Group Benefits Package for Employees Represented by IAM 751, 70, and W24

Health and Insurance Plans Attachment A

Effective January 1, 2026~~2013~~ (Unless Otherwise Noted)

PENDING RATIFICATION AND FINAL PROOFING BY THE UNION AND THE COMPANY

Where to Get More Information

The plans described in this document are intended to reflect current provisions of your summary plan descriptions (SPDs)—including the most recent collective bargaining changes. Your SPDs provide more comprehensive information than is contained in this document.

For active employee benefit plans, you can access the SPDs by visiting Worklife online.

- Go to boeing.service-now.com/worklife ~~*www.boeing.com/benefits*~~.
- From Worklife, select My Total Rewards & Benefits~~the left side of the screen, click Union-Represented Employees~~.
- Scroll to the bottom of the page and click the Summary Plan Descriptions link~~From the drop-down menu that appears, click Health and Insurance Plans~~.
- ~~From the next drop-down menu, click Summary Plan Descriptions.~~
- ~~From the middle of the screen, select~~
  - ~~Health Care Plans, or~~
  - ~~Disability, Life, and Accident Plans.~~
- ~~To view your chosen document, select your bargaining unit from the middle of the screen.~~

ATTACHMENT A
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Eligibility

Eligible Employees

You are eligible for the Package if you are an active Boeing employee represented by one of the following International Association of Machinists and Aerospace Workers, AFL-CIO, Collective Bargaining Agreements: Aerospace Industrial District Lodge No. 751, District Lodge No. 70, and District Lodge No. W24. You are not eligible to enroll if you are working in a capacity that, at the sole discretion of the plan administrator, is considered contract labor or independent contracting.

Eligible Dependents

Dependents eligible for the medical and dental plans are your legal spouse and eligible domestic partner (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, including children of your eligible domestic partner) who are under age 26, 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.
- A ~~same gender~~ domestic partner if
  - You and your domestic partner live in the same permanent residence in a permanent, exclusive, emotionally committed, and financially responsible relationship similar to a marriage and intend to remain so indefinitely.
  - Your domestic partner is at least 18 years old, is legally competent to enter into a contract, is not related to you by blood to a degree that would prohibit marriage in their state of permanent residence, is not married to or separated from another person or involved in another domestic partner relationship.
  - Your domestic partner relationship is not solely to obtain coverage under the Plan or a Component Benefit Program.

A ~~same gender~~ domestic partner is considered a spouse for the purpose of the medical and dental plans.

~~Some states have laws that require insured health plans to offer coverage for certain registered domestic partners.~~

- Unmarried children of your ~~same-gender~~ domestic partner who are under age 26 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 26, unmarried, and dependent on you for principal support:
  - Children who are related to you either directly or through marriage (e.g., grandchildren, nieces, nephews).
  - Children for whom you have legal custody or guardianship (or 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. You must provide the Boeing Service Center with any required supporting documentation by the date specified by the Boeing Service Center or your request will be denied.

Special Provisions When Family Members Are Boeing Employees

If both an employee and their spouse or domestic partner are employed by the Company and both in the IAM 751/W24 bargaining unit, one employee may elect to cover the other under their Company-sponsored medical and dental plans. An active employee may also cover a spouse or domestic partner who has retired from the Company and who waives retiree medical coverage.

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 1 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 1 parent's plans. As an alternative, parents may elect medical coverage for eligible children under 1 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 26 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 26. 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 26 or older.

Enrollment

Life and Disability Plans

You automatically are enrolled in the Life Insurance Plan, Accidental Death and Dismemberment Plan, Short-Term Disability Plan, and Survivor Income Plan when eligible. You may designate a beneficiary for life and accident benefits through the Boeing Service Center.

Medical Plans

In designated locations, the Company provides you with a choice of medical plans.

You receive enrollment instructions at the time of employment and may elect medical coverage under 1 medical plan available in your location by the date indicated on the enrollment worksheet. You and all your eligible dependents must be enrolled in the same medical plan, except as specified in the Eligibility section.

- If you do not enroll in a medical plan by the date indicated on the enrollment worksheet, you will be enrolled automatically in the Traditional Medical Plan for employee-only coverage.
- For your spouse or ~~same-gender~~ domestic partner, you must provide information regarding coverage available through another employer to determine whether or not special contributions are required to enroll him or her. If you do not authorize a required contribution, he or she will not be enrolled for medical coverage. You will not be able to enroll your spouse or ~~same-gender~~ domestic partner until the earlier of:
  - The next annual enrollment period.
  - The date your spouse or ~~same-gender~~ domestic partner loses the option to be covered under the other employer-sponsored medical plan.

The Company will require periodic verification of data.

Dental Plans

In designated locations, the Company provides you with a choice of dental plans. You receive enrollment instructions at the time of employment and may elect dental coverage under 1 dental plan available in your location by the date indicated on the enrollment worksheet.

If you do not enroll in a dental plan by the date indicated on the enrollment worksheet, you will be enrolled automatically in the Network Dental Plan for employee-only coverage.

Annual Enrollment Period

The Company establishes an annual enrollment period on or before January 1 each year when you may change medical and/or dental plans.

Special Enrollment Events

If you declined coverage in the medical or dental plans for yourself and/or your eligible dependents when you were first eligible because you or your dependents had other health care coverage, you may enroll yourself and/or your eligible dependents if you or your dependent experiences one of these special enrollment events:

- You or your dependent loses or becomes ineligible for other health care coverage because of an event such as loss of dependent status under another health care plan (through divorce, legal separation, termination of a ~~same-gender~~ domestic partnership, or dependent

child reaching the limiting age), death, termination of employment, reduction in hours of employment, termination of employer contributions toward the coverage, elimination of coverage for the class of similarly situated employees or dependents, moving out of the plan's service area with no other coverage available from the other health care plan, or reaching the lifetime limit on all benefits under the other health care plan.

- You or your dependent becomes ineligible for Medicaid or a state Children's Health Insurance Program and loses coverage; you or your dependent becomes eligible for premium assistance under Medicaid or a state's child health care plan.
- You or your dependent exhausts any continuation coverage from another employer; that is, coverage provided under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), ends.
- You gain a new dependent because of marriage, entering a ~~same-gender~~ domestic partnership, birth, adoption, or placement for adoption.

Note: For this purpose, "other health care coverage" does not include coverage through Medicare or Medicaid.

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

Except as provided in Reinstatement of Coverage below, s~~S~~pecial enrollment is not available if you lose coverage because of failure to make timely premium payments or termination from the plan for cause (such as for making a fraudulent claim).

If you decline enrollment in the medical and dental plans because of other employer-sponsored health care coverage (such as through a spouse's employer), you may be able to enroll yourself and eligible dependents in the Company-sponsored medical and dental plans during the year as long as enrollment is within 60 days after other coverage ends.

If you have a new dependent as a result of marriage, entering into a ~~same-gender~~ domestic partner relationship, birth, adoption, or placement for adoption, you may enroll the new dependent during the year as long as enrollment is requested within 120 days after the qualified event.

Qualified Status Changes

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

Qualified status changes are the following events:

- You marry, divorce, or become legally separated, or the marriage is annulled.
- You enter into or dissolve a ~~same-gender~~ domestic partner relationship.
- You acquire a new, eligible dependent child, such as by birth, adoption, or placement for adoption.
- Your spouse or ~~same-gender~~ domestic partner or dependent child dies.
- You or your spouse or ~~same-gender~~ domestic partner or dependent child starts or stops working.
- You or your spouse or ~~same-gender~~ domestic partner or dependent child has any other change in employment status that affects eligibility for coverage such as changing from full time to part time (or part time to full time), salaried to hourly (or hourly to salaried), strike or lockout, a transfer between a nonunion salaried position and a union-represented position, or beginning or returning from an unpaid leave of absence, including an approved leave of absence in accordance with the Family and Medical Leave Act.
- You or your spouse or ~~same-gender~~ domestic partner or dependent child experiences a significant increase in the cost of employer-sponsored health care coverage or the employer-sponsored health care coverage ends, including expiration of COBRA coverage.
- The Company adds a new benefit option or significantly improves an existing benefit option.
- You or your spouse or ~~same-gender~~ domestic partner or dependent child experiences a significant curtailment or cessation of employer-sponsored health care coverage.
- You or your spouse or ~~same-gender~~ domestic partner or dependent child becomes eligible or ineligible for Medicare or Medicaid or

becomes ineligible and loses coverage under Medicaid or a state Children's Health Insurance Program.

- You or your covered dependent becomes eligible for premium assistance under Medicaid or a state's child health care plan.
- Your dependent child becomes eligible for, or no longer is eligible for, health care coverage due to age limits, principal support status, or a similar eligibility requirement.
- You or your spouse or ~~same-gender~~ domestic partner or dependent child makes an enrollment change in his or her employer-sponsored health care coverage, either because of a qualified change in status or an annual enrollment.
- You or your spouse or ~~same-gender~~ domestic partner or dependent child changes place of residence or work, affecting access to care within the current plan or access to network providers.
- You are transferred to a different division, affecting eligibility for benefits under Company-sponsored health care plans.
- You or your spouse or ~~same-gender~~ domestic partner or dependent child loses coverage under a group health plan sponsored by a governmental or educational institution.

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

In most situations, you must request enrollment within 60 days after the qualified event. You can enroll a new dependent within 120 days following your marriage or entering into a ~~same-gender~~ domestic partner relationship or a dependent child's birth, adoption, or placement for adoption. To request enrollment for a new dependent more than 60 days but within 120 days after marriage, entering into a ~~same-gender~~ domestic partner relationship, birth, adoption, or placement for adoption, you must call the Boeing Service Center and speak with a customer service representative. You must provide the Boeing Service Center with any required supporting documentation by the date specified by the Boeing Service Center or your request will be denied.

Effective Date of Coverage

Employees
If you are a newly hired employee, the Package becomes effective as follows:

- Medical and dental coverage becomes effective on the first day of the month following your first day of employment.
- Life insurance, accidental death and dismemberment, short-term disability, and survivor income coverage becomes effective on the first day of the month following your first day of employment, provided you are actively at work on that date.

You must be on the active payroll on the first day of the month.

For coverage during a leave of absence, see the Leaves of Absence section.

Dependents
Current eligible dependents are covered for medical and dental benefits on the same date your coverage is effective. Eligible dependents acquired after your coverage is effective become covered on the date of marriage or entering into a ~~same gender~~ domestic partner relationship, date of birth, or date the child is legally placed with you for adoption, if application is made within 120 days of the event. For other newly eligible dependents, coverage is effective on the date dependency is established, if application is made within 60 days.

You authorize required contributions when enrolling eligible dependents.

Life Insurance Plan

The life insurance benefit is $50,000~~$32,000~~. The total amount is payable in the event of your death from any cause at any time or place while covered. Payment is made in a lump sum or installments to the designated beneficiary. You may change beneficiaries at any time by contacting the Boeing Service Center.

If you become permanently and totally disabled for longer than 6 full calendar months at any time before age 60 and while covered under the plan, the life insurance benefit is paid as a permanent and total disability benefit in monthly installments of $500 beginning the first day of the month after the service representative receives proof of the disability. The disability must have existed continuously for 6 months and be expected to keep you, for life, from performing any work for compensation or profit. The installments

continue while you remain totally and permanently disabled until the life insurance benefit, with interest on the unpaid balance, is exhausted. (The final installment is for the balance of the fund.) If you die while entitled to receive this monthly benefit, your beneficiary receives the balance of the life insurance benefit and the accrued interest credited to date of death in a lump sum. Separate periods of total disability resulting from the same or related causes and separated by less than 30 days of active work are considered one period of total disability.

If you recover and return to work, the unpaid installments plus accrued interest to date are reinstated as the total life insurance benefit. Payments for a subsequent disability are limited to this reduced amount.

If you recover but do not return to work, all coverage terminates. You may then convert the total unpaid installments plus accrued interest under the conversion of benefits provision.

The rate of interest allowed on the unpaid balance is the rate for special settlement methods under the individual life insurance policies issued by the service representative.

Proof of disability must be furnished within 12 months of the date active work ends.

If you are hired or rehired on or after January 3, 2014, and you are not a participant in The Boeing Company Employee Retirement Plan (BCERP), the Company will provide a $15,000 disability insurance benefit in the event you become disabled and satisfy the conditions that would otherwise have qualified for a disability retirement benefit under the BCERP. You will not be eligible for this disability insurance benefit if you are eligible for any disability retirement benefit under the BCERP.

Supplemental Life Insurance

Beginning January 1, 2026, the Company will make available employee-paid Supplemental Life Insurance coverage under the same terms and conditions applicable to Boeing non-bargaining-unit employees working in Washington and Oregon state. The Company reserves the right to unilaterally alter, amend, and/or modify any or all terms of the supplemental coverage benefit at its sole discretion on an enterprise wide or regional basis without further bargaining.

Accidental Death and Dismemberment Plan

Accidental death and dismemberment benefits are provided if your loss of life, paralysis, or loss of hand, foot, eyesight, hearing, or speech is caused by a covered accident (including an occupational accident) that occurs while you are covered under the plan.

The full principal sum, $32,000, is paid to your beneficiary if you die. This amount is in addition to any amount payable under the group life insurance coverage.

The following benefits are payable if the covered injury causes any of the following losses within 365 days after the covered accident:

Loss	Percentage of Principal Sum
• Life	100%
• Quadriplegia	100%
• Both Hands or Both Feet	100%
• Sight of Both Eyes	100%
• 1 Hand and 1 Foot	100%
• 1 Hand and the Sight of 1 Eye	100%
• 1 Foot and the Sight of 1 Eye	100%
• Speech and Hearing in Both Ears	100%
• Paraplegia	75%
• Hemiplegia	50%
• 1 Hand or 1 Foot	50%
• Sight of 1 Eye	50%
• Speech or Hearing in Both Ears	50%
• Hearing in 1 Ear	25%
• Thumb and Index Finger of Same Hand	25%

"Loss" of a hand or foot means the complete severance through or above the wrist or ankle joint. "Loss" of sight of an eye means the total and irrecoverable loss of the entire sight in that eye. "Loss" of hearing in an ear means the total and irrecoverable loss of the entire ability to hear in that ear. "Loss" of speech means the total and irrecoverable loss of the entire ability to speak. "Loss" of a thumb and index finger means the complete severance through or above the metacarpophalangeal joint of both digits.

"Quadriplegia" means the complete and irreversible paralysis of both upper and both lower limbs. "Paraplegia" means the complete and irreversible paralysis of both lower limbs. "Hemiplegia" means the complete and irreversible paralysis of the upper and lower limbs of the same side of the body.

"Injury" means bodily injury caused by an accident occurring while you are covered under the plan, and resulting directly and independently of all other causes in death or loss as listed above.

If you sustain more than 1 loss as the result of the same accident, no more than 100% of the principal sum will be paid.

If you are unavoidably exposed to the elements due to an accident occurring while covered under this plan, and as a result of such exposure suffer a loss for which a benefit is otherwise payable, the loss will be covered under the terms of this plan.

If your body has not been found within 1 year of the disappearance, forced landing, stranding, sinking, or wrecking of a vehicle in which you were an occupant while covered under this plan, the loss will be covered as an accidental death under the terms of the plan.

No plan benefits will be paid for a death or loss caused in whole or in part by, or resulting in whole or in part from:

Suicide or intentionally self-inflicted injury.

