** The service representative reviews the medical necessity, appropriateness, level of care, and setting for most hospital-based services and procedures.

- **Preapproval.** The service representative verifies whether the plan will cover a specific type of service or procedure. This determination is based on plan provisions and the medical necessity of the service or procedure.
Generally, you should request preadmission review before a hospital admission (except emergencies and childbirth) or admission to a skilled nursing facility. You should request preapproval before obtaining home health care or hospice services, undergoing any procedure for obesity or transplantation, or entering a clinical trial.

If you do not obtain preadmission review or preapproval as required, the plan may limit, reduce, or deny your benefit. To request preadmission review or preapproval, contact the service representative.

If you receive care through a network provider, the physician may contact the service representative for you. However, you are ultimately responsible for obtaining any required preadmission review or preapproval.

**Request Preadmission Review for Hospital Services**

If you do not request preadmission review before you are admitted to one of the following types of facilities, the plan may limit or deny coverage for services that otherwise may have been covered:

- **Hospital**—after the first 48 hours of stay after the normal delivery of a child (or 96 hours after a cesarean section).
- **Hospital**—as an inpatient after admittance to an emergency room.
- **Hospital**—for nonemergency inpatient services and procedures.
- Skilled nursing facility.

You do not need to request preadmission approval before emergency or childbirth admissions. However, you should contact the service representative soon after the admission to check whether or not the rest of your hospitalization will be covered.

You must call Aetna to request a referral to an approved mental health or substance abuse provider, and you or your provider must request preapproval for services or treatment. For more information, see “Mental Health and Substance Abuse Program,” on page 20.

You must request preapproval before you receive home health care or hospice care. If you do not request preapproval, the plan may limit or deny coverage for those services even if they otherwise may have been covered.

**Preadmission Review or Preapproval**

You or your physician must contact the service representative at least 10 days before any nonemergency admission to a hospital or skilled nursing facility and at least 10 days before home health or hospice care. You or your physician may be required to provide documentation of your medical condition.

Your request for preadmission review or preapproval will be processed in accordance with the plan’s provisions for preservice claims.

*With Preadmission Review or Preapproval*

If the service representative approves your request for preadmission review or preapproval for a hospital or skilled nursing facility stay, the PPO+Account will pay its regular benefit when the bill is submitted for payment.

If you request and receive preapproval for home health care or hospice agency services, the plan will pay its regular benefit when the bill is submitted for payment. See the “PPO+Account Schedule of Benefits” table, beginning on page 6.

*Without Preadmission Review or Preapproval*

If your request for preadmission review or preapproval is denied, the PPO+Account will not pay a benefit for the service or procedure. You will be responsible for payment if you receive the service.
If you do not request preadmission review or preapproval (as applicable) before you are admitted to a hospital or skilled nursing facility or begin receiving home health care or hospice services, and the service representative later determines that the care was medically necessary, your benefit will be paid at 50 percent of the first $2,000 of usual and customary charges for that particular service, after the deductible. The 50 percent you pay will not apply toward the annual deductible or annual coinsurance maximum. Any amounts you pay for services that are denied by the service representative do not count toward your 50 percent.

If you do not receive approval for other services where preapproval is required (such as for obesity treatment and certain transplants), you will not be reimbursed for the cost of any services determined by the service representative to not be medically necessary.

If you do not receive preapproval for mental health or substance abuse treatment and the service representative determines the services were medically necessary, covered charges will be reimbursed at the nonnetwork level.

Although the plan may not cover a particular service or procedure, you and your physician always have the right to make final decisions about your medical treatment. However, you will be responsible for paying any expenses that the plan does not cover.

**Individual Case Management**

In the event of a severe or long-term illness or injury, the service representative will assist the network provider in identifying treatment alternatives that are cost-effective and enhance quality of life through an individual case manager.

**Covered Services and Supplies**

**Acupuncture**

The PPO+Account will cover medically necessary acupuncture for a covered illness or in place of covered anesthesia. Treatment must be by a licensed acupuncturist (L.A.C.), doctor of medicine (M.D.), or doctor of osteopathy (D.O.).

**Ambulance**

The plan will cover professional ambulance services to transport you from the place where you are injured or become ill to the first hospital where you receive treatment. These services also will be covered when the physician requires an ambulance to transport you to a hospital in your residence area when medically necessary. Air ambulance transportation will be covered when medically necessary.

Ambulance transportation from one hospital to another, including return, will be covered but only to the nearest hospital with appropriate regional specialized treatment facilities, equipment, or staff physicians.

Ambulance transportation from or to your home will be covered when medically necessary.

No other costs in connection with travel will be covered.

**Christian Science Sanatorium**

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

The plan will cover a semiprivate sanatorium room if you are admitted for healing (not rest or study) and are under the care of an authorized Christian Science practitioner. If you have a private room, you will be responsible for the difference between the cost of the private room and the sanatorium’s average charge for a semiprivate room. If the facility offers only private rooms, the plan will cover up to the amount charged for semiprivate rooms in similar facilities in the area.
Congenital Abnormalities and Hereditary Complications
The plan will cover medically necessary services and supplies that are required to treat congenital abnormalities and hereditary complications. This benefit applies to covered newborns and to all other plan participants.

Cosmetic Surgery
The plan will cover cosmetic surgery only in three cases:
- As specifically described for treatment after mastectomy. (See “Reconstructive Breast Surgery,” on page 17.)
- When it is required for the prompt repair of accidental injury.
- When it is required to improve a function due to congenital abnormality.

Dental Repair Due to Accidental Injury
The plan will cover services and supplies to promptly repair natural teeth after an accidental injury. This may include surgical procedures of the jaw, cheek, lips, tongue, and other parts of the mouth and treatment for fractures of the facial bones (maxilla or mandible).

Any teeth that are repaired must have been free from decay or in good repair and firmly attached at the time of the accident. If the repair includes the installation of crowns, dentures, bridgework (fixed or removable), or appliances, this plan will cover only the
- Appliance installed as the first course of orthodontic therapy after the injury.
- First crown to repair each damaged tooth.
- First denture or bridgework to replace lost teeth.

If these services also are covered by your Company-sponsored dental plan, the dental plan pays first, and the medical plan pays second under the plan’s coordination of benefit rules.

Diagnostic X-Ray and Laboratory Services
Generally, the plan will cover the following services when the indications for the services meet the service representative’s guidelines, including when they are performed in connection with a voluntary second surgical opinion:
- Computerized axial tomography (CAT or CT) scans.
- Diagnostic X-rays.
- Magnetic resonance imaging (MRI) performed in a facility accredited by the American College of Radiology.
- Nuclear medicine.
- Prescribed laboratory tests and related procedures.
- Ultrasound.

Durable Medical Equipment
The plan will cover the rental (or purchase, when approved by the service representative) of medically necessary durable medical or surgical equipment that is prescribed by a physician. Covered equipment must be
- Able to withstand repeated use.
- Appropriate for use in the home.
- Not useful to a person without the medical condition.
- Solely for the treatment or improvement of a critical function related to the medical condition.

The plan also will cover the repair or replacement of durable medical equipment due to normal use or a change in the patient’s condition (including the growth of a child).
Examples of covered durable medical equipment are crutches, wheelchairs, kidney dialysis equipment, standard hospital beds, oxygen equipment, and diabetic supplies such as blood glucose monitors, insulin infusion devices, and insulin pumps.

**Emergency Room**

Emergency room treatment—at a network or nonnetwork facility—will be paid at the network level when the condition is determined by the service representative to be a true medical emergency.

A true medical emergency is the sudden, unexpected onset of serious illness or severe injury that could result in (or that a prudent person would have reason to believe could result in) death, permanent damage or impairment of bodily function, or loss of limb use if not treated immediately.

For mental health and substance abuse coverage, a situation also is considered an emergency when there is imminent danger to yourself or others or you are medically compromised as a result of mental illness or substance abuse.

If you are admitted to a nonnetwork hospital, you will retain emergency status (with benefits paid at the network level) for 24 hours or until you can be transferred safely to a network facility. However, care that is received at a nonnetwork hospital when the condition is not a true medical emergency will be covered at the nonnetwork level.

**Erectile Dysfunction**

The plan will cover organic erectile dysfunction treatment when the patient has a history of one or more of the following conditions:

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

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

**Freestanding Surgical Facility**

The plan will cover the services of an approved freestanding surgical center if the services would be covered when received in a hospital.

**Hearing Aids**

The plan will cover hearing aids, up to certain benefit maximums. Benefits include

- Cost and installation of a hearing aid when recommended in writing by a physician or certified audiologist.
- Hearing aid overhaul in place of a new hearing aid.

For hearing aid benefit maximums, see the “PPO+Account Schedule of Benefits” table, beginning on page 6.

**Hemodialysis**

The plan will cover repetitive hemodialysis treatment for chronic, irreversible kidney disease, including rental or lease of hemodialysis equipment.
Under certain conditions, the plan may cover the purchase of major hemodialysis equipment as well as supplies and necessary training to operate the dialyzer. To be covered in these instances, the purchased items must be of no use to you in the absence of the disease and of no value to other household members. The service representative establishes specific conditions for purchasing the equipment, including an amortization period.

**Home Health Care**

The plan will cover home health care visits and supplies, but only when inpatient hospital or skilled nursing facility care otherwise would be required. You also must be considered homebound, which means that leaving home involves a considerable, taxing effort and that you cannot use public transportation without help.

Home health care requires prior approval. For details, see “Preadmission Review or Preapproval,” on page 9.

