

The Boeing Company National Employee Assistance Plan

Summary Plan Description / 2005 Edition

Eligible Employees

Plan Highlights

This booklet describes The Boeing Company National Employee Assistance Plan (the “Plan”). The Plan may be available to you and your dependents if you are an eligible employee (as described in “Eligibility and Enrollment,” beginning on page 5) of one of the following approved companies (jointly referred to as the “Company”):

- The Boeing Company.
- McDonnell Douglas Corporation.
- Jeppesen Sanderson, Inc.
- Jeppesen DataPlan, Inc.
- Nobeltec Corporation.
- Alteon Training Services, Inc.
- Alteon Leasing Corporation.
- Autometric, Inc.
- Boeing–Irving Co.
- Boeing–Corinth Co.
- Boeing–Oak Ridge Co.
- Boeing Aerospace Operations, Inc.
- Boeing Satellite Systems, Inc.
- Boeing Service Company.
- Frontier Systems, Inc.
- Conquest, Inc.
- Spectrolab, Inc.
- Boeing Pharmacy, Inc.

The Plan provisions described in this booklet are effective as of January 10, 2005.

As described in this booklet, the Plan is a confidential and voluntary assessment, counseling, and referral service that is designed to help you and your dependents resolve personal problems.

The Company provides coverage for you and your eligible dependents under the Plan. Boeing sponsors the Plan; the service representative is ValueOptions, Inc., and ValueOptions of California, Inc. (jointly referred to as “ValueOptions”). The Company may change the service representative at any time.

Generally, you and your eligible dependents each may receive from one to six sessions with a ValueOptions counselor per problem, per calendar year. These sessions are for brief therapy or the assessment of primary problems and referral for appropriate treatment by licensed professionals. The one to six sessions with a ValueOptions counselor are provided at no cost to you.

This booklet explains the eligibility and termination provisions of the Plan as well as benefits and exclusions.

ValueOptions provides other services that are part of the Company Employee Assistance Program, *not* part of this Plan. Those services include ValueOptions legal and financial services; Company-mandated referrals such as those required for the Drug and Alcohol Free Workplace Program (PRO-388), Threat Management (PRO-1870), Medical Services for International Assignments (PRO-1036), and Boeing Occupational Health Examination Program (PRO-1043 and the Occupational Health Examination Guide for Providers, RF-020M); critical incident debriefing sessions for work groups; management consultation; and training courses provided by ValueOptions staff.

General Plan Provisions

Please read this booklet carefully and share it with your family. If you have questions, call the service representative at the telephone number listed in Exhibit 1, on page 21.

This booklet describes The Boeing Company National Employee Assistance Plan (Plan 630), which may be available to certain employees of the Company and their eligible dependents. The Boeing Company National Employee Assistance Plan is referred to as the “Plan” in this booklet. Although the Company fully intends to continue the Plan, the Company reserves the right to change, modify, amend, or terminate the Plan at any time and for any reason for employees, former employees, retirees, and their dependents.

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

Any representations contrary to the Plan are not binding.

The Plan includes voluntary assessment, counseling, and referral benefits for eligible employees of the Company and their dependents. Benefits provided under the Plan are limited to the benefits specified by the Plan. The Plan Administrator and service representative (ValueOptions) administer the Plan strictly in accordance with its provisions. The Company authorizes ValueOptions to administer the Plan, interpret its terms, and decide claim appeals. The Employee Benefit Plans Committee (EBPC) is authorized to decide eligibility appeals. Participants’ appeal rights and the responsibilities of the service representative and Plan Administrator are specified in the Plan.

For More Information

- Whenever you see this symbol  in the page margin, see Exhibit 1, on page 21, for contact information.

This booklet is the summary plan description for The Boeing Company National Employee Assistance Plan. The Plan document for this Plan includes this booklet, the insurance contracts, and the Plan document for The Boeing Company Master Welfare Plan.

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Eligibility and Enrollment

You and your eligible dependents are enrolled in the Plan automatically if you are an eligible employee.

Eligible Employees

You are eligible for coverage under the Plan described in this booklet if you are an active employee of the Company and you are based in the United States.

