COLLECTIVE BARGAINING AGREEMENT

BETWEEN

BOEING AEROSPACE OPERATIONS ("BAO")

And

THE INTERNATIONAL ASSOCIATION OF MACHINISTS AND AEROSPACE WORKERS, AFL-CIO

March AFB,
District 725, Local Lodge 821

McChord AFB,
District 751, Local Lodge 751-C

Travis AFB,
District 725, Local Lodge 946

C-17 (ATS)

Effective Date: April 4, 2009

TABLE OF CONTENTS

COLLECTIVE BARGAINING AGREEMENT

BETWEEN

BOEING AEROSPACE OPERATIONS ("BAO")

AND

THE INTERNATIONAL ASSOCIATION OF MACHINISTS

AND AEROSPACE WORKERS,
AFL-CIO

THIS AGREEMENT, dated as of the 4th of April 2009, by and between Boeing/Boeing Aerospace Operations (hereinafter referred to as The Company) and The International Association of Machinists and Aerospace Workers, AFL-CIO, March AFB, District 725, Local Lodge 821, McChord AFB, District 751, Local Lodge 751-C, Travis AFB, District 725, Local Lodge 946, (hereinafter referred to as "the Union").

WITNESSETH that

WHEREAS, the Union is the exclusive bargaining agent of certain employees of the Company, and

WHEREAS, the Union and the Company have negotiated a Collective Bargaining Agreement covering wages, hours and other conditions of employment, and

WHEREAS, the parties desire to reduce the Agreement to writing,

NOW, THEREFORE, in consideration of the mutual promises hereinafter set forth, the parties hereto agree as follows:

ARTICLE 1
RECOGNITION

Section 1.1 Recognition. The Company recognizes The International Association of Machinists and Aerospace Workers, AFL-CIO, March AFB, District 725, Local Lodge 821, McChord AFB, District 751, Local Lodge 751-C, Travis AFB, District 725, Local Lodge 946, as the sole and exclusive bargaining agent with respect to rates of pay, wages, hours of work and all other conditions of employment for all employees covered by this Agreement.

Section 1.2 Bargaining Unit. The Employer and the Union agree that the employees covered by this Agreement shall consist of the following: designated employees of Boeing Aerospace Operations, C-17 Aircrew Training System Program, who are classified in jobs set out in this Agreement, as certified by the National Labor Relations Board in Case Numbers March 21-RC-1211105, McChord AFB, 19-RC-15179, and Travis AFB, 20-RC-18230. Excluded from the unit are all supervisors and managers, office clerical employees, professional employees and guards as defined by the National Labor Relations Act, and all other employees of Integrated Defense Systems or BAO or their parent organization, including those employees on contracts other than those identified above.

ARTICLE 2
RIGHTS OF MANAGEMENT

The management of the Company and the direction of the work force is vested exclusively in the Company subject to the terms of this Agreement. All matters not specifically and expressly covered or treated by the language of this Agreement may be administered for its duration by the Company in

accordance with such policy or procedure as the Company from time to time may determine. The Company does have the right to subcontract work and designate the work to be performed by the Company and the places where it is to be performed, which right shall not be subject to arbitration.

ARTICLE 3
UNION AND COMPANY RELATIONS

Section 3.1 Union Activity During Working Time. Solicitation of Union membership, collection or checking of dues, will not be permitted during working hours. The Company agrees not to discriminate in any way against any employee for the filing of complaints or grievances or for Union activity. Any employee engaged in unsanctioned Union activity during working time, except as specifically allowed by the provisions of this Agreement, or by other agreement between the Company and the Union, is subject to disciplinary action.

Section 3.2 Strikes and Lockouts. The Union agrees that during the terms of this Agreement and regardless of whether an unfair labor practice is alleged (a) there will be no strike, slow-down, sit-down, or walk-out and (b) the Union will not directly or indirectly authorize, encourage or approve any refusal on the part of employees to proceed to the location or normal work assignment. Any employee who violates this clause shall be subject to discipline. The Company agrees that during the term of this Agreement there will be no lock-out of employees covered by this Agreement. Any claim by either party that the other has violated this Section 3.2 shall not be subject to the grievance procedure or arbitration provisions of this Agreement and either party shall have the right to submit such claim(s) to the courts.

Section 3.3 Union Payroll Deduction. It is agreed between the Company and the Union that any employee in the bargaining unit defined in Article 1 of this Agreement, who is or may hereafter become a member of the Union, or pays an agency fee, may authorize the collection of Union dues or agency fees by the signing of a payroll deduction form. The employee's authorization shall be irrevocable for a period of one (1) year from the date they are signed or until this Agreement expires whichever occurs sooner, irrespective of their membership status in the Union.

3.3(a) This authorization and assignment shall continue in full force and effect for yearly periods beyond the irrevocable period set forth above, and such subsequent yearly period shall be similarly irrevocable unless revoked within ten (10) calendar days nor less than three (3) days prior to the date of termination of any irrevocable period hereof. Such revocation shall be affected by written notice to the Company, and a copy sent by certified mail, return receipt requested, to the Union within such ten (10) day period.

3.3(b) Collection of any back dues or agency fees owed at the time of starting deductions for any employee and collection of dues or agency fees missed because the employee's earnings were not sufficient to cover the payment of dues for a particular pay period will be the responsibility of the Union and will not be the subject of payroll deductions.

3.3(c) As allowed by law, all employees in the bargaining unit must, as a condition of continued employment, be either a member of the Union and pay Union dues or pay an agency fee to the Union, but not both.

3.3(d) As allowed by law, all employees within the bargaining unit on the effective date of this Agreement who are not Union members must, as a condition of continued employment, pay to the Union while on the active payroll, an agency fee equal in amount to monthly membership dues, beginning with the month following the month in which they accumulate thirty (30) days' continuous service in the bargaining unit since their last date of hire or rehire. Employees entering the bargaining unit or employees who are rehired with seniority or transferred with seniority into the bargaining unit after the effective date of this Agreement who do not become Union members, or having become but do not remain Union members, must, as a condition of employment, while on the active payroll, pay such fee to the Union commencing the month following the month in which they accumulate thirty (30) days' continuous service in the bargaining unit if such entry is prior to the

fifteenth (15th) day of that month or commencing with the month following the month of such entry into the bargaining unit if such entry is on or after the fifteenth (15th) day of that month.

3.3(e) As allowed by law, employees who are Union members on the effective date of the Agreement shall continue to pay membership dues to the Union as a condition of continued employment while in the bargaining unit and on the active payroll as long as they remain members of the Union; employees within the bargaining unit who after the effective date of this Agreement become members of the Union shall pay, while on the active payroll, an original initiation fee and membership dues to the Union, as a condition of continued employment while in the bargaining unit and while remaining a Union member; provided that in no event shall the initiation fee and membership dues exceed the amount specified in the Constitution and/or by-laws of the Union.

3.3(f) Any employee required to pay an agency fee, membership dues, or initiation or reinstatement fee as a condition of continued employment who fails to tender the agency fee or initiation, reinstatement, or periodic dues uniformly required, shall be notified in writing of the employee's delinquency. A copy of such communication shall be mailed to the Company not later than fifteen (15) days prior to such request that the Company take final action on a delinquency.

3.3(g) Deduction of membership dues or agency fees shall be made in a flat sum provided there is a balance in the paycheck sufficient to cover the amount after all other deductions authorized by the employee or required by law have been satisfied. In the event of termination of employment, the obligation of the Company to collect dues or agency fees shall not extend beyond the pay period in which the employee's last day of work occurs.

3.3(h) The Company shall issue all Union payments such as Union dues, Initiation Fees, Political Action Contributions, etc. via electronic funds transfer process only (Direct Deposit). The Union shall ensure the Company has been provided with a valid Bank Account and Routing number to set up the process. It will be the responsibility of the Union to submit all changes in Bank information to the Company immediately.

3.3(i) The Company shall issue all reports distributed to the Union electronically. Accounts will be established for a focal designated by the Union. It will be the responsibility of the Union to submit all changes in focals to the Company.

Section 3.4 Indemnity. The Union will indemnify and hold the Company harmless from and against any and all claims, demands, charges, complaints, or suits instituted against the Company which are based on or arise out of any action taken by the Company in accordance with or arising out of the foregoing provisions of this Article 3.

Section 3.5 Business Representatives/Grand Lodge Representative - Access to Site. The Business Representative/Grand Lodge Representative of the Union shall have access to the Company facilities where bargaining unit employees are normally assigned during working hours for the purpose of conducting legitimate Union Business pertaining to this Agreement including, but not limited to, the investigation and advising in the handling of grievances, and will not interfere with the normal conduct of the Company's operation. The Company will not impose regulations which will render the intent of this provision ineffective. The Union shall keep the Company Manager of Human Resources currently informed in writing of the name of the accredited Business Representative/Grand Lodge Representative. The Business Representative/Grand Lodge Representative shall notify the Human Resources Manager or his/her designee prior to any visit to the site. The necessary Company badges and credentials will be given to the Business Representative/Grand Lodge Representative. Visits shall be made subject to such regulations as may be made from time to time by the Company.

Section 3.6 Shop Stewards. The Union may select not to exceed, except by mutual agreement, one (1) employee per shift as Shop Steward. An employee while serving as a Shop Steward shall not be laid off from his/her job classification so long as other employees remain in his/her job classification and is designated Shop Steward.

Section 3.7 Departure from Work Assignment by Stewards to Investigate Complaints or Claims of Grievance. Each Steward shall notify and obtain permission from his/her supervisor before leaving his/her work assignment for the purpose of investigating complaints or claims of grievance on the part of employees or the Union or contacting the Business Representative/Grand Lodge Representative in regard to such claim or grievance. Such permission shall be granted except where there is a substantial reason for delaying the contact or the investigation due to safety conditions or the fact that a critical operation is in process. The supervisor may be present during any discussion relating to any complaint or grievance. However, upon the request of an employee or Steward, the supervisor shall authorize a Steward to participate in a private discussion with an employee, Business Representative/Grand Lodge Representative, or his/her designee, relating to a complaint or grievance. Discussions of the type described in this Section 3.7 shall be conducted without requiring the employee or Steward to be on unpaid time provided the discussion does not extend beyond the time that the supervisor considers reasonable under the circumstances.

Section 3.8 Bulletin Boards. The Company will provide bulletin boards for the use of the Union at locations mutually agreed to. Their use will be restricted to the following.

(a) Notices of Union meetings;

(b) Notices of Union elections and results thereof;

(c) Notices of Union recreational and social affairs;

(d) Such other notices as are mutually agreed upon.

Only notices approved by the Business Representative/Grand Lodge Representative, or his/her designee, authorized in writing by the Union and approved by the Company may be placed on the bulletin boards.

Section 3.9 Nothing in this Agreement is intended to abridge the right of a supervisor to privately discuss with any employee under his or her supervision topics pertinent to the workplace, including but not limited to, the employee's job performance.

Section 3.10 Joint Meetings. Should either party desire to discuss with the other any matter affecting generally the relationship of the parties, a meeting of Union and Management representatives shall be arranged upon request of either party. Such meeting shall take place at a time mutually convenient to both parties. Any use of Company time for attendance at such meetings shall be arranged in advance by mutual agreement.

This Section is intended to provide a free avenue of communication between the Union and the Company, and suggestions, complaints, or other matters may be presented by either party, provided that neither party shall be required to discuss any item brought up by the other party nor be bound to act upon any item presented. However, both parties agree to discuss informal grievances and complaints.

Section 3.11 Leaves without pay for Union business may, by mutual agreement, be granted to employees of the Company who have been selected by the Union to attend such functions as conferences, conventions and Union educational courses, not to exceed ten (10) days annually provided the Union notifies the Company in writing fourteen (14) days in advance.

ARTICLE 4
GRIEVANCE PROCEDURE AND ARBITRATION

Section 4.1 Establishment of Grievance and Arbitration Procedure. Grievances or complaints arising between the Company and its employees subject to this Agreement, or the Company and the Union, with respect to the interpretation or application of any of the terms of this Agreement, shall be settled according to the following procedure. Subject to the terms of this Article relating to cases of dismissal or suspension for cause or of involuntary resignation, only matters dealing with the interpretation or application of terms of this Agreement shall be subject to this grievance machinery.

Section 4.2 Employee Grievances. In the case of grievances on behalf of employees and subject to the further provisions of Section 4.3 below, relating to cases of layoff or dismissal or suspension for cause of involuntary resignation:

STEP 1. Oral Discussion. The employee first shall discuss his/her grievance with the Steward and if the Steward considers the grievance to be valid then the employee and the Steward will contact the employee's supervisor and will attempt to effect a settlement of the complaint. This procedure, however, will not prevent an employee from contacting his/her supervisor if he/she so chooses. If the purpose of the employee's contacting his/her supervisor is to adjust the grievance, the Steward shall be given an opportunity to be present and such adjustment shall be in conformity with this Agreement.

STEP 2. Grievance Reduced to Writing - **Handling at Supervisory Level.** If no settlement is reached in Step 1, the Steward, if he/she considers the grievance to be valid, may at any time reduce to writing a statement of the grievance or complaint which the grievant must sign and it shall contain the following:

(a) The facts upon which the grievance is based.

(b) Reference to the section or sections of the Agreement alleged to have been violated (this will not be applicable in cases of dismissal or suspension for cause or of involuntary resignation).

(c) The remedy sought.

The Steward shall sign and submit the written statement of grievance to the manager for consideration, with a copy to Human Resources. After such submission, the manager and the Steward may, within the next five (5) workdays, unless mutually extended, settle the written grievance and, over their signatures indicate the disposition made thereof. Otherwise, promptly after the expiration of such five (5) day period, or agreed extension thereof, the manager and the Steward shall sign the grievance and their signatures will indicate that the grievance has been discussed and reconsidered by them and that no settlement has been reached.

STEP 3. Written Grievance Handling at Business Representative/Grand Lodge Representative/Company Representative Level. If no settlement is reached in Step 2 within the specified or agreed time limits, the Business Representative/Grand Lodge Representative or his/her designee may at anytime thereafter submit the grievance to the Site Manager or the designated representative of the Company. After such submission, the designated representative of the Company and the Business Representative/Grand Lodge Representative or his/her designee may, within the next ten (10) workdays, unless mutually extended, settle the grievance and, over their signatures, indicate the disposition made thereof. Otherwise, promptly after the expiration of such ten (10) day period, or agreed extension thereof, the designated representative of the Company and the Business Representative/Grand Lodge Representative, or his/her designee, shall sign the grievance and their signatures will indicate that the grievance has been discussed and reconsidered by them and that no settlement has been reached.

STEP 4. Arbitration. If no settlement is reached in Step 3 within the specified or agreed time limits, then either party may in writing, within thirty (30) calendar days thereafter, request that the matter be submitted to an arbiter for a prompt hearing as hereinafter provided in Sections 4.6 to 4.7, inclusive.

Section 4.3 Dismissals, Suspensions, Layoff, etc. In cases of layoff or suspension for cause, or of involuntary resignation, the employee shall be given a copy of the layoff, suspension or termination of service slip, as the case may be, if he/she is available to be presented with such copy. If he/she is not available, copies of the slip will be sent to the employee and to the Union office. The employee shall have the right to appeal the action shown on the slip providing the Union files a written grievance with the designated representative of the Company within seven (7) workdays after the date of layoff dismissal, or

suspension for cause, or involuntary resignation, or within seven (7) workdays after the date of the mailing of the copy of the slip. The written grievance then may be processed through subsequent steps.

Section 4.4 Union Versus Company. Processing of grievances which the Union may have against the Company shall begin with Step 3 and shall be limited to matters dealing with the interpretation or application of terms of this Agreement. Such grievance shall be submitted in writing to the designated representative of the Company, and shall contain the following:

(a) Statement of the grievance setting forth the facts upon which the grievance is based.

(b) Reference to the section or sections of the Agreement alleged to have been violated.

(c) The correction sought.