Before you receive home health care, your attending physician must provide a written treatment plan that describes your continued care and treatment. The physician must review the treatment plan at least once every two months and certify that your condition and treatment continue to meet these criteria. See examples of home health care services listed in the following table.

### PPO+ Account Home Health Care Covered Services and Supplies*

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health aide visits.**</td>
<td></td>
</tr>
<tr>
<td>Medical social visits by a person with a master’s degree in social work (M.S.W.).</td>
<td></td>
</tr>
<tr>
<td>Medical supplies that are covered when provided on an inpatient basis.</td>
<td></td>
</tr>
<tr>
<td>Nursing visits by a registered nurse (R.N.) or licensed practical nurse (L.P.N.).</td>
<td></td>
</tr>
<tr>
<td>Nutritional guidance by a registered dietitian.</td>
<td></td>
</tr>
<tr>
<td>Nutritional supplements (such as diet substitutes) that are administered intravenously or through hyperalimentation.</td>
<td></td>
</tr>
<tr>
<td>Occupational therapy visits by an occupational therapist.</td>
<td></td>
</tr>
<tr>
<td>Physical therapy visits by a physical therapist.</td>
<td></td>
</tr>
<tr>
<td>Physician services.</td>
<td></td>
</tr>
<tr>
<td>Respiratory therapy visits by an inhalation therapist who is certified by the National Board of Respiratory Therapists.</td>
<td></td>
</tr>
<tr>
<td>Services and supplies for infusion therapy.†</td>
<td></td>
</tr>
<tr>
<td>Speech therapy visits by a speech therapist.</td>
<td></td>
</tr>
</tbody>
</table>

* An approved home health care agency is a public or private agency or organization that (1) administers and provides home health care and (2) is either Medicare approved or licensed and regulated by the applicable governmental agency in its location.

** A home health aide is an individual who is employed by a home health care agency or a hospice agency who (1) provides, under the supervision of a registered nurse or physical or speech therapist, part-time or intermittent personal care, ambulation and exercise, household services that are essential to home health care, and assistance with medications that normally are self-administered, (2) reports on changes in the patient’s conditions and needs, and (3) completes appropriate records.

† Patients do not need to meet the treatment plan and homebound requirements.

**Hospice Care**

This plan will cover hospice care to control pain and other symptoms for terminally ill patients whose life expectancy is six months or less. Covered services include visits and supplies of a hospice agency in place of confinement in a hospital or skilled nursing facility.

Hospice care requires prior approval. Before the patient receives any hospice services, the attending physician must provide a written treatment plan to the service representative that describes continued care and treatment. If the service representative approves the care, the physician must review the treatment plan at least once every two months and certify that the patient’s condition and treatment continue to meet these criteria.
The plan will cover the same home health care visits and supplies listed in “Home Health Care” if they are provided and billed by an approved hospice agency.

An approved hospice agency is a public or private organization that

- Administers and provides hospice care and
- Is either approved by Medicare or licensed and regulated by the applicable governmental agency in its location.

The PPO+Account also will cover respite care as temporary relief to family members and friends who care for the terminally ill patient.

In addition to hospice visits, the plan will cover the following services:

- If the service representative approves hospital inpatient care, the plan will cover hospice care on the same basis as other types of hospital inpatient care.
- The plan will cover skilled nursing facility or hospital outpatient care for the hospice patient on the same basis as for other patients.
- Prescriptions and durable medical equipment for hospice care will be covered on the same basis as for other types of care.

**Hospital**

An accredited general hospital is a covered provider under this plan.

All inpatient and outpatient hospital services require prior approval, except in an emergency. See “Request Preadmission Review for Hospital Services,” on page 9.

The plan will cover medically necessary hospital services, such as emergency care and planned inpatient or outpatient surgeries, and supplies.

For inpatient care, the plan will cover the cost of a semiprivate room. The plan will cover a private room when medically necessary.

If you have a private room when it is not medically necessary, you will be responsible for the difference between the cost of a private room and the hospital’s average charge for a semiprivate room. If the hospital offers only private rooms, the plan will cover up to the amount charged for semiprivate rooms in similar facilities in the area.

Alternatives to inpatient hospital care, when approved by the service representative, are

- Home health care.
- Hospice care.
- Skilled nursing facilities.

**Infertility**

The plan will cover these services only to diagnose and treat the underlying cause of infertility:

- Conventional treatment such as office visits, laboratory services, and prescription drugs.
- Diagnostic tests necessary to determine the cause.
- Surgical correction of a condition that is causing or contributing to infertility.

**Mental Health Treatment**

The plan will cover certain services and treatments for mental health and substance abuse. For benefit levels and coverage details, see “Mental Health and Substance Abuse Program,” on page 20.
Oral Surgery
The plan will cover certain medical services and supplies that are provided by a physician or dentist. These services and supplies include
- Correcting developmental abnormalities of the jaw or malocclusion of the jaw by osteotomy (surgical cutting of the bone or bony tissue), with or without bone grafting.
- Excising a tumor or cyst of the jaw, cheek, lips, tongue, or roof or floor of the mouth.
- Excising exostoses of the jaw and hard palate.
- Incising accessory sinuses, salivary glands, or ducts.
- Incising and draining cellulitis.
- Surgical placement of endosseous implants, but only if success is reasonably expected for at least five years or longer.

If these services also are covered by your Company-sponsored dental plan, the dental plan will pay benefits first, and the medical plan will pay second under the medical plan’s coordination of benefit rules.

Orthopedic Appliances and Braces (Orthotics)
The plan will cover braces, splints, orthopedic appliances, and orthotics that are medically necessary. The plan also will cover repair and replacement required by normal use or a change in the patient’s condition (such as the growth of a child). Orthopedic shoes, lifts, wedges, and inserts (orthotics) will be covered if prescribed by a physician and custom made.

These items are covered as part of durable medical equipment benefits. Over-the-counter items are not covered.

Orthoptic Therapy (Vision Training)
The plan will cover up to six months of medically necessary orthoptic therapy to treat muscle imbalance (strabismus, esotropia, or exotropia) for children through age 11. Orthoptic therapy can be provided by an ophthalmologist, optometrist, or other licensed provider under the direction of an ophthalmologist or optometrist.

Oxygen and Anesthesia
The plan will cover oxygen and anesthesia.

Physician
The plan will cover the services of a licensed physician to diagnose or treat nonoccupational accidental injuries, illnesses, or other covered conditions. The plan also will cover physician services for
- Allergy serum, insulin, and other drugs, medicines, and medical devices (including contraceptive injections, devices, and implants) dispensed by a physician.
- Injectable legend drugs that are administered in the physician’s office to treat a covered condition.
- Preventive care.
- Voluntary second surgical opinions.

The plan will cover certain health care services by a physician or other health care professional who is licensed by the state where the services are performed and is acting within the scope of that license. If there are no licensing requirements, appropriate certification is required. Covered health care professionals include
- An acupuncturist (L.A.C.) for covered acupuncture services. (See “Acupuncture.”)
- Chiropractors for chiropractic services. (See “Spinal and Extremity Manipulations.”)
- Christian Science practitioners who are listed in the current Christian Science Journal when they provide a service. (See “Christian Science Sanatorium.”)
Clinical psychologists and master’s level therapists for mental health or substance abuse treatment of covered conditions. (See “Mental Health and Substance Abuse Program.”)

Dentists for dental work or surgery that is covered under the PPO+Account. (See “Dental Repair Due to Accidental Injury” and “Oral Surgery.”)

Neurodevelopmental, occupational, physical, and speech therapists. (See “Therapies.”)

Physician assistants (P.A.) for services that are covered when performed by a physician who is licensed as an M.D.

Podiatrists for covered podiatric services.

Registered nurses (R.N. and A.R.N.P.) for services that are covered when performed by a physician who is licensed as an M.D. The plan also covers intermittent R.N. visits when skilled care in place of hospitalization is not available through another provider at a lesser cost.

The plan will not cover services received from a naturopath, unless he or she meets one of the licensing requirements listed above and is acting within the scope of that license.

Pregnancy-Related Conditions and Coverage of Newborns

The plan will cover services and supplies for pregnancy-related conditions, including

- Cesarean section.
- Complications of pregnancy.
- Legal abortion.
- Normal delivery.
- Spontaneous abortion (miscarriage).

The plan will cover the services of an approved birthing center if they would be covered when received in a hospital. (A birthing center is a facility for normal delivery that is licensed and regulated by the applicable governmental agency in its location.)

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

A newborn is eligible from the date of birth for the automatic coverage period described below if he or she qualifies as your dependent and the mother's hospital stay is for delivery and is covered by the plan. The following services and supplies are covered for a newborn dependent during the automatic coverage period, subject to the plan’s annual deductible and benefit payment levels:

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

Coverage of a newborn continues beyond the automatic coverage period as long as the child remains an eligible dependent and is enrolled in the plan within applicable changes in status time frames.

Prescription Drugs

Through the prescription drug program, the plan will cover drugs and medicines that legally require a physician’s or dentist’s prescription. The only exceptions to the prescription requirement are insulin and certain related supplies that are provided for known diabetes.

The program offers you a retail pharmacy card option for short-term medications and a mail-order option for long-term (maintenance) medications. For details, see “Prescription Drug Program,” on page 21.
Preventive Care
The PPO+Account will cover the following preventive care services if you use a network provider and you live in the network service area. (If you do not live in the network service area, you may use any licensed provider.)

- Immunizations for your covered child in accordance with American Academy of Pediatrics guidelines and the schedule recommended by his or her physician.
- Physical examinations for dependent children.
- Physical examinations for employees and spouses, including related X-ray and laboratory charges.
- Pneumococcal and influenza vaccinations.
- Screenings such as Pap tests, mammograms, prostate screenings, and colorectal screenings (including colonoscopies) as recommended by the patient’s physician.

