ATTACHMENT B

Retiree Medical Plan

PENDING RATIFICATION AND FINAL PROOFING BY THE UNION AND THE COMPANY

ATTACHMENT B
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Eligibility

You are eligible for the pre-65 Retiree Medical Plan ("Retiree Medical Plan" or "Plan") if you retire from the service of the Company under the Company-sponsored retirement plan (The Boeing Company Retirement Plan, or "BCERP") as follows (See below for employees hired or rehired on or after January 3, 2014, who are not participants in the BCERP):

- You are an active employee and meet the following requirements:
  - You are age 55 or older with 10 or more years of vesting service under a Company-sponsored retirement plan.
  - You are disabled, become eligible for disability benefits under the Company-sponsored retirement plan, and are at least age 50 with 10 or more years of vesting service at retirement.
  - You are on an approved leave of absence, you are age 55 or older with 10 or more years of vesting service at retirement, and you retire under the Company-sponsored retirement plan within 2 years following the start of your approved leave of absence.
  - You are on layoff, you are at least age 55 with 10 or more years of vesting service at retirement, and you retire under the Company-sponsored retirement plan within 6 years following your layoff.

If you are hired or rehired on or after January 3, 2014, and are not a participant in The Boeing Company Employee Retirement Plan (BCERP), the eligibility requirements described above will be applied in a manner that retains retiree medical eligibility under comparable circumstances for those employees not participating in the BCERP. Specifically, the eligibility provisions will be modified as follows:

- "At retirement" or "retire under the Company-sponsored retirement plan" will mean "at termination of employment" or "terminate employment",
- "10 or more years of vesting service under the Company-sponsored retirement plan" will mean the employee would have had 10 or more years of vesting service under the BCERP had he or she been a participant in the BCERP (with vesting service to be determined in the same manner as under the BCERP), and
- "Disabled or become eligible for disability benefits under the Company-sponsored retirement plan" will mean that the employee

would have become eligible for disability benefits under the BCERP had he or she been a participant in the BCERP.

You are no longer eligible for coverage under the Retiree Medical Plan after attaining age 65 or becoming eligible for Medicare. Effective January 1, 2026, the Company will provide employees retiring during the term of this Agreement access to a Medicare plan that is available to eligible retirees in the Puget Sound region (the "Post-65 Retiree Medical Plan"). The current plan offered to this population is the Aetna Medicare Advantage ESA PPO.

Eligible Dependents of Retired Employees

Dependents eligible for the Retiree Medical Plan are your legal spouse (as recognized under both applicable state law and the Internal Revenue Code) or your eligible domestic partner (as defined in Attachment A), 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. [Note: Any reference to an employee's spouse in this Attachment B includes reference to an employee's domestic partner, to the extent applicable in the context.]

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.
- 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. Some states have laws requiring insured health plans to offer coverage for certain registered domestic partners.

In accordance with Federal law, the Company also provides medical 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, or a spouse. 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

- Your dependents.

  If you or any of your dependents is covered or becomes covered (or eligible for benefits by reason of having been covered) under another Company-sponsored plan providing medical benefits, that person is not eligible for the Retiree Medical Plan. If you and your spouse are both ~~employed by or~~ retired from Boeing, ~~you each must be covered by your own Boeing-sponsored medical coverage~~one retiree may elect to cover the other under the company-sponsored retiree medical plan. Additionally, ~~However,~~ if your spouse is a part-time Boeing employee or on an approved leave of absence or layoff, your spouse and eligible children are considered eligible dependents if other Boeing coverage is waived. If your spouse and eligible children are covered under your spouse's active Boeing-sponsored plan, they will be considered eligible for the Retiree Medical Plan at the time they no longer are eligible for coverage under your spouse's plan.

  No person may be covered both as a retired employee and as a dependent and no person will be considered as a dependent of more than 1 retired or active employee.

- Your death.