The grievance shall be signed by the designated representative of the Union. If no settlement is reached within ten (10) workdays (unless mutually extended) from submission of the grievance to the designated representative of the Company, both shall sign the grievance and indicate that it has been discussed and reconsidered by them and that no settlement has been reached. Within ten (10) workdays thereafter the Union may in writing request that the matter be submitted to an arbiter for a prompt hearing as hereinafter provided in Sections 4.6 to 4.7, inclusive.

Section 4.5 Retroactive Compensation. Grievance claims involving retroactive compensation shall be limited to thirty (30) calendar days; prior to the written submission of the grievance to Company representatives, provided, however, that this thirty (30) day limitation may be waived by mutual consent of the parties.

Section 4.6 Selection of Arbiter - From Federal Mediation and Conciliation Service. The parties shall jointly request the Federal Mediation and Conciliation Service to submit a panel of seven (7) arbiters. Such requests shall state the general nature of the case and ask that the nomineesbe qualified to handle the type of case involved. When notification of the names of the panel of seven (7) arbiters is received, the parties in turn shall have the right to strike a name from the panel until only one name remains. The right to strike the first name shall be determined by lot. The remaining person shall be the arbiter.

Section 4.7 Arbitration - Rules of Procedure. Arbitration pursuant to Step 4 shall be conducted in accordance with the following

4.7(a) The arbiter shall hear and accept pertinent evidence submitted by both parties and be empowered to request such data as he/she deems pertinent to the grievance and shall render a decision in writing to both parties within thirty (30) days, unless mutually extended, after the completion of the hearing.

4.7(b) The arbiter shall be authorized to rule and issue a decision in writing on the issue presented for arbitration which decision shall be final and binding on both parties.

4.7(c) The arbiter shall rule only on the basis of information presented in the hearing before him/her and shall refuse to receive any information after the hearing except when there is a mutual agreement, in the presence of both parties.

4.7(d) Each party to the proceedings may call such witnesses as may be necessary in the order in which their testimony is to be heard. Such testimony shall be limited to the matters set forth in the written statement of grievance. The arguments of the parties may be supported by oral comment and rebuttal. Either or both parties may submit written briefs with a time period mutually agreed upon. Such arguments of the parties, whether oral or written, shall be confined to and directed at the matters set forth in the grievance.

4.7(e) Each party shall pay any compensation and expenses relating to its own witnesses or representatives.

4.7(f) The Union or the Company, whichever is ruled against by the arbiter, shall pay the compensation of the arbiter including his/her necessary expenses.

4.7(g) The total cost of the stenographic record (if requested) will be paid by the party requesting it. If the other party also requests a copy, that party will pay one half of the stenographic costs.

Section 4.8 Extension of Time Limits by Agreement. Time limits designated in this Article for processing grievances and for bringing a matter to arbitration may only be extended by mutual written consent.

Section 4.9 Agreement Not to be Altered. In arriving at any settlement or decision under the provisions of this Article, neither the parties nor the arbiter shall have the authority to alter this Agreement in whole or in part.

Section 4.10 Conference During Working Hours. All conferences resulting from the application of provisions contained in this Article shall be held during working hours.

Section 4.11 Business Representative/Grand Lodge Representative, When Not Available May Authorize Designee. For any period that the Business Representative/Grand Lodge Representative is unavailable to serve in that capacity under this Article 4, he/she may designate an accredited Steward or another accredited Business Representative/Grand Lodge Representative to act for him/her, as his/her designee. As to each such period of unavailability, authorization of the designee will be accomplished by the Business Representative/Grand Lodge Representative informing the appropriate Company representative of the expected period of the Business Representative/Grand Lodge Representative's unavailability to perform his/her duties under this Article 4, he/she shall promptly notify the Company representative of the fact and such notice will terminate the period during which the designee is authorized to act.

Section 4.12 Signing Grievance Does Not Concede Arbitrable Issue. The signing of any grievance by any employee or representative either of the Company or of the Union shall not be construed by either party as a concession or agreement that the grievance constitutes an arbitrable issue or is properly subject to the grievance machinery under the terms of this Article.

ARTICLE 5
SENIORITY

Section 5.1 Purpose and Definition. Both parties hereto agree that continued service over a period of time should, and in most cases does, increase the worth of an employee to his/her employer, and that length of service should receive recognition in case of promotion, and therefore agree:

That the principle of seniority, where qualifications, productivity and dependability are substantially equal, shall be the determining factor and shall apply upon a Company-wide basis in accordance with the specific application provisions of this Agreement.

Section 5.2 Probationary Employees.

5.2(a) For the first ninety (90) days of employment, employees shall be considered as on probation and without seniority. However, if a probationary employee is laid off and rehired within a period of time not in excess of the time he/she had previously spent as a probationary employee, he/she will be credited with the time previously worked toward the completion of his/her probationary period. Upon the completion of his/her probationary period, his/her seniority date will then be established as of ninety (90) days prior to the completion date of his/her probationary period.

5.2(b) During such ninety (90) day period, probationary employees may be laid off or terminated at the discretion of the Company. Such layoffs or terminations during the probationary period shall not be subject to the grievance and arbitration procedure.

Section 5.3 Establishment of Seniority. The seniority date of each employee, who, as of the effective date of this Agreement, is in the unit defined in Article 1, or on authorized leave of absence from the unit, or acting in a supervisory capacity over employees in the unit, shall be in conformance with the date agreed on the date of ratification. Seniority shall be specific to a job classification at a site identified in Article 1. The seniority date of each employee, who, subsequent to the effective date of this Agreement is hired, rehired, or transferred into the site, shall be the effective date of such hire, rehire, or transfer.

Section 5.4 Employees With Identical Seniority Dates. When two (2) or more employees have the same seniority date as herein provided, the employee having the lowest number (the last four (4) digits of one's social security number) shall be considered as having the least seniority for tie breaking purposes.

Section 5.5 Accumulation Seniority. Seniority shall accumulate to:

5.5(a) Employees who are on the active payroll of the Company and in the bargaining unit defined in Article 1 of this Agreement:

5.5(b) Employees who are promoted to non-represented positions supervising bargaining unit employees, shall retain seniority and continue to accumulate additional seniority for a maximum of one (1) year while they remain in such supervisory position;

5.5(c) Employees while on active military service and reinstated in compliance with applicable law;

5.5(d) Time spent on authorized leave of absence for Union business in accordance with Article 8;

5.5(e) Time lost by reason of industrial injury, or industrial illness not to exceed the time limits on layoff statue provided in Section 5.5(h);

5.5(f) Time spent on authorized leave of absence granted because of pregnancy or to cover periods of non-industrial injury or illness, not to exceed twelve (12) months during any such period;

5.5(g) The first thirty (30) days of any other authorized leave of absence;

5.5(h) Time spent on layoff for a period not to exceed five (5) years, or for employees with less than one (1) year seniority, time spent on layoff for a period not to exceed one (1) year;

Section 5.6 Loss of Seniority. An individual shall lose seniority rights for the following reasons:

5.6(a) Resignation. In addition to normal resignations, an individual who, while on leave of absence, engages in other employment without prior written approval by the Company, or fails to report for work or to obtain renewal of his/her leave on or before its expiration, will be considered as having resigned;

5.6(b) Discharge for cause;

5.6(c) Failure to respond with an acceptance within seven (7) calendar days after receipt of a recall from layoff notice by certified mail (unless such period is extended by the Company);

5.6(d) Failure to report for work within fourteen (14) calendar days after acceptance or on such later date as may be designated by the Company;

5.6(e) Failure to keep the Company advised of any changes in current mailing address, while on layoff. The Company will fulfill its obligation for notice of recall by mailing a certified notice to the employee's last address of record;

5.6(f) Layoff for a period in excess of five (5) years (or for employees with-less than one (1) year seniority, layoff in excess of one (1) year);

5.6(g) Retirement;

5.6(h) Absence in excess of three (3) consecutive working days without notification shall constitute RESIGNATION as in Section 5.6(a) above, unless satisfactory evidence of inability to report for work is shown.

Section 5.7 Transfers To and From the Bargaining Unit.

5.7(a) The Company may transfer or promote employees covered by this Agreement to supervisory positions.

5.7(b) Employees transferring to salaried positions other than that described in Section 5.5(b), shall retain their bargaining unit seniority but shall not accumulate additional seniority while they remain in such salaried positions.

5.7(c) The Company at any time may transfer or demote to positions within this unit those employees who have accumulated or are accumulating seniority under Section 5.3 of this Article 5. Such transfers or demotions may be made subject only to the job return rights of others to the extent provided in Article 12.

ARTICLE 6
WORKWEEK, HOURS OF WORK, SHIFTS

Section 6.1 Workweek: The purpose of this Article is to define the normal hours of work, but nothing in this Agreement shall be construed as a guarantee of specified numbers of hours of work either per day or per week. The pay period shall consist of a period of seven (7) consecutive twenty-four (24) hour periods.

Normal shifts are:

First Shift	Beginning at or after 4:00 a.m. but before 12:00 p.m.
Second Shift	Beginning at or after 12:00 p.m. but before 8:00 p.m.
Third Shift	Beginning at or after 8:00 p.m. but before 4:00 a.m.

The normal work week shall be forty (40) hours. Determination of starting time and hours of work, including an unpaid lunch, shall be made by the Company and such schedules may be changed from time to time to suit varying conditions of business. The Company will provide as much advance notice to the employees as possible. Employees posted shifts shall not be changed to avoid the payment of overtime. This Section is not subject to Article 4.

Section 6.2 Non-Standard Workweek. It is agreed that the Company may schedule employees to work a non-standard work schedule consisting of shifts of longer duration than those specified in Article 6, work weeks of less than five (5) full consecutive days, or non-consecutive days off, as set forth in Article 6 of the Agreement, for a total work week of forty (40) hours. By way of illustration, but not in limitation, a non-standard work schedule could be four (4) ten (10)-hour days.

Any other matters relating to non-standard work schedules will be subject to mutual agreement by the parties.

Section 6.3 Employees will be allowed one (1) scheduled fifteen (15) minute rest period before and one (1) fifteen (15) minute rest period after lunch in each complete scheduled workday, the time will be established by the Company. Determination of starting time and hours of work shall be made by the Company and such schedules may be changed from time to time to suit varying conditions of business.

Section 6.4 Employees shall work up to the start of the rest and lunch periods and be at their place of work at the end of their rest and lunch periods. Depending on operations and schedules, employees may be required to work through their rest and/or lunch periods and take them at a later or earlier time during the shift.

Section 6.5 The Company may, providing there are no employees on active layoff status in the classification, to accommodate schedule requirements, hire employees specifically to work a daily or weekly work schedule which is less than the current regular normal workday or workweek.

Section 6.6 When operational requirements necessitate shifts in excess of twelve (12) hours, management will attempt to meet the requirement with volunteers first. Absent sufficient qualified volunteers, management may schedule employees in reverse seniority order to work. The Company shall not require an employee to work more than two (2) shifts per week of greater than ten (10) hours.

ARTICLE 7
OVERTIME

Section 7.1 Overtime. In order for the Company to meet its support obligations, certain employees from time to time will be required to work overtime as well as shift work during the week, on holidays and weekends. When it becomes necessary to schedule overtime, it will first be offered to qualified employees on a voluntary basis within the work group/work area where the overtime requirement exists. The Company will attempt to equalize overtime among those qualified employees. If management fails to obtain a sufficient number of volunteers to meet the overtime requirement(s), then qualified employees may be directed to work the necessary overtime within the work group/work area where the overtime requirement exists, in reverse seniority order. The Company will provide as much advance notice of overtime requirements as possible.

The Company shall not require an employee to work overtime who has worked, three (3) consecutive weekends (either the first or second day of rest), or one hundred sixty (160) overtime hours in the calendar quarter, except in extraordinary circumstances mandated by the customer.

Section 7.2 Overtime shall be paid at one and one-half (1.5) times an employee’s base rate, for all hours compensated in excess of forty (40) hours in the workweek.

Section 7.3 Subject to Section 7.2 above for the first eight (8) hours of work by an employee on the first day of this two (2) consecutive days of rest, such employee shall be paid one and one-half (1.5) times his/her base rate and double such base rate thereafter.

Section 7.4 Subject to Section 7.2 above any time worked on the second day of an employee's two (2) consecutive days of rest shall be paid for at double his/her base rate and such double time shall remain in effect for all hours continuously worked.

Section 7.5 Wage Payment Basis. Employees shall be paid for time worked computed to the nearest one-tenth hour.

Section 7.6 There shall be no pyramiding of overtime and/or other premium payments. No overtime shall be worked except by direction of the Company’s appropriate management.

Section 7.7 In any dispute regarding any claim that an employee was not given an opportunity to work overtime, the only award, if any, will be that the employee shall be provided an opportunity to work such overtime at the next overtime opportunity.

ARTICLE 8
LEAVE OF ABSENCE

Section 8.1 Authorized Leaves of Absence. For the time period indicated in each instance, not to exceed thirty (30) months except for Sections 8.1(c) and (d), leaves of absence (without pay except to the extent vacation credit or sick leave credit can be used and is used under and in accordance with Articles 16 and 17) shall be granted to an employee on the active payroll:

8.1(a) In case of accident or illness, for the period of time the injury or illness requires that the employee be absent from work. The Company may require satisfactory proof of such injury or illness.

8.1(b) In pregnancy cases, upon request of the employee or at such time as leave shall be mandatory under any applicable law.

8.1(c) For the period of time necessary to serve in the Armed Forces of the United States.

8.1(d) When he/she is appointed by the President or Directing Representative of the Union representing the particular unit, or selected to a full-time Union position, for the period of time necessary to fill such position.

8.1(e) The Company may grant leaves of absence without pay for other reasons that the Company considers valid. Should the request for Leave of Absence be rejected by the Company, the reason will be discussed with the employee.

8.1(f) Requests for leaves of absence must be made in writing to the Company and specify the reason for the absence.

Section 8.2 Return from Leave of Absence. An employee who applies for return from leave of absence on or before the expiration date of his/her leave will be returned in accordance with the following:

8.2(a) When an employee returns from a leave of absence that was granted due to industrial injury or industrial illness and is medically able to perform the job which was last held,

8.2(a)(1) The employee will be returned to the job and shift if this does not conflict with Article 12,

8.2(a)(2) If this does conflict with Article 12, the employee will be considered for any job that he/she is qualified and able to perform, or (if a surplus occurred that would have affected him/her during such leave) be subjected to surplusing procedures with Article 12.

8.2(b) When an employee returns from a leave of absence described in Section 8.2(a) and is not able to perform the job last held due to medical limitation, he/she will be considered for any job that he/she is qualified and able to perform, or (if a surplus occurred that would have affected him/her during such leave) be subjected to surplusing procedures, all in accordance with Article 12

8.2(c) When an employee returns from a leave of absence that was granted due to non-industrial injury or illness, and the period of the leave has not exceeded one year, and the employee is able to perform the job last held, the steps and procedures of subparagraphs 8.2(a)(1) and 8.2(a)(2), limitation will apply.

8.2(d) When an employee returns from a leave of absence described in Section 8.2(c) and is medically not able to perform the job which he/she last held due to medical limitation, he/she will be considered for any job which he/she is qualified and able to perform; otherwise, he/she may be placed on layoff, in accordance with Article 12.

8.2(e) If leave was granted due to nonindustrial injury or illness and the period of leave is in excess of one (1) year, the employee may be returned to the job title / classification last held providing there is an opening in such job title and placement in such opening is not inconsistent with Article 12; otherwise, he/she may be placed on layoff.

8.2(f) If leave was granted for military service, the provisions of applicable laws shall apply.

8.2(g) If leave, irrespective of length, was granted for any reason other than those stated in Sections 8.2(a) to 8.2(f) inclusive, the employee will be returned to the job title last held providing there is an opening in such job title and placement in such opening is not inconsistent with Article 12; otherwise, the employee may be placed on layoff.

ARTICLE 9
SAFETY

Section 9.1 Health and Safety. The Company will continue to make reasonable provisions for the safety and health of employees. The Company agrees to Union shall have the right to confer with the Company on matters pertaining to safety of the employees. The parties agree to meet no less than annually or as requested by either party to discuss and review safety issues and concerns.