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

Prostheses
The plan will cover

- Artificial limbs, artificial eyes, and other prostheses that replace a missing body part.
- Repair and replacement of prostheses when required because of normal use or a change in condition (such as the growth of a child).

Wigs and hair prostheses will not be covered unless needed because of hair loss resulting from chemotherapy or radiation therapy. Limits apply; see the “PPO+Account Schedule of Benefits” table, beginning on page 6.

Radiation and Chemotherapy
The plan will cover radiation therapy (including X-ray therapy) and chemotherapy.

Reconstructive Breast Surgery
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 and coinsurance applicable to other medical and surgical benefits provided under this plan.

Second Surgical Opinion
The Company encourages you to get a second opinion before having nonemergency surgery. To facilitate this, the plan will cover a second or third surgical opinion, subject to the network and nonnetwork benefit levels and annual deductible amounts.

Skilled Nursing Facility
Under this plan, a skilled nursing facility is an institution approved as such by Medicare.

All nonemergency admissions to a skilled nursing facility require prior approval. See “Medical Review Program,” on page 8.
The plan will cover a semiprivate room in a skilled nursing facility and resulting medically necessary services and supplies that are provided in place of covered hospital inpatient care. The plan also covers skilled nursing facility care for a terminally ill patient when the illness reaches a point of predictable end.

If you have a private room, you will be responsible for the difference between the cost of the private room and the facility’s average charge for a semiprivate room. If the facility offers only private rooms, the plan will cover up to the amount that similar facilities in the area charge for semiprivate rooms.

**Smoking Cessation**
The plan will cover smoking cessation services and supplies (including prescription drugs) that are provided by

- A physician.
- Another health care professional who is practicing within the scope of his or her license.
- An approved smoking cessation provider.

However, the plan will cover the cost only if the patient completes the full course of treatment. Smoking cessation treatment is subject to the benefit maximum shown in the “PPO+Account Schedule of Benefits” table.

**Spinal and Extremity Manipulations**
The plan will cover manipulations of the spine and extremities that are performed by hand by an approved provider. Examples of approved providers include a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), and a chiropractic doctor (D.C.).

Manipulations of the spine and extremities are subject to a benefit maximum. See the “PPO+Account Schedule of Benefits” table, beginning on page 6.

The plan also will cover related services such as an initial examination and initial X-rays.

**Substance Abuse Treatment**
The plan will cover substance abuse treatment under the mental health and substance abuse program. See “Mental Health and Substance Abuse Program,” on page 20.

**Temporomandibular Joint Dysfunction and Myofascial Pain Dysfunction Syndrome Treatment**
The plan will cover the following services and supplies from a physician or dentist to treat temporomandibular joint dysfunction and myofascial pain dysfunction syndrome (TMJ/MPDS) or any condition related to the temporomandibular joint, regardless of cause:

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

All TMJ/MPDS treatment must be approved in advance by the service representative in accordance with written guidelines and is subject to a benefit maximum. See the “PPO+Account Schedule of Benefits” table, beginning on page 6.
Therapies (Neurodevelopmental, Occupational, Physical, and Speech Therapy)
The plan will cover certain types of therapies, but only if the therapy will restore function significantly. You may use the following types of therapists:

- Occupational therapist for occupational therapy.
- Physical, occupational, or speech therapist for neurodevelopmental therapy for children through age six.
- Physical therapist for physical therapy.
- Speech therapist for speech therapy.

The type and duration of the therapy must be under an attending physician’s direction and supervision while you remain under that attending physician’s care. Your attending physician must evaluate the therapy treatment at least once every three months and certify that continuing therapy is necessary.

Neurodevelopmental therapy is physical, occupational, and speech therapy that treats neurodevelopmental delay (lack of motor or speech development that is not due to injury or trauma). The plan will cover neurodevelopmental therapy for children ages six and under, including in-home therapy for homebound children.

Neurodevelopmental therapy is subject to a benefit maximum. See the “PPO+Account Schedule of Benefits” table, beginning on page 6.

After three months, continued therapy must be approved by the service representative. The service representative bases its decision on the attending physician’s evaluation of the treatment and the therapist’s progress reports. The service representative reviews that information against established medical criteria to determine whether the recommended care will continue to improve function and will be covered.

Occupational, physical, and speech therapists must be duly licensed in the areas where services are performed and must be practicing within the scope of that license.

In the absence of licensing requirements, the therapist must be certified as a registered

- Occupational therapist by the American Occupational Therapy Association.
- Physical therapist by the American Physical Therapy Association.
- Speech therapist by the American Speech and Hearing Association.

Transplants
The plan will cover services and supplies for medically necessary transplants that meet the service representative’s guidelines, including certain transplants that are part of an approved clinical trial. You must request prior approval for a transplant. See “Medical Review Program,” on page 8.

The plan limits coverage to

- Selection of the organ.
- Removal of the organ.
- Storage of the organ.
- Transportation of the surgical harvesting team and organ.
- Other medically necessary organ procurement costs.

Vasectomy or Tubal Ligation
The plan will cover services and supplies required for a vasectomy or tubal ligation but not for a reversal.
**Mental Health and Substance Abuse Program**

This program will cover mental health and substance abuse treatment, including treatment for eating disorders and the abuse of or addiction to alcohol, recreational drugs, or prescription drugs. Aetna administers the program.

Mental health and substance abuse benefits are subject to the deductible, coinsurance, and benefit maximums shown in the “PPO+Account Schedule of Benefits” table.

**Referral**

This program uses a network of approved mental health and substance abuse treatment providers that is separate from the medical plan network of physicians and hospitals.

Your benefits generally will be greater when you see a network mental health or substance abuse treatment provider that has been recommended to you by Aetna. These network providers have agreements with the service representative to provide services at discounted rates.

All treatment will be reviewed for medical necessity.

**Emergency Mental Health or Substance Abuse Treatment**

If you are hospitalized in an emergency for mental health or substance abuse treatment and you are unable to call Aetna before admission, then you, your physician, a family member, or a friend must call within 48 hours of the admission. Aetna will determine whether the plan will cover your hospital stay and will coordinate coverage with the service representative.

If you are admitted to a nonnetwork hospital, you may be asked to transfer to a network hospital once your condition stabilizes. Plan payment levels will be lower if you choose to remain in a nonnetwork hospital. (A situation is considered an emergency when there is imminent danger to yourself or others or you are medically compromised because of mental illness or substance abuse.)

**Mental Health Treatment**

This program will cover mental health treatment when it is medically necessary and is received from any provider referred by Aetna or from an eligible provider, including any licensed

- Clinical psychologist.
- Hospital or treatment facility.
- Psychiatric physician (M.D.).
- Psychiatric nurse (R.N.) or psychiatric professional at the master’s level or above.

Generally, if the mental health treatment is related to, accompanies, or results from substance abuse, the program will cover only substance abuse treatment, as described next.

**Substance Abuse Treatment**

The program will cover the following substance abuse treatments and services:

- Medically necessary treatment for alcoholism.
- Other types of medically necessary substance abuse treatment at an approved treatment facility or hospital.
- Medically necessary services of a physician and licensed therapist.
- Prescription drugs in connection with your physician’s specific treatment plan.

An approved substance abuse treatment facility is one that treats chronic alcoholism and/or drug abuse and that is licensed and regulated by the appropriate governmental agency in its location.

The plan will cover detoxification only when it is followed immediately by rehabilitation. To receive coverage for substance abuse treatment, the patient must complete the prescribed course of medically necessary treatment.
Call for Preapproval
Before you begin any mental health or substance abuse treatment, call Aetna. If you are hospitalized in an emergency, call within 48 hours to request approval for coverage. No additional review will be required for the period that was approved.

Your claim will be denied if you do not preauthorize care through Aetna. Your denied claim will be reconsidered only after Aetna reviews and certifies your care as covered.

Prescription Drug Program
Pharmacy benefits are provided through Aetna and Aetna Rx Home Delivery®.

Schedule of Benefits

<table>
<thead>
<tr>
<th>PPO+Account Prescription Drug Program Schedule of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>The PPO+Account prescription drug program is administered by Aetna and Aetna Rx Home Delivery (the service representatives).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Retail pharmacy card program</th>
<th>Supply limited to 30 days (annual deductible does not apply for certain preventive medications)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>90%</td>
</tr>
<tr>
<td>Brand formulary</td>
<td>80%</td>
</tr>
<tr>
<td>Brand nonformulary</td>
<td>70%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mail-order pharmacy program</th>
<th>Supply limited to 90 days (annual deductible does not apply for certain preventive medications)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>90%</td>
</tr>
<tr>
<td>Brand formulary</td>
<td>80%</td>
</tr>
<tr>
<td>Brand nonformulary</td>
<td>70%</td>
</tr>
</tbody>
</table>

How the Prescription Drug Program Works
The prescription drug program will cover medically necessary prescription drugs and medicines that are required by Federal or state law to be prescribed in writing by a physician or dentist and dispensed by a licensed pharmacist.

You can buy prescription drugs and medicines in two ways:
- Retail pharmacy card program for short-term or immediate prescriptions (Aetna participating pharmacies).
- Mail-order pharmacy program for maintenance or long-term prescriptions (Aetna Rx Home Delivery).
- The prescription drug program also features a formulary, which is a list of generic and preferred brand drugs.

