PROPOSAL SUMMARY

The Boeing Company

Employees Represented by Society of Professional Engineering Employees in Aerospace (SPEEA), Professional and Technical Units

January 8, 2016

ACTIVE MEDICAL, DENTAL, AND INSURANCE PLANS

The existing medical, dental and insurance plans will continue through December 31, 2017. The Company proposes the following benefit changes as described below or referenced in Article 16, Group Benefits, effective January 1, 2018, unless otherwise noted.

Insurance Benefits

The Company will pay the full cost of the Basic Life Insurance, Accidental Death and Dismemberment, Short-term Disability and Basic Long Term Disability Plans for eligible employees. The Company will provide access to an employee-paid Supplemental Life Plan, Supplemental Accidental Death and Dismemberment Plan, a ten percent supplemental Long Term Disability Plan benefit, and Health Care and Dependent Care Spending Account Plans under the same terms, conditions and limitations as described in the Summary Plan Description for BCA Puget Sound nonunion salaried employees in effect as of January 1, 2016. Company and employee cost will be based on SPEEA claims experience.

Dental Plan Benefits

Preferred Dental Plan

Effective January 1, 2020, the Preferred Dental Plan annual maximum coverage per person will increase from $2,000 to $2,500.

Scheduled Dental Plan

The referenced dental codes will be updated to conform to American Dental Association standard coding references.

Active Employee Medical Plan Benefits

The Company will revise medical plan benefits as described below.

Traditional Medical Plan

Annual Deductible

The annual deductible (now network-non-network combined) will change to separate deductibles for network and non-network. It will increase from the greater of $225 or 0.225% base annual salary per individual ($675 or 0.675% base annual salary per family) to:

- Network — $300 per individual, no more than $900 per family of 3 or more.
• Non-network — $600 per individual, no more than $1,800 per family of 3 or more. Non-network charges will apply toward the network deductible.

**Copayments**

The employee cost for an office visit will change from a $15 copayment to 10% coinsurance after the deductible for network providers.

The emergency room copayment will change from $50 to 10%.

**Network Coinsurance**

The plan’s coinsurance will decrease from 100% to 90% for network services.

**Non-network Coinsurance**

The plan’s coinsurance will be 60% for all non-emergency non-network services.

**Annual Medical Out-of-Pocket Maximum**

The annual out-of-pocket maximum for medical services and supplies (network-non-network combined) will increase from $2,000 per individual ($4,000 per family) to $2,000 per individual ($4,500 per family).

Concurrent with increasing the annual out-of-pocket maximum, the annual deductible will be included in these values, and copayments for medical services (excluding vision plan and prescription drug copayments) will apply to the annual out-of-pocket maximum.

**Preventive Care**

Preventive care will be covered according to U.S. Preventive Services Task Force guidelines, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the US Health Resources and Services Administration in accordance with the Patient Protection and Affordable Care Act. [Currently age and frequency limitations apply]

**Hemodialysis**

Clarify that following the first 30-months if the employee or covered dependent does not enroll in Medicare when it becomes the primary plan, benefits under the Plan will be reduced in the same manner as if the employee (or covered dependent) were enrolled in Medicare.

**Prescription Drug Program**

The prescription drug program will be revised as follows:

- An annual prescription drug out-of-pocket maximum of $4,000 per individual ($8,000 per family) will be added for prescription drugs purchased through a network retail pharmacy.

- Coverage for generic contraceptives and single-source contraceptives will be 100%. [Currently subject to applicable retail and mail order coinsurance/copayments]

- The Schedule of Benefits for prescription drugs purchased through a network retail pharmacy will remain unchanged.

- Prescription drugs purchased through the mail service program will be covered as follows:
  - $10 copayment generic. [No change]
  - $40 copayment brand-name formulary. [Currently $30 copayment]
  - $70 copayment brand-name nonformulary. [Currently $60 copayment]
– 90-day supply.

- The prescription drug program will cover emergency use at a nonparticipating pharmacy. [Currently not covered.]

**Coordinated Care Plans, EPO, and HMOs**

**Copayments**

The copayment for a primary care office visit will increase from $10 to $20.

The copayment for a specialist office visit (including chiropractic) will increase from $10 to $25.

The copayment for an inpatient admission will be $250.

The copayment for emergency room visit will increase from $50 to $75.

**Annual Out-of-Pocket Maximum**

For Select Network, Selections Plus, Group Health HMO, and Select Health HMO, the annual out-of-pocket maximum for covered medical services and supplies, copayments, and prescription drugs will be $6,850 per individual ($13,700 per family). There is currently no annual out-of-pocket maximum.