- Declared or undeclared war or act of declared or undeclared war occurring in the continental limits of the United States, unless it is an act of terrorism.
  ("Terrorism" means any violent act intended to cause injury, damage, or fear and committed by or purportedly committed by one or more individuals or members of an organized group to make a statement of the individual's or group's political or social beliefs, concepts, or attitudes and/or to intimidate a population or government into granting the individual's or group's demands.)

- An illness, sickness, disease, bodily or mental infirmity, medical or surgical treatment, or bacterial or viral infection, regardless of how contracted, except bacterial infection resulting from an accidental cut or wound or accidental food poisoning. However, if a covered loss results from medical or surgical treatment of an injury, benefits will be provided for the loss.

Supplemental Accidental Death and Dismemberment Coverage

Beginning January 1, 2026, the Company will make available employee-paid Supplemental Accidental Death and Dismemberment Insurance coverage under the same terms and conditions applicable to Boeing non-bargaining-unit employees working in Washington and Oregon state. The Company reserves the right to unilaterally alter, amend, and/or modify any or all terms of the supplemental coverage benefit plan at its sole discretion on an enterprise wide or regional basis without further bargaining.

Short-Term Disability Plan

Benefits are paid for disabilities due to pregnancy-related conditions, illness, and accidental injuries on or off the job. Disabled means you are unable to perform the essential functions of your regular occupation or other appropriate work Boeing makes available as a result of a pregnancy-related condition, illness, or accidental injury (on or off the job).

The following schedules state the benefit amounts, classes of disability, and the maximum period of payment. Benefit amounts are determined by your labor grade.

Labor Grade	Weekly Benefit for Disabilities Not Covered by Workers' Compensation	Weekly Benefit for Disabilities Covered by Workers' Compensation
A-1-2-3	$750~~280~~.00	$140.00
4-5-6-7	$750~~300~~.00	150.00
8-9-10-11	$750~~330~~.00	165.00

Workers' compensation benefits for illness and accidental injuries are payable in addition to this Plan.

Payment periods:

Benefits Begin	In the Event of	Maximum Periods
1st day of disability	Accidental injury not covered by workers' compensation	26 weeks
1st day of confinement	Confinement in a hospital for nonoccupational or occupational injuries or illnesses or for pregnancy-related conditions	26 weeks
7th day of disability	Pregnancy-related conditions, accidental injury covered by workers' compensation, and all other illnesses	26 weeks

Your non-occupational short-term disability payments are reduced by payments received from:

- A state workers' compensation program.
- A state disability income or insurance program.
- Any other income rehabilitation earnings you may receive.
- Any additional pay above those necessary to reach 100% of your weekly salary when combined with your short-term disability benefit.

You may supplement your short-term disability benefits with your accrued sick leave or vacation up to 100 percent of your weekly earnings. Alternatively, you may use your accrued sick leave or vacation instead of short-term disability benefits.

If you are absent for 7 or more consecutive days due to a disability resulting from a surgery in an outpatient hospital or surgical facility, benefits will be retroactive to the first day of the disability.

No benefits are payable for any period during which you are not under the regular care of a physician. To receive benefits according to the schedule, you must be seen by a physician within the first 14~~7~~ days of disability; otherwise benefits begin on the date you are actually seen and treated. For this benefit, physician refers to a legally qualified, licensed physician, with a course of treatment that is consistent with the diagnosis of the disabling condition and according to guidelines established by medical, research, and rehabilitation organizations. All determinations of total disability are made

by the service representative within the terms of its contract with the Company.

An increase or decrease in your short-term disability coverage amount is effective the first day of the month following or coinciding with a change in labor grade. If you are both disabled and away from work on the date an increase or decrease would be effective, the change is delayed until you return to an active work schedule.

Reinstatement of Benefits

Benefits are reinstated after a period of disability when you return to active work for at least 30 consecutive days.

If you are absent due to the same or a related disability during this 30-day period, benefits are not reinstated. However, you are eligible for any benefits remaining from the original 26-week period on the first day of the subsequent disability.

If you return to active employment for at least 1 full day and the subsequent disability is due to entirely different and unrelated causes from the prior disability, you are considered as having started a new period of disability.

Income Tax Withholding

Short-term disability payments are reported to the Federal government and may be considered taxable income. Income tax will be withheld if required by law.

Social Security (FICA) withholding is made from employee disability payments and reported to the government. The amount is the current FICA withholding rate. This withholding is required by law and is matched by the employer.

Long Term Disability Plan

Effective January 1, 2026, the Company will provide basic long-term disability coverage at no cost to you. You may purchase supplemental long-term disability coverage if you enroll and make the required contributions.

You are eligible to receive long-term disability benefits after you have been disabled for 26 weeks. Your disability must begin while you are covered by the plan. If your disability continues after the 26-week waiting period, you receive a monthly basic long-term disability benefit that is equal to 50 percent of your monthly earnings. Your monthly earnings at the time of your disability benefit may be reduced to take into account income you receive from other sources and rehabilitative employment.

You may purchase coverage of an additional 10 percent of your monthly earnings by enrolling in supplemental long-term disability coverage. You pay for supplemental long-term disability coverage through after-tax contributions taken from your paycheck. This additional 10 percent benefit is not reduced by any other income, except earnings from rehabilitative employment, as described below.

The maximum monthly benefit from this plan is $15,000, basic and supplemental coverage combined.

Your benefits under this plan will be determined using the monthly earnings reflected in Boeing Service Center records at the time your disability begins, based on your base pay including cost of living allowance, shift differentials, and pay additives. Monthly earnings do not include bonuses, overtime pay, incentive compensation, or other compensation you receive from the Company or a participating subsidiary. For part-time employees, the plan first figures your pay as if you were full time; your earnings are that amount multiplied by a percentage equal to your scheduled weekly hours divided by 40. This is referred to as your "predisability earnings."

If your earnings change, your long-term disability benefit amount changes as follows:

- Your monthly earnings are determined on the first day of each month.
- If you are actively at work when your monthly earnings increase or decrease, your maximum available long-term disability benefit amount automatically will change the first day of the month after or coinciding with the date of the change in earnings.
- If you are not actively at work when your monthly earnings increase or decrease, your long-term disability benefit amount will change the first day of the month after the date you return to active work.
- If you are already on an approved disability, your benefit amount will not change until you return to active work.
- Any retroactive change to your monthly earnings will not retroactively change your eligible benefit amount under this plan.
- Any change to your monthly earnings will not affect a benefit payable for a second disability that is considered a continuation of the first disability.

Long-term disability benefits end on the earliest of these dates:

- The date you no longer are disabled.
- The date you return to work.
- The last day of your maximum benefit period.
- The date you are not under the regular care of a physician for your disability.
- The date you fail to provide proof of continued disability, refuse to be examined, or withhold information about any employment.
- The date you die.

The maximum time that long-term disability benefits may be paid depends on your age when your disability begins, as shown in the following table:

Long-Term Disability Benefit Period	
Age When Disability Begins	**Maximum Benefit Period***
59 or younger	Until age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months
* Or to your Social Security normal retirement age, if later.	

Separate Periods of Disability

If you experience a second disability, the cause and the length of time between the first and second disability will determine whether the second disability is treated as a continuation of the first or as a separate disability unrelated to the first.

Your second period of disability is considered a continuation of the first if:

- the recurrence is due to the same or related cause as the first, and
- you returned to work or were not considered disabled (a period of temporary recovery) for
  - 60 days or less during the initial 26-week waiting period, or

- 26 consecutive weeks or less (for each period of temporary recovery) during the payment period.

The following provisions apply to a period of temporary recovery:

- No new 26-week waiting period is required.
- The monthly earnings amount used to determine your benefit during your previous period of long-term disability stays the same.
- No long-term disability benefits are paid for the time you are temporarily recovered.
- Your period of temporary recovery does not count toward your
  - Initial 26-week waiting period.
  - Maximum benefit period.
  - Initial 24-month payment period.
  - 24-month limit on disabilities due to mental illness or substance use.

Your second period of disability is treated as a new and separate disability if you no longer are disabled from your first disability or returned to active work for at least one day and

- your disability is due to a different cause than the first disability,
- your disability is due to the same cause as the first disability, but your recovery is longer than the time limits listed above; or
- the first period of disability began before you were covered under this plan.

When any of these applies, you will need to initiate a new claim and meet the waiting period requirements before benefits are paid.

When the Plan does Not Pay Benefits

The Long-Term Disability Plan will not cover any disability that begins during the first 12 months of coverage if the disability results from a preexisting condition or if the disability is caused by:

- Committing (or attempting to commit) an assault, battery, or felony.
- Declared or undeclared war or act of war (unless it occurs while you are traveling on Company business).
- Insurrection, rebellion, or taking part in a riot or civil commotion.
- Intentionally self-inflicted injury (while sane or insane).
- Military duty other than temporary active duty of less than 31 days.

You are not eligible for disability benefits during any period you are confined in a penal or correctional institution for conviction of a criminal or other public offense.

Disability due to Mental Illness or Substance Use Disorder

The plan pays benefits to a maximum of 24 months if mental illness or substance use disorder is the primary cause of your disability. After 24 months, benefits continue only if you are confined to a hospital or similar institution for the condition causing the disability.

If inpatient confinement lasts:

- Less than 30 days: Benefits stop when you are no longer confined.
- 30 days or more: Benefits continue until you have not been confined because of that condition for a total of 90 days in any 12-month period.

The rules regarding separate periods of coverage described above do not apply to disabilities caused by mental illness or substance use disorder after the first 24 months of benefit payments.

Income from Other Sources

If you are eligible to receive income from certain other sources while disabled, the amount of that income will be subtracted from your monthly disability benefit under this plan. However, if you are enrolled in supplemental long-term disability coverage, your supplemental long-term disability benefit will not be reduced by income other than earnings from rehabilitative employment (described below).

You must apply for all other income benefits for which you may be eligible, except retirement benefits before your normal retirement age. If Social Security, workers' compensation, or other benefits are denied, you must reapply and send the service representative evidence that you have reapplied.

Income That Reduces Your Long-Term Disability Benefit

The following income benefits reduce your disability benefit under this plan:

- Disability, retirement, or unemployment benefits required or provided under any law of a government, including but not limited to
  - Automobile no-fault wage replacement benefits to the extent required by law.
  - Social Security, Railroad Retirement Act, Canada Pension Plan, and Quebec Pension Plan benefits.
  - Statutory disability benefits.

- − Unemployment compensation benefits.
- − Veterans' benefits.
- − Workers' compensation benefits. •

- Group credit or mortgage disability insurance.
- Half of any award under The Jones Act or The Maritime Doctrine of Maintenance, Wages, and Cure.
- Insured or uninsured disability income plans of any employer, multiemployer or multiple employer welfare plan, union welfare plan, or welfare plan of a group or an association
- Retirement income benefits from the Company or any Company subsidiaries, except
  - − Any retirement benefit you are eligible to receive before the plan's normal retirement age but elect not to receive before that age. After normal retirement age, long-term disability benefits are reduced by retirement benefits you are eligible to receive (whether or not you receive them).
  - − The portion of any lump-sum distribution attributable to employee contributions.
  - − The portion of any retirement benefit attributable to employee contributions.
- Salary or wage continuation.
- Salary, wages, other compensation from any employer, or income from any occupation for compensation or profit, except for approved rehabilitative employment.

Other income benefits include primary and family Social Security benefits as well as other benefits you, your spouse, and your other dependents receive.

Other income benefits paid in a lump sum are allocated over the period specified in the lump-sum settlement. If no period is specified, other income benefits paid in a lump sum will be allocated over the lesser of your remaining benefit period or 60 months.

Rehabilitative Earnings

To encourage your return to gainful employment before you fully recover from your disability, the plan allows you to receive pay, called rehabilitative earnings, for approved rehabilitative work without a reduction in your disability benefits:

Payment Period	**Maximum You May Earn from Long-Term Disability Benefits + Rehabilitative Earnings**
First 24 months	100% of predisability earnings*
After 24 months	80% of predisability earnings*
* To help protect you from the effects of inflation, your predisability earnings are indexed to the cost of living.	

If the sum of your rehabilitative earnings, long-term disability benefits, and other sources of income goes over the maximum allowed, the excess will be subtracted from your long-term disability benefit.

Income That Does Not Reduce Your Long-Term Disability Benefit

Some sources of income do not reduce your long-term disability benefit, including:

- Accelerated benefits paid under a life insurance policy.
- Cost-of-living increases in other income benefits.
- Employer-sponsored deferred compensation, thrift, savings, profit-sharing, stock ownership, stock option, and tax-sheltered annuity plans, including plans qualified under Internal Revenue Code sections 401(k), 403(b), 457, and similar plans.
- Individual disability insurance policies.
- Keogh (HR-10) plans.
- Sick and/or vacation pay, or their functional equivalent.
- Severance pay.
- The amount of any retirement or disability benefits you were receiving from these sources when you became disabled:
  - Military or other government service pensions.
  - Retirement benefits from a previous employer.
  - Veterans' benefits for service-related disabilities.
  - Social Security.
- Traditional or Roth individual retirement accounts (IRA).

Increases in other income benefits will reduce your long-term disability benefits if due to other reasons, such as a change in the number of your family members, recomputation of other income benefits, or a change in the severity of your disability.

Retirement Benefits

If you are eligible for long-term disability benefits after attaining age 65, you must elect to start receiving any Boeing-sponsored retirement benefits to which you are entitled by the later of:

- 60 days after the end of the retirement plan year in which you reach age 65 (generally, December 31— visit Worklife for confirmation).
- Six months after your period of disability begins.

If you have not elected retirement benefits by then, the service representative will estimate how much you would be eligible to receive and subtract that amount from your long-term disability benefits. The estimate will be used until you provide evidence of the exact amount of your retirement benefit.

How Long-Term Disability Benefits are Taxed

Benefit payments under the Basic Long-Term Disability Plan generally are taxable income to you. If your benefits are considered taxable income, you will be responsible for paying any required taxes.

Federal law requires Social Security (FICA) withholding from your benefit payments under this plan. The amount withheld will be the current FICA withholding rate applied to the taxable portion of the benefit. The Company will match the amount withheld.

Benefit payments under the Supplemental Long-Term Disability Plan are not taxable to you because you pay the cost of this coverage with after-tax contributions.

Survivor Income Plan

If you die from any cause, at any time or place, while covered under the plan, survivor income benefits are payable to eligible survivors, as listed below. Survivor income benefits are composed of transition benefits and bridge benefits.

Transition Benefit

The transition benefit is $210 per month for any month the survivor receives either no Social Security benefits or Social Security benefits reduced solely because of age. If the survivor receives unreduced Social Security benefits, the transition benefit is $140 per month.

The transition benefit is paid for a maximum of 24 months to these survivors, in the following priority:

- Your widow or widower lawfully married to you or your domestic partner.

- Your unmarried child or children under age 2625 if living with and dependent on you for at least 50% of their support during the year immediately preceding your death. The child continues to be eligible regardless of age if totally and permanently disabled and living with and dependent on you.
- Your parents or parent if dependent on you for at least 50% of their support in the year before your death.

Benefits begin the first day of the month following the date you die and are payable on the first day of each month thereafter. Benefits are divided equally where 2 or more persons are to receive the benefits. If there are no qualified survivors, no benefits are paid.

