<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$1,400 Self Only or $2,800 Self + Family, family level deductible may be met by one or a combination of members. Network-nonnetwork combined.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Deductible does not apply to copayments, preventive care or vision.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Network: $3,100 Self Only or $6,200 Self + Family for medical and prescription drug expenses; Nonnetwork: $4,800 Self Only or $9,600 Self + Family for medical and prescription drug expenses; Family level out-of-pocket maximum may be met by one or a combination of members, plan year deductible is included in out-of-pocket maximum.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges, health care this plan doesn't cover, penalties for failing to obtain preauthorization, vision</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td>Important Questions</td>
<td>Answers</td>
<td>Why this Matters:</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------</td>
<td>------------------</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.bcbsil.com/boeing">www.bcbsil.com/boeing</a> or call 1-888-802-8776 for a list of network providers</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use a nonnetwork provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network might use a nonnetwork provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

---

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>No charge after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>10% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge, deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network</td>
<td>Nonnetwork</td>
</tr>
</tbody>
</table>
| If you need drugs to treat your illness or condition | Generic drugs | Retail: No charge after deductible  
Mail Order: No charge after deductible | Not covered | Retail: 30 day supply, up to 90 days of maintenance medications at select pharmacies only, certain preventive care medications are not subject to the deductible  
Mail order: 90 day supply, certain preventive care prescription drugs are not subject to the deductible |
| More information about prescription drug coverage is available at www.express-scripts.com/boeing. | Preferred brand drugs | Retail: 25% after deductible  
Mail Order: 25% after deductible | Not covered | Retail: 30 day supply, up to 90 days of maintenance medications at select pharmacies, member pay the difference rule applies if generic available, deductible waived for preventive drugs  
Mail order: 90 day supply, certain preventive drugs not subject to deductible, member pay the difference rule applies if generic available |
| | Non-preferred brand drugs | Retail: 35% after deductible  
Mail Order: 35% after deductible | Not covered | Retail: 30 day supply, up to 90 days of maintenance medications at select pharmacies, member pay the difference rule applies if generic available, deductible waived for preventive drugs  
Mail Order: 90 day supply, certain preventive drugs not subject to deductible, member pay the difference rule applies if generic available |
<p>| Specialty drugs | Specialty drug programs apply for certain high cost items | Specialty drug programs apply for certain high cost items | Preauthorization may apply or you may need to obtain specialty drugs from a pharmacy designated by the service representative, failure to follow plan procedures may result in non-payment by the plan |</p>
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% after <strong>deductible</strong></td>
<td>40% after <strong>deductible</strong></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% after <strong>deductible</strong></td>
<td>40% after <strong>deductible</strong></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>10% after <strong>deductible</strong>, non-emergent care 40% after <strong>deductible</strong></td>
<td>10% after <strong>deductible</strong>, non-emergent care 40% after <strong>deductible</strong></td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% after <strong>deductible</strong>, non-emergent care 40% after <strong>deductible</strong></td>
<td>10% after <strong>deductible</strong>, non-emergent care 40% after <strong>deductible</strong></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>No charge after <strong>deductible</strong> for office visit</td>
<td>40% after <strong>deductible</strong></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% after <strong>deductible</strong></td>
<td>40% after <strong>deductible</strong></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>10% after <strong>deductible</strong></td>
<td>40% after <strong>deductible</strong></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>No charge after <strong>deductible</strong> for office visit</td>
<td>40% after <strong>deductible</strong></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% after <strong>deductible</strong></td>
<td>40% after <strong>deductible</strong></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network</td>
<td>Nonnetwork</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% after deductible</td>
<td>40% after deductible</td>
</tr>
</tbody>
</table>