For Kaiser HMOs in Oregon and California, the annual out-of-pocket maximum for covered medical services and supplies will not change, but prescription drug copayments will apply to the annual out-of-pocket maximum.

**Select Network Plan**

The Select Network Plan eligibility and service area will be expanded to the entire state of Washington.

**Preventive Care**

Preventive care will be covered according to U.S. Preventive Services Task Force guidelines, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the US Health Resources and Services Administration in accordance with the Patient Protection and Affordable Care Act. [Currently age and frequency limitations apply]

**Hemodialysis**

Clarify that following the first 30-months if the employee or covered dependent does not enroll in Medicare when it becomes the primary plan, benefits under the Plan will be reduced in the same manner as if the employee (or covered dependent) were enrolled in Medicare.

**Prescription Drug Program**

The prescription drug program will be revised as follows:

- Coverage for generic contraceptives and single-source contraceptives will be 100%. [Currently subject to applicable retail and mail order coinsurance/copayments]

- Select Network, Selections Plus, and Select Health HMO
  - Prescription drugs purchased through a network retail pharmacy will be covered as follows:
    - $5 copayment generic. [No change]
    - $25 copayment brand-name formulary. [Currently $15 copayment]
• $40 copayment brand-name nonformulary. [Currently $30 copayment]
• 30-day supply. [No change]
  – Prescription drugs purchased through the mail service program will be covered as follows:
    o $10 copayment generic. [No change]
    o $40 copayment brand-name formulary. [Currently $30 copayment]
    o $70 copayment brand-name nonformulary. [Currently $60 copayment]
    o 90-day supply. [No change]

• Group Health HMO, Kaiser CCP, and Kaiser HMO
  – Prescription drugs purchased through a network retail pharmacy will be covered as follows:
    o $5 copayment generic. [No change]
    o $25 copayment brand-name formulary. [Currently $15 copayment]
    o Brand-name nonformulary not covered. [No change]
    o 30-day supply. [No change]
  – Prescription drugs purchased through the mail service program will be covered as follows:
    o $10 copayment generic. [No change]
    o $60 copayment brand-name formulary. [Currently $30 copayment]
    o Brand-name nonformulary not covered. [No change]
    o 90-day supply. (100-day supply Kaiser California). [No change]

**Advantage+ Health Plan**

**Annual Deductible**

The annual deductible (network-non-network combined) will change from a 3-tier design to a 2-tier design and will be the lowest permitted by the federal regulations. It will be $1,300 per individual ($2,600 per family of 2 or more). [Currently $1,500 per individual, $2,625 employee & spouse or employee & child(ren) and $3,750 employee & family]

**Coinsurance**

The plan’s coinsurance will decrease from 95% to 90% for network services.

**Annual Out-of-Pocket Maximum**

The annual out-of-pocket maximum will change from a 3-tier design to a 2-tier design and shall be two times the applicable deductible for network and three times the applicable deductible for non-network.

The annual deductible will be included in the annual out-of-pocket maximum.

[Current network: $1,600 employee, $2,800 employee & spouse or employee & child(ren), employee & family $4,000; non-network: $3,200 employee, $5,600 employee & spouse or employee & child(ren), employee & family $8,000; annual deductible is not included]
Emergency Room Care
Coverage of nonemergency network care will decrease from 95% to 60%.

Hemodialysis
Clarify that following the first 30-months if the employee or covered dependent does not enroll in Medicare when it becomes the primary plan, benefits under the Plan will be reduced in the same manner as if the employee (or covered dependent) were enrolled in Medicare.

Naturopathy
A Naturopath will be recognized as a covered provider when services received are within the scope of their license.

Prescription Drug Program
The prescription drug program will cover emergency use at a nonparticipating pharmacy.

Health Savings Account Contributions
For the 2018 plan year, company HSA contributions under the Advantage+ health plan shall be 75% of the applicable deductible.

[Currently $700 employee, $1,250 employee & spouse or employee & child(ren) and $1,750 employee & family]

Effective January 1, 2019 and thereafter, company HSA contributions shall be 50% of the applicable deductible.