You are not eligible for coverage under the Plan if you

- Are an employee of a covered subsidiary who resides outside the United States.
- Do not meet the eligibility requirements under the Plan.
- Have had coverage terminated under the Plan or any other mental health benefit plan or program operated or administered by ValueOptions or any of its affiliates, if that termination was because of any reason described in “Other Termination Dates,” on page 11.
- Work in a capacity that, at the sole discretion of the Plan Administrator, is considered contract labor or independent contracting.

Eligible Dependents

Your eligible dependents may be covered under the Plan if you are covered as an employee. Under the Plan, the definition of eligible dependents includes your legal spouse and children who are under age 25, unmarried, and dependent on you for principal support (including children who are attending school). These criteria apply to natural children, adopted children, children legally placed with you for adoption, stepchildren, and children who are related to you either directly or through marriage.

The definition of an eligible dependent also includes children for whom you have legal custody or guardianship or a pending application for legal custody or guardianship if they are under age 25, unmarried, dependent on you for principal support (including children who are attending school), and living with you.

Principal support means that you, your spouse, and/or your former spouse provide more than one half of your child’s support. In determining whether you provide more than one half of your child’s support, you can ignore any student scholarships, unless the child is not your natural or adopted child or stepchild.

A disabled child of any age may be eligible if he or she is incapable of self-support as a result of any mental or physical condition. The child must be unmarried. Coverage may continue under the Plan for the duration of the incapacity, as long as you continue to be eligible under the Plan and the child continues to meet these eligibility requirements. You may be required to verify the incapacity from time to time.

In accordance with Federal law, the Company also provides coverage to certain children (called alternate recipients) if directed to do so by a qualified medical child support order (QMCSO) issued by a court or state agency of competent jurisdiction. (See the description of QMCSO procedures, beginning on page 15.)

You also may request coverage for the following dependents:

- Your common-law spouse if your relationship meets the common-law requirements for the state in which you entered into the common-law relationship.

- Your same-gender domestic partner if you and your domestic partner meet all of the following requirements. You and your partner are
 - Of the same gender.
 - Eighteen years of age or older.
 - Financially interdependent and share the same residence.
 - Not married to or legally separated from any other person or involved in another same-gender domestic partner relationship.
 - Not blood relatives to a degree of closeness that would prohibit marriage.
 - Not in the same-gender domestic partner relationship solely to obtain eligibility under the plan.
 - In a permanent, exclusive, emotionally committed relationship similar to marriage.

An eligible same-gender domestic partner is considered a spouse for the purpose of the Plan described in this booklet. You must complete the Affidavit of Domestic Partnership for your same-gender domestic partner to receive benefits under this Plan.

- For more information about same-gender domestic partner eligibility and coverage and to request an affidavit, contact the Boeing Service Center for Health and Insurance Plans through Boeing TotalAccess or call your Human Resources representative, as applicable.

For More Information

- You may request information from ValueOptions about specific covered services, the nature of the services provided, conditions under which you and your family are eligible to receive such services, circumstances under which services may be denied, procedures to follow to obtain services, and procedures for a review when services are denied.
- If you have questions about eligibility, call the Boeing Service Center for Health and Insurance Plans through Boeing TotalAccess or your Human Resources representative, as applicable.

How to Participate

Although you are enrolled in the Plan automatically, you may choose whether or not to use services under the Plan.

Effective Date of Coverage

Employees

If you are a newly hired employee, your coverage will become effective on the first day of active employment.

Dependents

If you are a newly eligible employee, coverage for your current eligible dependents generally will become effective on the same date your coverage begins.

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

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

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

Contributions for Coverage

The Company pays the full cost of coverage under this Plan.

Benefits

The Plan is a confidential and voluntary assessment, counseling, and referral service that is designed to help you and your family resolve personal problems. Plan counselors may provide brief counseling to help define the nature of the problem, develop an action plan, and if indicated, refer you to an appropriate provider to help resolve the problem.

Generally, you and your eligible dependents each may receive from one to six sessions with a ValueOptions counselor per problem, per calendar year, at no cost to you. For more information about Plan services, see “Covered Services,” on this page.