Cost sharing does not apply for preventive services, maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound), depending on the type of services, a coinsurance or deductible may apply.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>10% after deductible</td>
<td>40% after deductible</td>
<td>Preadmission review or preapproval required or penalty is 50% of first $2,000 of eligible charges</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>10% after deductible</td>
<td>40% after deductible</td>
<td>30 visits limited per therapy per year, additional visits may be available if medically necessary, visit limit does not apply to mental health and substance use disorders</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>10% after deductible</td>
<td>40% after deductible</td>
<td>Preadmission review or preapproval required or penalty is 50% of first $2,000 of eligible charges</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>10% after deductible</td>
<td>40% after deductible</td>
<td>none</td>
</tr>
<tr>
<td>Hospice services</td>
<td>10% after deductible</td>
<td>10% after deductible</td>
<td>Subject to 6 month review, preadmission review or preapproval required or penalty is 50% of first $2,000 of eligible charges</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children's eye exam</td>
<td>Coverage offered through separate vision benefit</td>
<td>Coverage offered through separate vision benefit</td>
<td>Not covered under the medical plan, coverage offered through separate vision benefit</td>
</tr>
<tr>
<td>Children's glasses</td>
<td>Coverage offered through separate vision benefit</td>
<td>Coverage offered through separate vision benefit</td>
<td>Not covered under the medical plan, coverage offered through separate vision benefit</td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>Coverage offered through separate dental benefit</td>
<td>Coverage offered through separate dental benefit</td>
<td>Not covered under the medical plan, coverage offered through separate dental benefit</td>
</tr>
</tbody>
</table>
Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Children's dental check-up</td>
</tr>
<tr>
<td>• Children's eye exam</td>
</tr>
<tr>
<td>• Children's glasses</td>
</tr>
<tr>
<td>• Cosmetic surgery (unless reconstructive)</td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
</tr>
<tr>
<td>• Habilitation services</td>
</tr>
<tr>
<td>• Infertility treatment (limited coverage may apply)</td>
</tr>
<tr>
<td>• Long-term care</td>
</tr>
<tr>
<td>• Private-duty nursing (limited coverage may apply)</td>
</tr>
<tr>
<td>• Routine eye care (Adult)</td>
</tr>
<tr>
<td>• Routine foot care (limited coverage may apply)</td>
</tr>
<tr>
<td>• Weight loss programs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Bariatric surgery (limited coverage may apply)</td>
</tr>
<tr>
<td>• Chiropractic care</td>
</tr>
<tr>
<td>• Hearing aids</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside the U.S.; <a href="http://www.bcbsil.com/boeing/resources/international_travel.html">www.bcbsil.com/boeing/resources/international_travel.html</a></td>
</tr>
</tbody>
</table>

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-888-802-8776. You can also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwiijige holne' 866-473-2016.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
<table>
<thead>
<tr>
<th>Coverage Example</th>
<th>Total Example Cost</th>
<th>Plan Deductible</th>
<th>Specialist Coinsurance</th>
<th>Hospital (Facility) Coinsurance</th>
<th>Other Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peg is Having a Baby</td>
<td>$12,800</td>
<td>$1,400</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Managing Joe’s type 2 Diabetes</td>
<td>$7,400</td>
<td>$1,400</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Mia’s Simple Fracture</td>
<td>$1,900</td>
<td>$1,400</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
</tbody>
</table>

**About these Coverage Examples:**

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.
The Boeing Company

Grievance Procedure under Section 1557 of the Affordable Care Act

It is the policy of The Boeing Company ("Boeing"), as the sponsor of the Boeing health care plans ("Plans"), not to discriminate on the basis of race, color, national origin, sex, age or disability in its administration of the Plans. Boeing has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. § 18116) and its implementing regulations at 45 C.F.R. pt. 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined by contacting the Director, Benefits Compliance and Governance, The Boeing Company, 100 N. Riverside, MC 5002-8421, Chicago, IL 60606-1596, telephone 1-312-544-2297.