Section 9.2 Requirement of Medical Examination. In the interest of continued safety of individuals and their fellow employees, any applicant for employment or any employee may be required through Government regulations or by the Company to undergo a medical examination by a doctor of the Company's selection. If the diagnosis or examination results furnished by the Company doctor are not satisfactory to the employee, he/she may obtain an opinion from his/her own doctor. If a disagreement still exists, an additional doctor, mutually agreed upon by the Company and the Union, will be retained for his/her opinion. The Company shall pay for the services of the mutually agreed upon doctor. The cost incurred for services of all other non-Company physicians shall be the sole responsibility of the employee who gave rise to the dispute.

Section 9.3. Safety Shoes. The Company will provide an annual allowance of $100.00 per calendar year to offset the cost of safety shoes to all employees who are required by management to wear safety shoes in the workplace.

ARTICLE 10
SEPARABILITY

Should any part hereof or any provision herein contained be rendered or declared invalid by reason of any existing or subsequently enacted legislation or by any decree by a court of competent jurisdiction, such invalidation of such part or portion of this Agreement shall not invalidate the remaining portions hereof and they shall remain in full force and effect.

The Company and the Union shall meet as soon as possible after the enactment of such legislation or decree to reestablish compliance.

ARTICLE 11
MISCELLANEOUS

Section 11.1 Sabotage. The Union agrees to report to the Company when it has knowledge of any acts of sabotage or damage to or the unauthorized or unlawful taking of Company, Government, customer or any other person's or employee's property. The Union further agrees, if any such acts occur, to use its best efforts in assisting to identify the guilty person or persons and notify the Company of its investigation.

Section 11.2 Security Clearance. Nothing in this Agreement shall require the Company to employ or continue to employ or give access to any of its facilities or work locations, any person or persons to whom the cognizant Security Agency, in the interest of security against espionage or subversive activity, refuses

to give access to classified information and/or work. However, the Company will give consideration to assigning an employee in his/her job title to an area for which he/she is qualified and a clearance is not required.

Section 11.3 Non-Discrimination. All terms and conditions of employment included in this Agreement shall be administered and applied without regard to race, color, religion, national origin, status as a disabled or Vietnam era veteran, age, sex, or the presence of a handicap except in those instances where age, sex or the absence of a handicap may constitute a bona fide occupational qualification. If administration and application of the contract is not in contravention of Federal laws, such administration shall not be considered discrimination under this Section 11.3.

Notwithstanding any other provision of Section 11.3 of this Agreement, a grievance alleging a violation of this Section 11.3 shall be subject to the grievance procedure and arbitration of Article 4 only if it is filed on behalf of and pertains to a single employee. Class grievances based on alleged violation of this Section 11.3 shall not be subject to the grievance procedure and arbitration under this Agreement.

Section 11.4 Successor and Assigns. This Agreement shall be binding upon and shall inure to the benefit of the parties hereto, their successors and assigns; but in the event the Company ceases to perform on the contract as identified in Article 1, the Company shall be released from all obligations on the project(s) so affected under this Agreement.

Section 11.5 Performance of Work. Supervisors and managers may perform the duties of employees in the bargaining unit, in emergency situations, or for the purpose of instructing employees. Managers and supervisors of instructor classifications can instruct classes for the purpose of maintaining proficiency. Supervisors or other non-represented employees are not to perform any unit work solely to prevent a unit employee from earning overtime.

Section 11.6 Bargaining Unit Status Report. A quarterly seniority list will be provided to the Union. The report will include the following information:

(a) Employee name

(b) Employee Number (BEMS ID)

(c) Job number and title

(d) Seniority date

(e) Employee's on active layoff

Section 11.7 Masculine - Feminine References. In construing and interpreting the language of this Agreement, reference to the masculine such as "he", "him", or "his" shall include reference to the feminine.

Section 11.8 Contributions to Machinists Nonpartisan Political League. Upon receipt by the Company of a signed voluntary authorization by an employee, on a form approved by the Company, requesting that there be deductions made from his/her wages, in a monthly amount designated by the employee, such deductions to be forwarded to the Union for use by the Machinists Nonpartisan Political League, the Company will thereafter make such deductions and forward them to the Machinists Nonpartisan Political League, in care of the Union. Such authorization will remain in effect for the duration of this Agreement, unless earlier canceled in writing by the employee.

Section 11.9 Contributions to Guide Dogs of America. Upon receipt by the Company of a signed voluntary authorization by an employee, on a form approved by the Company, requesting that there be deductions made from his/her wages, in a monthly amount designated by the employee, such deductions to be forwarded to the Union. Such authorization will remain in effect for the duration of this Agreement, unless earlier canceled in writing by the employee.

ARTICLE 12
WORK FORCE ADMINISTRATION

Section 12.1 Surplus Action.

12.1(a) In effecting a reduction in force within a job classification, the following procedure shall be followed. The first selection would be probationary employees, followed by voluntary layoff in the classification, followed by part time employees, then by full time employees in the classification in reverse seniority order.

12.1(b) Affected full time employees referenced in Section 12.1(a) will be offered the job classification immediately held prior to their present job classification in the bargaining unit at the site if their seniority permits.

Section 12.2 Recall From Layoff. Employees who are on active layoff status will be recalled in order of seniority.

12.2(a) Employees will be notified of recall in writing by certified mail to their last known address on the Company's records, with a copy to the Union, and the employee will be required to report to work within fourteen (14) calendar days following receipt of the written notice. Failure to do so will result in automatic loss of seniority and the employee will be terminated. It is the sole responsibility of the employee to keep the Company properly informed of his/her address and telephone number.

Section 12.3 Temporary Layoffs. When the Company determines it is necessary to reduce the number of employees working within a job classification, employees may be temporarily laid off for not more than fourteen (14) calendar days within a sixty (60) calendar-day period. Such layoff shall be in the reverse order of seniority. The Company agrees that the Union will be notified when possible in advance.

Section 12.4 Temporary Assignment. The Company may temporarily assign bargaining unit employees to perform work assignments described for other job classifications. A temporary assignment shall not be longer than sixty (60) calendar days unless extended by mutual agreement. If the temporary work falls within a higher rated job classification, the employee shall receive the higher rate of pay for the duration of the temporary assignment. This temporary assignment is not intended to displace bargaining unit employees at the site.

Section 12.5 The parties agree that employees from the other contractors, non-bargaining unit employees, or employees from other locations may from time to time be assigned to perform work identified in this Agreement. This temporary assignment is not intended to displace bargaining unit employees at the site.

ARTICLE 13
JURY AND WITNESS DUTY

Section 13.1 An employee absent from work due to required jury duty will be paid for such lost hours at his/her current straight time base rate, including shift differential where applicable, up to a maximum of eight (8) hours per day, for each regular workday the governmental body that summoned the employee for jury duty pays the employee. Employees will be paid eight (8) hours jury duty pay and will be excused from their scheduled shift if they serve more than four (4) hours on the day so assigned as a juror. All other employees must report for work provided there are more than four (4) hours available on their shift either prior to their scheduled report time for jury duty or after their release from jury duty (two (2) hours of this time will be considered as travel preparation time). Second and third shift employees summoned to jury duty will be temporarily assigned to first shift on a weekly basis during the time required to serve. Fees received for jury duty will not be deducted from such pay. The employee will furnish to the Company evidence satisfactory to the Company showing the performance of jury duty that meets the requirements of this Section 13.1

Section 13.2 An employee absent from work in order to comply with a subpoena as a witness in a federal or state court of law, will be paid for such lost hours at his/her current straight time base rate, including shift differential where applicable, up to a maximum of eight (8) hours per day, for each regular workday for which he/she is paid a daily witness fee. Employees will be paid eight (8) hours witness duty and will be excused from their scheduled shift if they serve more than four (4) hours on the day so serving as a witness. All other employees must report to work provided there are more than four (4) hours available on their shift either prior to their scheduled report time for witness duty or after their release from witness duty (two (2) hours of this time may be considered as travel preparation time). Witness fees will not be deducted from such pay. An employee is not entitled to such pay under this Section 13.2 in circumstances where the employee (1) is called as a witness against the Company or its interests; or (2) is called as a witness on his/her own behalf in an action in which he/she is a party; or (3) voluntarily seeks to testify as a witness; or (4) is a witness in a case arising from or related to his/her outside employment or outside business activities. The employee will furnish to the Company evidence satisfactory to the Company showing his/her attendance as a witness that meets the requirements of this Section 13.2.

ARTICLE 14
SHORT-TERM MILITARY DUTY

An employee who is a member of a reserve component of the Armed Forces, who is required to enter active annual training duty or temporary special services, shall be paid his/her normal straight time earnings, including differentials where applicable, up to a maximum of ten (10) workdays each United States Government fiscal year. The amount due the employee under this Article shall be reduced by the amount received from the government body identified with such training duty or services, for the period of such duty (up to the maximum period mentioned above). Such items as subsistence (does not include allowance for quarters), uniform and travel allowance shall not be included in determining pay received from state or federal government.

ARTICLE 15
RATES OF PAY

Section 15.1 Minimum Base Wage By Classification.

March			
Job Title	**May 2009**	**October 2009**	**October 2010**
Loadmaster Instructor	$40.90	$44.50	$46.06
Pilot Instructor	$39.91	$48.00	$49.68
Training Device Technician	$29.96	$37.89	$39.22
Resource Scheduler	$19.31	$19.89	$20.59

McChord			
Job Title	**May 2009**	**October 2009**	**October 2010**
Administrative Assistant	$16.95	$20.63	$21.35
Resource Scheduler	$23.77	$24.48	$25.34
Loadmaster Instructor	$39.09	$44.50	$46.06
Pilot Instructor	$39.59	$48.00	$49.68
Training Device Technician	$29.22	$37.89	$39.22
Logistics Specialist	$23.08	$23.08	$23.89

Travis			
Job Title	May 2009	October 2009	October 2010
Resource Scheduler	$19.31	$19.89	$20.59
Loadmaster Instructor	$40.11	$44.50	$46.06
Pilot Instructor	$40.61	$48.00	$49.68
Training Device Technician	$29.71	$37.89	$39.22

Base wages in Section 15.1 represent the minimum base wage paid in each classification for each site. The actual base wage to be paid for each employee who was on the active payroll upon ratification of the Collective Bargaining Agreement is specified in Appendix A. An employee's base wage shall not exceed the minimum base wage for their classification except where specified in Appendix A. Employees upon returning to work from an approved leave of absence or layoff shall be paid the greater of the base wage specified for them in Appendix A or the minimum base wage for their classification at their site in Section 15.1.

Employees affected by the following transactions shall receive the minimum base wage in Section 15.1 for their classification at their site.

1. New hires or rehires
2. Permanent transfers from any other Boeing site
3. Temporary Assignments to a classification with a higher base wage
4. Any reclassification within a site

If an employee is temporally assigned to a different site, they will retain the base wage of their home site.

Section 15.2 Lump Sum Payments. Lump sum payments shall be paid to employees in lieu of a general wage increase during the duration of this Agreement as detailed in Appendix A. In addition, any bargaining unit employee not listed in Appendix A shall receive a lump sum payment in lieu of a general wage increase in October, 2010 equal to the lump payment paid to other employees listed in Appendix A in their classification being paid the same base wage at that time.

To be eligible to receive a lump sum payment under this Section, employees must be on the active payroll or on an approved leave of absence for ninety (90) days or less on the effective date of the lump sum payment.

Employees who are temporally assigned to a higher rated classification or a different site shall receive lump sum payments subject to all the provisions herein and based on their regular classification at their home site, not in the classification or site they are temporarily assigned to.

Section 15.2 Paydays. For employees working in states where mandatory direct deposit is permitted by law, paychecks will be delivered via direct deposit on Thursday of every second week, covering all wages, including overtime, earned through Thursday of the preceding week, except when other circumstances intervening beyond the Company's control make such practice impossible. For employees working in other states, paychecks shall be delivered on or before Thursday of every second week, or placed in the U.S. mail on or before Tuesday of every second week, covering wages, including overtime, earned through Thursday of the preceding week, except when holidays or circumstances intervening beyond the Company's control make such practice impossible.

Section 15.3 Report Time/Call-In Time. If an employee reports for work in accordance with instructions he/she shall receive a minimum of four (4) hours pay at his/her base wage. Report time will not apply in

case of emergency shut down arising out of any condition beyond the Company's control. An employee who leaves work of his/her own volition, or because of incapacity (other than industrial injury), or is discharged or suspended after beginning work, will be paid only for the number of hours actually worked during that day. An employee that leaves work because of incapacity due to industrial injury will be paid eight (8) hours pay at this base wage.

Section 15.4 Effective Date of Increases. The actual date of all increases as identified in this Section will be the beginning of the first pay period following the effective date of change.

Section 15.5 Shift Differential. When an employee is assigned to the second shift, he/she shall receive a shift differential of fifty (50) cents per hour. When an employee is assigned to the third shift he/she shall receive a shift differential of seventy-five (75) cents per hour. Shift differentials are to be included in the calculation of overtime, vacation, sick leave, jury and witness duty, and short-term military duty.

Section 15.6 Pay Additives. Pay additives can be added and removed at the sole discretion of management and are not subject to the grievance and arbitration procedure. Pay additives are to be included in the calculation of overtime, vacation, sick leave, jury and witness duty, and short-term military duty.

15.6(a) Check Airman $1.25 per hour

15.6(b) Simulator Certification Pilot $1.25 per hour

15.6(c) Simulator Certification Loadmaster $1.25 per hour

15.6(d) Simulator Certification Training Device Technician $0.625 per hour

15.6(e) Lead pay $2.00 per hour

15.6(f) Instructors assigned to Formal Training Unit (FTU) $2.00 per hour

Section 15.7 Lead. The decision to create a lead position and the appointment of an employee to a lead shall be at the sole discretion of the Company and such rights shall not be subject to the grievance procedure. Management has the right to assign additional responsibilities to these employees selected over and above their current job responsibilities with exception of the following: recommendations concerning employment, release, transfer, upgrading or disciplinary action relative to other employees.

An employee so assigned in writing by the Company, a minimum of eight (8) hours shall be paid a premium of $2.00 per hour above his/her base wage. Lead pay is to be included in the calculation of overtime, vacation, sick leave, jury and witness duty, and short-term military duty.

ARTICLE 16
VACATIONS

Section 16.1 General. It is the policy of the Company to grant vacation to employees after each year of service. It is believed that a reasonable period of time away from the job is conducive to good health and well-being and can have a refreshing effect that is to the advantage of the Company as well as the employee. Accordingly, it is management's responsibility to give each eligible employee the opportunity to take a vacation each year. Every effort will be made to ensure that each employee uses all his/her vacation credits for time off within the period of time available to him/her.

Section 16.2 Accumulation of Credits.

16.2(a) Vacation credits will be awarded at the rate of 1/12 of their annual vacation each month on their vacation eligibility date in accordance with the schedule as listed in Section 16.4(a) of this Article. Credit will be given for the employee's total length of service which is continuous with the Company, and other predecessor contractors who performed similar work, and was determined to be a predecessor to the Company under the Service Contract Act.

16.2(b) Vacation credits will not be accumulated during period on layoff, strike, or after the first thirty (30) calendar days of a leave of absence. Such absence during a service year will reduce the vacation credit granted at the beginning of an employee's next vacation eligibility date. The reduction will be in proportion of 1/365th for each day of absence, rounded to the nearest one-tenth hour, of the hours applicable to the employee per the vacation schedule in Section 16.4(a) of this Article.

Section 16.3 Eligibility Conditions. The vacation eligibility date will be the date of last hire by the Company or predecessor contractor when service was continuous, or the most recent rehire date following a termination.

Section 16.4 Allowance for Use of Credits.