Bridge Benefit

After transition benefits are paid, if your eligible spouse or domestic partner was at least age 50 at the time of your death, monthly payments of $210 are made to your spouse or domestic partner while living and unmarried until the earliest of these dates:

- Your spouse or domestic partner remarries.
- Your spouse or domestic partner reaches age 62.
- Full widow's or widower's insurance benefits under the Federal Social Security Act become payable.

However, if your surviving spouse or domestic partner is eligible to receive mother's or father's insurance benefits under the Social Security Act, monthly payments are deferred until your spouse or domestic partner stops receiving mother's or father's insurance benefits.

Medical Plans

The Company-sponsored medical plan is the Traditional Medical Plan. Where appropriate, Health Maintenance Organizations (HMOs) and Coordinated Care Plans (CCPs) will be offered to employees, retirees (subject to Attachment B) and their dependents in addition to the Traditional Medical Plan. See your Summary Plan Description or Certificate of Coverage for a description of medical plan benefits.

Summary of Traditional Medical Plan Benefits

This section shows general plan features of the Traditional Medical Plan; the Schedule of Benefits section shows benefit amounts and other plan information.

Benefit and plan payment provisions are based on a benefit year, January 1 through December 31.

Prescription drug benefits are as shown in the "Prescription Drug Program" section. Vision care benefits, as shown in the "Vision Care Program" section, are available to active employees.

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Summary of Traditional Medical Plan Benefits See the Schedule of Benefits section for benefit amounts		
	Network	**Nonnetwork**
Plan Features		
Annual Deductible	The deductible applies to all covered network services and supplies except network provider outpatient visits where the copayment applies, preventive care, tobacco and nicotine cessation treatment, routine vision care, and prescription drugs	

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Summary of Traditional Medical Plan Benefits See the Schedule of Benefits section for benefit amounts		
	Network	**Nonnetwork**
Office Visit Copayment (Annual deductible does not apply)	~~$15 office visit copayments apply to physician office visits, pregnancy-related conditions, and spinal and extremity manipulations; does not apply to mental health or substance abuse disorder treatment, preventive care, or tobacco and nicotine cessation treatment.~~	Does not apply; charges of nonnetwork providers are subject to the annual deductible and coinsurance
	~~**Effective January 1, 2017:** $20 office visit copayment applies to primary care provider office visits, $25 office visit copayment applies to specialist office visits~~	

Summary of Traditional Medical Plan Benefits See the Schedule of Benefits section for benefit amounts		
	Network	**Nonnetwork**
	~~(including chiropractic)~~ ~~Primary care providers are physicians in general practice, family practice, internal medicine, osteopath, pediatrics, obstetrics, or gynecology; advanced registered nurse practitioner (in any of these practice); physician assistant (in any of these practices); and urgent care providers.~~	
	~~**Effective January 1, 2020:**~~ $30 office visit copayment applies to primary care provider office visits, $40 office visit copayment applies to specialist office visits (including chiropractic) Primary care providers are physicians in general practice, family practice, internal medicine, osteopath, pediatrics, obstetrics, or gynecology;	

Summary of Traditional Medical Plan Benefits See the Schedule of Benefits section for benefit amounts		
	Network	**Nonnetwork**
	advanced registered nurse practitioner (in any of these practices); physician assistant (in any of these practices); and urgent care providers.	
Annual Medical Out-of-Pocket Maximum	The annual out-of-pocket maximum is shown in the Schedule of Benefits section	
Annual Prescription Drug Out-Of-Pocket Maximum	The prescription drug annual out-of-pocket maximum is shown in the Prescription Drug Program Schedule of Benefits section	
Lifetime Maximum Benefit	None	
Provider Choice		
Network Providers	Special fee arrangements with the service representative make it possible for the plan to cover a higher percentage of most network services and supplies; in most cases, the only out-of-pocket expenses are: • Deductible, copayment, and coinsurance amounts • Expenses for services and supplies not covered by the plan • Any amounts that exceed plan maximum benefits	
Nonnetwork Providers	In a location where qualified network providers are available, the plan covers a lower percentage of most nonnetwork services and supplies; in a location where there is no qualified network provider, the plan covers services and supplies at the network level; benefit payments are based on usual and customary charges	
Providers in a Category Not Eligible	The plan covers services and supplies at 80%; you can call the service representative to find	

Summary of Traditional Medical Plan Benefits See the Schedule of Benefits section for benefit amounts		
	Network	**Nonnetwork**
to Participate in the Network	out which types of providers are network providers in a particular location; benefit payments are based on usual and customary charges	
Covered Services and Supplies	Network coinsurance applies to most covered network services and supplies, except as shown below	Nonnetwork coinsurance applies to most covered nonnetwork services and supplies, except as shown below
Ambulance	Network coinsurance applies	See network provisions
Christian Science Sanatorium	Network coinsurance applies; certain limits apply	See network provisions
Emergency Room		
Medical Emergency	Network coinsurance applies after emergency room copayment (waived if admitted as an inpatient immediately following emergency room treatment, is treated in the emergency room for more than 12 hours, or dies in the emergency room)	See network provisions
All Other Treatment	Network coinsurance applies after emergency room copayment	Nonnetwork coinsurance applies after emergency room copayment
Hearing Aids	~~Network coinsurance applies for aids up to~~	~~Network coinsurance applies~~

Summary of Traditional Medical Plan Benefits See the Schedule of Benefits section for benefit amounts		
	Network	**Nonnetwork**
	~~$800 per ear; limit 1 aid per ear every 3 benefit years.~~ ~~Hearing aid overhaul in place of new hearing aid after 3 years.~~ **~~Effective January 1, 2020:~~** Network coinsurance applies for aids up to $1000 per ear; limit 1 aid per ear every 3 benefit years. Hearing aid overhaul in place of new hearing aid after 3 years	~~for aids up to $800 per ear; limit 1 aid per ear every 3 benefit years.~~ ~~Hearing aid overhaul in place of new hearing aid after 3 years.~~ **~~Effective January 1, 2020:~~** Network coinsurance applies for aids up to $1000 per ear; limit 1 aid per ear every 3 benefit years. Hearing aid overhaul in place of new hearing aid after 3 years
Home Health Care	Network coinsurance applies at 90%	Nonnetwork coinsurance applies at 60%
Hospice Care	Network coinsurance applies at 90% subject to 6-month review Skilled care by registered nurse, licensed practical nurse, or home health aide Apply to the service representative for	See network provisions

Summary of Traditional Medical Plan Benefits See the Schedule of Benefits section for benefit amounts		
	Network	**Nonnetwork**
	physician-recommended extensions	
Mental Health Treatment (including eating disorders)		
Covered Inpatient, Partial Hospital, Residential, or Intensive Outpatient Services	See the Schedule of Benefits section for payment level at 90%	See the Schedule of Benefits section for payment level at 60%
Other Covered Outpatient Services	See the Schedule of Benefits section for payment level	See the Schedule of Benefits section for payment level at 60%
Neurodevelopmental Therapy ~~(for children age 6 and under)~~	Network coinsurance applies at 90%~~up to $1,000 each benefit year (network and nonnetwork combined)~~	Nonnetwork coinsurance applies at 60%~~up to $1,000 each benefit year (network and nonnetwork combined)~~
Occupational, Physical, and Speech Therapy	Network coinsurance applies at 90%	Nonnetwork coinsurance applies at 60%
Preventive Care		
Routine Physical Examinations (for employees, spouses and dependents over age 18)	See the Schedule of Benefit section for payment level; includes related X-ray and laboratory charges	Not covered when received in a network service area
Well Child Benefits	See the Schedule of Benefits section for payment level	Not covered when received in a network service area

Summary of Traditional Medical Plan Benefits See the Schedule of Benefits section for benefit amounts		
	Network	**Nonnetwork**
Tobacco and Nicotine Cessation	See the Schedule of Benefits section for payment level	See the Schedule of Benefits section for payment level
Spinal and Extremity Manipulations	~~Network coinsurance applies; 26 spinal and/or extremity manipulation visits per benefit year (network and nonnetwork combined)~~ ~~**Effective January 1, 2017:**~~ Specialist office visit copayment applies; 26 spinal and/or extremity manipulation visits per benefit year (network and nonnetwork combined)	Nonnetwork coinsurance applies; 26 spinal and/or extremity manipulation visits per benefit year (network and nonnetwork combined)
Substance U~~Ab~~use Disorder Treatment		
Covered Inpatient, Partial Hospital, Residential, Detoxification, or Intensive Outpatient ~~or~~ Outpatient Services	See the Schedule of Benefits section for payment level at 90% At 100%	See the Schedule of Benefits section for payment level at 60% At 60%
Temporomandibular Joint Dysfunction and Myofascial Pain	See the Schedule of Benefits section for payment level	See the Schedule of Benefits section for payment level

Summary of Traditional Medical Plan Benefits See the Schedule of Benefits section for benefit amounts		
	Network	**Nonnetwork**
Dysfunction Syndrome (TMJ/MPDS) Treatment		

See "Covered Medical Services and Supplies" for more details on benefits.

Out-of-Pocket Maximums

For some services, you are required to pay a certain percent of charges, called out-of-pocket expenses.

When your out-of-pocket expenses (or when your family members' combined out-of-pocket expenses) reach the annual out-of-pocket maximum, most other benefits are paid at 100% of usual and customary charges for the rest of that benefit year, up to any maximum benefit amounts.

The following expenses do not count toward the out-of-pocket maximums:

- Any balance remaining after a benefit maximum has been reached.
- Benefits paid at a reduced amount or denied when you fail to follow medical review program procedures and requirements.
- ~~Covered medical services for TMJ/MPDS treatment.~~
- ~~Covered medical services for treatment of mental illness or substance abuse.~~
- ~~Covered services for tobacco cessation.~~
- Covered medical services paid at 100% of usual and customary charges or in full.

  ~~Deductibles.~~
- Expenses for services or supplies not covered by the plan.
- ~~Hospital emergency room copayments.~~
- ~~Office visit copayments.~~
- The difference between usual and customary charges and the provider's actual charge.
- Vision care out-of-pocket expenses

Provider Choice

Network Providers

Network providers are physicians, hospitals, and other health care providers who have contracts with the plan's service representative to provide efficient, cost-effective health care. Although you may receive care from any licensed provider covered under the plan, the plan offers certain advantages if a network provider is used.

The contracts with network providers include direct billing and payment systems. This means you do not need to submit a claim form when a network provider is used.

Nonnetwork Providers

Covered services obtained from nonnetwork physicians, hospitals, and other covered health care providers in a license category eligible to participate in the network (for example, M.D.s) are paid according to whether network providers are available in that location.

Providers in a Category Not Eligible to Participate in the Network

Certain types of providers may or may not be network providers depending on their location. The plan may not have network contracts with providers in a specific category in a particular location (such as podiatrists or chiropractors in certain locations).

Medical Review Program

The medical review program lets you and your physician know whether certain types of nonemergency care will be covered under the plan before the care is provided and the expense is incurred.

The plan pays regular benefits for certain types of nonemergency care only if the medical review program is contacted before care is received. Benefits may be limited or denied if these requirements are not followed.

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

If preadmission or prior approval is...	Then the plan pays...
Obtained through the medical review program	Regular benefit levels shown in the "Summary of Traditional Medical Plan Benefits" table
~~Required but not obtained and it is later determined that the care was medically necessary~~	~~50% of the first $2,000 of usual and customary charges (after the annual deductible)~~
Not obtained and the admission or care is not considered medically necessary under the medical review program's guidelines	No benefits; you are responsible for 100% of the charges

Although contacting the program is not required before emergency or pregnancy-related admissions, you or your physician should contact the program soon after admission to be assured whether the rest of the confinement is covered. Hospital preadmission review for childbirth is not required for a mother and newborn for the first 48 hours following a normal delivery or 96 hours following a cesarean section.

Voluntary Second Surgical Opinion

The plan encourages you to get a second opinion before having any nonemergency surgery.

A second (or third) surgical opinion will be covered under the network/nonnetwork provider payment levels, subject to the plan's copayments and/or deductibles and coinsurance.

Individual Case Management

In the event of a severe or long-term illness or injury, the service representative assists your network provider in identifying treatment alternatives that offer cost-effective care and enhancements to quality of life.

Covered Medical Services and Supplies

In general, the plan covers medically necessary services and supplies used to diagnose or treat a nonoccupational accidental injury or illness as well as medically appropriate services and supplies for certain types of preventive care and other conditions, up to plan limits.

Acupuncture

The plan covers medically necessary acupuncture for a covered illness or in place of covered anesthesia. Treatment must be provided by a licensed acupuncturist (L.A.C.), doctor of medicine (M.D.), or doctor of osteopathy (D.O.). You can contact the service representative to determine if acupuncture is covered for a particular condition.

Ambulance

Professional ambulance services are covered to transport you from the place where you are injured or become ill to the first hospital where treatment is given. These services also are covered when the physician requires an ambulance to transport you to a hospital in your area of residence to protect your health or life. Air ambulance transportation is covered when medically necessary.

Ambulance service from one hospital to another, including return, is covered only if the facility is the nearest one with appropriate regional specialized treatment facilities, equipment, or staff physicians. Ambulance transportation from or to your home is covered when medically necessary. No other expenses in connection with travel are covered.

Centers of Excellence

The plan offers a higher level of benefits for covered transplants and/or bariatric (weight loss) surgery at approved Centers of Excellence—facilities that specialize in a particular treatment. When you use a Center of Excellence, your eligible expenses will be paid at 100 percent. This means you will not be required to pay coinsurance. The deductible still applies where applicable. If you must travel a minimum of 75 miles from your residence to use a Center of Excellence, the plan also offers certain travel benefits. For additional information about this program, including facilities that qualify for the higher benefit level, call the member services number on the back of your medical plan ID card.

Christian Science Sanatorium

Charges for a semiprivate room in a sanatorium are covered if you are admitted for the process of healing (not rest or study) and are under the care of an authorized Christian Science practitioner. If a private room in a sanatorium is used, you are responsible for the difference between the charge for the private room and the sanatorium's average charge for a semiprivate room. If the facility provides only private rooms, the plan covers up to the charge for semiprivate rooms in similar local facilities.

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

Congenital Abnormalities and Hereditary Complications

Medically necessary services and supplies are covered when required for the treatment of congenital abnormalities and hereditary complications. This coverage applies to newborn children as well as to all other persons covered under the plan.

Cosmetic Surgery

The plan covers necessary services and supplies for cosmetic surgery only if the surgery is required for the prompt repair of an accidental injury or improvement of function due to congenital abnormality. All other surgery performed for cosmetic purposes is excluded, except as specifically provided for treatment after a mastectomy (see "Reconstructive Breast Surgery").

Dental Repair of Accidental Injury

Services and supplies for the prompt repair of sound natural teeth or other body tissues as a result of an accidental injury are covered, but only to the extent they are not covered by your Company-sponsored dental plan. This may include surgical procedures of the jaw, cheek, lips, tongue, and other parts of the mouth and treatment of fractures in the facial bones (maxilla or mandible).

Diagnostic X-Ray and Laboratory Services

Diagnostic X-ray and laboratory examinations are covered, including those in connection with a voluntary second surgical opinion.

Durable Medical Equipment

The plan covers the rental (or purchase, when approved by the service representative) of medically necessary durable medical or surgical equipment when prescribed by a physician. Covered equipment must be:

- Able to withstand repeated use.
- Solely for the treatment or improvement of a critical function related to the medical condition.
- Appropriate for use in the home.