Prescription Drug Program Benefit Levels
The prescription drug program has three benefit levels:
- Generic prescription drugs.
- Brand-name prescription drugs that are on the formulary (brand formulary drugs).
- Brand-name prescription drugs that are not on the formulary (brand nonformulary drugs).

Each coinsurance level is shown in the “PPO+Account Prescription Drug Program Schedule of Benefits” table, above.
A formulary is a list of medications that are

- Approved by the FDA.
- Determined effective in treatment and cost.
- Manufactured by major drug companies.

An independent group of practicing physicians and pharmacists developed the formulary and reviews it routinely. When clinical data show that several drugs are equally effective, the most cost-effective drug usually is chosen.

A nonformulary drug also may be effective for treatment, but it is not as cost-effective as formulary or generic prescription drugs.

**Filling Your Short-Term or Immediate Prescriptions**

You can fill a prescription for a short-term medication at any Aetna retail participating pharmacy. The maximum supply is 30 days. However, the supply of certain medications may be limited by clinically established guidelines and/or Federal dispensing standards.

**Filling a Prescription by Mail Order**

If you take maintenance prescription drugs for the treatment of a long-term or recurring condition (such as arthritis, asthma, contraception, diabetes, high blood pressure), you can obtain up to a 90-day supply per prescription or refill through the mail for addresses within the United States and its territories.

The service representative provides two convenient ways for you to submit orders for new or renewal prescriptions:

- **By U.S. Mail:** Complete the mail-order pharmacy form and submit it with your prescription.
- **By fax:** Ask your physician to complete the fax request form and submit it directly to the service representative. The service representative must receive the forms and prescriptions from a secure fax machine that is associated with the physician’s office and will verify them.

After you enroll in the PPO+Account, the service representative will send you an information kit, which will contain a mail-order request form. To request additional forms, contact the service representative or print them directly from the service representative’s web site.

If you place your order by mail, you generally will receive new prescriptions within 7 to 11 days. Orders placed through the Internet or by telephone or fax may be received faster. You should have at least a 14-day supply when you place your order.

You can order refills

- By telephone.
- On line.
- By mail.

Because of the time required for mail-order shipments, this part of the prescription drug program is not suitable for one-time prescriptions, emergencies, or temporary conditions.

**Covered Prescriptions**

To be covered under the prescription drug program, the prescription drug or device must

- Be approved by the U.S. Food and Drug Administration (FDA).
- Be dispensed by a licensed pharmacist.
- Be prescribed on an outpatient basis by a doctor.
- Not be sold over the counter.
- Not be specifically excluded by the plan.
When an existing drug changes or when the FDA approves new drugs, these drugs also must meet the above criteria before the drug is covered under the prescription drug program. Furthermore, the plan has the right to determine which drugs will be covered, limited, or excluded under the prescription drug program.

This program covers most kinds of prescription drugs as long as they meet the above criteria, including the following drugs and supplies:

- Insulin as well as test strips and lancets.
- Needles and syringes when prescribed with insulin or other covered injectables.
- Legend drugs, including allergy serum, contraceptive medications, and smoking cessation medications.

Refills can be obtained near the end of your supply, as authorized by your prescription.

A legend drug is any drug that, according to Federal law, must be labeled “Caution: Federal law prohibits dispensing without a prescription.”

For information about drugs that are not covered under the prescription drug program, see “PPO+Account Exclusions,” below.

Certain dosages, quantities, and medications require preapproval by the service representative. If your prescription exceeds the Federal or clinically recommended dosage or quantity limits or is prescribed for a certain condition, your prescription may be denied. In this case, your physician must contact the service representative to provide clinical information needed for the preauthorization process.

The service representative will apply standards based on FDA-approved labeling and clinical guidelines. The service representative will seek to ensure that you receive the most appropriate prescription for your condition by reviewing

- Possible interactions with other current prescriptions.
- Cost-effectiveness.
- Whether the prescription is age appropriate.
- Whether the dosage and quantity are appropriate.

In certain situations, it may be more clinically appropriate to take a stronger dose once a day than to take a lower dose twice a day. If this opportunity exists, the service representative may ask your physician to approve the changes to the dosage and strength before authorizing payment with your pharmacist.

**Vision Service Program**

Vision Service Plan (VSP) administers the vision care program and is the service representative. When you receive services from a network provider, the provider will verify eligibility and will bill the service representative directly. When you receive services from a nonnetwork provider, claims for these vision care services or hardware must be submitted to the service representative for reimbursement.
### PPO+Account Vision Care Schedule of Benefits

The PPO+Account vision care is administered by VSP (the service representative).

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Network*</th>
<th>Nonnetwork**,†</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eye examination</strong></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 every 12 months (network and nonnetwork combined)</td>
<td>▪ Limited to one eye examination every 12 months (network and nonnetwork combined)</td>
</tr>
<tr>
<td><strong>Lenses</strong></td>
<td>Limited to two sets of lenses every two years (network and nonnetwork combined)</td>
<td>Limited to two sets of lenses every two years (network and nonnetwork combined) and subject to the following benefit maximums (annual deductible does not apply)</td>
</tr>
<tr>
<td><strong>Single vision</strong></td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td><strong>Bifocal</strong></td>
<td>$80</td>
<td>$80</td>
</tr>
<tr>
<td><strong>Trifocal</strong></td>
<td>$95</td>
<td>$95</td>
</tr>
<tr>
<td><strong>Lenticular</strong></td>
<td>$155</td>
<td>$155</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td>▪ $90</td>
<td>▪ $90</td>
</tr>
<tr>
<td></td>
<td>▪ Limited to two frames every two years (network and nonnetwork combined); annual deductible does not apply</td>
<td>▪ Limited to two frames every two years (network and nonnetwork combined); annual deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>▪ 20% discount on complete pairs of prescription glasses</td>
<td>▪ No discount applies</td>
</tr>
<tr>
<td><strong>Contact lenses</strong> (in place of allowance for conventional lenses and frames)</td>
<td>▪ $120 (annual deductible does not apply)</td>
<td>▪ $120 (annual deductible does not apply)</td>
</tr>
<tr>
<td></td>
<td>▪ $15 discount on contact lens fitting and evaluation examination</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.

** The nonnetwork payment level is based on the usual and customary charge (as defined by this plan). You are responsible for paying any charges in excess of the amount the service representative determines to be the usual and customary charge.

† For certain benefits, the plan will pay 90% of usual and customary charges if the service representative does not maintain a network of providers in a particular license category in a certain area.

### PPO+Account Exclusions

The PPO+Account does not pay charges for or related to the following items.

**Cosmetic Surgery**

The plan does not cover any type of cosmetic surgery, except as described in "Covered Services and Supplies," beginning on page 10.

**Dental Services**

The plan does not cover the following dental services:

- Any dental services, except as specifically provided for prompt repair of accidental damage and certain oral surgery services.
- Banding treatment.
- Correction of the gums, teeth, or tissues of the mouth for dental purposes.
- Nonsurgical orthodontia treatment, except as described for TMJ/MPDS.
- Removing, repairing, replacing, restoring, or repositioning teeth lost or damaged in the course of biting or chewing.
- Restorative techniques to build occlusion unless the tooth is diseased or accidentally damaged.

**Diagnostic X-Ray and Laboratory Services**
The plan does not cover a full-body computerized axial tomography (CAT) scan or other full-body imaging procedure.

**Durable Medical Equipment**
The plan does not cover medical equipment or supplies that are not solely related to medical care of a diagnosed illness or injury, including but not limited to
- An adjustable bed.
- Any luxury or convenience item or supply.
- Environmental control devices (air conditioners, purifiers, humidifiers).
- Equipment used primarily to prevent illness or injury.
- General exercise equipment.
- Items designed primarily to assist a person who is caring for the patient.
- Items that generally are useful in the absence of a medical condition.
- Modification to a home (wheelchair ramps, support railings), an automobile, or a van (ramps, lifts).
- Orthopedic chair.
- Over-the-counter items related to orthopedic appliances and braces.
- Personal hygiene items.
- Special car seats.
- Swimming pool, spa, or whirlpool.

**Hearing Aids and Related Supplies and Services**
The plan does not cover the following hardware or supplies when they are related to hearing aids:
- Eyeglass-type hearing aids if the charge exceeds the covered charge for one hearing aid.
- Hearing aids ordered before the patient becomes eligible for coverage or after coverage ends.
- Hearing aids ordered before coverage ends but delivered more than 60 days after coverage ends.
- Hearing aids that do not meet professionally accepted standards, including any experimental services or supplies.
- Hearing or audiometric examinations, unless disease is present.
- Replacement batteries.
- Replacement of lost, broken, or stolen hearing aids, unless the three-year period is exhausted.
- Replacement parts for hearing aid repair, unless part of an overhaul after three years from the date of purchase.

**Home Health Care and Hospice Care**
The plan does not cover the following home health care or hospice care services or providers:
- Homemaker or housekeeping services.
- Hospice services that are provided by financial, legal, or spiritual counselors.
- Hospice services to other family members, including bereavement counseling.
- Maintenance or custodial care.
- Psychiatric care.
- Services that are provided by volunteers, household members, family, or friends.
- Social services.
- Supplies or services not included in the written home health or hospice care treatment plan or not otherwise covered.
- Unnecessary or inappropriate services, food, clothing, housing, or transportation.

**Infertility**
The plan does not cover the following services, tests, or procedures related to infertility:

- Any tests, visits, consultations, or treatment that is related to, leads to, or results in a charge not covered by the plan.
- Artificial insemination.
- Consecutive follicular ultrasounds, cycle therapy, or corresponding laboratory tests when associated with any artificial means of conception.
- Embryo transfer.
- Fertility drugs when associated with any artificial means of conception.
- Gamete intrafallopian transfer (GIFT).
- In vitro fertilization.
- Microinjections.
- Reversal of a sterilization procedure.
- Sperm preparation.
- Sperm separation.
- Zona drilling.