How to Receive Benefits

To contact the Plan, call ValueOptions. You can call ValueOptions 24 hours a day, seven days a week. When you call, a Plan representative will refer you to a local Plan counselor, who will schedule an interview with you within 72 hours of your request. (In the case of an **i** emergency, counselors will be available immediately.) The counselor will spend from one to six sessions working with you to address your problem. If you require additional counseling, self-help resources, or specialized counseling, the counselor will provide you with referrals for the follow-up assistance you need.

If at any time during your treatment the counselor determines that your issue cannot be resolved within six sessions, the counselor will refer you to another provider whose services will not be covered under this Plan. Those services might be covered by your medical plan, if applicable, but they are not a part of this Plan. You decide whether or not to use the other provider’s services.

Covered Services

Coverage of Plan services is subject to general Plan provisions, including the exclusions (on page 8) and the definitions (beginning on page 19).

Generally, the Plan will provide from one to six counseling sessions per problem, per calendar year for brief therapy or the assessment of primary problems and referral for appropriate treatment of such issues as

- Depression.
- Anxiety.
- Grief.
- Trauma.
- Family problems.
- Marital problems.
- Substance abuse.

Plan Counselors

All Plan counselors are experienced professionals who

- Hold a master’s degree in behavioral sciences, counseling, social work, or a related field.
- Have a minimum of five years of postgraduate supervised clinical experience.
- Are established in their geographical area for at least two years.
- Understand the 12-step recovery process.
- Have knowledge of mental health issues.
- Are trained in assessment, referrals, and short-term therapy.

Disciplinary Action

Participation in the Plan is voluntary. Participation in the Plan does not affect the Company's right to take disciplinary action in the event of unsatisfactory performance, attendance, or conduct before, during, or after participation in the Plan.

Exclusions

The Plan does not pay for charges for or related to the following:

- Services or supplies that ValueOptions determines are not medically necessary for treatment of a condition covered under the Plan.
- Services or supplies not recommended by a Plan network provider or those that were provided before the person became covered under this Plan.
- Services or supplies that are covered under your medical plan's mental health and/or substance abuse benefits.
- Experimental or investigational services or supplies or related complications.
- Services or supplies to the extent they are covered under any Company-sponsored plan that has been discontinued.
- Services or supplies to the extent they are covered under any Federal, state, or other government plan, except where required by law.
- Services related to a court or government agency requirement.
- Completion of claim forms or reports.
- Missed appointments.

Claim and Eligibility Review and Appeal Procedures

- i** Plans that offer health care benefits are required by Federal law to implement the following procedures for review and appeal of claims and eligibility determinations. You may obtain a complete copy of the benefit or eligibility claim review and appeal procedures for the Plan by calling ValueOptions.

Benefit Claim Review and Appeal

This section describes claim review and appeal procedures for the Plan.

- i** Your claims should be sent to ValueOptions at the address listed on page 21.

Your claim will fall within one of the following categories:

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

When you submit a *postservice claim*, ValueOptions will notify you of its decision within 30 days of receiving your claim for benefits. When you submit a *preservice claim*, ValueOptions will notify you of its decision within 15 days. If matters beyond the control of the Plan require more time, the review period may be extended up to an additional 15 days. You will be notified of this extension before the end of the initial 15-day review period. For *concurrent claims*, ValueOptions will notify you of its decision within 24 hours, provided you

i notify the Plan at least 24 hours before the expiration of the previously approved services. If your claim for benefits has been filed improperly, ValueOptions will notify you within five days (24 hours in the case of an *urgent claim* or *preservice claim*). If additional information is required in order to review your claim, ValueOptions will notify you of the specific information needed and allow you at least 45 days to provide that information.

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

An expedited claim process is available. It applies when

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

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

If your claim is denied, you may be able to resolve the denied claim without a formal appeal by calling ValueOptions and discussing the situation. If the claim is not resolved with a telephone call (an informal review process), you may file a formal appeal. You (or your legal

i representative) may file an appeal within 180 days after receiving notification of the claim denial. Your appeal to ValueOptions must be in writing except in the case of an *urgent appeal*, which can be made orally by calling ValueOptions. You must include the reasons for your appeal and may include any information or documentation that will be relevant to the review.