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

Preferred Partnership Plans
Boeing entered into a partnership with 2 leading health care systems in the Puget Sound region — Providence-Swedish Health Alliance and UW Medicine Accountable Care Network — to offer a unique health plan service delivery approach, called the Preferred Partnership. These options are designed to improve quality, provide a better patient experience and be more cost effective. Should either or both of the partnerships terminate, or should the terms of the existing partnerships change significantly, the company will be under no obligation to continue the plan design, HSA contributions or contribution credits stated below. In no event will incentives listed below be less favorable than what is offered for nonunion employees in the Puget Sound.

This new arrangement will apply to the following standard plans:

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

If you enroll in the Preferred Partnership option for any of the plans listed above, you will use Puget Sound–region providers in the Preferred Partnership option that you choose to receive the network level of benefits.

The Preferred Partnership option benefits will be the same as those of the standard Traditional Medical Plan, Select Network Plan and Advantage+ health plan with certain improvements as noted below:
Traditional Medical Plan and Select Network Preferred Partnership Plans

- Primary care physician office visits will be covered at 100%.
- Generic prescription drugs purchased through a network retail pharmacy or through the mail service program will be covered at 100%.

Advantage+ Health Plan Preferred Partnership Plan

- Primary care physician office visits will be covered at 100% after you meet the annual deductible.
- Generic prescription drugs purchased through a network retail pharmacy or through the mail service program will be covered at 100% after you meet the annual deductible.

Health Savings Account Contributions

For the 2018 plan year, company HSA contributions under the Advantage+ health plan Preferred Partnership option shall be 100% of the applicable deductible.

Effective January 1, 2019 and thereafter, company HSA contributions under the Advantage+ health plan Preferred Partnership option shall be 80% of the applicable deductible.

Other Voluntary Benefit Programs

The Company is committed to promoting employee well-being while providing the highest quality of care through programs in which the employee may participate voluntarily. As such, the Company may implement, at its sole discretion, efficient, cost-effective programs on an enterprise-wide or regional basis without further bargaining (for example, Carena, weight management, stress management, etc.)

Centers of Excellence

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

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

ACTIVE MEDICAL PLAN CONTRIBUTIONS

Beginning January 1, 2018, active employee medical plan contributions will be as follows:

Advantage+ health plan will be offered as a no contribution plan.

The employee will contribute on a pre-tax basis 5% of the Traditional Medical Plan for eligible employees, spouses and dependents. Miami employees will contribute on a pre-tax basis 8% of the cost of the Traditional Medical Plan for eligible employees, spouses and dependents.
For those employees, spouses and dependents whose coverage is with another plan, employees will contribute on a pretax basis 12% of the cost of the plan the employee chooses.

Employee contributions under the Traditional Medical Plan and the Advantage+ health plan shall be based on the same rates, regardless of geographic region.

In locations where the Preferred Partnership Plan is available, employee’s monthly contribution for the Preferred Partnership Plan will be reduced by $30 for an employee, $60 employee + spouse or child(ren), or $90 employee + family (but in no event will the employee’s monthly contribution be less than $0).

Beginning January 1, 2018, there will be an additional contribution each calendar year as follows for employees and spouses where applicable who do not complete certain health and Well Being assessment activities.

- Beginning in 2017 for the 2018 plan year, those health assessment activities will consist of 1) completing the online health assessment and, 2) completing health screenings (e.g. blood pressure, cholesterol, blood glucose, and body mass).

- The health assessment activities associated with this contribution provision may change from year to year without further bargaining and will be generally applicable on an enterprise-wide basis. The additional contributions will be as follows:
  - For either employee-only coverage or employee + child(ren) coverage, the additional contribution will be $20 per month if the employee does not complete the online assessment and screenings.
  - For either employee + spouse or employee + spouse or child(ren) coverage, the additional contribution will be $20 per month if the employee does not complete both the online assessment and screenings, and an additional $20 per month ($40 per month total) if the spouse does not also complete the health assessment.

The additional $100 monthly working spouse contribution will continue to apply to all plans.

RETIREE MEDICAL BENEFITS FOR EMPLOYEES WHO RETIRE DURING THE TERM OF THIS AGREEMENT

Traditional Medical Plan
The same changes that apply to this plan for active employees will apply.

Coordinated Care Plans, EPO and HMOs
The same changes that apply to these plans for active employees will apply.

Retiree Medical Plan Contributions for Employees Who Retire During the Term of This Agreement
The Company will continue the current provisions.

Miami Employees
Any Miami employee who was not eligible for company-subsidized retiree medical coverage prior to November 25, 2013, shall not be eligible for retiree medical coverage under Article 16 of the Agreement; including those hired prior to January 1, 2007.