**Maintenance Therapy**
The plan does not cover treatment that seeks to prevent disease, promote health, or prolong and enhance the quality of life or therapy performed to maintain or prevent deterioration of a chronic condition. Once the maximum therapeutic benefits have been achieved for a given condition, any additional therapy is considered maintenance therapy.

**Prescription Drugs**
The prescription drug program does not cover the following prescription drugs or related services:

- Administration or injection charges for any drug.
- Any prescription drug for which the person is covered or eligible to receive benefits under another employer's group benefit plan or a workers' compensation law or from any municipality, state, or Federal program, including a Medicare prescription drug plan, except as required by law.
- Any prescription filled in excess of the quantity prescribed.
- Any refill after one year from the date of the prescription.
- Any service or supply otherwise excluded by the PPO+Account or vision care program.
- Appliances, devices, or other nondrug items, including but not limited to therapeutic devices or artificial appliances. However, this does not apply to needles and syringes when they are prescribed along with insulin or other covered injectables or to other diabetic supplies.
- Delivery or handling charges.
- Drugs that are dispensed during an inpatient admission by a hospital, skilled nursing facility, sanatorium, or other facility unless covered as part of a hospital stay or administered by a physician as part of an office visit.
- Drugs that are not medically necessary for the treatment of an illness, injury, or other covered condition, including vitamins, except as specifically provided by the plan.
- Experimental or investigational drugs.
- Fertility agents, unless approved by the service representative.
- Immunizing agents, except allergy serums.
- Infusion therapy drugs, except as described in the home health care benefit.
- Medication to treat sexual dysfunction, obesity, or infertility, unless the patient is being treated for a diagnosed medical condition and the medication is authorized in advance by the service representative.
- Obesity drugs, unless approved by the service representative.
- Over-the-counter drugs that can be obtained without a prescription, except for insulin.
- Replacement of lost or misplaced prescriptions.

**Prostheses**
The plan does not cover wigs or hair prostheses unless hair loss is due to chemotherapy or radiation therapy.

**Smoking Cessation**
The plan does not cover the following services or supplies for smoking cessation:
- Acupuncture.
- Books or tapes.
- Hypnotherapy (unless performed by an approved provider).
- Inpatient services.
- Over-the-counter drugs.
- Vitamins, minerals, or other supplements.

**Therapies**
The plan does not cover the following services relating to neurodevelopmental, occupational, physical, and speech therapies:
- Custodial maintenance.
- Educational therapy.
- Recreational therapy.
- Self-help programs.
- Therapy elected by you.
- Therapy given at a therapist’s discretion.
- Therapy to slow body degeneration but not to improve or restore functionality.

**Transplants**
The plan does not cover the following services or supplies relating to transplants:
- Any portion of the cost of a covered treatment that is funded by government or private entities as part of an approved clinical trial.
- Donor or procurement services or costs incurred outside the United States, unless specifically approved by the service representative.
- Donor services or supplies when donor benefits are available through other group coverage.
- Expenses incurred when the transplant recipient is not covered under this plan.
- Experimental or investigational services or supplies, unless part of an approved clinical trial.
- Living (noncadaver) donor transplants, unless specifically approved by the service representative.
- Lodging, food, or transportation costs, unless otherwise specifically covered under this plan.
- Nonhuman, artificial, or mechanical transplants, unless specifically approved by the service representative.

**Other Medical Exclusions**

In addition to the services and supplies listed above, the plan also does not cover the following:

- An accident or illness that is covered by workers’ compensation law.
- Amounts that exceed covered charges or usual and customary charges.
- Benefits for services and supplies that, in the opinion of the service representative, are associated with injuries, illnesses, or conditions suffered due to the acts or omissions of a third party.
- Charges for completing claim forms or reports.
- Confinement or surgical, medical, or other treatment, services, or supplies that are received in or from a U.S. Government hospital, except as required by law.
- Counseling (career, child, family, financial, marriage, pastoral, or social adjustment), unless certified as medically necessary through Aetna.
- Custodial care that does not require continuing services by skilled medical or health professionals and primarily assists in the activities of daily life. Custodial care includes but is not limited to help in walking, getting into and out of bed, toileting, bathing, dressing, feeding, preparing special diets, and supervising medications that ordinarily are self-administered.
- Education, special education, or job training, whether or not from a facility that also provides medical or psychiatric care.
- Experimental or investigational services or supplies or complications related to those services.
- Impotence that is not organic in origin such as psychosexual dysfunction.
- Inpatient hospital care (including physician visits while hospitalized) that is not considered medically necessary when it can be provided safely in an outpatient setting without adversely affecting your physical condition. (An outpatient setting includes a hospital outpatient department, a physician’s office, or a freestanding surgical facility.)
- Inpatient psychiatric care to control or change the patient’s environment.
- Institutional care primarily to support self-care and to provide room and board.
- Intentionally self-inflicted injury, unless it results from a medical condition.
- Missed appointments.
- Obesity services or supplies, unless approved in advance by the service representative according to written guidelines (available by calling the service representative).
- Recovery houses, school programs, or emergency service patrols.
- Services or supplies for which no charge is incurred or that you are not required to pay.
- Services or supplies not recommended and approved by a physician or other covered health care professional or those provided before coverage begins.
- Services or supplies required by law to be provided by any school system.
- Services or supplies the service representative determines are not medically necessary to treat an accidental injury, illness, or other covered condition. This includes routine physical examinations, immunizations, or other preventive services or supplies, except as specifically covered by the plan as described in “Covered Services and Supplies,” beginning on page 10.
- Services or supplies to the extent they are covered under any discontinued Company-sponsored plan.
Definitions

Benefit Year
The 12-month period that each plan uses to calculate the annual deductible, annual coinsurance maximum, and other benefit limits. The benefit year for the PPO+ Account is January 1 through December 31.

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

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 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, or payment limitation of the plan.

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

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.
- 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 below.

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.
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.

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

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.

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

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

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.

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.

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

Service Area
The geographical area designated by the plan that determines eligibility for a health care plan and the network level of coverage.
Substance Abuse
An alcohol- or drug-related disorder that exhibits signs, symptoms, history, and other characteristics congruent with those required for a substance-related disorder in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV).

Health Savings Account
If you enroll in the PPO+Account medical plan, you may be eligible to set up a special tax-advantaged bank account, the Aetna Health Savings Account (HSA), for paying health care services.

The current service representative is Aetna/JPMorgan Chase.

Aetna HSA Highlights
- Boeing will make tax-free contributions to your account each pay period. You can choose to make your own additional contributions through payroll deductions. Your contributions will not be subject to Federal income tax, but if you live in certain states, including California, they will be subject to state tax.
- Money in your account earns interest free from Federal tax and is not taxed when withdrawn to pay for qualified health care expenses. However, if you live in certain states, including California, your HSA earnings are subject to state tax.
- If you do not use the money in one year to pay medical expenses, the balance rolls into the next year to use for future medical expenses—even after you retire. There is no limit on how much you can accumulate in your account.
- For 2008, your Aetna HSA will accumulate in an interest-bearing account. There is no minimum balance requirement to earn interest, and the interest rate is based on the JPMorgan Chase Money Market Account. In future years, you may have additional investment options.
- You own the money in your Aetna HSA and choose how to spend or save the funds. If you leave Boeing, the funds are yours to take with you.

Aetna HSA Eligibility
The Federal Government has special eligibility rules for an HSA, as described below (these requirements differ from Boeing health plan eligibility rules).

You may be eligible to set up an HSA if you
- Are covered by a high-deductible health plan, such as the PPO+Account.
- Are not claimed as a dependent on someone else's tax return (except your spouse).
- Are not covered by another health plan such as
  - Your spouse’s health plan (unless it is a high-deductible health plan).
  - A health care flexible spending account, including your spouse’s flexible spending account (unless it is a “limited-use” spending account designed to work with an HSA).
  - Medicare.
  - TRICARE.
  - Veterans Affairs medical benefits (used during the past three months).

You will have to certify that you meet the HSA eligibility requirements when you enroll.

If your spouse is enrolled in a high-deductible health plan, it may affect how much you can contribute to your HSA.

Contributing to Your Aetna HSA
The amount Boeing will contribute to your account is based on the coverage level you elect. The contribution will be equally divided among your paychecks for the year.
You can make your own optional contributions to your Aetna HSA through payroll deductions. The amount you can contribute is subject to Federal limits. You can change your contributions at any time during the year, for any reason. Even if you decide not to contribute, you still will receive Boeing’s contribution.

The amount Boeing contributes to your HSA will change each year.

**Using the Aetna HSA**

When contributions are made and you have funds in your Aetna HSA, you can use them tax free to pay the PPO+Account medical coverage deductible and coinsurance or other qualified medical expenses for yourself or eligible family members.

Eligible family members include your spouse or any family member who is eligible to enroll as your dependent in a Boeing medical plan. It also includes any dependent who is claimed on your Federal income tax return. (They do not have to be enrolled in the PPO+Account medical coverage.) Some same-gender domestic partners may not be considered eligible family members for HSA reimbursement purposes if they do not qualify as your Section 105 dependent.

Aetna will make your HSA funds available to you through an ATM debit card from JPMorgan Chase to:

- Pay providers, including doctors and pharmacies.
- Make cash withdrawals to pay providers or reimburse yourself for expenses you have paid with other funds.