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

If your benefit claim appeal is denied, ValueOptions will notify you in writing of the specific reasons for the denial; the specific Plan provisions, rules, protocols, or guidelines on which the determination was based; your right to additional appeals or legal action; and your right to obtain copies of documentation related to the decision, without charge. If your benefit

claim appeal is denied based on a medical necessity, experimental treatment, or other similar exclusion or limitation, an explanation of the scientific or clinical judgment used in the claim determination will be provided without charge on request.

Eligibility Claim Review and Appeal

If you have eligibility questions or believe you have been improperly denied participation in the Plan or the opportunity to make an election as a result of a change in status, follow the claim procedures previously described.

You may be able to resolve questions about eligibility for Plan benefits without filing a formal eligibility claim by calling ValueOptions. If your question is not resolved, you may file a

- i** formal eligibility claim by requesting a claim form from ValueOptions. (*Urgent claims* can be submitted by calling ValueOptions at 1-866-719-5788. ValueOptions may require you to provide information from your provider to substantiate your urgent eligibility claim.)

ValueOptions will review your eligibility claim and notify you of its decision within the same time frames as outlined in “Benefit Claim Review and Appeal,” beginning on page 8. If your eligibility claim is denied, ValueOptions will notify you in writing of the specific reasons for the denial; a description and explanation of any additional information needed to process your eligibility claim; the specific Plan provisions, rules, protocols, or guidelines on which the eligibility claim determination was based; your right to appeal; and your right to obtain copies of documentation related to the decision, without charge.

You (or your legal representative) may file an appeal with the Employee Benefit Plans Committee (EBPC) or its delegate. Appeals must be sent to the Employee Benefit Plans Committee, The Boeing Company, 100 North Riverside, MC 5002-8421, Chicago, IL 60606-1596. The telephone number for *urgent appeals* is 312-544-2799. You also may send a fax to the EBPC at 312-544-2077. The EBPC may require you to provide information from your provider to substantiate your *urgent appeal*. It is the EBPC’s exclusive right to interpret and apply the terms of the Plan and exercise its discretion to determine all questions arising under the Plan. The decisions of the EBPC are final and binding. Benefits will be paid under the Plan only if the EBPC decides in its discretion that you have met the eligibility and participation requirements and ValueOptions has determined you are entitled to the benefits. Your appeal to the EBPC must be written (or oral or faxed for an *urgent appeal*) and must be filed within 180 days after receiving notification of the ValueOptions denial. You must indicate the reason for your appeal and may include any information or documents that you believe are relevant.

The EBPC will notify you of its decision within 60 days after receiving your *postservice appeal* or within 30 days after receiving your *preservice* or *concurrent appeal*. The EBPC will notify you of its decision in writing. If your eligibility appeal is denied, the notification will include the specific reasons for the denial; the specific Plan provisions, rules, protocols, or guidelines on which the determination was based; notification of your right to bring legal action; and notification of your right to obtain copies of documentation related to the decision, without charge. In the case of an *urgent appeal*, you will be notified of the appeal determination within 72 hours after the appeal is received.

For Plan Participants in California

- i** In addition to the procedures outlined here, participants in California may file a complaint with the California Department of Managed Health Care. Contact ValueOptions for more information or answers to your questions. The department’s web site includes complaint forms and instructions.

If you have a grievance against the Plan, you should first call ValueOptions at the telephone number listed on page 21 and use the Plan’s grievance process before contacting the department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by the Plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. The Plan’s grievance process and the department’s complaint review process are in addition to any other dispute resolution procedures that may be available to you. Not using these processes does not prevent your use of any other remedy provided by law.

Legal Action

If ValueOptions or the EBPC makes an adverse benefit determination on your appeal, you may bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA). If you would like to commence a lawsuit against the Plan with respect to a 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). A lawsuit that does not meet these deadlines will be considered untimely.

Termination of Coverage

Normal Termination Dates

Coverage for you and your eligible dependents under the Plan ends as described below:

- If your employment terminates, your coverage will end on the last day of the month in which your employment ends.
- If the Plan is canceled, your coverage will end.

Coverage may be continued beyond these normal termination dates under certain special circumstances, as described in “Continuing Coverage Through COBRA,” beginning on page 12.