  Upon your death, your spouse and any other covered dependents remain eligible for coverage under the Retiree Medical Plan until the earliest of these dates:

  - Your spouse or other dependent attains 65 years of age.
  - Your spouse or other dependent becomes eligible for Medicare.
  - Your spouse's death.
  - The end of the last month that contributions are paid.

  Surviving covered dependents under age 65 may continue their coverage as described above, or as described in the Termination of Retiree Medical Coverage section, or convert their medical coverage as described in that section.

Disabled Children

A disabled child age 26 or older continues to be eligible 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 Retiree Medical Plan for the duration of the incapacity as long as you continue to be enrolled in the plan and the child continues to meet these eligibility requirements.

Special applications for coverage are required for disabled dependent children age 26 or older.

Retiree Medical Plan Enrollment

Initial Enrollment

You and your eligible dependents automatically will be enrolled at the time you become eligible, provided you pay any required contributions. You and your dependents will be enrolled in the same plan as immediately before retirement, if available.

You may elect to change medical plans by calling the Boeing Service Center within 31 days of the date you retire. The Company will supply enrollment instructions at the time of your retirement.

All family members, including you, must be enrolled in the same medical plan.

Spouse Coverage

Each retired employee enrolling a spouse (including a~~or~~ domestic partner as noted above) must provide information regarding coverage available through another employer to determine whether special contributions are required to enroll the spouse. If you do not authorize a required contribution, your spouse will not be enrolled for medical coverage. You will not be able to enroll your spouse until the date your spouse loses the option to be covered under the other employer-sponsored medical plan.

The Company will require periodic verification of data.

Company Couples

If a retiree and their spouse or domestic partner are both retired from the Company, one retiree may elect to cover the other (who waives retiree medical coverage) under their Company-sponsored retiree medical plan.

Special Enrollment Events

If you declined coverage in the Retiree Medical Plan for yourself and/or your eligible dependents when you were first eligible because you or your dependents had other employer-sponsored medical 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 employer-sponsored medical coverage because of an event such as loss of dependent status under another employer's plan (through divorce, legal separation, termination of a domestic partner relationship, 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 employer, or reaching the lifetime limit on all benefits under the other employer's 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 into a domestic partner relationship, birth, adoption, or placement for adoption.

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

In addition, a retiree who fails to make timely premium payments resulting in a loss of coverage under the Retiree Medical Plan due to non-payment will be allowed a one-time special re-enrollment opportunity to reinstate the coverage, provided that the employee seeks and completes reenrollment within 180 days of the loss of coverage and timely repays all missed premium payments.

Deferred Enrollment

If you decline enrollment in the Retiree Medical Plan because of other employer-sponsored health care coverage (such as through your spouse's employer), including Boeing, you may be able to enroll yourself and your eligible dependents in the Company-sponsored Retiree Medical Plan at a later date as long as enrollment is within 60 days after other coverage ends.

If you decline dependent enrollment when first eligible and your dependent's other health care coverage was through continuation coverage

from a previous employer (coverage mandated by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended), your dependent must exhaust his or her COBRA coverage to be eligible for deferred enrollment.

If you are *not* enrolled in the Company-sponsored Retiree Medical Plan and have a new dependent as a result of an event such as marriage, entering into a domestic partner relationship, birth, adoption, or placement for adoption, you may enroll yourself, your spouse or domestic partner, and any dependent children during the year as long as enrollment is requested within 60 days after the event by contacting the Boeing Service Center.

If you *are* enrolled in the Retiree Medical Plan and have a new dependent as a result of marriage, entering into a domestic partner relationship, birth, adoption, or placement for adoption, you may enroll your new dependent during the year as long as enrollment is requested within 120 days after the qualified event. See "Changes in Status" below for more information.