The full amount of your and Boeing’s contributions will not be available for use on January 1 because the contributions are evenly divided among your pay periods. If there is not enough money in your account to cover a qualified health care expense, you can pay it with your personal funds and reimburse yourself later when enough money is in your HSA; there is no time limit. However, you cannot use your Aetna HSA to pay for expenses incurred before you opened the account.

There are certain fees associated with an Aetna HSA. Boeing will pay the monthly maintenance fee; you will be responsible for the others.

**Withdrawals and Tax Implications**

If you withdraw money to pay qualified health care expenses, there is no Federal or state tax in any state. Money withdrawn from an HSA for anything other than qualified medical expenses generally is taxable under Federal law as ordinary income and is subject to a 10 percent tax penalty. The additional 10 percent tax does not apply if the withdrawal is made after your death, disability, or reaching age 65.

**Important HSA Information**

The Aetna HSA is not subject to ERISA (the PPO+Account medical coverage is subject to ERISA).

Because Boeing does not sponsor or endorse the Aetna HSA, there are some differences between it and medical plans sponsored by Boeing:

- Your Aetna HSA will not offer COBRA continuation rights (unlike the PPO medical coverage, which may be continued through COBRA). However, the HSA is your account and it is portable, which means you can maintain it with Aetna after you leave Boeing, or you can move it to another qualified HSA. You also can continue making contributions to your HSA after you leave Boeing, provided you are enrolled in a high-deductible health plan and meet all other contribution requirements.
- Aetna sponsors and administers the HSA; neither Boeing nor the Employee Benefit Plans Committee will have any involvement in HSA administration or claim issues.
- Please keep in mind the HSA is your personal account with Aetna. As a result, Boeing cannot sponsor or endorse it.
HMO Plans
The following changes will apply to all the HMO plans:

- The annual out-of-pocket maximum per individual will be $2,500. The annual out-of-pocket maximum per family will be $5,000.
- Inpatient hospital services copayment will be $250 per inpatient confinement.
- Emergency room copayment will be $75 per visit.

Health Net HMO
Prescription drugs will be covered as follows:

<table>
<thead>
<tr>
<th>Health Net HMO Prescription Drug Schedule of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating retail pharmacy</td>
</tr>
<tr>
<td>Generic</td>
</tr>
<tr>
<td>$5 copayment</td>
</tr>
<tr>
<td>Brand formulary</td>
</tr>
<tr>
<td>$20 copayment</td>
</tr>
<tr>
<td>Brand nonformulary</td>
</tr>
<tr>
<td>$35 copayment</td>
</tr>
<tr>
<td>Mail-order program</td>
</tr>
<tr>
<td>Generic</td>
</tr>
<tr>
<td>$10 copayment</td>
</tr>
<tr>
<td>Brand formulary</td>
</tr>
<tr>
<td>$40 copayment</td>
</tr>
<tr>
<td>Brand nonformulary</td>
</tr>
<tr>
<td>$70 copayment</td>
</tr>
</tbody>
</table>

Kaiser Permanente HMO
Prescription drugs will be covered as follows:

<table>
<thead>
<tr>
<th>Kaiser HMO Prescription Drug Schedule of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating retail pharmacy</td>
</tr>
<tr>
<td>Generic</td>
</tr>
<tr>
<td>$5 copayment</td>
</tr>
<tr>
<td>Brand</td>
</tr>
<tr>
<td>$20 copayment</td>
</tr>
<tr>
<td>Mail-order program</td>
</tr>
<tr>
<td>Generic</td>
</tr>
<tr>
<td>$5 copayment</td>
</tr>
<tr>
<td>Brand</td>
</tr>
<tr>
<td>$20 copayment</td>
</tr>
</tbody>
</table>

Dental Plans
The changes and clarifications in this section will apply to the McDonnell Douglas Group Life, Disability & Health Benefits Plan (Plan 529). Contact the Boeing Service Center through Boeing TotalAccess for details.

Dental Plan Choices
Dental plan choices will be as follows:

California
- Delta Dental PPO Plan
- Delta Dental prepaid dental plan
- Safeguard prepaid dental plan
**All Other Locations**

- Delta Dental PPO Plan

**Dental PPO Plan**

The Delta Dental PPO Plan described here will be available to you and your eligible dependents.

This plan will help you and your eligible dependents pay for minor and major dental work, including routine examinations, crowns, and orthodontia.

You and your eligible dependents may receive dental care from any licensed dentist or other licensed professional who is approved by the plan. However, your out-of-pocket costs generally will be lower if you use a network dentist. If you use a nonnetwork dentist, your out-of-pocket costs generally will be higher. If you live outside of the network service area, the plan generally will cover dental care at the network benefit level.

**Changes to the PPO Plan**

The following changes will apply to the Delta Dental PPO Plan:

- The annual dental maximum will be $2,000 in paid benefits (network and nonnetwork combined).
- The lifetime orthodontia maximum will be $2,000 in paid benefits (network and nonnetwork combined).
- Eligible nonnetwork preventive care and diagnostic X-rays will be covered at 80 percent after the deductible.
- Eligible network major dental services will be covered at 60 percent.
- The PPO network service area will expand from the greater five-county area to include all counties in California. The network benefit for nonnetwork providers outside the five-county area no longer will apply in California.

**Frequency Limits**

The frequency of covered dental services will change as follows:

- Supplementary bitewing X-rays will be covered once every year for dependent children through age 17.
- Scaling and root planing will be covered once per area every two years.
- Osseous surgery will be covered once per area every three years.

**Medical Plan Contributions**

The changes and clarifications in this section will apply to the McDonnell Douglas Group Life, Disability & Health Benefits Plan (Plan 529). Contact the Boeing Service Center through Boeing TotalAccess for details.

Your contribution amount is governed by your collective bargaining agreement. Monthly contribution amounts will change effective January 1, 2008. For additional information regarding your contributions, please refer to your contract/bargaining agreement.

**Other Health Care Plan Changes and Clarifications**

The changes and clarifications in this section will apply to the McDonnell Douglas Group Life, Disability & Health Benefits Plan (Plan 529). Contact the Boeing Service Center through Boeing TotalAccess for details.

**Continuation of Medical Coverage (COBRA)**

Medical and dental coverage continued after the sixth calendar month of medical leave will be considered COBRA continuation coverage.
Special Enrollment (Health Care Plans)
If you or your eligible dependent reaches the lifetime maximum benefit under a Company-sponsored plan, you may enroll in another Company-sponsored plan in your area if you are eligible.

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

Retiree Medical Plan
Deferred Enrollment
If you defer enrollment in retiree medical coverage because of other employer-sponsored health care coverage (such as through your spouse’s employer), you may be able to enroll yourself and your eligible dependents in a Company-sponsored retiree medical plan at a later date as long as enrollment is within 60 days after other coverage ends. Your later enrollment is not contingent on commencing your pension benefit.
Savings Plan
The changes in this section apply to The Boeing Company Voluntary Investment Plan. Contact the Boeing Service Center through Boeing TotalAccess for details.

The following change is effective July 1, 2007:
- You no longer are required to complete one year of service before employer-matching contributions begin.

The following changes will be effective January 1, 2008:
- If you are a newly hired or rehired eligible employee, you will be enrolled automatically in the Voluntary Investment Plan at a pretax employee contribution rate of 4 percent of base pay unless you actively enroll or elect not to participate. These automatic employee contributions will begin 60 days after you become eligible for the Plan. These contributions are eligible for an employer-matching contribution.
- If you are eligible to participate in the Plan, you may choose the contribution rate escalator feature, which automatically increases your contribution rate as you specify. You select a percentage increase (in one percent increments up to the Plan’s maximum) and the frequency of future rate increases (quarterly, semi-annually, or annually). The contribution rate escalator does not apply to catch-up contributions.

At any time before or after contributions begin, you may change your contribution rate or elect not to participate. To make changes, go to the Boeing Savings Plans Online web sites through Boeing TotalAccess or contact the Boeing Service Center through Boeing TotalAccess, as described in “For More Information” below.

Retirement Plan
The changes in this section apply to the Employee Retirement Income Plan of McDonnell Douglas Corporation—Hourly West Plan. Contact the Boeing Service Center through Boeing TotalAccess for details.

The following change is effective June 1, 2007:
- For retirements from the active payroll, the retirement accrued benefit is $70 for each year of benefit service.

The following change is effective July 1, 2007:
- Employees who are at least age 49 and have 10 years of vesting service on their layoff date are eligible to elect to start their early retirement pension anytime within six years of the layoff date (but not before age 55). Their benefit must begin on the first day of the month following the month in which they elect to start their benefit as long as it is within the six-year layoff period. If they do not elect to commence retirement benefits within six years of layoff, employees become deferred vested. This bridge does not age employees into eligibility for retiree medical benefits.

For More Information
Contact the Boeing Service Center through Boeing TotalAccess.

- On the Boeing Web: Log on to https://my.boeing.com and click the TotalAccess tab.
- On the World Wide Web: Log on to https://my-ext.boeing.com using your BEMS ID number (or Social Security number) and your Boeing TotalAccess password.
- By telephone: Call 1-866-473-2016. TTY/TDD services are available at 1-800-755-6363. You must have your BEMS ID number (or Social Security number) and your Boeing TotalAccess password. Customer service hours vary by service center; representatives generally are available during regular business hours.
Plan Amendment Information

This Update is a summary of material modifications to your summary plan descriptions for

- The Boeing Company Voluntary Investment Plan (Plan 002).

This document is provided to you in accordance with the Employee Retirement Income Security Act of 1974, as amended (ERISA).