16.4(a) An employee who meets the requirements as set forth in Section 18.3 in this Article shall be eligible for vacation credits in accordance with the following:

VACATION SCHEDULE

Years of Service	Annual Vacation
1-4 years	10 days
5-11 years	15 days
12-13 years	16 days
14-15 years	17 days
16-17 years	18 days
18-19 years	19 days
20 + years	20 days

Section 16.5 Accumulative Credits. Vacation credits will accumulate in an employee's vacation account up to a maximum of two (2) times their current accrual rate. No additional vacation credits will be accrued or awarded until the number of credits in the account drops below this maximum.

Section 16.6 Use of Vacation Credits. Between eligibility dates, an employee shall use his/her unused vacation credit accumulated in the twelve (12)-month period preceding his/her last eligibility date as vacation with pay at the rate in effect at the time his/her vacation begins, including shift differential where applicable, subject to the following conditions:

16.6(a) He/she shall request vacation dates on forms provided by the Company and the Company will endeavor to schedule his/her vacation as requested.

16.6(b) In instances where Company management believes the awarding of vacations as requested would interfere seriously with production requirements, the scheduling of vacations shall be as near to the dates requested as possible.

16.6(c) In scheduling vacations, the Company will attempt to meet its production requirements by use of employees on a voluntary basis, and, failing in this, the seniors will be given their preference of available vacation dates to the extent established vacation schedules will permit.

16.6(d) There will be no pay-in-lieu of time off for vacation. The intent of this provision is to cause each employee to use the vacation credits awarded for time off.

16.6(e) Vacation may be used in minimum increments of one tenth (1/10) of an hour.

ARTICLE 17
SICK LEAVE

Section 17.1 Accumulation of Sick Leave.

17.1(a) Employees, on the active payroll their first year of employment shall earn sick leave credits at

the rate of eight (8) hours for each month worked not to exceed a maximum of forty (40) hours.

17.1(b) An employee who cycles on his/her sick leave eligibility date with unused sick leave credits available will continue to accumulate such credits from year to year, without limitation.

17.1(c) Sick leave credits will not be accrued during period on layoff, strike, or after the first thirty (30) calendar days of a leave of absence.

Section 17.2 Eligibility conditions.

17.2(a) The sick leave eligibility date is the date on which sick leave credits are awarded each year. The sick leave eligibility date of an employee shall be the date of last hire by the Company, which the exception of former employees who are rehired with reinstatement rights following military service or recalled from active layoff status, who will retain their previous sick leave eligibility dates.

17.2(b) An employee's sick leave eligibility date will not be affected by time spent on an approved leave of absence or other payroll classification.

Section 17.3 Use of Sick Leave.

17.3(a) An employee shall be eligible to use sick leave credits as soon as monthly credits have been awarded during his/her first year of employment. However, thereafter, an employee shall be eligible to use sick leave credits only when awarded such credits on each eligibility date or to the extent of available accumulated credits in his/her sick leave account. Payment for sick leave shall not exceed the regularly scheduled hours (excluding scheduled overtime) for any one day of absence.

17.3(b) Sick leave shall be granted under the following conditions:

1. Illness of employee.

2. Illness or death in the immediate family, i.e., spouse, mother, father, step-mother, step-father, mother-in-law, father-in-law, children, step-children, brother, sister, son-in-law, daughter-in-law, grandparents, and grandchildren.

3. Medical or dental appointments which can only be arranged during working hours. (Employees should be encouraged to arrange medical or dental appointments so as to avoid absence from work when reasonably practical.)

17.3(c) All sick leave payments must be approved by the employee's supervisor.

17.3(d) When sick leave cannot be charged because the employee has exhausted all sick leave credits and he/she is not yet eligible for an award of his/her next sick leave credits, the employee may use available vacation credits or be granted leave without pay.

17.3(e) Employees on leave of absence may use sick leave credits only if the leave is for medical reasons.

17.3(f) Sick leave may be used in minimum increments of one tenth (1/10) of an hour.

17.4 It is expressly agreed between the parties that the terms of this Agreement, and any accrual benefits are binding on any successor contractor or successor employer whether said successor takes over all or part of the operation. Specifically, but without limitation accrued but untaken sick leave shall continue as an obligation of any successor contractor or successor employer, and the employees covered by the Collective Bargaining Agreement shall continue to have their individual credit with said successor the full amount of sick leave accrued, and shall continue to accrue benefits of this article.

17.5 Bereavement Leave. Up to three (3) days bereavement leave with pay will be granted to an employee on the active payroll who, because of death in his/her immediate family, takes time off from work during his/her normal work schedule as such term is defined in Article 6 of this Agreement. Such pay shall be for eight (8) hours at his/her straight time base rate, including shift differential, for each such day off; however, such pay will not be applicable if the employee received pay for such days off under any other provision of this Agreement. Bereavement leave must be taken within the seven (7) days following the death, funeral or service. For the purpose of this Section, the "immediate family" is defined as follows: spouse, mother, father, mother-in-law, father-in-law, sister-in-law, brother-in-law, children, brother, sister, son-in-law, daughter-in-law, grandparents, spouse's grandparents, grandchildren, stepmother, stepfather, stepchildren, stepbrother, stepsister, half brother, and half sister. The Company will require proof of death. In addition, an employee will be granted bereavement leave for a stillborn child if the employee provides a certificate of fetal death which has been certified by the attending physician.

ARTICLE 18
HOLIDAYS

Section 18.1 The following holidays shall be observed by the bargaining unit personnel:

New Years Day
Martin Luther King Day
Presidents' Day
Memorial Day
Independence Day
Labor Day
Columbus Day
Veterans' Day
Thanksgiving Day
Christmas Day

*The actual date of observance will be determined by the customer.

Section 18.2 Unworked Holidays. Eligible employees shall receive eight (8) hours pay for unworked holidays (those holidays designated above), at their base rate in effect at the time the holiday occurs, plus shift differential, if applicable.

Section 18.3 Worked Holidays. Employees who are required to work on the above-named holidays shall receive the pay due them for the holidays plus double their base rate for all hours worked on such holiday, plus shift differential, if applicable, unless the employee starts to work at 10:30 p.m., or thereafter on that day.

Section 18.4 Holidays During Vacation. Should a holiday occur while an employee is on vacation, the employee shall be allowed to take one (1) extra day of vacation with pay in lieu of the holiday as such.

Section 18.5 Holiday Observance When Occurring on a Scheduled Day of Rest. When a holiday falls on an employee's scheduled day of rest, the holiday will be moved in accordance with the following:

18.5(a) If the holiday falls on the first day of rest, the last workday immediately proceeding the holiday will be observed as the holiday.

18.5(b) If the holiday falls on the second day of rest, the first workday immediately following the holiday will be observed as the holiday.

Section 18.6 Employees on Non-Regular Workweek. For those employees who regularly work Saturday and/or Sunday, receiving two (2) consecutive days off during the week, the two (2) days off shall be treated as "Saturday" and "Sunday," in that order, for the purpose of this Article 18. Should any of the holidays observed by the Company occur on such a "Sundays, the following day shall be considered as a

holiday for such employees: Should any of the holidays observed by the Company occur on such a "Saturday," the preceding day shall be considered as a holiday for such employees.

ARTICLE 19
GROUP BENEFITS

Section 19.1 Group Benefits Program for Employees on the Active Payroll. The Company will provide Group Life, Accidental Death and Dismemberment, Medical, Dental, and salary continuation disability benefits for eligible employees and Medical and Dental benefits for covered dependents of eligible employees effective the first of the month following one (1) full calendar month of employment. The Company-paid group benefits and optional, employee-paid Long Term Disability, Supplemental Life and AD&D Plans as described in the Summary Plan Descriptions for Boeing Aerospace Operations, Inc. salaried employees will be continued through December 31, 2010. Thereafter, the Company will provide the Group Life, Accidental Death and Dismemberment, Short-Term Disability, Medical benefits, and Dental benefits for eligible employees and Medical benefits and Dental benefits for covered dependents of eligible employees as summarized in the document entitled Attachment A, and an optional, employee-paid Supplemental Life Insurance plan.

Section 19.2 Cost of the Group Benefits Program for Employees on the Active Payroll. The Company will pay the full cost of Life, Accidental Death and Dismemberment, Short-Term Disability and Dental benefits for eligible employees on the active payroll. The Company also pays the full cost of the Dental Plan for eligible dependents. The Company and the employee share the cost of employee and dependent coverage under the Medical Plan.

19.2(a) Health Care and Insurance Cost

	2009	1/1/10	1/1/11	1/1/12
w/Traditional Medical Plan				
Employee	$ 433.70	$ 459.57	$ 495.33	$ 533.33
Emp + Spouse	$ 861.84	$ 913.57	$ 966.33	$1,040.33
Emp + Child(ren)	$ 874.25	$ 925.57	$ 978.33	$1,053.33
Emp + Family	$1,302.38	$1,379.57	$1,449.33	$1,562.33
w/Health Net HMO				
Employee	$ 439.13	$ 474.57	N/A	N/A
Emp + Spouse	$ 872.69	$ 942.57	N/A	N/A
Emp + Child(ren)	$ 885.40	$ 954.57	N/A	N/A
Emp + Family	$1,318.66	$1,423.57	N/A	N/A
w/PacifiCare HMO				
Employee	$ 494.33	$ 533.57	N/A	N/A
Emp + Spouse	$ 982.73	$1,061.57	N/A	N/A
Emp + Child(ren)	$ 995.14	$1,073.57	N/A	N/A
Emp + Family	$1,483.72	$1,601.57	N/A	N/A

19.2(b) Monthly Employee Medical Plan Contributions. The employee will contribute a fixed amount of the medical plan cost through December 31, 2010, as follows:

Employee Monthly Medical Plan Contributions		
	Traditional Medical Plan	Health Maintenance Organization
Employee	$ 56.34	$34.67
Emp + Spouse	$ 99.67	$56.33
Emp + Child(ren)	$ 99.67	$56.33
Emp + Family	$130.00	$88.67

Thereafter, the employee will contribute fifteen (15) percent of the applicable medical plan cost. The employee is required to contribute an additional $100.00 per month for medical coverage to enroll a spouse if the spouse is a full-time employee eligible for medical coverage under another employer-sponsored plan and waives such coverage. This $100.00 contribution will not be required for a spouse who waived coverage under another employer-sponsored plan prior to eligibility for medical coverage under the Group Benefits Program, provided the spouse enrolls at the other plan's next enrollment period or, if earlier, at an enrollment date allowed by the other plan.

19.2(c) Maintenance of Benefits. The above stated medical, dental and insurance plan costs referenced in Section 19.2(a) apply through December 31, 2010. As there may be increases in the cost or utilization of care during the term of this Agreement, in order to maintain the benefits of the Group Benefits Program, it may be necessary for the Plan Administrator to adjust appropriately Company contribution rates for subsequent years.

Section 19.3 Details and Method of Coverage. The benefits summarized in the Group Benefits Program shall be procured by the Company under contracts and/or administrative agreements with insurance companies or health care contractors which will be in the form customarily written by such carriers and administrative agents, and the Group Benefits Program shall be subject to the terms and conditions of such contracts and/or administrative agreements, consistent with the Plan Documents.

Such contracts and/or administrative agreements may require the carriers and/or administrative agents to develop various Programs designed to contain costs, based on those portions of the Group Benefits Program which contain the requirement that charges are covered only on the basis of medical necessity. Such cost containment programs or procedures may be utilized to determine the medical necessity of the treatment itself, the appropriateness of the services provided, the place of treatment or the duration of treatment.

These programs may include incentives for employees and dependents to use services of an approved Preferred Provider Organization. The carriers or administrative agents and Company will announce each such program or procedure before it is required or available to the affected employees. Any such cost containment program will not operate to reduce the benefits of such program to any covered person or to shift the costs covered under such program to the covered person. The failure of an insurance company or health care contractor to provide for any of the services or benefits for which it has contracted shall result in no liability to the Company, nor shall such failure be considered a breach by the Company of the obligations which it has undertaken by this Agreement. However, in the event of any such failure, the Company shall immediately attempt to provide substitute coverage.

Section 19.4 Flexible Spending Accounts. The Company will provide employees with the option of making pre-tax contributions to a health care spending account and/or a dependent care spending account.

Section 19.5 Administration. The Group Benefits Program shall be administered by the insurance companies, health care contractors or administrative agents with whom the Company enters into contractual relationships for the purpose of providing and/or administering the coverage contemplated by the Group Benefits Program and no question or issue arising under the administration of such Group Benefits Program or the contracts and/or administrative agreements identified therewith shall be subject to the grievance procedure or arbitration provisions of Article 4 of this Agreement.

Section 19.6 Copies of Policies to be Furnished to Union. Copies of the policies, contracts and administrative agreements executed pursuant to this Article 19, Group Benefits, shall be furnished to the Union upon request. The coverages and benefits indicated in the Group Benefits Program, the rights of eligible employees in respect to such coverages, and the settlement of all claims arising out of such coverages shall be in accordance with the provisions, terms and rules set forth in such policies, contracts or administrative agreements.

Section 19.7 Federal or State Programs. If during the term of this Agreement, there is mandated by federal or state government a program that affords to employees covered by this Agreement similar benefits (such as but not limited to medical and dental benefits) to those that are afforded by this Agreement, benefits afforded by this Agreement shall be replaced by such federal or state program. The Company will comply with the provisions for the furnishing of such program to the extent required by law. No question or issue regarding the level of benefits under the state or federal program will be subject to the grievance and arbitration procedure of Article 4.

ARTICLE 20
SAVINGS PLAN

Section 20.1 Continuation of Plan. Subject to the continuing approval of the Commissioner of Internal Revenue and of other cognizant governmental authorities, as more particularly hereinafter specified, and to the provisions of Section 20.4, the BAO Voluntary Savings Plan (hereinafter called the Plan), for all employees within the unit to which this Agreement relates. The Plan shall continue to be effective while this Agreement is in effect as to such employees in accordance with and subject to the terms, conditions and limitations of the Plan. Throughout this Agreement, words which are capitalized shall have the same meaning and application as such are defined and applied in the Plan.

Section 20.2 Approval of Plan. Approval of the Plan by the Commissioner of Internal Revenue as referred to in Section 20.1 means a continuing approval sufficient to establish that the Plan is at all times qualified and exempt from income tax under Section 401(a), Section 401(k) and other applicable provisions of the Internal Revenue Code of 1986, and that contributions made under the Plan are deductible for income tax purposes in accordance with law. The cognizant governmental authorities referred to in Section 20.1 include, without limitation, the Department of Labor and the Securities and Exchange Commission, and their approval means their confirmation with respect to any matter within their regulatory authority that the plan does not conflict with applicable law.

Section 20.3 Continuation Beyond Agreement. The Company shall not be precluded from continuing the Plan in effect as to employees within the unit to which this Agreement relates after expiration or termination of this Agreement, subject to the terms, conditions, and limitation of the Plan.

Section 20.4 Principal Eligibility, Participation and Contributions to the Plan. The BAO Voluntary Savings Plan incorporates the following provisions:

20.4(a) Eligibility. All employees within the unit to which this agreement relates shall be eligible for the Plan.

20.4(b) Participation Requirements. Participation in the Plan is automatic. Eligible employees will become Members of the Plan on their date of hire. Employees will be automatically enrolled at a rate of four (4) percent of base pay on a pretax basis sixty (60) days after becoming eligible. Employees may elect to opt out or enroll at a different percentage of base pay at any time after becoming eligible, in accordance with the plan provisions and procedures.

20.4(c) Retirement Contributions. Each pay period, the Company will contribute to the Plan in a separate account on behalf of each eligible employee an amount equal to three and six-tenths (3.6) percent of the employee's base salary for the payroll period. These contributions will be fully vested (non-forfeitable). Participants will not be eligible for a retirement contribution while on unpaid leave (i.e., educational leave, military leave, personal leave, or other forms of unpaid leave). Retirement contributions will continue during leave under the Family Medical Leave Act (FMLA) or while on weekly disability.

20.4(d) Member Elective Contributions.