Examples of covered durable medical equipment are crutches, wheelchairs, kidney dialysis equipment, standard hospital beds, oxygen equipment, and diabetic supplies and equipment such as blood glucose monitors, insulin infusion devices, and insulin pumps. Covered equipment must not be useful to a person in the absence of the medical condition.

The repair or replacement of durable medical equipment due to normal usage or change in the patient's condition, including growth of a child, also is covered.

Emergency Room

Emergency room treatment at either a network or nonnetwork facility is paid at the network level if it is a medical emergency. A patient admitted to a nonnetwork hospital retains emergency status (and benefits are paid at the network level) for 24 hours or until the patient can be transferred safely to a network facility. However, for care at a nonnetwork facility when the condition is not a medical emergency, covered services are paid at the nonnetwork level.

Erectile Dysfunction

Organic erectile dysfunction treatment is covered when the patient has a history of one or more of the following:

- ~~Insulin-dependent d~~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, a penile prosthesis, urethral pellets, and prescription medications.

Hearing Aids

Plan benefits include cost and installation of a hearing aid when recommended in writing by a physician or certified audiologist as well as the overhaul of a hearing aid in place of a new hearing aid. Benefit periods are described in the "Summary of Traditional Medical Plan Benefits" table.

Hemodialysis

The plan covers repetitive hemodialysis treatment for chronic, irreversible kidney disease. Covered services and supplies include the rental, lease, or (under certain conditions) purchase of hemodialysis equipment. Purchase of specific supplies is contingent on the supplies having no real utility to the patient in the absence of the disease and having no value to other household members. Coverage of the purchase of equipment is subject to specific conditions, including an amortization period, decided by the service representative.

Hemodialysis treatment and equipment are covered by the plan for the first 30 months following Medicare entitlement due to end-stage renal disease. After this 30-month period, Medicare provides primary coverage and the plan provides secondary coverage.

Home Health Care

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

Home health care requires prior approval; see "Medical Review Program". Before receiving home health care, the attending physician must provide a written treatment plan (a written program for continued care and treatment). The following home health care visits and supplies are covered if provided and billed by an approved home health care agency:

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

Hospice Care

Hospice care is provided to terminally ill patients in an effort to control pain and other symptoms associated with terminal illness. The plan covers these services for a patient whose life expectancy has been determined to be 6 months or less.

Hospice care requires prior approval; see "Medical Review Program". Before receiving hospice care, the attending physician must provide a written treatment plan (a written program for continued care and treatment).

An approved hospice treatment plan may include both inpatient and outpatient care. If hospital inpatient care is approved, the plan covers hospice care on the same basis as for other types of hospital inpatient care. Skilled nursing facility or hospital outpatient care also are covered for the hospice patient on the same basis as for other patients. The plan also covers prescription drugs and durable medical equipment for hospice care on the same basis as for other types of care.

The plan covers home health care visits and supplies listed in "Home Health Care" above if they are part of an approved hospice treatment plan and 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 Medicare approved or operating under the direction and control of the licensing or regulatory agency in its location.

In addition, the plan covers respite care services to provide temporary relief to family members and friends who care for the patient as shown in the "Summary of Traditional Medical Plan Benefits" table.

***Hospital* Services**

The plan covers charges for a semiprivate room and medically necessary hospital services and supplies.

The cost of a private room is covered if medically necessary. If a private room is used when it is not medically necessary, the patient is responsible for the difference between the charge for the private room and the hospital's average charge for a semiprivate room. If the hospital provides only private rooms, the plan covers up to the charge for semiprivate rooms in similar local facilities.

Advance approval is needed for:

Nonemergency admissions (see "Medical Review Program").

Inpatient mental health and substance ~~ab~~use disorder treatment or outpatient electroconvulsive therapy (see "Mental Health and Substance U~~Abu~~se Disorder Program" below).

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

Infertility

The plan covers the following services in connection with the diagnosis and treatment of infertility:

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

Mental Health and Substance ~~Abuse~~ Use Disorder Program

The Boeing mental health and substance ~~ab~~use disorder program provides benefits for mental health treatment and substance ~~ab~~use disorder treatment (including abuse of or addiction to alcohol, recreational drugs, or prescription drugs). The program is administered by the Boeing behavioral health manager.

To be reimbursed under the plan, all mental health and substance ~~ab~~use disorder treatment must be determined medically necessary. When treatment is obtained from a referred provider, the plan payment level is higher. All care is reviewed for medical necessity whether or not you contact the Boeing behavioral health manager.

Mental Health Treatment Coverage. The plan covers medically necessary mental health treatment from any provider contracted with the Boeing behavioral health manager, including any licensed clinical psychologist, hospital or treatment facility, psychiatric doctor (M.D.), psychiatric nurse (R.N.), or professional at the master's level or above who is licensed in the area where services are performed.

If the mental health treatment is related to, accompanies, or results from substance ~~ab~~use disorder, coverage is provided solely under substance ~~ab~~use disorder provisions.

Substance ~~Abuse~~ Use Disorder Treatment Coverage. The plan covers medically necessary alcoholism treatment and other types of substance ~~ab~~use disorder treatment at an approved treatment facility or hospital as well as physician and licensed therapist services and prescription drugs. The treatment, services, and drugs must be part of a specific treatment plan prepared by your attending physician and certified as covered under the plan. (An approved substance ~~ab~~use disorder treatment facility is one that treats chronic alcoholism and/or drug abuse that is licensed and regulated by the appropriate governmental agency in its location.)

The plan covers detoxification only if followed immediately by a rehabilitation program. To receive coverage for substance ~~ab~~use disorder treatment, you must complete the prescribed course of treatment.

Neurodevelopmental Therapy

The plan covers neurodevelopmental therapy for children. ~~age 6 or under, up to the maximum benefit shown in the "Summary of Traditional Medical Plan Benefits."~~ In-home neurodevelopmental therapy is covered if the patient is homebound. Therapists must meet licensing or certification requirements as described below.

Neurodevelopmental therapy is physical, occupational, and speech therapy for treatment of neurodevelopmental delay. Neurodevelopmental delay means lack of development of motor or speech function not due to injury or trauma.

Occupational, Physical, and Speech Therapy

Certain types of therapy are covered, but only to the extent that the therapy will significantly restore function. To be covered, the services of a physical therapist for physical therapy, an occupational therapist for occupational therapy, and a speech therapist for speech therapy must be prescribed by a physician as to type and duration of treatment.

Services must be provided under a physician's supervision while you remain under the attending physician's care. The physician must reevaluate the therapy at least every 3 months and certify that continuing therapy is required. All therapy beyond 3 months must be approved by the service representative. Benefit determination is based on the attending physician's evaluation of the therapy as well as the therapist's progress reports. The information from the physician and therapist is then reviewed against established medical criteria to determine medical necessity.

No benefits are payable for therapy given at the therapist's discretion, elected by the covered person, for any treatment for delayed development or therapy that is solely for the purpose of slowing body degeneration rather

than restoring functional improvement, custodial maintenance, self-help, recreational, or educational therapy.

Licensing and Certification Requirements Occupational, physical, and speech therapists must meet licensing or certification requirements as follows:

- The therapist 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.

Oral Surgery

The plan covers certain services and supplies provided by a physician or dentist to the extent they are approved by the service representative and are not covered under a dental plan.

Orthopedic Appliances and Braces; Orthotics

Braces, splints, orthopedic appliances, and orthotic supplies are covered. This includes necessary repair and replacement required by normal usage or change in the patient's condition such as growth of a child. Orthopedic shoes, lifts, wedges, and inserts (orthotics) are covered if prescribed by a physician and custom made for the patient. These items are covered as part of the durable medical equipment benefits. Over-the-counter items will not be covered.

Oxygen and Anesthesia

The plan covers oxygen and anesthesia.

Physician Services

Services of a licensed physician generally are covered when medically necessary for the diagnosis or treatment of nonoccupational accidental injuries, illnesses, or other covered conditions. (See definition of physician.) Physician services also are covered for:

- An eye examination (including refraction) if performed because of another medical condition such as diabetes, glaucoma, or cataracts

(routine eye examinations are covered under the vision care program).

- Antigen, allergy vaccine, insulin, and other drugs and devices (including contraceptive injections, devices, and implants) dispensed by a physician.
- Injectable legend drugs administered in a physician's office and used to treat a covered condition.
- Preventive care.
- Voluntary second surgical opinions.

Other Professional Services. The plan covers certain health care services when provided either by a physician or another type of health care professional. All health care professionals must be licensed by the state where the services are performed and must be acting within the scope of that license. In the absence of licensing requirements, appropriate certification is required.

- Covered health care professionals include:
- Acupuncturists (L.A.C.) for covered acupuncture services.
- Chiropractors providing covered chiropractic services.
- Christian Science practitioners listed in the current *Christian Science Journal* at the time they provide a service.
- Clinical psychologists and master's level therapists for mental health or substance ~~ab~~use disorder treatment for conditions covered under the plan.
- Dentists for covered dental work or surgery.
- Neurodevelopmental, occupational, physical, and speech therapists.
- Physician assistants for services that would have been covered if performed by a physician licensed as an M.D. or D.O.
- Podiatrists providing covered podiatric services.
- Registered nurses (R.N.) for services that would have been covered if performed by a physician licensed as an M.D. or D.O. The plan also covers intermittent visits by an R.N. when skilled care in place of hospitalization is not available through an alternative provider at a lesser cost.

Pregnancy-Related Conditions and Coverage of Newborns

Medically necessary services and supplies are covered for pregnancy-related conditions of you and your dependents if they are provided while covered under the plan.

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

Approved birthing center services are covered if they would be covered when received in a hospital. (A birthing center is a facility for normal delivery operating under the direction and control of the licensing or regulatory 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 vaginal 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 if he or she qualifies as your dependent and is enrolled within applicable changes in status time frames. The following services and supplies are covered for an enrolled newborn, subject to the plan's annual deductible, copayments, and benefit payment levels:

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

Coverage of a newborn continues as long as the child remains an eligible dependent and is enrolled in the plan.

Preventive Care

The plan covers the following preventive care 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.)

- Routine well-baby care from birth.

- Routine pediatric, routine gynecological, and adult physical examination.
- Pediatric and adult immunizations.
- Office visits and related laboratory and X-ray service, including routine hearing examinations, Papanicolaou (Pap) test, routine mammography and prostate cancer screening, and routine colorectal cancer screening services, such as colonoscopies.

Preventative care services (such as routine physical examinations), tests, and immunizations are covered as recommended by the U.S. Preventative Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the U.S. Health Resources and Services Administration in accordance with the Affordable Care Act.

- ~~Physical examinations for you, your spouse and dependents over age 18 including related X-ray and laboratory charges. Benefits are limited to 1 examination every 3 benefit years through age 34, then 1 examination every benefit year. The plan also covers screening Papanicolaou (Pap) tests, mammograms, and prostate screenings as recommended by your physician.~~
- ~~Well child benefits, including physical examinations and related X-ray and laboratory charges. Benefits are limited to 8 examinations from birth through 24 months, then one examination per benefit year through age 18. The plan also covers immunizations in accordance with American Academy of Pediatrics guidelines and the schedule recommended by the child's physician.~~

~~The annual deductible and office visit copayment do *not* apply to covered preventive care.~~

Prostheses

Artificial limbs, artificial eyes, and other prostheses to replace a missing body part are covered, including the necessary repair and replacement required by normal usage or change in the patient's condition such as growth of a child.

Radiation and Chemotherapy

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

Reconstructive Breast Surgery

Covered individuals who have had or are going to have a mastectomy 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 are provided subject to the same deductible, copayment, and coinsurance applicable to other medical and surgical benefits provided under this plan.

Skilled Nursing Facility

The plan covers charges for a semiprivate room in a skilled nursing facility as well as medically necessary services and supplies when provided in place of covered hospital inpatient care. Skilled nursing facility services also are covered for a terminally ill patient when the illness has reached a point of predictable end. Nonemergency admissions must be approved in advance; see "Medical Review Program".

A skilled nursing facility is an institution approved as such by Medicare. If a private room is used, you are responsible for the difference between the charge for the private room and the facility's average charge for a semiprivate room. If the facility provides only private rooms, the plan covers up to the charge for semiprivate rooms in similar local facilities.

Spinal and Extremity Manipulations

This plan covers spinal and extremity manipulations by an approved provider, such as a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), or a chiropractic doctor (D.C.), for spinal and extremity manipulations performed by hand. Related services, such as an initial examination and initial X-rays, also are covered.

Substance ~~Abuse~~ Use Disorder Treatment

See "Mental Health and Substance ~~Abuse~~Use Disorder Program".

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

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

- 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, or mandibular orthopedic devices.
- Follow-up office visits.
- Initial diagnostic examinations and X-rays.
- Surgical procedures and related hospitalizations.
- It is recommended that you obtain preapproval from the service representative for all TMJ/MPDS treatment, in accordance with written guidelines (including those for medical necessity). ~~This treatment is subject to a benefit maximum shown in the Schedule of Benefits.~~

Tobacco and Nicotine Cessation

The plan covers tobacco and nicotine cessation services that are provided by a physician, another health care professional who is practicing within the scope of his or her license, and an approved tobacco and nicotine cessation provider.

~~However, the plan will cover the cost only if the patient completes the full course of treatment. Tobacco cessation treatment is subject to the benefit maximum shown in the Schedule of Benefits.~~

Transplants

The plan covers medically necessary services and supplies related to covered transplants. Transplants that are part of an approved clinical trial also may be covered. Contact the service representative for more information about covered services and supplies as well as maximums.

If you or your covered dependent receives a human organ or tissue transplant covered by this plan, certain donor organ procurement costs also may be covered. Benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ, and other medically necessary procurement costs.

See "Centers of Excellence" for a description of a higher level of benefits for covered transplants at approved Centers of Excellence. For further

details about this program, including facilities that qualify for the higher benefit level, call the member services number on the back of your medical plan ID card.

Vasectomy or Tubal Ligation

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

Exclusions

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

- Accident or illness covered by a workers' compensation law.
- Amounts exceeding allowed charges or usual and customary charges. An allowed charge is the amount that would have been paid for like services or supplies to a network provider; (for participants entitled to Medicare, an allowed charge is the Medicare allowed charge).
- Benefits payable under any automobile medical, personal injury protection (PIP), automobile no-fault, automobile uninsured or underinsured motorist, homeowner's, or commercial premises medical coverage, when that contract or insurance is issued to or provides benefits available to the patient. Any benefits paid by the plan before benefits are paid under one of these other types of contracts or insurance are to assist the patient, and do not indicate the service representative is acting as a volunteer or waiving any right to reimbursement or subrogation.
- Completion of claim forms or reports.
- ~~Confinement or surgical, medical, or other treatment, services, or supplies received in or from a U.S. Government hospital, except as required by law.~~
- ~~Counseling – career, child, family, financial, marriage, pastoral, or social adjustment.~~
- Custodial care as follows:
  - Care that does not require the continuing services of skilled medical or health professionals and primarily is provided to assist in activities of daily living.
  - Institutional care primarily to support self-care and provide room and board.

Custodial care includes, but is not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding, preparing special diets, and supervising medications that ordinarily are self-administered.