If there is any discrepancy between this Update and the Plan documents listed above, the Plan documents will control. Although the Company fully intends to continue the Plans described here, the Company reserves the right to change, modify, amend, or terminate them at any time and for any reason for employees, former employees, retirees, and their dependents.
Summary of Benefit Plan Change

Employees Represented by DASO

This Update summarizes the collectively bargained change to your retirement plan and updates your summary plan description. The effective date of the change is January 1, 2009.

The change described in this Update will apply to you if you are an active employee of The Boeing Company (the “Company”) who is represented by the Douglas Association of Security Officers (DASO). The change in this Update applies to the Employee Retirement Income Plan of McDonnell Douglas Corporation—Hourly West Plan (Plan 002) (the “Plan”).

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

Retirement Plan Change

If you retire from the active payroll with a benefit commencement on or after January 1, 2009, your accrued benefit will be $70 for each year of benefit service.

For More Information

Contact the Boeing Pension Service Center through Boeing TotalAccess.

- On the Boeing Web: Log on to 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 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 description for the Employee Retirement Income Plan of McDonnell Douglas Corporation—Hourly West Plan (Plan 002).

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 official Plan document for the Plan listed above, the official Plan document will control. Copies of the summary plan description may be obtained from the Boeing Pension Service Center through Boeing TotalAccess.

Although the Company fully intends to continue the Plan described here, the Company reserves the right to change, modify, amend, or terminate it at any time and for any reason for employees, former employees, retirees, and their beneficiaries.
Summary of Benefit Plan Changes and Clarifications

Employees Represented by IAFF I-66 (California), IAM 725, IBEW 2295, IUOE 501 (Welders), and SPFPA 159 and 160

This Update summarizes the collectively bargained and administrative changes and clarifications that will affect your benefit plans and updates your summary plan descriptions. The effective date of each change is January 1, 2010, unless otherwise noted.

The changes and clarifications in this Update will apply to you if you are an active employee of The Boeing Company (the “Company”) who is represented by the

- International Association of Firefighters (IAFF), Local No. I-66 (California).
- International Association of Machinists and Aerospace Workers (IAM), Local No. 725.
- International Brotherhood of Electrical Workers (IBEW), Local No. 2295.
- International Union of Operating Engineers (IUOE), Local No. 501 (Welders).
- International Union, Security, Police and Fire Professionals of America (SPFPA), Local Nos. 159 and 160.

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 or clarifications in this Update will apply to the following plans:

- The Boeing Company Voluntary Investment Plan (Plan 002).

Dependent Eligibility

Eligible Dependents

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

You may request coverage for the following dependents:

- An opposite-gender common-law spouse if the relationship meets the common-law requirements for the state where you entered into the common-law relationship.

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A same-gender domestic partner if you and your same-gender domestic partner meet all of the following requirements:

- You and your partner live in the same permanent residence in a permanent, exclusive, emotionally committed, and financially responsible relationship similar to a marriage, and
- 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, and
- Your domestic partner relationship does not exist solely to obtain coverage under the Plan.

If an individual is recognized under state law as your same-gender spouse, he or she qualifies as a same-gender domestic partner under the Plan.

Unmarried children of your same-gender domestic partner who are under age 25 and dependent on you for principal support. These children are considered stepchildren for the purpose of the medical and dental plans.

Other children, as follows, who are under age 25, unmarried, and dependent on you for principal support:

- Children who are related to you either directly or through marriage (e.g., grandchildren, nieces, and nephews).
- Children for whom you have legal custody or guardianship (or for whom you have a pending application for legal custody or guardianship) and are living with you.

Proof of dependent eligibility will be required.

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

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

Special Provisions When Family Members Are Boeing Employees

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

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

Disabled Children

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

Special applications for coverage are required for disabled dependent children age 25 or older.
Medical Plan Choices
Medical plan choices will be as follows:
- Regence Traditional PPO.
- Aetna PPO+Account.
- Health Net HMO.
- Kaiser HMO.

Aetna PPO+Account Medical Coverage
The current PPO+Account with a Health Reimbursement Account (HRA) will be replaced by the PPO+Account with an Aetna Health Savings Account (HSA). The new PPO+Account meets Federal guidelines for a high-deductible health plan. Plan provisions are highlighted below. Generally, the plan pays 90% of covered services and supplies after the annual deductible.

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| Annual deductible              | $1,500 employee only
                                         $2,625 employee + spouse or child(ren)
                                         $3,750 employee + spouse and child(ren)  |
| Network out-of-pocket maximum  | $1,600 employee only
                                         $2,800 employee + spouse or child(ren)
                                         $4,000 employee + spouse and child(ren)  |
| Nonnetwork out-of-pocket       | $3,200 employee only
                                         $5,600 employee + spouse or child(ren)
                                         $8,000 employee + spouse and child(ren)  |
| maximum                         |                                                                                      |
| Lifetime maximum benefit       | $2 million                                                                           |
| Preventive cancer screenings   | 100%; not subject to $500 annual maximum for preventive care                         |
| Emergency room copayment       | None; subject to the deductible                                                      |
| Retail prescription drugs      | 90% generic
                                         80% brand formulary
                                         70% brand nonformulary
                                         Subject to the deductible (except for certain preventive care drugs)             |
| (30-day supply)                |                                                                                      |
| Mail-order prescription drugs  | 90% generic
                                         80% brand formulary
                                         70% brand nonformulary
                                         Subject to the deductible (except for certain preventive care drugs)             |
| (90-day supply)                |                                                                                      |
| Nonnetwork hearing aid benefits| Covered at the network level                                                        |
| Physical, speech, and          | No visit maximum                                                                      |
| occupational therapy benefits  |                                                                                      |
| Home health care benefits       | No visit maximum                                                                      |
| TMJ benefits                    | $3,500 lifetime maximum                                                               |
| Transplant benefits             | No maximum; subject to the deductible                                                |
Health Savings Account
If you enroll in the PPO+Account medical plan, you may be eligible to set up a special tax-advantaged bank account, the Aetna HSA, for paying health care services.

The current service representative is Aetna/JPMorgan Chase.

Aetna HSA Highlights
- Boeing will make tax-free contributions to your account each pay period. You can choose to make your own additional contributions through payroll deductions. Your contributions will not be subject to Federal income tax, but if you live in certain states, including California, they will be subject to state tax.
- Money in your account earns interest free from Federal tax and is not taxed when withdrawn to pay for qualified health care expenses. However, if you live in certain states, including California, your HSA earnings are subject to state tax.
- If you do not use the money in one year to pay medical expenses, the balance rolls into the next year to use for future medical expenses—even after you retire. There is no limit on how much you can accumulate in your account.
- Your Aetna HSA will accumulate in an interest-bearing account. There is no minimum balance requirement to earn interest, and the interest rate is based on the JPMorgan Chase Money Market Account. In future years, you may have additional investment options.
- You own the money in your Aetna HSA and choose how to spend or save the funds. If you leave Boeing, the funds are yours to take with you.

Aetna HSA Eligibility
The Federal Government has special eligibility rules for HSAs, as described below (these requirements differ from Boeing health plan eligibility rules).

You may be eligible to set up an HSA if you
- Are covered by a high-deductible health plan, such as the PPO+Account.
- Are not claimed as a dependent on someone else’s tax return (except your spouse).
- Are not covered by another health plan such as
  - Your spouse’s health plan (unless it is a high-deductible health plan).
  - A health flexible spending account, including your spouse’s flexible spending account (unless it is a “limited-use” spending account designed to work with an HSA).
  - Medicare.
  - TRICARE.
  - Veterans Affairs medical benefits (used during the past three months).

You will have to certify that you meet the HSA eligibility requirements when you enroll.

If your spouse is enrolled in a high-deductible health plan, it may affect how much you can contribute to your HSA.

Contributing to Your Aetna HSA
The amount Boeing will contribute to your account is based on the coverage level you elect. The contribution will be equally divided among your paychecks for the year.

You can make your own optional contributions to your Aetna HSA through payroll deductions. The amount you contribute is subject to Federal limits. You can change your contribution amount at any time during the year, for any reason. Even if you decide not to contribute, you still will receive Boeing’s contribution.

The amount Boeing contributes to your HSA will change each year.
Using the Aetna HSA

When contributions are made and you have funds in your Aetna HSA, you can use them tax free to pay the PPO+Account medical coverage deductible and coinsurance or other qualified medical expenses for yourself or eligible family members.

Eligible family members include your spouse or any family member who is eligible to enroll as your dependent in a Boeing medical plan. It also includes any dependent who is claimed on your Federal income tax return. (They do not have to be enrolled in the PPO+Account medical coverage.) Some same-gender domestic partners may not be considered eligible family members for HSA reimbursement purposes if they do not qualify as your Section 105 dependent.

Aetna will make your HSA funds available to you through an ATM debit card from JPMorgan Chase to
- Pay providers, including doctors and pharmacies.
- Make cash withdrawals to pay providers or reimburse yourself for expenses you have paid with other funds.

The full amount of your and Boeing’s contributions will not be available for use on January 1 because the contributions are evenly divided among your pay periods. If there is not enough money in your account to cover a qualified health care expense, you can pay it with your personal funds and reimburse yourself later when enough money is in your HSA; there is no time limit. However, you cannot use your Aetna HSA to pay for expenses incurred before you opened the account.

There are certain fees associated with an Aetna HSA. Boeing will pay the monthly maintenance fee as long as you are employed by Boeing and enrolled in the PPO+Account; you will be responsible for the other fees.