20.4(d)(1) Plan Members may elect to defer from 1 (one) to 25 (twenty-five) percent of their base pay to the Plan into an Elective Account on a pretax basis, an after tax basis, or a combination of

both, not to exceed twenty-five (25) percent each payday. Base pay, as defined in the Plan, means a Member's base wage or salary from the Company including retroactive base wage adjustments and shift differential, if applicable, but will not include overtime pay, equivalency pay, bonus, per diem or other special compensation that is in addition to "base rate." The Member's percentage rate of Elective Contributions in effect on the date a retroactive wage adjustment is paid will determine the amount of any additional contributions to the Plan.

20.4(d)(2) In the event that the total amount of all Elective Contributions made under this Plan or similar plans sponsored by the Company would contravene the provisions of Sections 401(k)(3) or 401(m) of the Internal Revenue Code, the elections of those persons who are highly compensated as defined in Section 414(q) of the Internal Revenue Code shall be reduced, in accordance with the terms of the Plan, to that level which will cause the average deferral percentage for this group to not exceed the maximum percentages permitted under 401(k)(3) and 401(m) of the Code. If a Member's election is reduced in accordance with this Section, his or her total compensation for each payroll period shall be reduced only by the amount of the reduced election.

20.4(d)(3) The total amount of a Member's Contributions in any calendar year may not exceed the dollar maximum provided by Section 415 of the Internal Revenue Code.

20.4(e) Company Matching Contributions. The Company shall contribute to a Company Account on behalf of each Member. Such contribution shall be equal to fifty (50) percent of the first eight (8) percent on the Member's contribution.

20.4(f) Investment of Contributions. A Member's Elective contributions will be invested as directed by the Member into one or more of the investment funds offered through the Plan. The investment of the Member's Company matching contributions and retirement contributions will follow the Member's Elective contribution investment direction.

20.4(g) Vesting. Members shall be one hundred (100) percent vested in their Pretax Account, After Tax Account, Retirement Account, Company Match Account and Rollover Account at all times.

20.4(h) Expense Payments. Fees and expenses associated with the investment of fund assets, plan administration, and trustee fees shall be payable out of the trust.

20.4(i) Minimum and Maximum Fund Participation. Members may allocate their contributions in one (1) percent increments across the plan's investment funds.

Section 20.5 Required Plan Amendments. The Company reserves the right to amend the plan to satisfy all requirements of Section 401(a), Section 401(k) or any other applicable provisions of the Internal Revenue Code of 1986.

Section 20.6 Member Elective Contributions Not Applicable For Other Purposes. It is acknowledged that the election of a Member to convert a portion of his or her base pay under the term of the Plan will be effective for purposes of this Plan and will reduce the Member's compensation insofar as certain payroll taxes may be applicable. However, for all other employment related purposes, including all of the Member's rights and privileges under this labor Agreement, his or her base pay or compensation will be considered as though no election had been made.

Section 20.7 Plan Updates. The parties agree that innovations in technology and administrative practices can give plan participants better access to information about their benefits, increased investment options, timely online transaction capability, and enhanced administrative features. Accordingly, when the Company identifies administrative services that in its estimation reflect industry best practices, the Employee Benefit Plans committee has discretion to adopt these changes to the Plan. The Company will notify the Union in advance of implementation of any changes adopted by the employee Benefit Plans Committee.

ARTICLE 21
DURATION

This Agreement shall become effective as of April 4, 2009, and shall remain in full force and effect until midnight, May 20, 2011, and shall automatically be renewed for consecutive periods of one (1) year thereafter (after May 20, 2011), unless either party shall notify the other in writing, at least sixty (60) days, but not more than seventy-five (75) days prior to May of any calendar year, beginning with 2011, of its desire to terminate the Agreement, in which event this Agreement shall terminate at midnight at the close of such May 20 unless renewed or extended by mutual written agreement. In the case of such notice, the parties agree to meet immediately thereafter for the purpose of negotiating a new Agreement or a written renewal of this Agreement.

SIGNATURES OF THE PARTIES

IN WITNESS WHEREOF, the Company and the Union have caused this Agreement to be signed by their authorized representatives.

Dated this 4th day of April, 2009

International Association of Machinists and Aerospace Workers, AFL-CIO

Mark A. Blondin
IAM&AW Aerospace Coordinator

Ray Moffatt
IAM&AW Aerospace Coordinator

Robert M. Martinez
Directing Business Representative

Catarino A. Rodriguez
March Negotiating Committee

James L. Schneller
McCord Negotiating Committee

Richard A. Clark
McCord Negotiating Committee

Stephen C. Rainey
McCord Negotiating Committee

David R. Mendez
Travis Negotiating Committee

The Boeing Company

Thomas A. Easley
Director Labor Relations

R. Tracy Mead
Program Manager C-17 ATS

Robert E. Snook
Operations Manager C-17 ATS

Shelley E. Dixon
HR Generalist C-17 ATS

John Tulak III
HR Generalist BAO

Appendix A
RATES OF PAY

Section A.1 Wage Rates and Lump Sum Payments.

March						
ID #	**New Classification**	**April 1, 2009**	**May 2009**	**Oct 2009**	**Oct 2010**	**Lump Sum 2010**
1	Loadmaster Instructor	$39.71	$40.90	$44.50	$46.06	$0
2	Loadmaster Instructor	$40.53	$41.74	$44.50	$46.06	$0
3	Pilot Instructor	$38.75	$39.91	$48.00	$49.68	$0
4	Pilot Instructor	$39.71	$40.90	$48.00	$49.68	$0
5	Pilot Instructor	$39.95	$41.14	$48.00	$49.68	$0
6	Pilot Instructor	$40.00	$41.20	$48.00	$49.68	$0
7	Pilot Instructor	$40.79	$42.02	$48.00	$49.68	$0
8	Pilot Instructor	$40.80	$42.02	$48.00	$49.68	$0
9	Training Device Technician	$29.09	$29.96	$37.89	$39.22	$0
10	Training Device Technician	$29.11	$29.98	$37.89	$39.22	$0
11	Training Device Technician	$31.24	$32.18	$37.89	$39.22	$0
12	Training Device Technician	$33.65	$34.66	$37.89	$39.22	$0
13	Training Device Technician	$33.73	$34.74	$37.89	$39.22	$0
14	Resource Scheduler	$18.75	$19.31	$19.89	$20.59	$0

McChord						
ID #	**New Classification**	**April 1, 2009**	**May 2009**	**Oct 2009**	**Oct 2010**	**Lump Sum 2010**
1	Administrative Assistant	$16.46	$16.95	$20.63	$21.35	$0
2	Resource Scheduler	$23.08	$23.77	$24.48	$25.34	$0
3	Loadmaster Instructor	$37.96	$39.09	$44.50	$46.06	$0
4	Loadmaster Instructor	$37.96	$39.09	$44.50	$46.06	$0
5	Loadmaster Instructor	$39.18	$40.36	$44.50	$46.06	$0
6	Loadmaster Instructor	$40.77	$41.99	$44.50	$46.06	$0
7	Loadmaster Instructor	$40.87	$42.09	$44.50	$46.06	$0
8	Loadmaster Instructor	$43.46	$44.76	$44.76	$46.06	$600
9	Pilot Instructor	$38.44	$39.59	$48.00	$49.68	$0

McChord						
ID #	New Classification	April 1, 2009	May 2009	Oct 2009	Oct 2010	Lump Sum 2010
10	Pilot Instructor	$38.44	$39.59	$48.00	$49.68	$0
11	Pilot Instructor	$38.56	$39.71	$48.00	$49.68	$0
12	Pilot Instructor	$38.61	$39.76	$48.00	$49.68	$0
13	Pilot Instructor	$38.65	$39.81	$48.00	$49.68	$0
14	Pilot Instructor	$38.99	$40.16	$48.00	$49.68	$0
15	Pilot Instructor	$38.99	$40.16	$48.00	$49.68	$0
16	Pilot Instructor	$39.71	$40.90	$48.00	$49.68	$0
17	Pilot Instructor	$39.71	$40.90	$48.00	$49.68	$0
18	Pilot Instructor	$39.76	$40.95	$48.00	$49.68	$0
19	Pilot Instructor	$39.90	$41.10	$48.00	$49.68	$0
20	Pilot Instructor	$39.90	$41.10	$48.00	$49.68	$0
21	Pilot Instructor	$40.10	$41.30	$48.00	$49.68	$0
22	Pilot Instructor	$40.24	$41.45	$48.00	$49.68	$0
23	Pilot Instructor	$41.63	$42.88	$48.00	$49.68	$0
24	Pilot Instructor	$42.16	$43.43	$48.00	$49.68	$0
25	Pilot Instructor	$42.16	$43.43	$48.00	$49.68	$0
26	Pilot Instructor	$42.26	$43.53	$48.00	$49.68	$0
27	Pilot Instructor	$42.36	$43.63	$48.00	$49.68	$0
28	Pilot Instructor	$43.65	$44.96	$48.00	$49.68	$0
29	Pilot Instructor	$44.47	$45.81	$48.00	$49.68	$0
30	Pilot Instructor	$44.54	$45.88	$48.00	$49.68	$0
31	Training Device Technician	$28.37	$29.22	$37.89	$39.22	$0
32	Training Device Technician	$28.37	$29.22	$37.89	$39.22	$0
33	Training Device Technician	$29.57	$30.45	$37.89	$39.22	$0
34	Training Device Technician	$29.96	$30.86	$37.89	$39.22	$0
35	Training Device Technician	$30.02	$30.92	$37.89	$39.22	$0
36	Training Device Technician	$30.04	$30.94	$37.89	$39.22	$0
37	Training Device Technician	$30.05	$30.95	$37.89	$39.22	$0
38	Training Device Technician	$30.29	$31.20	$37.89	$39.22	$0
39	Training Device Technician	$31.01	$31.94	$37.89	$39.22	$0
40	Training Device Technician	$31.25	$32.19	$37.89	$39.22	$0
41	Training Device Technician	$31.95	$32.91	$37.89	$39.22	$0
42	Training Device Technician	$34.13	$35.16	$37.89	$39.22	$0
43	Training Device Technician	$35.34	$36.40	$37.89	$39.22	$0
44	Training Device Technician	$35.67	$36.74	$37.89	$39.22	$0

Travis						
ID #	**New Classification**	**April 1, 2009**	**May 2009**	**Oct 2009**	**Oct 2010**	**Lump Sum 2010**
1	Resource Scheduler	$18.75	$19.31	$19.89	$20.59	$0
2	Loadmaster Instructor	$38.94	$40.11	$44.50	$46.06	$0
3	Loadmaster Instructor	$40.05	$41.25	$44.50	$46.06	$0
4	Loadmaster Instructor	$40.38	$41.60	$44.50	$46.06	$0
5	Loadmaster Instructor	$40.63	$41.84	$44.50	$46.06	$0
6	Pilot Instructor	$39.42	$40.61	$48.00	$49.68	$0
7	Pilot Instructor	$39.47	$40.66	$48.00	$49.68	$0
8	Pilot Instructor	$39.66	$40.85	$48.00	$49.68	$0
9	Pilot Instructor	$39.90	$41.10	$48.00	$49.68	$0
10	Pilot Instructor	$40.14	$41.35	$48.00	$49.68	$0
11	Pilot Instructor	$40.26	$41.47	$48.00	$49.68	$0
12	Pilot Instructor	$40.63	$41.84	$48.00	$49.68	$0
13	Training Device Technician	$28.85	$29.71	$37.89	$39.22	$0
14	Training Device Technician	$28.87	$29.74	$37.89	$39.22	$0
15	Training Device Technician	$29.35	$30.23	$37.89	$39.22	$0
16	Training Device Technician	$31.88	$32.83	$37.89	$39.22	$0
17	Training Device Technician	$33.41	$34.42	$37.89	$39.22	$0
18	Training Device Technician	$33.46	$34.46	$37.89	$39.22	$0

LETTER OF UNDERSTANDING #1

Joint Company - Union Alcohol and Drug Dependency Program

The Union recognizes the Company's policy to maintain a drug and alcohol free workplace, and to comply with laws and regulations addressing that subject. The Company will implement drug and alcohol testing (a) to the extent necessary to comply with said laws and regulations and (b) to the extent the Company otherwise believes it necessary to achieve a drug- and alcohol-free workplace.

The Company and Union have agreed to use a balanced approach to achieving a drug- and alcohol-free workplace. A central component of that approach is the intent to help employees overcome substance abuse problems through a comprehensive Employee Assistance Program. To that end, the Company agrees to provide employees who have verified positive tests an opportunity for rehabilitation, except where termination for independent reasons is appropriate.

Nothing in this letter shall be construed as limiting the Company's right to impose discipline for cause in substance abuse related cases (or the implementation of any drug testing programs the Company deems appropriate.) The Union reserves the right to grieve the question of whether the Company's program is consistent with this letter.

Mark A. Blondin
IAM&AW Aerospace Coordinator

Thomas A. Easley
The Boeing Company

LETTER OF UNDERSTANDING #2

SHAREVALUE PROGRAM

The Boeing Company and the Union agree that all eligible represented employees may participate in the Boeing ShareValue Program (also known as the ShareValue Trust) for the duration of this Agreement. The parties agree that the Company's success depends upon the ability to return long-term value to its shareholders. The intent of this program is to help inform employees about what makes a business run and produces shareholder value, and to allow employees to share in the results of their efforts to increase shareholder value.

Employees will be eligible to participate in accordance with the governing provisions of the ShareValue Program as set forth in the official Program documents. In the event of any conflict between this Letter of Understanding and the official ShareValue Program documents, the official ShareValue Program documents will prevail in every case.

Eligible participants will proportionally share in a ShareValue Trust distribution based on the number of months they were eligible to participate during any investment period falling within the term of this Agreement or any preceding Agreement that provided for their participation in the ShareValue Program.

Mark A. Blondin
IAM&AW Aerospace Coordinator

Thomas A. Easley
The Boeing Company

LETTER OF UNDERSTANDING #3

SPECIAL BENEFIT ALLOWANCE
(For those employees opting out of the Group Benefit coverage)

This letter is intended to describe an employee's options relative to enrollment in the Company Benefits Package, employee contributions described in Article 19, and the special benefit allowance as negotiated in the Collective Bargaining Agreement between the Union and the Company.

All eligible employees automatically participate in a Company-funded retirement account that includes an optional pretax savings feature, life, accidental death and dismemberment and weekly disability plans, and PTO/sick leave program. Eligible employees may purchase benefits for which they and their dependents are eligible for as described in the Company Benefits Package. The Company will provide a pay additive to assist employees to purchase these benefits from an alternate source. (The rate is $1.76 per paid straight time hour, not to exceed **$**140.80 per two (2)-week pay period.) The pay additive is paid for that period of time that the Company Benefits Package would otherwise be available as an eligible employee on the active payroll who elected benefits.

New employees and current employees may elect the Company Benefits Package when initially offered. If the employee declines the initial opportunity to purchase the Company Benefits Package, later application may be made during a change in status described by the Plan. However, enrollment in the Life Plan will require evidence of insurability subject to approval by the life insurance Company, which may include the requirement for a physical examination at the expense of the employee.

Mark A. Blondin
IAM&AW Aerospace Coordinator

Thomas A. Easley
The Boeing Company

LETTER OF UNDERSTANDING #4

MACHINIST CUSTOM CHOICES WORKSITE BENEFITS PROGRAM

This Agreement acknowledges that The Boeing Company has agreed to allow the International Association of Machinists and Aerospace Workers to offer the Machinists Custom Choices Worksite Benefits program of supplemental life insurance, long-term disability insurance and cancer insurance to its members in the bargaining unit through their designated agent, Employee Benefit Systems, Inc. (EBS). Furthermore, the Parties agree that if any other product from EBS is added as a benefit for other IAM-represented employees of Boeing, then they will meet and confer on adding those products for employees covered by this Agreement. It is understood that all policyholder service will be provided by the underwriter and EBS and that members will be given an opportunity annually to spend up to fifteen (15) minutes with an EBS Counselor off site during off hours. This service will begin as soon as practicable. It is understood that the Company is not the plan sponsor and is not responsible for plan administration, enrollment, or communication.