Other Termination Dates

Coverage will terminate if you or an eligible dependent

- Makes repeated and unreasonable demands for services that are not Plan services.
- Threatens the life or well-being of a treatment provider’s personnel.

Coverage will terminate immediately on written notice if you or an eligible dependent

- Acts in a disruptive manner that prevents orderly Plan operations.
- Knowingly furnishes fraudulent or deceptive enrollment information to the Company or ValueOptions (including, but not limited to, your or your dependent’s date of birth, date of hire, or relationship to another covered individual).

If your coverage terminates for any of these other reasons, you will be ineligible to continue coverage.

Leaves of Absence

If you are eligible for coverage and you begin an approved leave of absence from the Company, coverage under the Plan will continue for you and your eligible dependents for the duration of the leave.

Layoff

If you are laid off, you may continue your Plan coverage for up to 18 months as described in “Continuing Coverage Through COBRA,” beginning on page 12.

Death

If you die, your eligible dependents may continue their Plan coverage as described in “Continuing Coverage Through COBRA,” next.

Continuing Coverage Through COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, otherwise referred to as COBRA, is a Federal law that entitles you and your covered dependents to continue health care coverage for a period of time after it otherwise would end. Continued COBRA coverage for benefits under this Plan is provided automatically and at no cost.

Anyone who continues coverage under COBRA is covered by the Plan just as before coverage was lost. COBRA coverage becomes available when a qualifying COBRA event occurs.

i The Boeing Service Center for Health and Insurance Plans administers COBRA coverage eligibility. For more information, call the Boeing Service Center for Health and Insurance Plans through Boeing TotalAccess.

Who Is Eligible for COBRA Coverage

You, your spouse or same-gender domestic partner, and your covered dependent children may be eligible for COBRA coverage. The circumstances that cause your loss of coverage determine your eligibility for COBRA. These circumstances are referred to as “qualifying events” and are described here. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your spouse or same-gender domestic partner, or your covered dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

Your Right to COBRA Coverage

You will have COBRA coverage if you are covered by the Plan and you lose coverage because your employment ends.

Your Spouse or Same-Gender Domestic Partner’s Right to COBRA Coverage

Your covered spouse or same-gender domestic partner will have COBRA coverage if he or she is covered by the Plan and loses coverage because of

- Your death.
- Your employment ending.
- Divorce, legal separation from you, or dissolution of the domestic partnership.

Your Child’s Right to COBRA Coverage

Your covered dependent child will have COBRA coverage if he or she is covered by the Plan and loses coverage because of

- Your death.
- Your employment ending.
- Your divorce, your legal separation, or dissolution of the domestic partnership.
- His or her loss of eligibility for coverage as a dependent. (See “Eligible Dependents,” on page 5.)

Receiving COBRA Coverage

The Company will notify the Boeing Service Center for Health and Insurance Plans if your coverage ends because of your termination or death. This notification will occur within 30 days from the date your coverage ends. No enrollment is required.

Notify the Service Center When Coverage Ends

You or your covered dependents must notify the Boeing Service Center for Health and Insurance Plans by telephone if your covered dependent loses eligibility for coverage because of divorce, legal separation, or dissolution of the domestic partnership or if your child loses eligibility for coverage.



You must notify the Boeing Service Center for Health and Insurance Plans of your loss of eligibility for coverage within 60 days from the end of the month in which the loss of eligibility occurs. *If notice is not received within this 60-day period, COBRA coverage will be forfeited.*



When COBRA Coverage Begins

COBRA coverage begins when your active coverage ends. For example, your COBRA coverage begins on the first day of the month after the month in which your employment ends. Although you will be enrolled in COBRA coverage automatically, you may choose whether or not to use services under the Plan.

Duration of COBRA Coverage

Generally, COBRA coverage may last for up to 18, 29, or 36 months, depending on the event that caused you or your dependent to lose coverage and whether or not any secondary event occurs during the COBRA coverage period. These COBRA coverage periods and the events that determine them are described here.

Continuing COBRA Coverage for 18 Months

You and/or your covered dependents may continue COBRA coverage for up to 18 months if coverage was lost because your employment ended for any reason, including layoff.