The Director – EEO Compliance, Global Diversity and Inclusion, The Boeing Company, 100 N. Riverside MC 5002-9140, Chicago, IL 60606-1596, telephone 800-617-1442, has been designated as the Section 1557 Coordinator to coordinate the efforts of Boeing and the Plans to ensure compliance with Section 1557 by investigating any complaints that the Plans have failed to comply with Section 1557. Any person who believes an eligible employee or eligible dependent under the Plans has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability by the Plans may file a grievance under this procedure. It is against the law for Boeing or the Plans to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the office of the Director – EEO Compliance, Global Diversity and Inclusion, The Boeing Company, 100 N. Riverside MC 5002-9140, Chicago, IL 60606-1596, telephone 800-617-1442 within sixty (60) days of the date the person filing the grievance becomes aware of the alleged discriminatory action.

- A complaint must be in writing, containing the name and address of the person filing it. Upon contacting the Director – EEO Compliance, Global Diversity and Inclusion, a Complaint Intake Form will be provided for the convenience of the person filing the grievance. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.

- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of Boeing relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.

- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, generally within thirty (30) days after its filing (unless the Section 1557 Coordinator informs the complainant of a reasonable extension), including a notice to the complainant of their right to pursue further administrative or legal remedies.
• The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the Vice-President - Global Diversity and Inclusion (“VP, GD&I”), The Boeing Company, 100 N. Riverside MC 5002-9140, Chicago, IL 60606-1596, telephone 800-617-1442 within fifteen (15) days of receiving the Section 1557 Coordinator’s decision. The VP, GD&I shall issue a written decision in response to the appeal generally within thirty (30) days after its filing (unless the VP, GD&I informs the appellant of a reasonable extension).

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services (DH&HS), Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

DH&HS complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination.

Boeing will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements and should be contacted at 800-617-1442 for such assistance.
Resources Available in Languages Other Than English

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-473-2016 (las personas con discapacidad auditiva deben utilizar el servicio de retransmisión que su operadora telefónica les ofrece para realizar llamadas).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-473-2016 (有聽力障礙的人打電話時應使用他們電話服務提供商提供的中繼服務)。

Vietnamese


Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-473-2016 번으로 전화해 주십시오. 청각 장애가 있는 발신자는 전화번호 서비스 제공자를 통해 제공되는 중계 서비스(relay service)를 이용해서야 합니다.

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-473-2016 (dapat gamitin ng mga tumatawag na may kapansanan sa pandinig ang relay service na inaalok sa pamamagitan ng service provider ng kanilang telepono).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-473-2016 (абонентам с нарушениями слуха следует пользоваться службой коммутируемых сообщений, услуги которой предлагаются их поставщиком услуг телефонной связи).

Arabic

ملحوظة: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 1-866-473-2016 (يتعين على مريض السمع الذين يعانون من مكافحة استخدام خدمة المرجل عبر مزود خدمات الهاتف الذي يتعاملون معه).

French-Creole

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis éd pou lang ki disponib gratis pou ou. Rele 1-866-473-2016 (moun ki gen pwoblèm pou tande dwe itilize sèvis relè ke konpayi telèfon pa yo ofri yo lè pou yo fè yon koutfil).
Portuguese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-473-2016 (utilizadores de telefone com deficiência auditiva devem usar o serviço de retransmissão, oferecido pelos seus provedores de serviços de telefonia).

French

ATTENTION : Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-866-473-2016 (les personnes malentendantes qui appellent doivent utiliser le service de relais offert par l’intermédiaire de leur opérateur téléphonique).

Polish

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-xxx-xxx-xxxx (osoby niedosłyszące zechcą skorzystać z pomocy udostępnianej przez swoją firmę telefoniczną).

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-473-2016までお電話にてご連絡ください。聴覚障害のお客様はご利用の電話会社によるリレーサービスをお使いください。

Italian

ATTENZIONE: In caso la lingua parlata sia l’italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-473-2016 (gli utenti con disabilità uditive dovrebbero utilizzare il servizio di conversione offerto attraverso il proprio operatore telefonico).

German


Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-866-473-2016 تماس بگیرید. کسانی که مشکلات شنوایی دارند، باید از خدمات انتقال تماس که توسط شرکت تلفن آراهه می شود، استفاده کنند.