It is further agreed as a condition of offering this payroll deduction service that EBS will comply with Company Payroll administration and procedures that will include the following basic requirements:

Each participating employee will complete a Deduction Authorization card that contains the employee's name, social security number, deduction name(s) or type(s), employee signature, and date.

Information affecting account activity, including, but not limited to enrollment, policy cancellations, deduction changes, premium rate changes, and other changes affecting the employee deduction amount, must be received by Boeing Payroll by the 20th of the month proceeding the month in which the deduction will be effective.

Any deduction amount not collected due to lack of earnings, will be the responsibility of EBS. Boeing payroll will not collect amounts in arrears or provide an account reconciliation service.

Deductions will be made from the employee's first paycheck each month.

Mark A. Blondin
IAM&AW Aerospace Coordinator

Thomas A. Easley
The Boeing Company

LETTER OF UNDERSTANDING #5

GROUP BENEFITS – PART-TIME

Employees on part-time work schedules of twenty (20) to thirty-two and nine-tenths (32.9) hours per week will be offered a group benefits package as shown in the table below. Healthcare and insurance benefits will not be available for part-time work schedules of less than twenty (20) hours per week. All employees are eligible to participate in the BAO VSP (a 401k plan) no matter how many hours worked per week and will receive a retirement contribution based on actual base pay received.

Sick leave, vacation, holidays and other pay practices will be in accordance with Company policy for nonexempt employees.

Benefit	**Part Time Benefits**
Healthcare Coverage	Full benefits. Employee pays medical plan contribution based on a full benefit plus thirty (30)% of full healthcare premium.
Short Term Disability	Benefit is based on twenty (20) hours per week regardless of actual work schedule. (Company paid)
Basic Life Insurance	Full benefit. (Company paid)
Supplemental Life (Optional)	Full benefit amount elected by employee. (employee paid)
Accidental Death and Dismemberment	Full benefit. (Company paid)
BAO Voluntary Savings Plan (401k Plan)	Eligible on date of hire. May contribute up to twenty-five 25% of base pay pretax and/or after tax. Enrolled automatically within sixty (60) days after hire date at four (4)% pretax, but encouraged to actively enroll sooner and at a higher percentage to receive the maximum company match. Company provides a three and six-tenths (3.6)% automatic retirement contribution and fifty (50)% Company match on employee's first eight (8)% of base pay contributed. All company contributions are immediately one hundred (100)% vested.
Business Travel Accident	Full benefit. (Company paid)

Mark A. Blondin
IAM&AW Aerospace Coordinator

Thomas A. Easley
The Boeing Company

HEALTH AND INSURANCE PLANS
ATTACHMENT A

CONTENTS

Eligibility

Eligible Employees

You are eligible for the Package if you are an active Boeing Aerospace Operations, Inc. C-17 Program employee represented by the International Association of Machinists and Aerospace Workers, AFL-CIO. 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 (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) who are under age 25, 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 partner live in the same permanent residence in a permanent, exclusive, emotionally committed, and financially responsible relationship similar to a marriage.
  - Your partner is at least 18 years old, is not related to you by blood, is not married to or separated from another person, and is not involved in another domestic partner relationship.
  - Your domestic partner relationship is not solely to obtain coverage under the Plan.

  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 25 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 25, 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, or a spouse or same-gender domestic partner. You must provide Human Resources with any required supporting documentation by the date specified by Human Resources or your request will be denied.

Special Provisions When Family Members Are Boeing Employees

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 25 or older continues to be eligible (or enrolled if you are a newly eligible employee) if a physician documents that the child is incapable of self-support due to any mental or physical condition that began before age 25. 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 may continue under the medical and dental plans for the duration of the disability as long as you continue to be eligible and enrolled in the plans and the child continues to meet these eligibility requirements.

Special applications for coverage are required for disabled dependent children age 25 or older.

Enrollment

Disability, Life, and Accident Plans

You automatically are enrolled in the Short-Term Disability Plan, Basic Life Insurance Plan, and AD&D Plan when eligible. You will receive a Beneficiary Designation form for completion.

Medical Plan

The Company provides the Traditional Medical Plan to employees and eligible dependents, which offers enhanced benefits when a network provider is used.

You receive enrollment instructions at the time of employment and may elect medical coverage during the first 31 days of employment. You may waive medical coverage for yourself and eligible dependents; otherwise, you may be enrolled automatically.

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 him or her until the earlier of:

- The next annual enrollment period.
- The date the 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 Plan

The Company offers coverage under the Network Dental Plan to employees and eligible dependents. You receive enrollment instructions at the time of employment and may elect dental coverage during the first 31 days of employment. You may waive coverage for yourself and eligible dependents; otherwise, you may be enrolled automatically.

Annual Enrollment Period

The Company establishes an annual enrollment period when you may add or drop medical and/or dental coverage for yourself and eligible dependents.

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. If you or your dependent reaches the lifetime limit under a Company plan, and you are eligible for another Company plan in your area, you and your dependents may enroll in that other 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 the medical and/or dental plan as described above. You can enroll in any family status tier and any health plan option available to you.

Special 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 partnership, 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.
- 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, legal separation, 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 partnership, birth, adoption, or placement for adoption, you must call Human Resources. You must provide Human Resources with any required supporting documentation by the date specified by Human Resources 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 1 full month of continuous employment.
- Short-term disability, basic life insurance, and AD&D coverage becomes effective on the first day of the month following 1 full month of continuous employment, provided you are actively at work on that date.

You must be on the active payroll on the effective date for coverage to begin.

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.

Short-Term Disability Plan

The Company provides disability income coverage for you under the Short-Term Disability Plan. You are eligible for a weekly benefit if you become totally disabled as a result of an accidental injury or illness, including a pregnancy-related condition while covered under this plan.

Benefits

Following the waiting period (if any), you receive a weekly benefit based on your weekly base salary, according to the schedule of benefits below.

Short-Term Disability Benefit Schedule			
In the Event of:	**Benefits Begin on the:**	**Benefit Amount:**	**For a Maximum Period of:**
An accidental injury	First day of disability	60% of weekly base salary, to a maximum of $350	26 weeks
A hospital confinement	First day of disability	60% of weekly base salary, to a maximum of $350	26 weeks
A nonoccupational illness, including pregnancy-related conditions	Fourth day of disability	60% of weekly base salary, to a maximum of $350	26 weeks
Note: If you are absent for a period of 4 or more consecutive days due to a disability resulting from an outpatient surgery in a hospital or surgical facility, benefits will be retroactive to the first day of your disability.			

Benefits under the Short-Term Disability Plan are determined using the weekly base salary reflected in Human Resources records when the disability first begins. For part-time employees, short-term disability benefits are determined using the average weekly base salary actually earned for the 6 weeks immediately preceding the date of disability. There is no minimum benefit payment under the Short-Term Disability Plan.

If you are actively at work and your weekly base salary either increases or decreases, the coverage amount (the weekly benefit for which you may be eligible) automatically changes on the first of the month following or coinciding with the date Human Resources is notified of the change in salary. If you are not actively at work on the day the coverage change is to become effective, the effective date of the new coverage amount is delayed until the first of the month following or coinciding with the day you return to work for 1 full day. Any retroactive change in weekly base salary does not retroactively change the disability coverage amount under this plan. If the period of disability has started, a change in weekly base salary does not change the benefit amount.

Total Disability

To be eligible for short-term disability benefit payments, you must be totally disabled and under the continuous care of a legally qualified, licensed physician throughout the period of total disability. Totally disabled means you are unable to perform the material duties of your own occupation or other appropriate work the Company makes available.

In addition, the service representative may require the employee to be examined by a physician of its choice as often as reasonably necessary to verify continuous total disability.

All determinations of total disability are made by the service representative within the terms of its contract with the Company.

Benefit Payment Period

Benefits begin as shown in the Short-Term Disability Benefit Schedule and continue while you are disabled, up through the 26th week of disability. You must submit a claim to the service representative and meet any waiting period requirements before benefits will be paid. Any retroactive amounts are paid as soon as the claim is approved.

You receive benefit payments as shown in the schedule while totally disabled. Benefits stop when you no longer are disabled, at the end of the maximum benefit period, or at death, whichever occurs first.

Separate Periods of Disability

A period of disability ends and benefit payments under the Short-Term Disability Plan stop when you no longer are disabled for 1 full day. If you have a second period of disability, the cause of the second disability and the length of recovery time between disability periods will determine whether it is treated as a temporary recovery (a continuation of the first disability claim) or as a separate disability claim.

Recovery is considered temporary if, within 30 consecutive days of your return to work, you are absent as a result of the same or a related disability.

The following provisions apply to periods of temporary recovery:

- No new waiting period (if any) applies.
- The weekly base salary used to determine initial short-term disability benefits does not change.
- No short-term disability benefits are paid for the period of temporary recovery.
- You may be eligible for any benefits remaining from the original 26-week period.

The second period of disability is considered a separate disability claim if you have returned to work for 1 full day and:

- It is due to a different cause than the first disability period.
- It is due to the same cause or causes but the recovery lasted longer than the allowable temporary recovery time limits.
- The first period of disability began before you were covered under the Short-Term Disability Plan.

You must submit a claim to the service representative and meet the waiting period requirements (if any) before benefits will be paid.

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 your 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.

Exclusions

The Short-Term Disability Plan does not cover any disability directly or indirectly caused by:

- Occupational injury or illness.
- Intentionally self-inflicted injury (while sane or insane).
- Committing, or attempting to commit, an assault, battery, or felony.
- War or any act of war (declared or not declared). The plan does, however, pay for disabilities caused by an act of war while you are traveling on business for the Company.
- Insurrection, rebellion, or taking part in a riot or civil commotion.
- Military duty other than temporary active duty of fewer than 31 days.

You are not considered disabled, and no benefits are paid for, any day of confinement in a penal or correctional institution for conviction of a crime or other public offense.

When an Injury or Illness Is Caused by the Negligence of Another—Disability

In some situations, you or a covered dependent may be eligible to receive, as a result of an accident or illness, disability 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 disability income replacement, 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 disability, 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 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.

Basic Life Insurance Plan

The basic life insurance coverage amount equals $25,000. The total amount is payable in the event of your death from any cause at any time or place while covered under the plan. Payment is made in a lump sum or by issuance of a checkbook to the designated beneficiary. You may change beneficiaries at any time by submitting a Beneficiary Designation form to Human Resources.

If you become totally disabled while covered under the Basic Life Insurance Plan and before age 60 from any cause, the basic life insurance benefit will remain in force until you recover. If such a disability begins between ages 60 and 65, coverage will continue until the earlier of your recovery or attainment of age 65. Proof of disability must be furnished within 12 months of the date active work ends. If you recover but do not return to work, all coverage terminates. You may then convert the total amount of basic life insurance coverage under the conversion of coverage provision.

If you become terminally ill while covered under the Basic Life Insurance Plan, you may request an accelerated death benefit of up to 50% of the basic life insurance benefit with a $5,000 minimum. Upon approval of the request by the service representative, the benefit will be paid in a lump sum. When the request is approved, the amount of basic life insurance then in effect is reduced by the amount of the accelerated death benefit. After the reduction, you cannot apply for an individual conversion policy with respect to the amount of basic life insurance received as an accelerated death benefit.

AD&D Plan

AD&D benefits are provided if your loss of life, paralysis, or loss of eyesight, speech, or hearing is caused by a covered accident (including an occupational accident) that occurs while you are covered under the plan.

Benefits

The full principal sum, $25,000, is paid to the 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%

Loss	Percentage of Principal Sum
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.

"Loss" of a limb means the loss of an entire arm or entire leg.

"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 AD&D 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.

Exposure and Disappearance

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.

Exclusions

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 that is intended to cause injury, damage, or fear and that is committed by or purportedly committed by 1 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 are provided for the loss.

Traditional Medical Plan Schedule of Benefits

The Traditional Medical Plan is available to active employees and their dependents.

This section shows general plan features of the Traditional Medical Plan, including benefit amounts and other plan information. See the Traditional Medical Plan Summary of Covered Medical Services and Supplies for benefit details.

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

Traditional Medical Plan Schedule of Benefits The Traditional Medical Plan is administered by Regence BlueShield (the service representative).		
	Network	**Nonnetwork**
Plan Features		
Annual Deductible	$350 per individual; $1,050 per family of 3 or more, but not more than $350 for any individual	$700 per individual; $2,100 per family of 3 or more, but not more than $700 for any individual; nonnetwork charges apply toward the network deductible
Coinsurance	90%	60%
Annual Out-of-Pocket Maximum (in addition to the annual deductible)	$5,000 per individual; $15,000 per family of 3 or more, but not more than $5,000 for any individual	See network provisions
Lifetime Maximum Benefit	$1,500,000 per individual (network and nonnetwork combined)	
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 to Participate in the Network	The plan covers services and supplies at 80%; you can call the service representative to find out which types of providers are network providers in a particular location; benefit payments are based on usual and customary charges	

Traditional Medical Plan Schedule of Benefits The Traditional Medical Plan is administered by Regence BlueShield (the service representative).		
	Network	**Nonnetwork**
Covered Services and Supplies	90% after deductible for most covered network services and supplies, except as shown below	60% after deductible for most covered nonnetwork services and supplies, except as shown below
Ambulance	90%	See network provisions
Christian Science Sanatorium	90%; limits apply	See network provisions
Durable Medical Equipment	80%	See network provisions
Emergency Room		
• Medical Emergency	90% after $50 copayment (waived if you are admitted as an inpatient immediately after emergency room care)	See network provisions
• All other treatment	90% after $50 copayment	60% after $50 copayment
Hearing Aids	90% 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	60% 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
Home Health Care	90%	60%
Hospice Care	100%; limits apply	See network provisions
Hospital Services and Supplies	90%	60%
Mental Health Treatment (including eating disorders)		
• Covered Inpatient, Partial Hospital, Residential, or Intensive Outpatient Services	90% when referred by Boeing behavioral health manager	60% when *not* referred by Boeing behavioral health manager; up to 20 days per benefit year
• Covered Outpatient Services	90% when referred by Boeing behavioral health manager	60% when *not* referred by Boeing behavioral health manager; up to 20 visits per benefit year
Preventive Care		
• Routine Physical Examinations (for employees, spouses or same-gender domestic partners, and children age 2 and older)	100% (deductible does not apply) up to $500 maximum per person per benefit year, including related office visits, laboratory and X-ray charges as well as childhood and adult immunizations and vaccines, excluding travel vaccines, as recommended by the U.S. Preventive Services Task Force (USPSTF) guidelines, including the applicable catch-up immunization schedule for children ages 2 through 18 as recommended by the USPSTF guidelines; deductible and coinsurance apply after $500 limit Limited to 1 examination per child every benefit year for age 2 through age 18 Limited to 1 examination per person every 3 benefit years for age 19 through age 34, then 1 examination per person every benefit year	Not covered when received in the network service area

Traditional Medical Plan Schedule of Benefits The Traditional Medical Plan is administered by Regence BlueShield (the service representative).		
	Network	**Nonnetwork**
• Routine Physical Examinations (for children to age 2)	100% (deductible does not apply) Limited to 8 examinations from birth to age 2 Immunizations and vaccines, excluding travel vaccines, as recommended by the U.S. Preventive Services Task Force (USPSTF) guidelines and as recommended by the physician, including the applicable catch-up immunization schedule for children age 4 months to 2 years as recommended by the USPSTF guidelines	Not covered when received in the network service area
• Routine Pap Tests, Mammograms, Prostate Screenings, and Colorectal Screenings (including colonoscopies)	100% (deductible does not apply) Covered as recommended by the physician	Not covered when received in the network service area
Prostheses	80%; $500 annual maximum for hair prostheses if hair loss is a result of chemotherapy or radiation therapy	See network provisions
Skilled Nursing Facility	100%	100%
Spinal and Extremity Manipulations	90%; limited to 26 visits for spinal and extremity manipulations combined per year (network and nonnetwork combined)	60%; limited to 26 visits for spinal and extremity manipulations combined per year (network and nonnetwork combined)
Substance Abuse Treatment		
• Covered Inpatient, Partial Hospital, Residential, Intensive Outpatient, or Outpatient Services	90% when referred by Boeing behavioral health manager; $7,500 maximum per course of treatment Limit 2 courses of treatment lifetime maximum (network and nonnetwork combined)	60% when *not* referred by Boeing behavioral health manager; $2,500 maximum per course of treatment (accrues toward the $7,500 network maximum) Limit 2 courses of treatment lifetime maximum (network and nonnetwork combined)
Temporomandibular Joint Dysfunction and Myofascial Pain Dysfunction Syndrome (TMJ/MPDS) Treatment	50% up to $3,500 lifetime maximum	
Therapies (outpatient and inpatient)		
Neurodevelopmental Therapy (for children age 6 and under)	90% up to $1,000 each benefit year (network and nonnetwork combined)	60% up to $1,000 each benefit year (network and nonnetwork combined)

Traditional Medical Plan Schedule of Benefits The Traditional Medical Plan is administered by Regence BlueShield (the service representative).		
	Network	**Nonnetwork**
Occupational, physical, and speech therapy	90%; limited to 60 combined visits per benefit year (network and nonnetwork combined)	60%; limited to 60 combined visits per benefit year (network and nonnetwork combined)

Prescription drug benefits are shown in Traditional Medical Plan Prescription Drug Program. Vision care benefits are shown in Traditional Medical Plan Vision Care Program.