Continuing COBRA Coverage for 29 Months

You and/or your covered dependents may continue COBRA coverage for up to 29 months if you or a covered dependent becomes disabled before active coverage ends or within 60 days of COBRA coverage beginning and he or she

- Receives a Social Security award within the first 18 months of COBRA coverage, *and*
- Provides notification of the award within 60 days after it is granted and during the first 18 months of COBRA coverage.



Family members of the disabled person who are not disabled but are entitled to COBRA coverage also may extend coverage for up to 29 months.

If the person with the qualifying disability is a child that was born to you or placed with you for adoption after your COBRA coverage began, the 60-day disability period will be measured from the date of birth or the date of enrollment, if later.

- If you or your dependent later is determined by Social Security to no longer be disabled,
- you must notify the Boeing Service Center for Health and Insurance Plans through Boeing TotalAccess within 30 days of the determination date.



Continuing COBRA Coverage for 36 Months

Your covered dependent may continue COBRA coverage for up to 36 months if his or her coverage ends because of

- Your death.
- Your divorce, your legal separation, or dissolution of the domestic partnership.
- Your becoming entitled to Medicare (under Part A, Part B, or both).
- His or her loss of eligibility for coverage as a dependent. (See “Eligible Dependents,” beginning on page 5.)

Secondary COBRA Qualifying Events

If your covered dependent experiences a secondary COBRA qualifying event during your 18- or 29-month COBRA period, he or she may continue COBRA coverage for up to 36 months from the date you lost active coverage due to termination of employment.

A secondary COBRA qualifying event occurs when your dependent loses coverage because one of these events occurs during your 18- or 29-month COBRA period:

- You die.
- You divorce, become legally separated, or dissolve your domestic partnership.
- Your dependent child reaches age 25, marries, is no longer dependent on you for principal support, or otherwise loses eligibility under Plan rules.

To qualify for this extended COBRA coverage, your dependent must be a qualified beneficiary. That is, your dependent must have been covered while you were an active employee and continuously enrolled under your COBRA coverage. If your child was born, adopted, or placed with you for adoption during your period of COBRA coverage, he or she must have been enrolled within 120 days and continuously covered.

When COBRA Coverage Ends

Generally, COBRA coverage ends on the last day of the month in which any of the following events occur:

- The 18-, 29-, or 36-month COBRA continuation period expires.
- The Company no longer provides group health coverage to any employees.
- The qualified beneficiary becomes covered, after receiving COBRA coverage, under another group health plan that contains no applicable exclusion or preexisting condition limit.
- The qualified beneficiary enrolls in Medicare after receiving COBRA coverage.
- The qualified beneficiary receives a Social Security determination that he or she is no longer disabled after COBRA coverage has been extended beyond 18 months, but not more than 29 months. In that case, coverage ends on the first of the month that is more than 30 days after the determination and after the initial 18-month COBRA coverage period ends.

Once COBRA coverage ends, it cannot be reinstated.

Cost of COBRA Coverage

The Company pays the full cost of your COBRA coverage under the Plan.

Qualified Medical Child Support Orders

The Company provides coverage under the Plan to employees' dependent children as long as they meet the eligibility requirements of the Plan. The Company also provides coverage under the Plan to certain children (called alternate recipients) if the Company is directed to do so by a qualified medical child support order (QMCSO) issued by a court or state agency of competent jurisdiction.

Under this law, courts may require an employee, in certain events such as a divorce, to provide coverage to a child who might not otherwise be covered.

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

A medical child support order

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

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

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

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

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

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

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

You may obtain a copy of the Plan procedures governing medical child support orders without charge by sending a written request to the Employee Benefit Plans Committee, The Boeing Company, 100 North Riverside, MC 5002-8421, Chicago, IL 60606-1596.

Special Disclosure and Other General Plan Information

Plan Name

The name of the Plan that provides the benefits described in this booklet is The Boeing Company National Employee Assistance Plan (Plan 630).

Plan Sponsor

The Plan sponsor is The Boeing Company, 100 North Riverside, MC 5002-8421, Chicago, IL 60606-1596.