Withdrawals and Tax Implications

If you withdraw money to pay qualified health care expenses, there is no Federal or state tax in any state. Money withdrawn from an HSA for anything other than qualified medical expenses generally is taxable under Federal law as ordinary income and is subject to a 10 percent tax penalty. The additional 10 percent tax does not apply if the withdrawal is made after your death, disability, or reaching age 65.

Important HSA Information

The Aetna HSA is not subject to ERISA (the PPO+Account medical coverage is subject to ERISA).

Because Boeing does not sponsor or endorse the Aetna HSA, there are some differences between it and medical plans sponsored by Boeing:
- Your Aetna HSA will not offer COBRA continuation rights (unlike the PPO medical coverage, which may be continued through COBRA). However, the HSA is your account and it is portable, which means you can maintain it with Aetna after you leave Boeing, or you can move it to another qualified HSA. You also can continue making contributions to your HSA after you leave Boeing, provided you are enrolled in a high-deductible health plan and meet all other contribution requirements.
- Aetna sponsors and administers the HSA; neither Boeing nor the Employee Benefit Plans Committee will have any involvement in HSA administration or claim issues.
- Please keep in mind the HSA is your personal account with Aetna. As a result, Boeing cannot sponsor or endorse it.

Regence Traditional PPO Changes

The following changes will apply to the Regence Traditional PPO.

Annual Deductible

The network annual deductible will be $300 per individual ($900 per family of three or more). The nonnetwork annual deductible will be $600 per individual ($1,800 per family of three or more).
Annual Out-of-Pocket Maximum
The network annual family out-of-pocket maximum will be $6,000 per family of three or more. The nonnetwork annual family out-of-pocket maximum will be $12,000 per family of three or more.

Lifetime Maximum Benefit
The lifetime maximum benefit will be $1.75 million per individual.

Emergency Room
The copayment for emergency room treatment will be $75.

Mental Health Treatment
The nonnetwork 20-day annual limit on inpatient services and 20-visit annual limit on outpatient services will be eliminated.

Hearing Aids
The hearing aid benefit will be $800 per ear.

Neurodevelopmental Therapy
The neurodevelopmental therapy benefit maximum will be $1,500 each benefit year.

Prescription Drug Program
- Prescription drugs purchased at a participating pharmacy will be covered as follows:
  - $5 copayment generic.
  - $20 copayment brand formulary.
  - $35 copayment brand nonformulary.
  - 30-day supply.
- Prescription drugs purchased through the mail-order program will be covered as follows:
  - $10 copayment generic.
  - $40 copayment brand formulary.
  - $70 copayment brand nonformulary.
  - 90-day supply.

Preventive Care and Routine Physicals
Network preventive care services and supplies will be covered as follows:
- 100 percent (deductible does not apply) up to a $500 annual maximum for all preventive care, including routine physical examinations, related laboratory and X-ray charges, as well as childhood and adult immunizations as recommended by the U.S. Preventive Care Task Force guidelines. Covered expenses that exceed the $500 maximum will be subject to the deductible and coinsurance.
- 100 percent (deductible does not apply) with no annual maximum for routine Pap tests, mammograms, prostate screenings, and colorectal screenings (including colonoscopies) as recommended by the physician.
- 100 percent (deductible does not apply) with no annual maximum for preventive care for children to age two; includes immunizations according to the U.S. Preventive Care Task Force guidelines and as recommended by the physician.
Prescription Drug Provisions—Regence Traditional PPO and Aetna PPO+Account

Pharmacy Management

Certain dosages, quantities, and medications require preapproval by the service representative. Specific drugs are reviewed by the service representative at the point of sale to determine if the prescription is covered by the plan, clinically appropriate, and consistent with usage guidelines.

The service representative applies standards based on FDA-approved labeling and clinical guidelines. The service representative will seek to ensure that the patient receives the most appropriate prescription for the condition by reviewing

- Possible interactions with other current prescriptions.
- Cost-effectiveness.
- Whether the prescription is age appropriate.
- Whether the dosage and quantity are appropriate.

In certain situations, it may be more clinically appropriate to take a stronger dose once a day than to take a lower dose twice a day. If this opportunity exists, the service representative may ask the physician to approve the changes to dosage and strength before authorizing payment with the pharmacist.

Specialty Care Pharmacy

Specialty medications are typically injectable medications administered by the individual or a health care professional, and they often require special handling. Newly prescribed medications may be purchased at any participating retail pharmacy up to two times. After that, the plan will cover these prescriptions only if they are purchased through the service representative’s specialty care pharmacy.

HMO Changes

The emergency room copayment for all the HMOs will be $75.

Health Net HMO

- The annual out-of-pocket maximum will be $2,500 per individual ($5,000 per family).
- Prescription drugs purchased at a participating pharmacy will be covered as follows:
  - $5 copayment generic.
  - $20 copayment brand formulary.
  - $35 copayment brand nonformulary.
  - 30-day supply.
- Prescription drugs purchased through the mail-order program will be covered as follows:
  - $10 copayment generic.
  - $40 copayment brand formulary.
  - $70 copayment brand nonformulary.
  - 90-day supply.

Kaiser HMO

- Prescription drugs purchased at a participating pharmacy will be covered as follows:
  - $5 copayment generic.
  - $20 copayment brand formulary.
  - 100-day supply.
prescription drugs purchased through the mail-order program will be covered as follows:
- $5 copayment generic.
- $20 copayment brand formulary.
- 100-day supply.

medical plan contributions
your contribution amount is governed by your collective bargaining agreement. monthly contribution amounts will be
- four percent of plan rates for the PPO+Account, not to exceed the maximum contribution caps indicated in the collective bargaining agreement.
- twelve percent of plan rates for all other plans, not to exceed the maximum contribution caps indicated in the collective bargaining agreement.

Contributions are made on a pretax basis. for additional information regarding your contributions, please refer to your collective bargaining agreement.

Dental Plans
Dental PPO Plan Changes
The following changes will apply to the Dental PPO Plan:
- Nonnetwork coinsurance for diagnostic care will be 80 percent.
- Network coinsurance for major services will be 60 percent.
- Two additional cleanings will be allowed per benefit year if periodontal disease is present.
- Periodontal scaling and root planing will be covered once per area every two benefit years.
- Osseous surgery will be covered once per area every three benefit years.

Other Health Care Plan Clarifications
When an Injury or Illness Is Caused by the Negligence of Another
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 which 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.

Basic Life Insurance Plan

The basic life insurance benefit will be $30,000.

AD&D Plan

- The AD&D principal sum will be $30,000.
- The disability premium waiver provision will be discontinued for disabilities that begin on or after January 1, 2010.

Short-Term Disability Plan

The $100 minimum outpatient surgery requirement (to qualify for first day of disability benefits following outpatient surgery) will be eliminated.

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

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

If a person covered by this plan is injured by another party who is legally liable for the disability income replacement, 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.
Benefits Information (continued)

- 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, which 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 disability, 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.

Savings Plan
The current employer matching contribution level will remain the same.
Effective January 1, 2009, employees no longer will be required to complete one year of service before employer matching contributions begin.
Effective January 1, 2009, employees may contribute from 1 to 25 percent of their base pay on a pretax or aftertax basis, or a combination of both (not to exceed 25 percent), in 1 percent increments.

Retirement Plan
Effective January 1, 2009, for employees who retire from the active payroll during the term of this collective bargaining agreement, with a commencement date on or after January 1, 2009, the retirement accrued benefit will be $75 for each year of benefit service.
Administrative Changes

The Pension Protection Act (PPA) of 2006 included legislation that affects forms of benefit in the Employee Retirement Income Plan of McDonnell Douglas Corporation—Hourly West Plan. The following changes will be made to conform to the new and existing laws and regulations.

Forms of Benefit

Effective with benefit commencements on or after January 1, 2009, the following changes will be made to the Employee Retirement Income Plan of McDonnell Douglas Corporation—Hourly West Plan:

- The PPA requires plans to offer a qualified optional survivor annuity (QOSA). For this plan, the QOSA will be a 75 percent annuity with a survivor feature for married participants. All married participants who are not already in pay status will be eligible to elect a 75 percent QOSA at their benefit commencement date. The single life annuity will be reduced to reflect payment in the form of the QOSA on an actuarially equivalent basis.

- To comply with the law, changes will need to be made to some of this plan's actuarial assumptions. The changes will affect two benefit features:
  - Accelerated income option, for employees who retire before age 62 and elect that option.
  - Cash out of small benefits, for employees who have a benefit with a value of $5,000 or less.

  (Note: It is extremely unlikely that any active participant would have a benefit small enough to be cashed out. The cash out provision affects mostly former employees with small vested benefits.)

For both features, the factors that the Company plans to use could result in slightly lower or slightly higher benefits to the plan participants. The factors will change each year because they are based on an interest rate that is determined annually by the Federal Government. The factors for the 10-year certain and continuous benefit will be the better of the current factors or actuarially equivalent factors.

Maximum Benefit Payable From Qualified Defined Benefit Plans

The Pension Funding Equity Act of 2004 and the PPA changed how to calculate the maximum benefit (415 limit) permitted to be paid to a retiree from pension plans and require plans to now include the modified limits in the pension plan documents. This change is not expected to affect benefits in this plan.

For More Information

Contact the Boeing service centers 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 http://www.boeing.com/express using your BEMS ID 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 hours vary by service center; representatives generally are available during regular business hours.
Plan Amendment Information

This Update is a summary of material modifications to your summary plan descriptions for the following Company benefit plans:

- The Boeing Company Voluntary Investment Plan (Plan 002).

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 the Plan documents listed above, the terms of The Boeing Company Master Welfare Plan document and/or the Plan documents 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.