Annual Deductible

The annual deductible amount applies to all covered network and nonnetwork services and supplies except preventive care, vision care, and prescription drugs.

Copayment

A copayment applies to emergency room visits, mail-order prescription drugs, and routine vision examinations.

Out-of-Pocket Maximum

For most 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:

- Annual deductibles.
- Any balance remaining after you reach a benefit maximum.
- Any difference between the usual and customary charge and the provider's actual charge.
- Covered charges for
  - Mental health and substance abuse treatment.
  - Preventive care.
  - Routine vision care and eyewear.
  - TMJ/MPDS treatment.
- Covered services that are paid in full or paid at 100% of usual and customary charges.
- Emergency room copayments.
- Mail-order prescription drugs.
- Services or supplies that are paid at a reduced amount or denied if you do not meet medical review program procedures and requirements.
- Services or supplies that the plan does not cover.

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 Traditional Medical Plan Schedule of Benefits
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 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.

All mental health and substance abuse treatment must be authorized by the behavioral health manager. Emergency hospital admissions must be reported and authorized within 48 hours of the admission. Nonemergency admissions and outpatient services must be authorized in advance. If you or your provider does not obtain authorization, the plan will not cover any charges for mental health or substance abuse treatment. If authorization is obtained after treatment is provided (except the first 48 hours of an emergency admission), covered services will be paid at the nonnetwork level of benefits, even if you use a network provider.

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.

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.

Traditional Medical Plan Summary of Covered Medical Services and Supplies

Covered 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.

Ambulatory Surgical Facility

The plan covers charges of an ambulatory surgical facility for treatment of a covered condition provided the services would be covered if received in a hospital. Charges of hospital-based facilities are covered as hospital services. Charges of approved free-standing facilities are covered as hospital alternatives.

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 or third 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 true 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 true 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 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 Traditional Medical Plan Schedule of Benefits.

Hemodialysis

The plan covers repetitive hemodialysis treatment for chronic, irreversible kidney disease. Covered services and supplies include the rental or lease of hemodialysis equipment.

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 physician must review the treatment plan at least once every 2 months and certify that your condition and treatment continue to meet home health care criteria.

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). The physician must review the treatment plan at least once every 2 months and certify that your condition and treatment continue to meet home health care criteria.

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 visits of 2 or more hours to provide temporary relief to family members and friends who care for the patient, up to 120 hours every 3 months.

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.
- Mental health and substance abuse treatment.

See Medical Review Program for more information.

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 Program

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

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

Mental Health Treatment Coverage The plan covers medically necessary mental health treatment from any provider contracted with the 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 abuse, coverage is provided solely under substance abuse provisions.

Substance Abuse Treatment Coverage The plan covers medically necessary alcoholism treatment and other types of substance abuse 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 abuse 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 abuse 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 Traditional Medical Plan Schedule of 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 service representative will review the therapy periodically. 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.

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 or third 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 abuse 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.
- 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. 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, copayment, 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 preventive care services 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.) See the Traditional Medical Plan Schedule of Benefits for details.

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 the 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

The 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. Multiple spinal and extraspinal manipulations performed by hand during the same visit are considered 1 manipulation visit. Related services, such as an initial examination and initial X-rays, also are covered.

Substance Abuse Treatment

See Mental Health and Substance Abuse 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.

TMJ/MPDS treatment must be approved in advance in accordance with written guidelines.

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 the 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.

Covered donor expenses are applied against the recipient's lifetime maximum benefit.

Vasectomy and Tubal Ligation

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

Wigs

The plan covers wigs (or hair prostheses) if hair loss is a result of chemotherapy or radiation therapy.

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.
- 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.
- Experimental or investigational services or supplies or related complications.
- Full-body computerized axial tomography (CAT) scans or other full-body imaging.
- 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.
  - Hearing aids ordered before you become eligible for coverage or after coverage terminates.
  - Hearing aids ordered before coverage ends 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 or providers that are not included in the written home health care or hospice agency treatment plan and are not medically necessary.
- Infertility services or supplies that result in artificial means of conception.
- 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.
- Inpatient psychiatric care to control or change the patient's environment.
- Intentionally self-inflicted injury, unless it results from a medical condition.
- Missed appointments.
- 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, orthopedic appliances, and braces.
- Prescription drugs unless covered as part of a hospital stay; see Traditional Medical Plan Prescription Drug Program 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.
- Routine physical examinations, immunizations, or other preventive services or supplies, except as specifically provided by the plan.
- 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 the 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.

- Services received from a naturopath or massage therapist, unless he or she meets one of the physician licensing requirements previously described and is acting within the scope of that license.
- Sex transformation treatment or services.
- 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.
- Tobacco cessation services and supplies, except prescription drugs that are covered under the prescription drug program.
- 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.

Traditional Medical Plan Prescription Drug Program

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

- Retail pharmacy card program—you can use the pharmacy card to facilitate reimbursement when you 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 (see Pharmacy Management) to help ensure cost-effective, clinically appropriate treatment.

Schedule of Benefits

Traditional Medical Plan Prescription Drug Program Schedule of Benefits The prescription drug program is administered by Medco Health Solutions, Inc. (the service representative).			
	Generic	**Brand-Name Formulary**	**Brand-Name Nonformulary**
Participating Retail Pharmacy (up to a 30-day supply)	90%*	80%*	70%*
Mail Service Program (Medco By Mail; up to a 90-day supply)	$10 copayment*	$40 copayment*	$70 copayment*
* The annual deductible does not apply.			

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 per prescription or refill.

Mail Service Program

The 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.

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

Certain dosages, quantities, and medications require preapproval by the service representative. Specific drugs are reviewed by the service representative at the point of sale to determine if your prescription is covered by the plan, clinically appropriate, and consistent with usage guidelines.

The service representative applies standards based on FDA-approved labeling and clinical guidelines. The service representative will seek to ensure that you receive the most appropriate prescription for your condition by reviewing:

- Possible interactions with other current prescriptions.
- Cost-effectiveness.
- Whether the prescription is age appropriate.
- Whether the dosage and quantity are appropriate.

In certain situations, it may be more clinically appropriate to take a stronger dose once a day than to take a lower dose twice a day. If this opportunity exists, the service representative may ask your physician to approve the changes to the dosage and strength before authorizing payment with your pharmacist.

Should a drug require preapproval, your physician will be required to furnish the service representative with clinical information. You, the pharmacy, or the physician may initiate the request for this review by calling the service representative.

Generic Incentive Program

To encourage the use of generic drugs, if a brand-name drug is purchased when a chemically 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/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/copayment for the brand-name drug. If coverage is not approved, coverage will be provided according to the generic incentive program.

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 quantity prescribed 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 prescription purchased at a nonparticipating pharmacy or nonnetwork mail-order program.
- Any service or supply otherwise excluded by the Traditional Medical Plan or the 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.
- 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 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 and the medication is authorized in advance by the service representative.
- 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.

Traditional Medical Plan Vision Care Program

Schedule of Benefits

Traditional Medical Plan Vision Care Program Schedule of Benefits The vision care program is administered by Vision Service Plan (VSP, the service representative).	
Services and Supplies	**VSP Plan**
Eye Examinations	Paid in full after $15 copayment for 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*
* 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 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.	

Accessing the VSP Network

VSP features a national network of licensed optometrists and ophthalmologists. These providers have contracted with VSP to provide vision care services and supplies. Although you may receive care from any covered licensed provider, the program offers certain advantages when using a network provider.

Network providers offer discounts on complete pairs of prescription glasses and on contact lens examinations (evaluation and fitting). The program pays the network provider the amounts shown in the Schedule of Benefits. You pay the excess over those amounts. Network providers also submit claims to the service representative.

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 above):

- 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.

Benefit Payment Levels

See the Schedule of Benefits 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). 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 2-set limit.

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, VSP network providers will offer discounts for refractive surgery.)
- Orthoptics or vision training or any associated supplemental testing. (However, the medical plan may cover this for children under age 12.)
- Plano lenses (less than a ± 0.38 diopter power), nonprescription glasses, 2 pair of glasses instead of bifocals, or extra charges for progressive lenses in excess of the bifocal allowance.
- Services or supplies not listed as covered expenses.
- Services or supplies received from network providers more than 60 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 or cleaning products for glasses or contact lenses.
- Special supplies, such as nonprescription sunglasses or subnormal vision aids.

Network Dental Plan Summary

The Network Dental Plan described in this section is available to active employees and their dependents. This plan helps you and your covered dependents pay for minor and major dental work, including routine examinations, crowns, and orthodontia.

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. If you use a nonnetwork dentist, your out-of-pocket costs generally will be higher. If you live outside of the network service area, the plan generally will cover dental care at the network benefit level.

Network Dental Plan Schedule of Benefits

Network Dental Plan Schedule of Benefits The Network Dental Plan is administered by Delta Dental (the service representative).		
	Network	**Nonnetwork***
Annual Deductible	$50 per individual; $150 per family of 3 or more, but not more than $50 for any individual	$75 per individual; $225 per family of 3 or more, but not more than $75 for any individual

Network Dental Plan Schedule of Benefits The Network Dental Plan is administered by Delta Dental (the service representative).		
	Network	**Nonnetwork***
Coinsurance Percentage		
• Class I (diagnostic and preventive services)	100% (deductible does not apply)	80%
• Class II (minor restorations)	80%	50%
• Class III (major restorations)	60%	50%
• Class IV (orthodontia services)	50% (network and nonnetwork combined; deductible does not apply)	
Annual Maximum Benefit (for Classes I, II, and III)**	$2,000 per individual (network and nonnetwork combined)	
Lifetime Maximum Benefit (for Class IV)***	$2,000 per individual (network and nonnetwork combined)	
1. *If your provider is not a Delta Dental member, you pay any amounts that exceed the maximum allowable fees recognized by the plan 2. ** 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.) 3. *** This lifetime maximum benefit for orthodontia applies to all periods during which the person is covered under any Company-sponsored dental plan. 4. **Note:** The plan reimburses 100% of a network provider's recognized fees for prompt repair of damage to sound natural teeth as a direct result of accidental bodily injury.		

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

Annual Deductible

Generally, the annual deductible is the amount you must pay out of your own pocket each year before the plan begins to pay benefits for Class I services received from a nonnetwork provider and for all (network and nonnetwork) Class II and III services. The following services and supplies are excluded from the annual deductible:

- Class I services and supplies received from network providers.
- Class IV services and supplies received from network or nonnetwork providers.

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

The 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. A coinsurance percentage does not apply to:

- Class I services and supplies received from network providers.
- Any amounts you pay for services and supplies 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 the 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 member dentist who is a nonnetwork dentist, recognized fees are the fees that the dentist filed with the service representative for specific dental services and supplies. The service representative approves these fees and agrees to pay the plan's nonnetwork benefit based on them.
- For a nonmember dentist, recognized fees are the lesser of either
  - The amount charged by the dentist, or
  - The maximum allowable fee that the service representative approved for member 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 will cover the more expensive procedure according to the appropriate benefit payment level.

Three Classes of Providers

The Network Dental Plan covers the charges of any licensed dental provider. The level of coverage is highest for network providers.

- Network providers are members of Delta Dental and participate in the Delta Dental preferred provider network in your state.
- Nonnetwork member providers are members of Delta Dental, but do not participate in the preferred provider network.
- Nonmember providers are not members of Delta Dental.

Covered Dental Services and Supplies

The Network Dental Plan covers the following 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

The plan covers the following Class I services and supplies:

- Diagnostic examinations, including
  - Biopsy/tissue examinations (also called histopathic examinations).
  - Complete mouth or panographic X-rays, once in each 5-year period.
  - Emergency examinations.
  - Examinations by a specialist (if the specialty is recognized by the American Dental Association and if you are not receiving treatment from the specialist), up to 3 times in a 6-month period.
  - Routine examinations, twice in each 1-year period.
  - Comprehensive oral examinations, once in a 3-year period, which count toward 1 of the 2 routine examinations in a year.
  - Supplementary bitewing X-rays, once in each 1-year period.
- Preventive care, including
  - Fissure sealants through age 14 for permanent molars with intact occlusal surfaces, no decay, and no prior restorations. The plan covers repair or replacement within a 3-year period as part of the original service.
  - Prophylaxis (cleaning), either regular or periodontal maintenance, twice in each 1-year period; 2 additional cleanings are allowed if periodontal disease is present.
  - Space maintainers when used to maintain space for eruption of permanent teeth.
  - Topical application of fluoride or preventive therapies (such as flouridated varnishes), twice in each 1-year period for dependent children through age 18.

Class II Covered Services and Supplies

The plan covers the following Class II services and supplies:

- Endodontics for the following procedures once in each 2-year period on the same tooth:
  - Pulpal and root canal treatment.
  - Pulpotomy and apicoectomy.

  For more information on root canals performed in connection with an overdenture, see Class III Covered Services and Supplies.
- General anesthesia or intravenous sedation, but not both, when administered by a licensed dentist in connection with covered endodontic, oral, or periodontic surgery.
- Oral surgery, including
  - Preparation of the alveolar ridge and soft tissues of the mouth to insert dentures.
  - Surgical and nonsurgical extractions.
  - Treatment of pathological conditions and traumatic facial injuries.
- 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.
  - Osseous surgery, once in each 3-year period per area.
  - Root planning, once per area every 2 years.
  - Site-specific therapies for patients with pockets of at least 5 mm but not more than 10 mm.
- Restorative services
  - If a tooth can be restored with filling material but you or your dentist chooses a crown, inlay, or onlay, the plan will cover up to the amount for a filling to repair the condition. (For more information on restorations using crowns, inlays, and onlays, see Class III Covered Services and Supplies.)
  - Restoration of a visibly decayed hard tooth surface (carious lesion) to a state of proper function using filling materials (amalgam, composite, plastic, or glass ionomer) or a stainless steel crown for primary teeth once in each 2-year period. If a posterior tooth is restored with composite, plastic, or glass ionomer, the plan will cover the cost up to the amount allowed for a tooth to be restored with amalgam.

- Use of a crown as an abutment to a partial denture only when the tooth is decayed to the extent a crown would be required whether or not a partial denture is required.