- Dental services except as otherwise specifically provided.
- Dyslexia, visual analysis therapy, or training related to muscular imbalance of the eye or for orthoptics. However, coverage is provided for up to 6 months when necessary to correct muscle imbalance (strabismus, esotropia, or exotropia) if treatment begins before the person's 12th birthday.
- Education, special education, or job training—whether or not by a facility that also provides medical or psychiatric care.
- Equipment or supplies not solely related to the medical care of a diagnosed illness or injury; examples include, but are not limited to:
  - 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 caring for the patient.
  - Items generally useful in the absence of a medical condition.
  - Modification to home (wheelchair ramps, support railings), automobile, or van (ramps, lifts).
  - Orthopedic chair.
  - Personal hygiene items.
  - Special car seat.
  - Swimming pool, spa, or whirlpool.
- Experimental or investigational services or supplies or related complications.
- Full-body computerized axial tomography (CAT) scans or other full-body imaging other than at a hospital or an institution having an agreement with a hospital to supply these services. However, expenses are covered under other circumstances if the equipment is required and certified by the physician for immediate use to diagnose a potentially life-threatening condition or if the services

are provided at a physician's office, clinic or other institution approved by the Company for other than emergency use.

- Hearing aid care as listed below:
  - Eyeglass-type hearing aids to the extent the charge exceeds the covered amount for hearing aids.
  - Hearing or audiometric examinations, unless disease is present; however, hearing examinations are covered if performed as part of a covered preventive care physical examination.
  - Hearing aids ordered before you become eligible for coverage or after coverage terminates.
  - Hearing aids ordered before termination of coverage but delivered more than 60 days after coverage ends.
  - Hearing aids that do not meet professionally accepted standards, including any experimental services or supplies.
  - Replacement batteries.
  - Replacement of lost, broken, or stolen hearing aids, unless the 3-year period has been exhausted.
  - Replacement parts for hearing aid repair, unless part of an overhaul after 3 years.
- Home health care and hospice care services as listed below:
  - Homemaker or housekeeping services.
  - Hospice services of financial, legal, or spiritual counselors.
  - Hospice services to other family members, including bereavement counseling.
  - Maintenance or custodial care.
  - Psychiatric care.
  - Services 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 services or supplies not specifically covered, including but not limited to any tests, visits, consultations, or treatment

related to, leading to, or resulting in one of the noncovered services listed below.

- 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 artificial means of conception.
- Gamete intrafallopian transfer (GIFT).
- In vitro fertilization.
- Microinjections.
- Sperm preparation.
- Sperm separation.
- Zona drilling.

- ~~Intentionally self-inflicted injury, unless resulting from a medical condition.~~
- Missed appointments.
- Impotence that is not the result of a diagnosed, covered medical or mental health condition.~~Nonorganic impotence such as psychosexual dysfunction.~~
- Obesity services and supplies unless approved in advance by the service representative in accordance with written guidelines. (A copy of the guidelines may be requested by calling the service representative.)
- Over-the-counter items, including but not limited to medications and orthopedic appliances and braces (unless otherwise covered under the prescription drug or durable medical equipment benefit).
- Prescription drugs unless covered as part of a hospital stay; see the "Prescription Drug Program" section for outpatient prescription drug benefits.
- Recovery houses, school programs, or emergency service patrols.
- Reversal of a sterilization procedure.
- Refractive surgery including radial keratotomy, Lasik, or other eye surgery to correct refractive errors, except when preoperative visual acuity is 20/50 or less with a lens.

- Services or supplies the service representative determines are not medically necessary for treatment of an accidental injury, illness, or other condition covered under the plan. This includes routine physical examinations, immunizations, or other preventive services or supplies, except as specifically provided by the plan.
- Inpatient hospital care (including physician visits while hospitalized) is not considered medically necessary when the care can be provided safely in an outpatient setting—such as a hospital outpatient department, physician's office, or an ambulatory surgical facility—without adversely affecting your physical condition.
- Examples of care that generally should be provided in an outpatient setting include observation and/or diagnostic studies, surgery that can be performed on a same-day basis, and psychiatric care primarily to control or change the patient's environment.
- Services or supplies for which no charge is made or charges you or your dependent is not required to pay.
- Services or supplies not recommended and approved by a physician or other covered health care professional or those provided before the person becomes covered under this plan.
- Services or supplies required by law to be provided by any school system.
- Services or supplies to the extent they are covered under any discontinued Company-sponsored plan.
- Services or supplies covered under any Federal, state, or other government plan, except where required by law.
- Sex transformation treatment or services, except when medically necessary to treat a mental health condition (e.g., gender dysphoria).
- Skilled nursing facility services when they are not usually provided by such facilities or are not expected to lessen the disability and enable the person to live outside the facility. However, skilled nursing facility services are covered for the terminal patient when the illness has reached a point of predictable end.

- Transplant services or supplies as listed below:
  - 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 for that portion of treatment funded by government or private entities as part of an approved clinical trial.
  - Expenses when the recipient is not covered under the medical plan.
  - Experimental or investigational services or supplies unless they are part of an approved clinical trial.
  - Living (noncadaver) donor transplants that are not specifically authorized and covered by the medical plan.
  - Lodging, food, or transportation costs, unless otherwise specifically provided under the medical plan.
  - Nonhuman, artificial, or mechanical transplants, unless specifically approved by the service representative.
- Vision care (routine or refractive) except as specifically provided (for active employees, routine or refractive vision care program benefits apply).
- Wigs or hair prostheses.

Definitions

Benefit Year is January 1 through December 31, annually.

Company-Sponsored Plan is a group medical or dental plan provided by the Company (or a subsidiary or affiliate) for employees and dependents. This includes the plan described in this summary. (To find out whether a particular plan is Company-sponsored, contact the Boeing Service Center for Health and Insurance Plans.)

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

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 and substance use disorder, a situation is also considered an emergency when there is imminent danger to you or others, or you are medically

compromised as a result of mental health condition~~illness~~ or substance ~~ab~~use disorder.

Medically Necessary Service or Supply meets the following criteria, as determined by the service representative. A service or supply may be medically necessary in part only. The fact the service or supply is furnished, prescribed, recommended, or approved by a physician does not, by itself, make it medically necessary. A service or supply is medically necessary if it is:

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

Mental Health Condition~~Illness~~ is a disorder (including an eating disorder) that exhibits signs, symptoms, history, and other characteristics congruent with those required for a mental disorder diagnosis enumerated in the International Classification of Diseases, 10th Revision (ICD-10)~~*Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV)~~.

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

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

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

Service Representative is an agent that has a contract with the Company to make benefit determinations and administer benefit payments under the plan and programs described in this summary. The Company may change a service representative at any time.

Substance ~~Abuse~~Use Disorder is an alcohol or drug-related disorder that exhibits signs, symptoms, history, and other characteristics congruent with

those required for a substance-related disorder as enumerated in the International Classification of Diseases, 10th Revision (ICD-10)~~*Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV)~~.

Traditional Medical Plan Schedule of Benefits

The Traditional Medical Plan will be as described in the following "Traditional Medical Plan Schedule of Benefits."

Traditional Medical Plan Schedule of Benefits The Traditional Medical Plan is administered by BlueCross BlueShield of Illinois (the service representative).		
	Network	**Nonnetwork**
~~**Annual Deductible**~~	~~$225 per individual; $675 per family of 3 or more, but not more than $225 for any individual~~	
	~~**Effective January 1, 2017:** $300 per individual; $900 per family of 3 or more, but not more than $300 for any individual~~	~~**Effective January 1, 2017:** $600 per individual; $1,800 per family of three or more, but not more than $600 for any individual Nonnetwork charges will apply to the network deductible~~
Annual Deductible	~~**Effective January 1, 2020:**~~ $400 per individual; $1,200 per family of 3 or more, but not more than $400 for any individual	~~**Effective January 1, 2020:**~~ $800 per individual; $2,400 per family of three or more, but not more than $800 for any individual Nonnetwork charges will apply to the network deductible

Traditional Medical Plan Schedule of Benefits The Traditional Medical Plan is administered by BlueCross BlueShield of Illinois (the service representative).		
	Network	**Nonnetwork**
Office Visit Copayment (annual deductible does not apply)	~~$15 office visit copayment applies to physician office visits, pregnancy-related conditions and spinal and extremity manipulations; does not apply to preventive care, mental health and substance abuse outpatient visits or tobacco cessation treatment.~~	Does not apply; charges of nonnetwork providers are subject to the annual deductible and coinsurance
	~~**Effective January 1, 2017:**~~ ~~$20 office visit copayment applies to primary care office visit~~ ~~$25 office visit copayment applies to specialist office visit (including chiropractic)~~	

Traditional Medical Plan Schedule of Benefits The Traditional Medical Plan is administered by BlueCross BlueShield of Illinois (the service representative).		
	Network	**Nonnetwork**
	~~**Effective January 1, 2020:**~~ $30 office visit copayment applies to primary care office visit $40 office visit copayment applies to specialist office visit (including chiropractic)	
Coinsurance	90%	60%
Annual Medical Out-of-Pocket Maximum (includes ~~addition to~~ the annual deductible)	~~$2,000~~$2,400 per individual; ~~$4,500~~$5,700 per family of 3 or more, but not more than ~~$2,000~~$2,400 for any 1 person	
Lifetime Maximum Benefit	None	
Centers of Excellence	100% for plan-identified Centers of Excellence for specified transplants and bariatric surgery plus specified travel expenses; for information about this program, including facilities that qualify for the higher benefit level, see “Centers of Excellence” on page 218.	
Hospital Services and Supplies	90%	60%
Emergency Room		

Traditional Medical Plan Schedule of Benefits The Traditional Medical Plan is administered by BlueCross BlueShield of Illinois (the service representative).		
	Network	**Nonnetwork**
Medical Emergency	$75 copayment, then 90% (copayment waived if you are admitted as an inpatient immediately after emergency room care)	See network provisions
All Other Treatment	90% after $75 copayment	60% after $50 copayment
Mental Health Treatment (including eating disorders)		
Covered Inpatient, Partial Hospital, Residential, or Intensive Outpatient Services	90%	60%
Other Covered Outpatient Services	100%	60%
Tobacco and Nicotine Cessation Treatment		
Covered physician, health care professional, and approved provider charges	100% (annual deductible does not apply) ~~$500 lifetime benefit maximum~~	

Traditional Medical Plan Schedule of Benefits The Traditional Medical Plan is administered by BlueCross BlueShield of Illinois (the service representative).		
	Network	**Nonnetwork**
Substance Use~~Abuse~~ Disorder Treatment		
Covered Inpatient, Partial Hospital, Residential, Detoxification or Intensive Outpatient, Services	90%	60%
Other Covered Outpatient Services	100%	60%
Preventive Care		
Routine Physical Examinations (for employees, spouses and dependents over age 18)	100% ~~for 1 examination per 3 years through age 34, then 1 examination per year;~~ covered according to prescribed guidelines~~plan approved schedule~~ (deductible does not apply). ~~Frequency exceptions in accordance with established guidelines.~~	Not covered when received in a network service area

Traditional Medical Plan Schedule of Benefits The Traditional Medical Plan is administered by BlueCross BlueShield of Illinois (the service representative).		
	Network	**Nonnetwork**
Well Child Benefits	100% ~~for 1 examination per year age 2-18; immunizations~~ covered according to prescribed guidelines ~~and as recommended by doctor~~ (deductible does not apply) ~~Frequency exceptions in accordance with established guidelines~~	Not covered when received in a network service area
Temporomandibular Joint Dysfunction and Myofascial Pain Dysfunction Syndrome (TMJ/MPDS) Treatment	50% ~~up to $3,500 lifetime maximum~~	

Prescription drug benefits are as shown in the "Prescription Drug Program" section. Vision care benefits, as shown in the "Vision Care Program" section, will continue to apply to active employees.

Vision Care Program

The vision care program described in this section is available to active employees and dependents enrolled in the Traditional Medical Plan and Selections Plans.

Vision Care Program Schedule of Benefits

Vision Care Program Schedule of Benefits The vision care program is administered by Davis Vision ~~Service Plan~~ (~~VSP,~~ the service representative).	
Services and Supplies	**VSP Plan**
Eye Examinations	Paid in full after $15 copayment for Davis Vision~~VSP~~ network provider; up to $50 for nonnetwork provider
Lenses (2):	
Single vision	$50*
Bifocal	$80*
Trifocal	$95*
Lenticular	$155*
Frames	$90*, **
Contact Lenses (in place of allowances for conventional lenses and frames above)	$120*, **
* Davis Vision~~VSP~~ network providers offer a 20% discount on complete pairs of prescription glasses and a 15% discount on contact lens examinations (evaluation and fitting); you pay the Davis Vision~~VSP~~ network provider only the excess over the amounts shown in the schedule above. Nonnetwork provider charges for lenses, frames, and contact lenses are reimbursed up to the amounts shown in the schedule above; no discount applies. ~~** Effective July 1, 2012.~~	

Covered Vision Services and Supplies

The program covers the following vision care services and supplies (up to the amounts shown in the Schedule of Benefits):

- Complete eye examination of visual function, performed by a licensed ophthalmologist or optometrist.

- Contact lenses if elected in place of conventional lenses and frames.
- Frames required for prescription lenses.
- Prescription lenses.
- Prescription safety glasses, subject to the schedule of benefits immediately above.

Benefit Payment Levels

See the Schedule of Benefits above for payment levels.

Patients incur an additional charge for noncovered lens options such as lens coatings or hardening, tints, photochromic, polycarbonate, and scratch-resistant or shatter-resistant lenses.

Other vision care services are not covered under this program, but some may be covered as a medical condition under the Traditional Medical Plan.

Benefit Limitations

Benefits are provided for 1 eye examination every benefit year and 2 sets of lenses and 2 frames every 2 years (network and nonnetwork combined). In addition, one set of safety prescription glasses will be provided every two (2) years. The program covers contact lenses when purchased in place of conventional lenses and frames. Any replacement of lost, stolen, or broken lenses and/or frames is subject to the two-set limit, subject to Article 16.4(a).

Vision Care Program Exclusions

The following vision care expenses are not covered:

- Corrective vision treatment of an experimental nature. (Experimental nature means a procedure or lens not used universally or accepted by the vision care profession, as determined by the service representative.)
- Costs above the maximum covered expenses.
- Lens options (such as coatings or hardening, tints, photochromic, polycarbonate, or scratch-resistant or shatter-resistant lenses).
- Medical or surgical treatment of the eye. (However, Davis Vision~~VSP network providers~~ will offer discounts for refractive surgery.)
- Orthoptics or vision training or any associated supplemental testing; dyslexia.

- Plano lenses (less than a ± 0.38 diopter power), nonprescription glasses, 2 pair of glasses instead of bifocals, or extra charge for progressive lenses in excess of the bifocal allowance.
- Services or supplies not listed as covered expenses.
- Services or supplies received more than ~~60~~180 days after the service representative authorizes vision care benefits.
- Services or supplies received while not covered or lenses or frames furnished or ordered before coverage begins.
- Solutions and/or cleaning products for glasses or contact lenses.
- Special supplies, such as nonprescription sunglasses or subnormal vision aids.

Prescription Drug Program

The prescription drug program described in this section is available to employees and dependents enrolled in the Traditional Medical Plan.

This program offers 2 coverage options for prescription drugs and medicines:

Retail pharmacy card program—you can use the pharmacy card to obtain covered prescriptions from a participating retail pharmacy.

Mail service program~~—called Medco By Mail~~.