Adopting Employers

The following employers have adopted the plan described in this booklet:

- The Boeing Company, 100 N. Riverside, MC 5002-8421, Chicago, IL 60606-1596.
- McDonnell Douglas Corporation, 100 N. Riverside, MC 5002-8421, Chicago, IL 60606-1596.
- Jeppesen Sanderson, Inc., 55 Inverness Drive East, Englewood, CO 80112.
- Jeppesen DataPlan, Inc., 121 Albright Way, Los Gatos, CA 95030.
- Nobeltec Corporation, 14657 SW Teal Boulevard, Suite 132, Beaverton, OR 97007.
- Alteon Training Services, Inc., 1301 SW 16th Street, Renton, WA 98055.
- Alteon Leasing Corporation, 1301 SW 16th Street, Renton, WA 98055.
- Autometric, Inc., 7700 Boston Boulevard, Springfield, VA 22153.
- Boeing–Irving Co., 3131 Story Road West, Irving, TX 75015-2707.
- Boeing–Corinth Co., 7801 S. Stemmons, Corinth, TX 75065.
- Boeing–Oak Ridge Co., 767 Boeing Road, Oak Ridge, TN 37830.
- Boeing Aerospace Operations, Inc., 8120 MidAmerica Boulevard, Suite 300, MC R7-03, Oklahoma City, OK 73135.
- Boeing Satellite Systems, Inc., 2260 E. Imperial Highway, MC S10-0026, El Segundo, CA 90245.
- Boeing Service Company, 3373 Breckinridge Boulevard, Richardson, TX 75082.
- Frontier Systems, Inc., Lakeview Park, 15320A Barranca Parkway, Irvine, CA 92618.
- Conquest, Inc., 131 National Business Parkway, Suite 120, Annapolis Junction, MD 20701.
- Spectrolab, Inc., 12500 Gladstone Avenue, Sylmar, CA 91342.
- Boeing Pharmacy, Inc., 3470 E. Miraloma Avenue, MC PC-01, Anaheim, CA 92806.

Plan Administrator and Agent for Service of Legal Process

The Plan Administrator is the Employee Benefit Plans Committee (EBPC), which may be reached at The Boeing Company, 100 North Riverside, MC 5002-8421, Chicago, IL 60606-1596 or by calling 312-544-2297. Legal process may be served upon the EBPC at Employee Benefit Plans Committee, The Boeing Company, c/o United States Corporation Company of Illinois, 33 North LaSalle Street, Chicago, IL 60602.

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

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

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

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

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

Type of Administration

The Plan is administered in accordance with the terms of the applicable administrative agreements and insurance contracts with ValueOptions for this coverage.

Type of Plan

The Plan is a health and welfare benefit plan that provides voluntary assessment, counseling, and referral benefits. This booklet describes coverage of these services.

The Plan is subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA), and is intended to comply with all other applicable Federal and state laws. The EBPC has full discretionary authority to interpret the Plan under these laws. If any part of this Plan is held to be invalid, the remaining provisions will continue in force.

Funding and Contributions

The cost of coverage under this Plan is paid by employer contributions. The Company pays the full cost of the Plan, including any costs that are higher or lower than expected. Any claim experience dividends, refunds, or other adjustments in premium, fees, or other Plan costs are retained by the Company. In general, the Company pays the administrative expenses of the Plan to the extent the Company determines that these expenses are not to be charged to or paid from the Plan.

Nothing in this Plan, including the receipt of benefits, is to be construed as a contract of employment, and nothing in the Plan gives any employee the right to be retained in the employ of the Company or to interfere with the rights of the Company to discharge any employee at any time.

Plan Records

Records of the Plan are kept on a calendar-year basis. The Plan Administrator (or its delegates) will keep records of all acts and determinations made under the Plan as well as any other documents that may be necessary for the administration of the Plan.

Plan Number and Employer Identification Number

The Plan number assigned by the Company pursuant to instructions by the U.S. Department of Labor is 630. The Company employer identification number is 91-0425694.

Service Representative

The Company contracts with ValueOptions to provide services to plan participants; ValueOptions also contracts with various health service organizations. ValueOptions is called the service representative for purposes of this Plan. For purposes of certain Federal regulations, the service representative is classified as a health insurance issuer.