Class III Covered Services and Supplies

The plan covers the following Class III services and supplies:

- Prosthodontics, including:
  - Cast chrome or acrylic partial denture. If a more elaborate or precision device is used, the plan covers up to the appropriate amount for covered partial dentures.
  - Crown buildups when approved by the service representative, once in each 2-year period.
  - Denture adjustments and relines provided more than 6 months after initial placement. Later relines and jump rebases (but not both) are covered once in each 1-year period. Denture adjustments are covered twice in a 1-year period.
  - Fixed bridge.
  - 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 treatment in conjunction with overdentures is limited to 2 teeth per arch.
  - Replacement of an existing prosthetic device once in each 5-year period if it is unserviceable and cannot be made serviceable. (Services to correct the device, if serviceable, are covered.)
  - Stayplate dentures for replacing anterior teeth during the healing period, or in children age 16 or younger for missing anterior permanent teeth.
- Use of a crown as an abutment to a partial denture only when the tooth is decayed to the extent a crown would be required whether or not a partial denture is required.

Class IV Covered Services and Supplies

Orthodontic services and supplies are in Class IV. The plan covers:

- Nightguards and occlusal splints.
- Straightening of teeth, including correction or prevention of malocclusion.

To facilitate benefit payments, your orthodontist or you should submit the treatment plan to the service representative before treatment starts.

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 (unless administered in connection with certain covered endodontic, oral, or periodontic surgery procedures), 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, 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.
  - Restorations on the same surface or surfaces of a tooth within 2 years of the original service.
  - 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 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.
  - 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 period after the date coverage would otherwise end. These services and supplies and the conditions for extending care are described below if the dentist started the course of treatment *before* your coverage ends:

- 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 and the crown is installed during the 31 days after your coverage ends.
- 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 31 days after your coverage ends.
- Orthodontia care will be extended for 31 days at the time coverage ends if services began before the initial coverage ended.
- Restorative, endodontic, periodontic, and oral surgical procedures completed within 31 days after your coverage ends.

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 Traditional Medical Plan is secondary, it adjusts benefits so that the total payable under both plans for expenses covered under the Traditional Medical Plan is not more than would be payable under the Traditional Medical 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 Traditional Medical 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 Traditional Medical Plan provides secondary coverage.

Network Dental Plan

Benefits payable under this 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 Network Dental Plan pays first when dental expenses performed by a dentist also are covered by any medical plan sponsored by the Company.

The Network 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.

No benefits are payable under this provision unless the charges were incurred in connection with a dental service or treatment.

When an Injury or Illness Is Caused by the Negligence of Another—Health Care

In some situations, the employee 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 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 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

Short-Term Disability Coverage

Short-Term disability coverage ends on the date your employment terminates.

Basic Life Insurance Coverage

Basic life insurance coverage ends on the date your employment terminates.

Within 31 days after you terminate employment, by making application and paying the first premium to the service representative, you may convert basic life insurance coverage to an individual whole life insurance policy. This individual policy will be issued, without medical examination, at the service representative'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 Basic Life Insurance Plan are continued because of 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 will be payable equal to the amount you could have converted to an individual policy.

AD&D Coverage

AD&D coverage ends on the date your employment terminates.

Medical Coverage

Medical coverage for you and your dependents ends at the end of the calendar month your employment terminates or the end of the last month required contributions are paid, whichever occurs first. If earlier, your dependent's coverage ends 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.

- In case of layoff, medical coverage for you and your dependents continues until you are covered by any other group medical plan either as an employee or as a dependent, but in no event beyond 3 months after the date of layoff.
- If you die (other than from an industrial accident), medical coverage continues for your eligible dependents until the earlier of 12 months after your death or when your dependents become covered by any other group medical plan.

- If you die from an industrial accident, medical coverage continues for you eligible dependents until the earlier of 36 months after your death or when your dependents become covered by any other group medical plan.

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 also is 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 ends at the end of the calendar month in which you terminate employment. If earlier, your dependent's coverage ends at the end of the calendar month in which the dependent no longer qualifies as a dependent.

- If you die (other than from an industrial accident), dental coverage continues for your eligible dependents until the earlier of 12 months after your death or when your dependents become covered by any other group dental plan.
- If you die from an industrial accident, dental coverage continues for your eligible dependents until the earlier of 36 months after your death or when your dependents become covered by any other group dental plan.

Change in Eligible Class of Employment

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

Continuation of Medical and Dental Coverage (COBRA)

If medical and dental coverage for you and your dependents 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.

- Reduction in hours or termination of employment for any reason.
- Your death.
- Your divorce.
- 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.

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, AD&D, short-term disability, 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, AD&D, 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, AD&D, short-term disability, 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 continues 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 you change directly from an approved nonmedical leave to an approved medical leave, or from an approved medical leave to an approved nonmedical leave, coverage provided with Company contributions under 1 type of leave reduces the coverage period provided with Company contributions through the other type of leave.

Successive Periods of Leaves of Absence

Two medical leaves of absence separated by fewer than 30 days of continuous work are considered 1 leave of absence unless the second leave is due to entirely unrelated conditions.

Definitions

- **Actively at work** means you are attending to your normal duties at the assigned place of employment. On a holiday, vacation day, weekend day, or other regularly scheduled day off, actively at work means you are not ill, injured, or otherwise disabled or confined to a hospital or similar institution, and are performing the normal activities of a person of your gender and age.
- **Allowable expenses** (Network Dental Plan) means any recognized fees incurred during a year and while eligible for benefits under the Network Dental Plan, part or all of which would be covered under any plan.
- **Allowed charge** (Traditional Medical Plan) means the amount that would have been paid for like services or supplies to a network provider or participating pharmacy who has a participation agreement with the service representative.
- **Benefit year** means January 1 through December 31, annually.
- **Birthing center** means a facility for normal delivery operating under the direction and control of the licensing or regulatory agency in its location.
- **Christian Science sanatorium** means 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.
- **Company-sponsored plan** means a group health care or dental plan approved by The Boeing Company or one of its subsidiaries or affiliates for its employees and dependents. This includes the Traditional Medical Plan and Network Dental Plan.
- **Custodial care** means care that does not require the continuing services of skilled medical or health professionals and is primarily to assist patients in activities of daily living, including 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 and preparation of special diets, and supervision of medications that are ordinarily self-administered.

- **Dentist** means a legally qualified dentist practicing within the scope of his or her license.
- **Emergency** means the sudden, unexpected onset of serious illness or severe injury that could result in (or a prudent person would have reason to believe could result in) death, permanent damage or impairment of bodily function, or loss of limb use if not treated immediately. For mental health coverage, a situation is also considered an emergency when there is imminent danger to you or others, or you are medically compromised as a result of mental illness or substance abuse.
- **Experimental nature** (vision care program) means a procedure or lens that is not used universally or accepted by the vision care profession, as determined by the service representative.
- **Experimental or investigational service or supply** (Traditional Medical Plan) means a service or supply that meets at least 1 of the following criteria:
  - It requires approval by the Food and Drug Administration or other government agency, which approval has not been granted when the service or supply is ordered.
  - It has been classified by the national Blue Cross and BlueShield Association as experimental or investigational.
  - It is under clinical investigation by health professionals.
  - It is not generally recognized by the medical profession as tested and accepted medical practice.

  However, a service or supply will not be considered experimental or investigational if it is part of an approved clinical trial. An approved clinical trial is one that meets each of the criteria in either Category 1 or 2 below.
  - Category 1
    1) The trial has been approved by the National Institutes of Health, the Food and Drug Administration, the Department of Veterans Affairs, or a research center approved by the plan's service representative.
    2) The trial has been reviewed and approved by a qualified institutional review board.
    3) The facility and personnel have sufficient experience and training to provide the treatment or use the supplies.
  - Category 2
    1) The trial is to treat a condition that is too rare to qualify for approval under Category 1.
    2) The trial has been reviewed and approved by a qualified institutional review board.
    3) The facility and personnel have sufficient experience and training to provide the treatment or use the supplies.
    4) The available clinical or preclinical data provide reasonable expectation that the trial treatment will be at least as effective as noninvestigational therapy.
    5) There is no therapy clearly superior to the trial treatment.
- **Experimental service or supply** (Network Dental Plan) means a service or supply whose use and acceptance as a course of dental treatment for a specific condition are still under investigation or observation. To determine whether services are experimental, the plan, using American Dental Association guidelines, will consider if the services:
  - Are in general use in the local dental community.
  - Are under continued scientific testing and research.
  - Show a demonstrable benefit for a particular dental condition.
  - Are proven to be safe and effective.
- **Home health aide** means an individual employed by a home health care agency or a hospice agency who provides, under the supervision of a registered nurse or physical or speech therapist, part-time or intermittent personal care, ambulation and exercise, household services essential to health care at home, and assistance with medications ordinarily self-administered; reports on changes in patients' conditions; and completes appropriate records.

- **Home health care agency** means a public or private organization that administers and provides home health care, and is either Medicare certified or operating under the direction and control of the licensing or regulatory agency in its location.
- **Home health (or hospice) care treatment plan** means a written program for continued care and treatment by the patient's attending physician. This plan must be reviewed and the continued need for care must be certified by a physician at least every two months.
- **Hospice agency** means a public or private organization that administers and provides hospice care, and is either Medicare certified or operating under the direction and control of the licensing or regulatory agency in its location.
- **Hospital** means an accredited institution licensed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a general hospital.
- **Mail service prescription drug program** means a mail service prescription company approved by the service representative to provide services under an arrangement with the service representative.
- **Medically necessary service or supply** means one that, as determined by the service representative, meets the following criteria. 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 Illness** means a disorder (including an eating disorder) that exhibits signs, symptoms, history, and other characteristics congruent with those required for a mental disorder diagnosis as enumerated in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM IV).
- **Network** means a group of health care providers approved by the service representative as meeting criteria for efficient care delivery and performing services under a contract with the service representative. The service representative may designate certain health care providers and facilities as network providers for specific medical services through a "centers of excellence" program.
- **Network provider** means a physician, hospital, or other health care provider who is a member of a network.
- **Nurse** means 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.
- **Participating pharmacy** means a pharmacy that has an agreement with the service representative to accept payments in excess of the prescription drug copayment as payment in full for covered prescription costs.
- **Physical therapist or occupational therapist or speech therapist** means a qualified physical, occupational, or speech therapist licensed in the jurisdiction where his or her services are rendered and practicing within the scope of that license. In locations without licensing requirements, the physical therapist must be certified by the American Physical Therapy Association, the occupational therapist must be certified by the American Occupational Therapy Association, and the speech therapist must be certified by the American Speech and Hearing Association.
- **Physician** (Traditional Medical Plan) means 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.

- **Physician** (Short-Term Disability Plan) means a legally qualified, licensed physician with a course of treatment that is consistent with the diagnosis of the disabling condition according to guidelines established by medical, research, and rehabilitation organizations.
- **Physician's assistant** means a person duly licensed in the area where his or her services are performed and practicing within the scope of such license.
- **Plan administrator** means the Boeing Employee Benefit Plans Committee.
- **Precertification** means prospective review and evaluation of proposed elective hospital, substance abuse treatment facility, and skilled nursing facility admissions as well as home health and hospice care by qualified health care professionals. This evaluation, which uses accepted medical criteria to determine medical necessity and whether treatment could be given in a less intense setting, may include:
  - Length of stay review: A process that begins during precertification review in which medical professionals indicate the number of inpatient days medically appropriate for the proposed admission or certify medical necessity of the intensity or type of services received for home health or hospice care. Follow-up reassessments and extensions are made as medically warranted.
  - Concurrent review: Ongoing review while the patient is undergoing treatment in the hospital, or receiving care from a home health care agency or hospice agency.
  - Discharge planning: Discharge planning is designed to identify patients who could be discharged early if appropriate arrangements are made for covered alternative care.
  - Retrospective review: Retrospective review includes all the steps of precertification review, but after services are rendered. Retrospective review occurs when the medical review program (or referral service for the treatment of mental illness and substance abuse) is not contacted before treatment.

  The role of the reviewing organization is to advise on medical appropriateness. The patient and physician decide on the treatment actually performed. Medical review affects payments under the Traditional Medical Plan as specified under Traditional Medical Plan Schedule of Benefits.
- **Principal support** means you and/or your current or former spouse provide more than half the financial support for your child. (In determining this, you can exclude any scholarships for study at a regular educational institution unless the child is not your natural child, adopted child, or stepchild.) In most cases, if you claim the child as a dependent on your annual Federal taxes, then you provide principal support for the purposes of eligibility for these plans.

  If you have never been married to the other parent of your child, then you must provide more than half the support for your child, regardless of the other parent's support. If you are divorced from the other parent of your child, special rules apply; contact your tax adviser. You also may want to review Internal Revenue Service Publication 502, *Medical and Dental Expenses*.
- **Prosthetic appliance** means a denture, partial denture, fixed or removable bridge, crown used as a bridge abutment, and other related items.
- **Psychologist** means 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.
- **Recognized fees** (Network Dental Plan) means the maximum fees recognized by the plan are the fees fixed by the dentist with Delta Dental. A member dentist may not charge more than these filed fees. A network dentist has agreed not to charge more than the network allowed charge. Nonmember dentists are paid the Delta Dental allowable fee.
- **Referral service** means an organization that manages treatment of mental illness and substance abuse by contracting with providers of this treatment. The organization is responsible for:
  - Assessment of the patient's condition (including crisis intervention).
  - Referrals to referral service providers.
  - Precertification review of treatment for mental illness, substance abuse, and eating disorders.
  - Initial and ongoing review of provider treatment plans to assure services are medically necessary and given in the appropriate setting.

The referral service is considered the service representative for determining medical necessity of mental illness and substance abuse.

- **Referral service provider** means a provider performing services under a contract with the referral service or a provider meeting referral service criteria for care to a designated patient.
- **Service representative** means 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.
- **Skilled nursing facility** means an institution approved as such by Medicare.
- **Substance abuse (alcoholism and/or drug abuse) treatment facility** means an institution providing treatment for chronic alcoholism and/or drug abuse and operating under the direction and control of the licensing or regulatory agency in its location.
- **Substance abuse** means an alcohol or drug-related disorder that exhibits signs, symptoms, history, and other characteristics congruent with those required for a substance-related disorder diagnosis as enumerated in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM IV).
- **Totally disabled/total disability** (Basic Life Insurance Plan) means all of the following conditions apply:
  - You are disabled as a result of accidental injury or illness (including a pregnancy-related condition).
  - During the first 30 months of disability, the accidental injury or illness prevents you from performing the material duties of your own occupation or other appropriate work the Company makes available.
  - After the first 30 months, the disability prevents you from working at any reasonable occupation for which you may be fitted by training, education, or experience.
- **Totally disabled/total disability** (Short-Term Disability Plan) means you are unable to perform the material duties of your regular occupation or other appropriate work the Company makes available as a result of an illness, accidental injury, or a pregnancy-related condition.
- **Usual and customary** (Traditional Medical Plan) means the maximum charge for a covered service or supply the service representative will consider for reimbursement from a nonnetwork provider. The service representative may refer to this as the “maximum reimbursable charge,” “maximum allowable charge,” “reasonable and customary charge,” “allowed amount,” or a similar term.

  The usual and customary charge is the least of:
  - The provider’s actual charge for the service or supply,
  - The provider’s normal charge for a similar service or supply, or
  - A predetermined percentile (negotiated between each carrier and plan sponsor) of charges made by providers of a comparable service or supply in the geographic area where it is received.

  To determine if a charge exceeds the usual and customary charge for medical services or supplies in situations involving unusual or complicated services or supplies, the nature and severity of the injury or sickness may be considered.

  The service representative uses a database of provider charges to determine the usual and customary charge in an area. Information about the database and percentile used to determine the usual and customary charge can be obtained by contacting the service representative.

  If you use a nonnetwork provider, you pay any charges above the usual and customary amount.
- **Weekly base salary** (Short-Term Disability Plan) means your salary, including shift, lead, and foreign and domestic pay differentials, but excluding bonuses, overtime pay, cost-of-living allowances, incentive compensation, or other compensation you receive from the Company or a participating subsidiary. For part-time employees, benefits are determined using the average weekly salary actually earned for the 6 weeks immediately preceding the disability date. If you have been employed by the Company for less than 6 weeks, the plan first figures your pay as if you were full time; the weekly salary is that amount multiplied by a percentage equal to your scheduled weekly hours divided by 40.