A formulary applies to all retail pharmacy and mail order purchases. (A formulary is a list of drugs determined to be effective in both cost and treatment and approved by the Food and Drug Administration (FDA). A nonformulary drug also may be effective for treatment, but is not as cost-effective as formulary or generic drugs. A group of practicing physicians and pharmacists routinely reviews drugs to include in the formulary. If clinical data show several drugs are equally effective, the most cost-effective drug usually is chosen. The formulary may change from time to time.)

There are 3 categories of prescription drug purchases:

- **Generic**—drugs that are chemically and therapeutically equivalent to their brand-name counterparts but usually cost less.
- **Brand-name formulary**—brand-name drugs selected for the formulary based on cost and effectiveness.
- **Brand-name nonformulary**—brand-name drugs not selected for the formulary.

The program includes utilization management services and generic incentives (see "Pharmacy Management" and "Member Pay the Difference Generic Incentive Program" below) to help ensure cost-effective, clinically appropriate treatment.

Prescription Drug Program Schedule of Benefits

Prescription Drug Program Schedule of Benefits The prescription drug program is administered by Prime Therapeutics~~Express Scripts~~ (the service representative).			
	Generic	**Brand-Name Formulary***	**Brand-Name Nonformulary***
Annual prescription drug out-of-pocket maximum	**Through December 31, 2024:** $7,050 per individual $13,200 per family of two or more **Effective January 1, 2025**: $6,800 per individual $12,700 per family of two or more **Effective January 1, 2026**: $4,000 per individual $8,000 per family of two or more		
Participating Pharmacy (up to a 30-day supply)	$5 copayment	~~$20 copayment if no generic is available OR if you are approved through the review process. Otherwise, if a brand-name drug is purchased when an equivalent generic is available—whether you or your physician requests the brand-name drug—you will pay the generic copayment plus the cost difference of the brand-name drug and generic drug.~~	~~$35 copayment if no generic is available OR if you are approved through the review process. Otherwise, if a brand-name drug is purchased when an equivalent generic is available—whether you or your physician requests the brand-name drug—you will pay the generic copayment plus the cost difference of the brand-name drug and generic drug.~~

		~~**Effective January 1, 2017:**~~$25 copayment if no generic is available OR if you are approved through the review process. Otherwise, if a brand-name drug is purchased when an equivalent generic is available—whether you or your physician requests the brand-name drug—you will pay the generic copayment plus the cost difference of the brand-name drug and generic drug.	~~**Effective January 1, 2017:**~~$40 copayment if no generic is available OR if you are approved through the review process. Otherwise, if a brand-name drug is purchased when an equivalent generic is available—whether you or your physician requests the brand-name drug—you will pay the generic copayment plus the cost difference of the brand-name drug and generic drug.

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Prescription Drug Program Schedule of Benefits The prescription drug program is administered by ~~Express Scripts~~ Prime Therapeutics (the service representative).			
	Generic	**Brand-Name Formulary***	**Brand-Name Nonformulary***
Mail Service Program (~~Medco by Mail;~~ up to a 90-day supply)**	$10 copayment	~~$40 copayment if no generic is available OR if you are approved through the review process. Otherwise, if a brand-name drug is purchased when an equivalent generic is available—whether you or your physician requests the brand-name drug—you will pay the generic copayment plus the cost difference of the brand-name drug and generic drug.~~	~~$70 copayment if no generic is available OR if you are approved through the review process. Otherwise, if a brand-name drug is purchased when an equivalent generic is available—whether you or your physician requests the brand-name drug—you will pay the generic copayment plus the cost difference of the brand-name drug and generic drug.~~

		~~**Effective January 1, 2017:**~~ $60 copayment if no generic is available OR if you are approved through the review process. Otherwise, if a brand-name drug is purchased when an equivalent generic is available—whether you or your physician requests the brand-name drug—you will pay the generic copayment plus the cost difference of the brand-name drug and generic drug.	~~**Effective January 1, 2017:**~~ $100 copayment if no generic is available OR if you are approved through the review process. Otherwise, if a brand-name drug is purchased when an equivalent generic is available—whether you or your physician requests the brand-name drug—you will pay the generic copayment plus the cost difference of the brand-name drug and generic drug.

Nonparticipating Pharmacy ~~(or participating pharmacy without identification card; participating pharmacy limits apply)~~	$5 copayment	~~$20 copayment if no generic is available OR if you are approved through the review process. Otherwise, if a brand-name drug is purchased when an equivalent generic is available—whether you or your physician requests the brand-name drug—you will pay the generic copayment plus the cost difference of the brand-name drug and generic drug.~~	~~$35 copayment if no generic is available OR if you are approved through the review process. Otherwise, if a brand-name drug is purchased when an equivalent generic is available—whether you or your physician requests the brand-name drug—you will pay the generic copayment plus the cost difference of the brand-name drug and generic drug.~~

		~~**Effective January 1, 2017:**~~ $25 copayment if no generic is available OR if you are approved through the review process. Otherwise, if a brand-name drug is purchased when an equivalent generic is available—whether you or your physician requests the brand-name drug—you will pay the generic copayment plus the cost difference of the brand-name drug and generic drug.	~~**Effective January 1, 2017:**~~ $40 copayment if no generic is available OR if you are approved through the review process. Otherwise, if a brand-name drug is purchased when an equivalent generic is available—whether you or your physician requests the brand-name drug—you will pay the generic copayment plus the cost difference of the brand-name drug and generic drug.

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*****If you choose a brand-name drug when a generic equivalent is available, you will pay more than the copayments shown in this table. For details, see "Member Pay the Difference Generic Incentive Program" below.

**Copays apply to drugs available for a 90-day supply at participating retail pharmacies.

Retail Pharmacy Card Program

This program covers medically necessary prescription drugs required by Federal or state law to be prescribed in writing by a physician or dentist and dispensed by a licensed pharmacist. Covered prescriptions include legend drugs, contraceptive medications, tobacco cessation drugs, self-administered injectable drugs, insulin, needles and syringes, test strips, lancets, and alcohol swabs.

Prior authorization may be required for certain medications.

The retail pharmacy card program covers up to a 30-day supply.

Mail Service Program

The Mail Service Program~~Medco By Mail program~~ covers medically necessary prescription drugs and medicines required by Federal or state law to be prescribed in writing by a physician or dentist and dispensed by a licensed pharmacist. Covered prescriptions include legend drugs, contraceptive medications, tobacco cessation drugs, self-administered injectable drugs, insulin, needles and syringes, test strips, lancets, and alcohol swabs.

Prior authorization may be required for certain medications.

The Mail Service Program~~Medco By Mail~~ covers up to a 90-day supply per prescription or refill. Authorized refills are covered only after the initial order has been used. Certain controlled substances are subject to quantity limits.

Unless the physician indicates otherwise, you will receive a generic equivalent of the prescribed drug when available and permissible under the law. You also may receive a different brand that is medically equivalent.

Pharmacy Management

Specific drugs are reviewed by the prescription drug program service representative at the point of sale to determine if your prescription is covered by the plan, clinically appropriate, and consistent with usage guidelines.

Member Pay the Difference Generic Incentive Program
To encourage the use of generic drugs, if a brand-name drug is purchased when an equivalent generic is available (for both retail pharmacy and mail service)—whether you or your physician requests the brand-name drug—you will pay the generic copayment plus the cost difference between the brand-name drug and generic drug.

If for any reason your physician believes that you must use a brand-name drug, he or she can ask for a coverage review by calling the service representative. The service representative will request information from your physician and review it to determine if your need for the brand-name drug meets the conditions to qualify for coverage. If coverage is approved, you will be charged the brand copayment for the brand-name drug. If coverage is not approved, coverage will be provided according to the member pay the difference generic incentive program.

Review Process for Brand-name Drugs
Brand name drugs are covered at no additional cost to you when your physician provides information to the service representative (~~Express Scripts~~Prime Therapeutics at 1-888-802-8776~~ 1-800-841-2797~~) showing that you:

- Experienced an adverse reaction, allergy, or sensitivity to a generic equivalent
- Experienced therapeutic failure with a generic equivalent
- May be destabilized by changing to a generic equivalent, or
- Would be at unnecessary risk by changing to a generic equivalent

Prescription Drug Program Exclusions

The following items are excluded under both the retail pharmacy card program and the mail service program:

- Any prescription filled in excess of the number prescribed by the physician or any refill after 1 year from the date of the prescription.
- Any prescription for which the person is eligible to receive benefits under another employer's group benefit plan or a workers' compensation law or from any municipal, state, or Federal program.
- Any service or supply otherwise excluded by the Traditional Medical Plan or vision care program.

- Appliances or devices, such as blood glucose monitors or other nondrug items, including but not limited to therapeutic devices and artificial appliances. This exclusion does not apply to needles or syringes or to test strips, lancets, or alcohol swabs.
- Administration or injection charges for any drug other than for vaccines and immunizations covered under the retail pharmacy benefit.~~Charges for the administration or injection of any drug~~.
- Delivery or handling charges.
- Drugs dispensed during an inpatient admission by a hospital, skilled nursing facility, sanatorium, or other facility.
- Experimental drugs or drugs used for investigational purposes.
- Fertility agents, unless approved by the service representative.
- Immunizing agents except~~or~~ allergy serum.
- Infusion therapy drugs, except as described in the home health care benefit.
- Medications to treat sexual dysfunction, unless the patient is being treated for a diagnosed medical or mental health condition.
- Obesity drugs, unless approved by the service representative.
- Over-the-counter drugs unless otherwise covered.
- Prescriptions purchased from a nonnetwork mail service program.
- Prescriptions that are not medically necessary to treat an illness, injury, or other covered condition, except as specifically provided by the program.
- Replacement of lost or misplaced prescriptions.

Coordinated Care Plans Schedule of Benefits

The coordinated care plan benefits will be as described in the following "Coordinated Care Plans Schedule of Benefits."

Coordinated Care Plans, Selections Plans & Health Maintenance Organizations Schedule of Benefits **The ~~coordinated care~~ plans are administered by BlueCross BlueShield of Illinois, and Kaiser Permanente~~, and Preferred Health Systems~~** **(the service representatives).**		
	Network	**Nonnetwork**
Annual Deductible	None	$450 per individual
Coinsurance	~~**Effective January 1, 2017:**~~ **90%**	60%
Annual Out-of-Pocket Maximum	~~None*~~	~~$2,250 per individual; $4,500 per family of 2 or more, but not more than $2,250 for any 1 person~~
Effective January 1, ~~15~~2026, prescription drugs will apply toward the network medical annual out-of-pocket maximum	**BCBSIL Selections and Selections Plus:** ~~Effective 1/1/2017 (Selections and Group Health Cooperative HMO):~~	
	$2,000 per individual; $4,500 per family of 2 or more, but not more than $2,000 for any 1 person	$2,450~~2,250~~ per individual; $5,850~~4,500~~ per family of 2 or more, but not more than $2,450~~2,250~~ for any 1 person
Annual Out of Pocket Maximum Prescription drugs will apply toward the	**Kaiser Permanente CCP (Oregon)**	

Coordinated Care Plans, Selections Plans & Health Maintenance Organizations Schedule of Benefits **The ~~coordinated care~~ plans are administered by BlueCross BlueShield of Illinois, and Kaiser Permanente~~, and Preferred Health Systems~~** **(the service representatives).**		
	Network	**Nonnetwork**
network medical annual out-of-pocket maximum.		
	$600 per individual, $1,200 per family	$2,250 per individual, $4,500 per family
	Kaiser Permanente HMO (Washington)	
	$2,000 per individual, $4,500 per family	Not applicable
	Kaiser Permanente HMO (California)	
	$1,500 per individual, $3,000 per family	Not applicable
Lifetime Maximum Benefit	None	
Emergency Room (Emergencies)	$75 copayment (copayment waived if you are admitted as an inpatient immediately after emergency room care)	
Office Visit and Urgent Care	~~$15 copayment per visit;~~	60%
	~~**Effective January 1, 2017:**~~ ~~$20 office visit copayment applies to primary care office visit~~ ~~$25 office visit copayment applies to specialist office visit~~	

Coordinated Care Plans, Selections Plans & Health Maintenance Organizations Schedule of Benefits **The ~~coordinated care~~ plans are administered by BlueCross BlueShield of Illinois, and Kaiser Permanente~~, and Preferred Health Systems~~** **(the service representatives).**		
	Network	**Nonnetwork**
	~~(including chiropractic and physical, occupational and speech therapy visits)~~	
	~~**Effective January 1, 2020:**~~ $30 office visit copayment applies to primary care office visit $40 office visit copayment applies to specialist office visit (including chiropractic and physical, occupational and speech therapy visits)	

Coordinated Care Plans, Selections Plans & Health Maintenance Organizations Schedule of Benefits **The ~~coordinated care~~ plans are administered by BlueCross BlueShield of Illinois, and Kaiser Permanente~~, and Preferred Health Systems~~** **(the service representatives).**		
	Network	**Nonnetwork**
Prescription Drugs		
Participating Pharmacy**	~~$5 copayment generic; $20 copayment brand name formulary; $35 copayment brand name nonformulary;* 30-day supply~~ ~~**Effective January 1, 2017:**~~ ~~$5 copayment generic;~~ ~~$25 copayment brand name formulary;~~ ~~$40 copayment brand name nonformulary;*~~ ~~30-day supply~~ ~~**NOTE:** Copayments above on brand name formulary and nonformulary apply if no generic is available. OR if you are approved through the review process. Otherwise, if a brand name drug is purchased when an~~	Not covered

Coordinated Care Plans, Selections Plans & Health Maintenance Organizations Schedule of Benefits **The ~~coordinated care~~ plans are administered by BlueCross BlueShield of Illinois, and Kaiser Permanente~~, and Preferred Health Systems~~** **(the service representatives).**		
	Network	**Nonnetwork**
	~~equivalent generic is available—whether you or your physician requests the brand-name drug—you will pay the generic copayment plus the cost difference of the brand-name drug and generic drug.~~	
	BCBSIL Selections and Selections Plus	
	$5 copayment generic; $25 copayment brand-name formulary; $40 copayment brand-name nonformulary 30-day supply	Not covered
	Kaiser CCP (Oregon) and Kaiser HMO (California)	
	$5 copayment generic; $25 copayment brand-name formulary; $25 copayment brand-name nonformulary 30-day supply	Not covered
	Kaiser HMO (Washington)	
	$5 copayment generic; $25 copayment brand-name formulary;	Not covered

Coordinated Care Plans, Selections Plans & Health Maintenance Organizations Schedule of Benefits **The ~~coordinated care~~ plans are administered by BlueCross BlueShield of Illinois, and Kaiser Permanente~~, and Preferred Health Systems~~** **(the service representatives).**		
	Network	**Nonnetwork**
	Not covered brand-name nonformulary 30-day supply	
	NOTE: Copayments above on brand-name formulary and nonformulary apply if no generic is available OR if you are approved through the review process. Otherwise, if a brand-name drug is purchased when an equivalent generic is available—whether you or your physician requests the brand-name drug—you will pay the generic copayment plus the cost difference of the brand-name drug and generic drug.	
Mail Service Program**	~~$10 copayment generic; $40 copayment brand-name formulary; $70 copayment brand-name nonformulary;* 90-day supply.~~	Not covered