- ❶ Exhibit 1, on page 21, shows the ValueOptions address and telephone numbers.

Participant Rights and Protections Under ERISA

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

Receive Information About Your Plan and Benefits

- You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites 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, the latest annual report (Form 5500 Series), and an 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.

Continue Plan Coverage

You can continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. This summary plan description and the documents governing the Plan explain the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on the people responsible for the operation of this 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 benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a Plan 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 it within 30 days, you may file suit in Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive 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 medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the 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 on the World Wide Web (<http://askebsa.dol.gov/>) or by calling the EBSA hot line at 1-866-444-EBSA (1-866-444-3272).

Definitions

Clinical referral line The clinical referral line is the ValueOptions 24-hour, toll-free telephone line through which participants receive assistance in obtaining access to a Plan affiliate or provider.

Company-sponsored plan A Company-sponsored plan is a plan that is approved by the Company or one of its subsidiaries or affiliates for its employees and eligible dependents. This includes the Plan described in this booklet.

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

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

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

Participating provider A participating provider is a health care provider that has entered into an agreement accepted by ValueOptions, or otherwise is expressly approved by ValueOptions, to provide Plan services to Plan participants. Providers include clinical social workers, counselors, and other mental health professionals.

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

Service representative A service representative is an agent who has a contract with the

- ❶ Company to make benefit determinations and administer benefit payments under the Plan described in this booklet.

Substance abuse Substance abuse is alcohol or drug dependence as classified in categories 292.0 through 304.9 of the most current edition of *International Classification of Diseases, 9th Revision, Clinical Modification*.

ValueOptions This refers to ValueOptions, Inc., or ValueOptions of California, Inc.,

- ❶ a corporation specializing in the management and administration of mental health and substance abuse care as well as employee assistance programs.

Exhibit 1

Where to Get Information

If you or your eligible dependent needs care, call ValueOptions directly at 1-866-719-5788 (hearing impaired: 1-800-855-2880). If you have questions about eligibility, or if you live in California and would like information from the California Department of Managed Health Care, see below for contact information.

ValueOptions, Inc., and Value Options of California, Inc.

Address for claims and appeals:

ValueOptions, Inc.
340 Golden Shore
Long Beach, CA 90802

ValueOptions of California, Inc.
340 Golden Shore
Long Beach, CA 90802

Telephone for claims and appeals and to arrange appointments with Plan counselors:

Seven days a week, 24 hours a day
1-866-719-5788 (toll free)
hearing impaired: 1-800-855-2880 (toll free)

Services:

Insurance, claim administration, and network management

California Department of Managed Health Care

Telephone:

1-888-HMO-2219 (1-888-466-2219) (toll free)
hearing impaired: 1-800-735-2929 (toll free)
hearing impaired: 1-888-877-5378 (toll free)

Services:

Assistance with grievances for Plan participants in California

Eligibility Information

| If you work for . . . | Contact . . . |
|--|--|
| <ul style="list-style-type: none"> • The Boeing Company • McDonnell Douglas Corporation • Jeppesen Sanderson, Inc. • Jeppesen DataPlan, Inc. • Nobeltec Corporation • Alteon Training Services, Inc. • Alteon Leasing Corporation • Autometric, Inc. • Boeing–Irving Co. • Boeing–Corinth Co. • Boeing Satellite Systems, Inc. • Boeing Service Company • Frontier Systems, Inc. • Conquest, Inc. • Spectrolab, Inc. • Boeing Pharmacy, Inc. | <p>The Boeing Service Center for Health and Insurance Plans, through Boeing TotalAccess</p> <ul style="list-style-type: none"> • Telephone: 1-866-473-2016 Hearing-impaired callers can access TTY/TDD services by calling 1-800-755-6363. • World Wide Web: https://my-ext.boeing.com <p>You must have your BEMS ID number (or Social Security number) and Boeing TotalAccess password when you contact the Boeing Service Center for Health and Insurance Plans.</p> |
| Boeing–Oak Ridge Co. | Human Resources: 865-481-7139 |
| Boeing Aerospace Operations, Inc. | Human Resources: 405-739-1988 |