If you *are* enrolled in the Retiree Medical Plan and have not enrolled your eligible dependents because of other employer-sponsored health care coverage, you may be able to enroll your eligible dependents in the Company-sponsored Retiree Medical Plan at a later date as long as enrollment is within 60 days after other coverage ends. The coverage loss must be due to loss of eligibility for the health care coverage (including from divorce, legal separation, termination of a domestic partner relationship, death, termination of employment, or reduction in hours of employment), termination of employer contributions toward such coverage, or reaching the other plan's lifetime maximum benefit.

Transfer Between Plans

Transfer between plans is permitted only during authorized annual enrollment periods or following a change of residence.

- Annual enrollment period.

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

- Change of residence.

  If you move out of a coordinated care plan or HMO service area, you have 60 days to select a medical plan available in the new location by calling the Boeing Service Center. It is your responsibility to notify the Company of the change in residence within the 60-day period.

Status Changes

If you already are enrolled for this retiree medical coverage, you may be able to change coverage or add an eligible dependent if you experience one of the status changes described below. 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.

Status changes include the following:

- You marry, divorce, or become legally separated, or the marriage is annulled.
- You enter into or dissolve a domestic partner relationship.
- You acquire a new, eligible dependent child, such as by birth, adoption, or placement for adoption.
- Your spouse or dependent child dies.
- You or your spouse or dependent child starts or stops working.
- Your spouse 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 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 dependent child experiences a significant curtailment or cessation of employer-sponsored medical coverage.
- You or your spouse or dependent child becomes eligible or ineligible for Medicare or Medicaid; 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.
- Your dependent child becomes eligible for, or no longer is eligible for, health care coverage due to age limits, principal support status, marriage, or a similar eligibility requirement.

- You or your spouse 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 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 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, legal separation, annulment, or change in legal custody.

If you are eligible to add new dependents, you must request the dependent enrollment change within 60 days after the qualified event. You can enroll a new dependent within 120 days following your marriage, entering into a domestic partner relationship, or your dependent child's birth, adoption, or placement for adoption. Enrollment may be requested by calling the Boeing Service Center. To request enrollment for a new dependent more than 60 days but within 120 days after marriage, entering into a 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 Retiree Medical Coverage

Retired Employees

If you are a newly retired employee, the plan becomes effective on the first day of the second month following the month in which your active employment ends, provided you pay any required contributions.

If you are eligible for retiree medical coverage at the time active employment with the Company ends, you may defer enrollment in the Retiree Medical Plan until the date your benefits begin under the Company-sponsored retirement plan. If you are hired on or after January 3, 2014, are not a participant in The Boeing Company Employee Retirement Plan (BCERP), and are eligible for retiree medical coverage at the time active employment with the Company ends, you may defer enrollment in the Retiree Medical Plan until any time before becoming eligible for Medicare or attaining age

65 as long as you have other employer sponsored medical coverage (such as through your spouse, as an active employee, or COBRA coverage).

You are not eligible for retiree medical coverage after becoming eligible for Medicare or attaining age 65.

Dependents

Current eligible dependents are covered for retiree medical benefits on the same date your coverage is effective, provided proper application is made and you pay any required contributions. Eligible dependents acquired after your coverage is effective become covered on the date of marriage, upon establishing entering into a 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 and you pay any required contributions. For other newly eligible dependents, coverage is effective on the date dependency is established, if application is made within 60 days and you pay any required contributions.

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 retirees 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 summary applies to the Traditional Medical Plan.

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

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

Covered medical expenses for the Traditional Medical Plan are described in the Summary of Traditional Medical Plan Benefits section of Attachment A. Highlights of specific benefit amounts are described in the Traditional Medical Plan Schedule of Benefits in Attachment A.

Vision care program benefits do not apply to the Traditional Medical Plan.

Prescription drug benefits are as shown below.