Coordinated Care Plans, Selections Plans & Health Maintenance Organizations Schedule of Benefits **The ~~coordinated care~~ plans are administered by BlueCross BlueShield of Illinois, and Kaiser Permanente~~, and Preferred Health Systems~~** **(the service representatives).**		
	Network	**Nonnetwork**
	~~**Effective January 1, 2017:**~~ ~~$10 copayment generic;~~ ~~$60 copayment brand-name formulary;~~ ~~$100 copayment brand-name nonformulary;*~~ ~~90-day supply~~ ~~**NOTE:** Copayments above on brand-name formulary and nonformulary apply if no generic is available OR if you are approved through the review process. Otherwise, if a brand-name drug is purchased when an equivalent generic is available—whether you or your physician requests the brand-name drug—you will pay the generic copayment plus the cost difference of the brand-name drug and generic drug.~~	

Coordinated Care Plans, Selections Plans & Health Maintenance Organizations Schedule of Benefits **The ~~coordinated care~~ plans are administered by BlueCross BlueShield of Illinois, and Kaiser Permanente~~, and Preferred Health Systems~~** **(the service representatives).**		
	Network	**Nonnetwork**
	BCBSIL Selections and Selections Plus	
	$10 copayment generic; $60 copayment brand-name formulary; $100 copayment brand-name nonformulary 90-day supply***	Not covered
	Kaiser CCP (Oregon) and Kaiser HMO (California)	
	$10 copayment generic; $50 copayment brand-name formulary; $50 copayment brand-name nonformulary 90-day supply	Not covered
	Kaiser HMO (Washington)	
	$10 copayment generic; $60 copayment brand-name formulary; Not covered brand-name nonformulary 90-day supply	Not covered
	NOTE: Copayments above on brand-name formulary and nonformulary apply if no generic is available OR if you are	

Coordinated Care Plans, Selections Plans & Health Maintenance Organizations Schedule of Benefits **The ~~coordinated care~~ plans are administered by BlueCross BlueShield of Illinois, and Kaiser Permanente~~, and Preferred Health Systems~~** **(the service representatives).**		
	Network	**Nonnetwork**
	approved through the review process. Otherwise, if a brand-name drug is purchased when an equivalent generic is available—whether you or your physician requests the brand-name drug—you will pay the generic copayment plus the cost difference of the brand-name drug and generic drug	
Vision		
Eye Exams	$15 copayment for 1 exam every 12 months	Not covered*
Lenses*	Varies by plan	Same as network*
Frames*	~~**Effective July 1, 2012:**~~ $90 allowance, limited to 2 frames every 2 benefit years	See network provisions
Contact Lenses*	~~**Effective July 1, 2012:**~~ $120 allowance, 2 pairs every 2 benefit years	See network provisions
*Varies by plan.		

Coordinated Care Plans, Selections Plans & Health Maintenance Organizations Schedule of Benefits **The ~~coordinated care~~ plans are administered by BlueCross BlueShield of Illinois, and Kaiser Permanente~~, and Preferred Health Systems~~** **(the service representatives).**		
	Network	**Nonnetwork**
**You pay the generic copayment plus the cost difference between the brand-name and generic drug (varies by plan). For details, see "Member Pay the Difference Generic Incentive Program" below. ***Copays apply to drugs available for a 90-day supply at participating retail pharmacies.		
These are highlights only. Benefits are paid in accordance with the terms of the coordinated care plan documents.		

Member Pay the Difference Generic Incentive Program

To encourage the use of generic drugs, if a brand-name drug is purchased when an equivalent generic is available (for both retail pharmacy and mail service)—whether you or your physician requests the brand-name drug—you will pay the generic copayment plus the cost difference between the brand-name drug and generic drug.

If for any reason your physician believes that you must use a brand-name drug, he or she can ask for a coverage review by calling the service representative. The service representative will request information from your physician and review it to determine if your need for the brand-name drug meets the conditions to qualify for coverage. If coverage is approved, you will be charged the brand copayment for the brand-name drug. If coverage is not approved, coverage will be provided according to the member pay the difference generic incentive program.

Review Process for Brand-name Drugs

Brand name drugs are covered at no additional cost to you when your physician provides information to the service representative (~~Express Scripts~~Prime Therapeutics at 1-888-802-8776~~1-800-841-2797~~) showing that you:

- Experienced an adverse reaction, allergy, or sensitivity to a generic equivalent
- Experienced therapeutic failure with a generic equivalent

- May be destabilized by changing to a generic equivalent, or
- Would be at unnecessary risk by changing to a generic equivalent

Network Dental Plan

Note: Effective July 1, 2012, the Incentive Dental Plan will be replaced with the Network Dental Plan, as described here.

The Network Dental Plan described in this section is available to active employees and their dependents. This plan also helps you pay for minor and major dental work, including fillings, crowns, dentures, bridges, and orthodontic services.

You and your covered 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.

Network Dental Plan Schedule of Benefits		
What you Pay	**Network Provider**	**Nonnetwork Provider**
Annual Deductible (based on the January 1–December 31 benefit year)	$50 per individual; $150 per family of 3 or more, but not more than $50 for any individual; applies to all covered services and supplies, except as noted below	$75 per individual; $225 per family of 3 or more, but not more than $75 for any individual; applies to all covered services and supplies, except orthodontia
Coinsurance Percentage		

Network Dental Plan Schedule of Benefits		
What you Pay	**Network Provider**	**Nonnetwork Provider**
Class I (diagnostics, preventive care, restorations using filling materials, oral surgery, periodontics, certain endodontics, and pedodontics)	100% of recognized fee (annual deductible does not apply to examinations, X-rays, cleanings, fluoride treatment, or fissure sealants)	80% of recognized fee after deductible is met.
Class II (restorations using crowns, inlays, or onlays)	80% of recognized fee	50% of recognized fee
Class III (prosthodontics)	60% of recognized fee	50% of recognized fee
Class IV (orthodontia)	50% of covered charges (deductible does not apply)	

Network Dental Plan Schedule of Benefits		
What you Pay	**Network Provider**	**Nonnetwork Provider**
Annual Maximum Benefit (for Classes I, II and III)*	~~$2,000 per individual (network and nonnetwork combined)~~ **~~Effective January 1, 2020:~~** ~~$2,500 per individual (network and nonnetwork combined)~~ **~~Effective January 1, 2024:~~** $3,000 per individual (network and nonnetwork combined)	~~$2,000 per individual (network and nonnetwork combined)~~ **~~Effective January 1, 2020:~~** ~~$2,500 per individual (network and nonnetwork combined)~~ **~~Effective January 1, 2024:~~** $3,000 per individual (network and nonnetwork combined)
Lifetime Maximum Benefit (for Class IV)**	$2,000 per individual (network and nonnetwork combined)	$2,000 per individual (network and nonnetwork combined)

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

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

You and your dependents are responsible for paying all charges for services and supplies the plan does not cover.

Annual Deductible

Generally, the annual deductible is the amount you must pay out of your own pocket each benefit year before the plan begins to pay benefits. The annual deductible applies to most covered services but not all. The following network diagnostic and preventive care services and supplies are excluded from the annual deductible:

- Cleanings (prophylaxis).
- Examinations.
- Fissure sealants.
- Fluoride treatment.
- X-rays.

Orthodontia (Class IV) also is excluded from the annual deductible.

This means that the plan begins to pay its coinsurance percentage immediately for these basic dental services. The coinsurance percentage you pay for these services does not count toward your annual deductible.

This plan has an individual annual deductible and a family annual deductible. If you and 3 or more of your dependents are covered under the plan, the family annual deductible limits the total annual deductible you are required to pay in any benefit year.

The annual deductibles are shown in the "Network Dental Plan Schedule of Benefits."

Coinsurance Percentages

For many services and supplies, you and the plan each pay a percentage of the recognized fee. These percentages are called coinsurance percentages.

Generally, except for certain diagnostic and preventive Class I services and supplies, you must first satisfy the entire annual deductible before the plan pays its coinsurance percentage.

A coinsurance percentage does not apply to

- Class I services and supplies received from network providers.
- Any amounts you pay for services that the plan does not cover.
- Any amounts that exceed the maximum allowable fees recognized by the plan.

Coinsurance percentages are shown in the "Network Dental Plan Schedule of Benefits."

Benefit Maximums

For Classes I, II, and III, an annual maximum applies to each covered person. The annual maximum amount is shown in the "Network Dental Plan Schedule of Benefits." You are responsible for paying any charges over the annual maximum benefit.

For Class IV, a lifetime maximum benefit applies to each covered person. The lifetime maximum benefit amount is shown in the "Network Dental Plan Schedule of Benefits."

Recognized Fees

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

Under this plan, recognized fees are determined as follows:

- For a network dentist, recognized fees are network allowed charges.
- For a nonnetwork dentist who is a contracted member dentist with Washington Dental Service, recognized fees are the fees that the dentist filed with the service representative for specific dental services and supplies.
- For a nonnetwork dentist who is a nonmember, recognized fees are the lesser of either
  - The amount charged by the dentist.
  - The maximum fee that the service representative approved for nonmember dentists in the state where services are performed.

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

Covered Dental Services and Supplies

The Network Dental Plan covers 4 classes of services and supplies in accordance with the benefit payment levels and maximums shown in the "Network Dental Plan Schedule of Benefits."

Class I Covered Services and Supplies (network covered at 100%)

The plan covers the following Class I services and supplies:

- Routine diagnostic examinations, including

- Routine examination, twice in each 1-year period.
- Specialist examinations, up to 3 in a 6-month period.
- Complete mouth or panographic X-rays, once in each 5-year period.
- Supplementary bitewing X-rays, once in each 1-year period.
- Emergency examinations.
- Comprehensive oral examination, once in a 36-month period, which counts as the routine examination once in a 6-month period.

• Preventive care, including
- Fissure sealants, through age 14, for permanent molar teeth with intact occlusal surfaces, no decay, and no prior restorations. The repair or replacement of a sealant on any tooth within 36 months is considered part of the original services.
- Prophylaxis (cleaning), either regular or periodontal, twice in each 1-year period, with 2 additional cleanings allowed in the event periodontal disease is present.
- Topical application of fluoride twice in each 1-year period, for dependent children through age 18.

• General anesthesia when administered by a licensed dentist in connection with certain covered
- Oral surgery.
- Endodontic surgery.
- Periodontic surgery.

• Restorative services (minor restoration), including the restoration of a visibly decayed hard tooth surface (carious lesion) to a state of proper function by using a filling material such as amalgam, silicate, plastic or glass ionomer, or a stainless steel crown. Restorations on the same surface(s) of the same tooth will be covered once in each 24-month period. Composite, plastic, or glass ionomer restorations on a posterior tooth are covered up to the amount allowed for an amalgam restoration.

• Oral surgery, including
- Surgical and nonsurgical extractions.
- Preparation of the alveolar ridge and soft tissues of the mouth to insert dentures.
- Ridge extension to insert dentures (vestibuloplasty).

  - Treatment of pathological conditions and traumatic facial injuries.
- Endodontics, including the following procedures:
  - Pulpal and root canal therapy.
  - Pulp exposure treatment, pulpotomy, and apicoectomy.
  - Root canal treatment on the same tooth, once in each 2-year period.
  - Retreatment of the same tooth when performed by a different dental office.
- Pedodontics, including space maintainers that are used to maintain space for the eruption of permanent teeth.
- Periodontics (surgical and nonsurgical procedures to treat tissues that support the teeth), including
  - Gingivectomy.
  - Limited adjustments to occlusion (8 or fewer teeth) such as smoothing teeth or reducing cusps.
  - Root planing or subgingival curettage, but not both, once in each 24-month period.

Class II Covered Services and Supplies (network covered at 80%)

The plan covers these Class II services and supplies, which are restorative services (major restoration):

- Restoration of a visibly decayed hard tooth surface (carious lesion) to a state of proper function by using crowns, inlays, or onlays (gold, porcelain, plastic, or gold-substitute castings or a combination) once in each 5-year period for the same tooth when the tooth cannot be restored effectively with a filling material (amalgam, silicate, or plastic). If a tooth can be restored with a filling material such as amalgam, silicate, or plastic but you choose a more expensive procedure, this plan will cover the cost up to the amount for a filling to repair the condition.
- Recementing a crown, inlay, or onlay~~, once in a 12-month period~~.
- Use of a crown as an abutment to a partial denture, but only when the tooth is decayed to the extent a crown would be required whether or not a partial denture is required.
- Temporary crown for a fractured tooth.

Class III Covered Services and Supplies (network covered at 60%*)

Under the Network Dental Plan, prosthodontics are in Class III. The plan covers these Class III services and supplies:

- A full denture, immediate denture, or overdenture. For any other procedure (such as personalized restorations or specialized treatment), the plan covers up to the appropriate amount for a full denture, immediate denture, or overdenture. Root canal therapy in conjunction with overdentures is limited to 2 teeth per arch.
- A cast chrome or acrylic partial denture. If a more elaborate or precision device is used, the plan will cover up to the appropriate amount for covered partial dentures.
- Denture adjustments and relines that are provided more than 6 months after initial placement. Later relines and jump rebases (but not both) are covered once in each 12-month period.
- Implant and related appliances attached to the implant once in each 5-year period. If you elect an implant and related attached appliances, the plan allows up to the amount the plan would have paid for a full or partial denture, once in a 5-year period.
    - *Surgical procedure for the placement or removal of implants or attachments to implants are covered at 90%* for network provider and 50% for nonnetwork provider. The surgical procedure will not be subject to the dental maximum.
- Replacement of an existing prosthetic device, once in each 5-year period, if the device is unserviceable and cannot be made serviceable. (Services to correct the device, if serviceable, are covered.)

Class IV Covered Services and Supplies

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

Pretreatment Estimate

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

Network Dental Plan Exclusions

The Network Dental Plan does not cover the following services or supplies.

- Analgesics such as nitrous oxide, intravenous sedation, euphoric drugs, injections, prescription drugs, or application of desensitizing agents.
- Appliances or cleaning of appliances and certain restorations as follows:
  - Appliances or restorations necessary to correct vertical dimension or to alter morphology (shape) or occlusion, overhang removal, or recontouring or polishing a restoration.
  - Cleaning of prosthetic appliances.
  - Duplicate dentures, temporary dentures, personalized dentures, or crowns and copings provided in connection with overdentures.
  - Fixed prosthodontics for children under age 16.
  - Habit-breaking appliances.
  - Replacement of a space maintainer previously covered by the plan.
- Cosmetic procedures (including laminates and tooth bleaching, whether vital or nonvital), appliances, or restorations primarily for cosmetic purposes.
- Experimental services or supplies (or related complications)—the plan does not cover experimental services or supplies whose use and acceptance as a course of dental treatment for a specific condition still are under investigation or observation. To determine whether services are experimental, the service representative uses American Dental Association guidelines and considers whether the services
  - Are in general use in the local dental community.
  - Are proven to be safe and effective.
  - Are under continued scientific testing and research.
  - Show a demonstrable benefit for a particular dental condition.
- Other dental exclusions as follows:
  - Caries (decay) susceptibility tests.
  - Charges for services or supplies that are received while the patient is not covered under the plan.
  - Consultations or elective second opinions.