Prescription Drug Program

The prescription drug program described in this section is available to retired 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” on page 291) 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			
Retail Pharmacy (up to a 30-day supply)	~~90%~~ $5 copayment	~~80% 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~~	~~70% 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 coinsurance plus the cost difference of the brand-name drug and generic drug.~~ $25 copayment; 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 coinsurance plus the cost difference of the brand-name drug and generic drug.	~~drug—you will pay the generic coinsurance plus the cost difference of the brand-name drug and generic drug.~~ $40 copayment; 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 coinsurance plus the cost difference of the brand-name drug and generic drug.
Mail Service Program (~~Medco By Mail;~~ up to a	$10 copayment	~~$40 copayment if no generic is available OR if you are~~	~~$70 copayment if no generic is available OR if you are~~

90-day supply)**		~~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	~~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.	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.

Under the Retiree Medical Plan, a $75 annual deductible applies to each individual for prescription drugs purchased under the retail pharmacy card program. For families of 3 or more, the annual deductible maximum is $225. This deductible is separate from the Traditional Medical Plan annual deductible described in the Schedule of Benefits.

A covered person's out-of-pocket expense is limited to $75 for each prescription or refill after the deductible is satisfied.

Usual and customary charges are the charges the service representative allows for participating pharmacies.

*If you choose a brand-name drug when a generic equivalent is available, you will pay more than the coinsurance and 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 ~~Medco By~~ Mail Service P~~p~~rogram 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 ~~coinsurance or~~ 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 coinsurance or 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, (Prime Therapeutics at 1-888-802-8776 ~~Express Scripts at 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, including a Medicare prescription drug plan, except as required by law.
- Any service or supply otherwise excluded by the Traditional Medical Plan.
- 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 condition.
- Obesity drugs, unless approved by the service representative.
- Over-the-counter drugs.
- 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.

Coordination of Benefits—Retired Employees

If you or your dependent has other health care coverage in addition to being covered under this Plan, 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 the retired 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 retired employee or dependent for the eligible expenses related to that hospital admission. If the retired employee or dependent does not have other coverage for hospital and related expenses, this plan is primary.

Benefits under a Company-sponsored health care 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 health care plan.

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

Payment Provisions

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, you will be covered by Medicare only.

Coordination of benefit provisions of Company-sponsored HMO and CCP plans vary by plan.

Post-65 Retiree Medical Plan

Effective January 1, 2026, the Company will provide employees retiring during the term of this Agreement access to a Medicare plan that is available to eligible retirees in the Puget Sound region. The current plan offered to this population is the Aetna Medicare Advantage ESA PPO.

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 Retiree Medical Coverage

Retiree Coverage

Your medical coverage stops on whichever of the following dates occurs first:

- You attain 65 years of age.
- You become eligible for Medicare.
- The end of the last month that any required contributions are paid.

Your covered dependents can continue their coverage until they reach their termination date as described below.

Dependent Coverage

Coverage for your eligible dependents terminates on whichever of the following dates occurs first:

- Your dependent no longer qualifies as an eligible dependent.
- Your dependent attains 65 years of age.
- Your dependent becomes eligible for Medicare.
- The death of your surviving spouse.
- The end of the last month that any required contributions are paid.

Your surviving covered dependents under the age of 65 may be permitted to convert their medical coverage as described below in "Conversion Privilege."

Continuation of Medical Coverage (COBRA)

If medical coverage for your dependents (including a domestic partner or 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.

- Your death.
- Your divorce or dissolution of a domestic partner relationship.
- You become entitled to Medicare.
- Your dependent child ceases to be a dependent as defined under this plan. (A child eligible to be continued under the plan's disabled child provision will still be considered to have dependent status.)

Conversion Privilege

If medical coverage terminates for reasons other than voluntary cancellation of coverage or by becoming eligible for another Company-sponsored plan,

you or your dependent may apply for an individual policy of insurance of a kind then being issued by the service representative for group conversion purposes. Evidence of good health will not be required, provided written application is made and the first retiree medical premium is paid within 31 days following the end of the month in which medical coverage terminates. The policy will be issued at the service representative's customary rate applicable to the age of the individual and to the form and amount of insurance provided under the converted policy.