- Crowns used as abutments to a partial denture for purposes of recontouring, repositioning, or to provide additional retention, unless the tooth is decayed to the extent that a crown would be required to restore the tooth in the absence of a partial denture.
- Crowns used to repair microfractures of tooth structure when the tooth displays no symptoms.
- Diagnostic services or X-rays related to temporomandibular joints (jaw joints).
- Fees for broken appointments.
- Fees for completing insurance forms.
- Full mouth (major) occlusal adjustment.
- Gingival curettage.
- Home fluoride kits.
- Hospitalization charges or any additional dental fees associated with hospitalization.
- Iliac crest or rib grafts to alveolar ridges.
- Injuries or conditions covered under workers' compensation or employers' liability laws.
- Oral hygiene or dietary instruction.
- Orthognathic surgery.
- Patient management problems.
- Periodontal splinting; any crown or bridgework provided with periodontal therapy or periodontal appliances.
- Plaque control programs.
- Porcelain or resin inlay bridges.
- Proposed treatment plan review or case presentation by the attending dentist.
- ~~Ridge extension to insert dentures (vestibuloplasty).~~
- Services or supplies covered by any Federal, state, or provincial government agency or provided without cost by any municipality, county, or other political subdivision or community agency. However, if government agency payments are insufficient for covered services or supplies or if benefits are provided by a government agency as an employer to its employees, dental coverage will not be excluded and will be subject to coordination of benefits.

- Services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.
- Services specifically excluded in this plan description and all other items that are not specifically included in this plan as covered dental benefits.
- Study or diagnostic models.
- ~~Surgical placement or removal of implants or attachments to implants, except as shown in "Class III Covered Services and Supplies."~~
- Tooth transplants or materials placed in extraction to generate osseous filling.
- Treatment of temporomandibular (jaw) joints.

How Dental Coverage May Be Extended

The plan generally does not cover services or supplies that you receive while you are not covered under the plan. However, the plan will cover certain services and supplies for an additional three months after the date coverage would otherwise end. These services and supplies and the conditions for extending care are described below:

- A crown that is required to restore a tooth (independent of the crown's use in connection with a partial denture) if the tooth is prepared for the crown while you are covered. If the tooth is prepared after your coverage ends, your dentist must have documented the need, such as by requesting a pretreatment estimate, before your coverage ended.
- A prosthetic device (including abutment crowns of a partial denture), if the impressions are taken while you are covered, and the device is installed or delivered within 3 months after your coverage ends. If the impressions are taken after your coverage ends, your dentist must have documented the need, such as by requesting a pretreatment estimate, before your coverage ended.
- Orthodontia care provided within 3 calendar months after your coverage ends.

- Restorative, endodontic, periodontic, and oral surgical procedures completed within 3 months after your coverage ends. If the services start after your coverage ends, your dentist must have documented the need, such as by requesting a pretreatment estimate, before your coverage ended.

Prepaid Dental Plan

The Prepaid Dental Plan benefits will be as follows:

Provider Selection

Participating providers offer complete dental care to you and your dependents. You must select a participating provider when you enroll in the Prepaid Dental Plan. All covered dental services, except orthodontic and out-of-area emergency care, are provided by this selected provider.

If you wish to transfer to another participating provider, you must contact the service representative. An approved transfer is effective the first day of the month following the service representative's receipt of the change request.

Orthodontic care may be obtained from any licensed dentist.

Plan Payment Levels and Maximum Benefits

The plan provides all necessary covered dental services at no cost to employees and eligible dependents except as specified below.

- The plan pays 50% of usual and customary orthodontic charges, to a $2,000 lifetime maximum benefit during all periods the eligible person is covered under the plan.
- The plan pays up to $50 of reasonable charges for out-of-area emergency services and supplies.

Out-of-Area Emergencies

The plan pays an out-of-area emergency benefit for dental services and supplies provided by a licensed dentist other than your selected participating provider.

Out-of-area means the covered person is more than 50 miles from the selected participating provider. The plan pays reasonable charges for these services and supplies, without prior approval, to a maximum of $50. Payment for out-of-area emergencies is made only if all these conditions apply:

- The dental care is provided by a dentist outside the plan's service area.
- The service or supply is covered under the plan.
- The dental care is required for an acute condition and is provided solely for the immediate relief of that condition.
- The patient could not have been reasonably expected to go to the selected participating provider for the care.

Coordination of Benefits

If you or your dependent has medical, dental, or other health coverage in addition to being covered under these medical and dental plans, the following rules govern coordination of benefits with the other coverage. Other coverage includes, whether insured or uninsured, another employer's group benefit plan, other arrangement of individuals in a group, Medicare (to the extent allowed by law), individual insurance or health coverage, and insurance that pays without consideration of fault.

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

Order of Payment

The primary plan pays its benefits first and pays its benefits without regard to benefits that may be payable under other plans. When another plan is the primary plan for health care coverage, the secondary plan pays the difference between the benefits paid by the primary plan and what would have been paid had the secondary plan been primary.

- A plan is considered primary if
  - It has no order of benefit determination rules.
  - It has benefit determination rules that differ from coordination of benefit rules under state regulations or, if not insured, that differ from these rules.
  - All plans that cover an individual use the same coordination of benefit rules, and under those rules, the plan is primary.
- If the aforementioned rules do not determine which group plan is considered primary, this plan applies the following coordination of benefit rules:

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

Benefits under a Company-sponsored medical or dental plan are not coordinated with benefits paid under any other group plan offered by the Company. You can receive benefits from only 1 Company-sponsored medical or dental plan. However, when dental services performed by a licensed dentist also are covered under the medical plan, the dental plan pays its benefits first and the medical plan is secondary.

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

Traditional Medical Plan

The primary plan pays benefits without regard to any other plan. When the Company-sponsored plan is secondary, it adjusts benefits so that the total payable under both plans for expenses covered under the Company-sponsored plan is not more than would be payable under the Company-sponsored plan. Neither plan pays more than it would without coordination of benefits.

Plan means any plan providing medical, dental, vision care, hearing aid benefits, or treatment under individual insurance, group insurance, or any other coverage for individuals in a group, whether on an insured or uninsured basis.

Treatment of end-stage renal disease is covered by the Company-sponsored plan for the first 30 months following Medicare entitlement due to end-stage renal disease, and Medicare provides secondary coverage. After this 30-month period, Medicare provides primary coverage and the Company-sponsored plan provides secondary coverage.

Network Dental Plan

Benefits payable under the Company-sponsored dental plan take into account any coverage (including orthodontic coverage) you or your eligible dependents have under other plans.

Plan means any plan providing medical, dental, vision care, hearing aid benefits, or treatment under group insurance or any other coverage for individuals in a group, whether on an insured or uninsured basis. However, plan excludes any medical plan sponsored by the Company. This means the dental plan pays first when dental expenses performed by a dentist also are covered by any medical plan sponsored by the Company.

The dental plan pays regular benefits in full or a reduced amount which, when added to benefits payable by another plan, equals 100% of allowable expenses.

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.

Termination of Coverage

Life Insurance Coverage

Life insurance coverage stops on the date your active employment terminates.

Within 31 days after you terminate employment, by making application and paying the first premium to the plan's insurer, you may convert life

insurance coverage to an individual life insurance policy on any regular whole life insurance plan. This individual policy will be issued, without medical examination, at the insurer's regular rates. The amount of life insurance converted cannot exceed the amount in force on the date insurance terminates.

If, after an individual conversion policy is issued, benefits under the Life Insurance Plan are payable due to permanent and total disability, the individual policy must be surrendered without claim other than the return of paid premiums.

If your death occurs within 31 days after your coverage ends, a life insurance benefit is payable equal to the amount you could have converted to an individual policy.

Accidental Death and Dismemberment and Survivor Income Coverage

Accidental death and dismemberment and survivor income coverage stops on the date your active employment terminates.

Short-Term Disability Coverage

Short-term disability coverage stops on~~at~~ the last day~~end~~ of ~~the calendar month~~ your active employment~~ terminates~~. If you experience a covered disability while you are an active employee, you will continue to receive benefits for up to the maximum period of 26 weeks subject to the terms and conditions of the Plan, regardless of whether your active employment ends during the benefit period.

Medical Coverage

Medical coverage for you and your dependents stops at the end of the calendar month your active employment terminates or the end of the last month required contributions are paid, whichever occurs first. If earlier, your dependent's coverage stops at the end of the month in which he or she no longer qualifies as a dependent.

However, coverage may be continued under certain circumstances as specified below. Any required contributions must be paid during these periods for coverage to continue.

If you are terminating employment, the service representative will make available an individual program of medical benefits similar to those then being issued for group conversion. The benefits provided under the individual plan will not exactly duplicate the benefits provided under this group medical plan. This conversion privilege is also available to your covered dependents who cease to qualify under the group policy and to

surviving covered dependents if you die. No evidence of insurability is required.

Dental Coverage

Dental coverage for you and your dependents stops at the end of the calendar month your active employment terminates. If earlier, your dependent's coverage stops at the end of the calendar month in which he or she no longer qualifies as a dependent.

However, coverage may be continued under certain circumstances as specified below. Any required contributions must be paid during these periods for coverage to continue.

Retirement

If you are eligible for, and enroll in, the Retiree Medical Plan, medical coverage for you and your dependents ends at the end of the month following the month in which your active employment ends.

Change in Eligible Class of Employment

When you remain employed by the Company but no longer in the class eligible for coverage under this Package, coverage for you and your dependents stops at the end of the month in which your transfer is effective. If you become totally disabled before coverage ends under the Package, the life insurance, accidental death and dismemberment, short-term disability, and survivor income benefits of the Package, which would have continued if you had stayed in the eligible class, will continue according to the terms governing benefits during leaves of absence instead of all other Company life insurance, accidental death and dismemberment, and disability benefits.

Continuation of Medical and Dental Coverage (COBRA)

If medical and dental coverage for you and your dependents (including a ~~same gender~~ domestic partner and his or her children) otherwise would terminate due to one of the following reasons, these benefits may continue for specified periods under Public Law 99-272, Title X, as amended, if the individual makes a timely request to the Company and pays the required contribution, subject to Reinstatement of Coverage below~~.~~

Reduction in hours or termination of employment for any reason.

- Your death.
- Your divorce or dissolution of a ~~same gender~~ domestic partner relationship.
- A dependent child ceasing to be a dependent as defined under this Package. (A child eligible to be continued under the Package's

incapacitated child provision will still be considered to have dependent status.)

- Your dependent's loss of eligibility because you became eligible for Medicare.

If you are laid off, the Company will contribute to the cost of COBRA medical coverage for you and your dependents. Company contributions will continue at the same rate as for active employees until you are covered by any other group medical plan either as an active employee or as a dependent, but in no event beyond the expiration of the COBRA period or 6 months after the date of layoff, whichever occurs first.

If you die (other than from an industrial accident), the Company will contribute to the cost of your dependents' COBRA medical and dental coverage for up to 12 months. Your dependents' contributions for the first 12 months of COBRA medical and dental coverage will be the same as for dependents of active employees.

If you die from an industrial accident, the Company will contribute to the cost of your dependents' COBRA medical and dental coverage for up to 36 months. Your dependents' contributions for COBRA medical and dental coverage will be the same as for dependents of active employees.

Leaves of Absence

When you are absent with leave, coverage may continue as follows; any required contributions must be paid during these periods for coverage to continue, subject to Reinstatement of Coverage below.

Approved Medical Leaves of Absence

If you are eligible for coverage and begin an approved medical leave of absence due to a total disability, you are eligible for the Package the same as an active employee until the last day of the calendar month in which your leave began. (Your eligible dependents also are eligible for medical and dental benefits.)

If you are totally disabled and remain on an approved medical leave of absence that extends beyond this period, your life insurance, accidental death and dismemberment, short-term disability, survivor income, medical, and dental benefits (and dependent medical and dental benefits) continue up to 6 full consecutive calendar months during the approved medical leave with Company contributions.

If the approved medical leave extends beyond this 6-month period due to continuous total disability, your medical coverage continues for up to an additional 24 months with Company contributions. Medical coverage ends

earlier if you become eligible for Medicare or are no longer considered totally disabled. You also may continue the life insurance, accidental death and dismemberment, survivor income, and dental benefits (and medical and dental benefits for eligible dependents) during this time by paying 100% of the cost of coverage on or before the tenth day of the month in which they are due.

If you or your covered dependent is considered disabled by Social Security during the seventh or eighth month of the absence, you may continue medical and dental coverage for yourself and eligible dependents for up to 5 additional months by paying 150% of the cost of coverage.

Medical and dental coverage continued after the sixth calendar month of medical leave is considered COBRA continuation coverage.

Other Approved Leaves of Absence

If you are eligible for coverage and begin an approved leave of absence, you are eligible for the Package the same as an active employee until the last day of the calendar month in which your leave began. (Your eligible dependents also are eligible for medical and dental benefits.)

If the approved leave extends beyond this time, your life insurance, accidental death and dismemberment, short-term disability, survivor income, medical, and dental benefits (and dependent medical and dental benefits) continue for up to 3 full consecutive calendar months with Company contributions.

After this 3-month period, you may continue medical and dental coverage for up to an additional 21 months by self-paying 100% of the cost of coverage; this is considered COBRA continuation coverage. You also may continue life insurance coverage for the duration of the approved leave of absence by self-paying 100% of the cost of coverage.

Family and Medical Leave Act of 1993

If the required coverage for family and medical leaves of absence under the Family and Medical Leave Act of 1993 is more generous than that already described in this section, the Company provides any required additional coverage under its group health plans.

Uniformed Services Leave of Absence

If you take a leave of absence for service in the U.S. uniformed services (including the military, National Guard, and the Commissioned Corps of the Public Health Service), you are covered under the Package until the end of the month in which your leave began. If you remain on an approved leave of absence, coverage under the Package continues until the end of the third

full calendar month of the leave as if you were an active employee on an approved nonmedical leave of absence.

If uniformed service extends beyond 3 months, you will be enrolled for COBRA coverage automatically as of the beginning of the fourth full calendar month of your leave. You may continue COBRA coverage for an additional 21 months while your uniformed services leave continues, in accordance with your rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

During a temporary period after September 11, 2001, military leave of absence can be extended for a total of 60 months, based on military orders. Your life insurance, medical, and dental coverage continue during this period. The cost of coverage during this 60-month period is the same as for active employees.

Your COBRA continuation period runs concurrently with coverage during USERRA leave.

If you return to active employment promptly after uniformed service, according to USERRA, the Package is reinstated on the date you return to the active payroll.

Changes in Leave Types

If your type of leave changes from a medical leave of absence to a nonmedical leave of absence (or vice versa), your periods of leave will be considered separate leaves of absence. However, if the type of your nonmedical leave of absence changes (for example, from family leave to personal leave), your maximum period of coverage in your new leave category will be reduced by the number of days or months for which you already received an extension of your active coverage.

Successive Periods of Leaves of Absence

Successive periods of leave are described below:

- 2 medical leaves of absence separated by less than 30 days of continuous work are considered 1 leave of absence unless the second leave is due to entirely unrelated conditions.
- 2 medical leaves of absence separated by 30 or more days of continuous work are considered new and separate medical leaves of absence.

Reinstatement of Coverage

An employee who is on an authorized leave of absence (subject to direct bill and pay) who fails to make timely premium payments resulting in a loss of

coverage due to non-payment will be allowed a special reenrollment opportunity to reinstate their coverage. The employee has 31 days from the date of the drop notice to seek and complete reenrollment and timely repay missed premium payments.

An employee who is enrolled in COBRA continuation coverage who fails to make timely premium payments resulting in a loss of COBRA coverage due to non-payment will be allowed a one-time special reenrollment opportunity to reinstate the COBRA coverage. The COBRA continuee then has 31 days from the date of the drop notice to seek and complete reenrollment and timely repay missed premium payments.