The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-888-802-8776, refer to group number 7FLB01 when calling or visit us at **www.bcbsil.com/boeing**. For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other underlined terms see the Glossary. You can view the Glossary at **www.healthcare.gov/sbc-glossary** or call 1-866-473-2016 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Network**: $400 per individual, $1,200 per family; Nonnetwork: $800 per individual, $2,400 per family. Nonnetwork charges apply toward the **network deductible**.	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes. **Deductible** does not apply to **copayments**, prescription drugs, **preventive care** or vision.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost sharing** and before you meet your **deductible.** See a list of covered **preventive services** at **https://www.healthcare.gov/coverage/preventive-care-benefits/.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**Network**: $2,200 per individual, $6,600 per family for medical expenses; Nonnetwork: $4,400 per individual, $13,200 per family for medical expenses; Nonnetwork applies toward **network** medical out-of-pocket maximum, **plan** year medical **deductible** is included in medical out-of-pocket maximum amount; Separate $5,150 per individual, $8,100 per family for **network** prescription drug expenses	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	**Premiums**, balance-billed charges, health care this **plan** doesn't cover, penalties for failing to obtain **preauthorization**, vision	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**

Important Questions	Answers	Why this Matters:
Will you pay less if you use a network provider?	Yes. See **www.bcbsil.com/boeing** or call 1-888-802-8776 for a list of **network providers**	This **plan** uses a **provider network.** You will pay less if you use a **provider** in the **plan's network.** You will pay the most if you use a **nonnetwork provider,** and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays (**balance billing**). Be aware, your **network provider** might use a **nonnetwork provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral.**

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network (You will pay the least)	Nonnetwork (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% after **deductible**	40% after **deductible**	——————none——————
	Specialist visit	10% after **deductible**	40% after **deductible**	——————none——————
	Preventive care/**screening**/immunization	No charge, **deductible** does not apply	Not covered	According to prescribed guidelines. You may have to pay for services that aren't preventive. Ask your **provider** if the services needed are preventive. Then check what your **plan** will pay for.
If you have a test	**Diagnostic test** (x-ray, blood work)	10% after **deductible**	40% after **deductible**	——————none——————
	Imaging (CT/PET scans, MRIs)	10% after **deductible**	40% after **deductible**	——————none——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network (You will pay the least)	Nonnetwork (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.express-scripts.com/boeing**.	Generic drugs	Retail: 10%, **deductible** does not apply, member pays minimum $10, maximum $50 per prescription Mail Order: 10%, **deductible** does not apply, member pays minimum $25, maximum $130 per prescription	Retail: 10%, **deductible** does not apply, member pays minimum $10, maximum $50 per prescription Mail Order: Not covered	Retail: 30 day supply, up to 90 days of maintenance medications at mail **copayment** at select pharmacies only Mail Order: 90 day supply
	Preferred brand drugs	Retail: 25%, **deductible** does not apply, member pays minimum $35, maximum $125 per prescription Mail Order: 25%, **deductible** does not apply, member pays minimum $85, maximum $310 per prescription	Retail: 25%, **deductible** does not apply, member pays minimum $35, maximum $125 per prescription Mail Order: Not covered	Retail: 30 day supply, up to 90 days of maintenance medications at mail **copayment** at select pharmacies only, Member Pay the Difference rule applies if generic available Mail Order: 90 day supply, Member Pay the Difference rule applies if generic available
	Non-preferred brand drugs	Retail: 35%, **deductible** does not apply, member pays minimum $50 (no maximum) per prescription Mail Order: 35%, **deductible** does not apply, member pays minimum $125 (no maximum) per prescription	Retail: 35%, **deductible** does not apply, member pays minimum $50 (no maximum) per prescription Mail Order: Not covered	Retail: 30 day supply, up to 90 days of maintenance medications at mail **copayment** at select pharmacies only, Member Pay the Difference rule applies if generic available Mail Order: 90 day supply, Member Pay the Difference rule applies if generic available

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network (You will pay the least)	Nonnetwork (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.express-scripts.com/boeing**.	**Specialty drugs**	**Specialty drug** programs apply for certain high cost items	**Specialty drug** programs apply for certain high cost items	**Preauthorization** may apply or you may need to obtain **specialty drugs** from a pharmacy designated by the service representative, failure to follow **plan** procedures may result in non-payment by the **plan**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% after **deductible**	40% after **deductible**	——————none——————
	Physician/surgeon fees	10% after **deductible**	40% after **deductible**	——————none——————
If you need immediate medical attention	**Emergency room care**	$100 **copayment** then no cost after annual **deductible** for emergency care, $100 **copayment**, then 40% after annual **deductible** for nonemergency care	$100 **copayment** then no cost after annual **deductible** for emergency care, $100 **copayment**, then 40% after annual **deductible** for nonemergency care	**Copayment** waived if admitted
	Emergency medical transportation	10% after **deductible**, non-emergent care 40% after **deductible**	10% after **deductible**, non-emergent care 40% after **deductible**	——————none——————
	Urgent care	10% after **deductible**	40% after **deductible**	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% after **deductible**	40% after **deductible**	Preadmission review or preapproval required or penalty is 50% of first $2,000 of eligible charges
	Physician/surgeon fee	10% after **deductible**	40% after **deductible**	——————none——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network (You will pay the least)	Nonnetwork (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% after **deductible**	40% after **deductible**	Failure to obtain preapproval for certain intensive level outpatient services may result in non-payment by the **plan**
	Inpatient services	10% after **deductible**	40% after **deductible**	Preadmission review or preapproval required or penalty is 50% of first $2,000 of eligible charges
If you are pregnant	Office visits	10% after **deductible**	40% after **deductible**	**Cost sharing** does not apply for **preventive services**, maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound), depending on the type of services, a **coinsurance** or **deductible** may apply.
	Childbirth/delivery professional services	10% after **deductible**	40% after **deductible**	**Cost sharing** does not apply for **preventive services**, maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound), depending on the type of services, a **coinsurance** or **deductible** may apply.
	Childbirth/delivery facility services	10% after **deductible**	40% after **deductible**	**Cost sharing** does not apply for **preventive services**, maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound), depending on the type of services, a **coinsurance** or **deductible** may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network (You will pay the least)	Nonnetwork (You will pay the most)	
If you need help recovering or have other special health needs	**Home health care**	10% after **deductible**	40% after **deductible**	Preadmission review or preapproval required or penalty is 50% of first $2,000 of eligible charges
	Rehabilitation services	10% after **deductible**	40% after **deductible**	30 visits limited per therapy per year, additional visits may be available if **medically necessary**, visit limit does not apply to mental health and substance use disorders
	Habilitation services	10% after **deductible**	40% after **deductible**	Habilitative services not meeting medical necessity/policy are excluded under the **plan**
	Skilled nursing care	10% after **deductible**	40% after **deductible**	Preadmission review or preapproval required or penalty is 50% of first $2,000 of eligible charges
	Durable medical equipment	10% after **deductible**	40% after **deductible**	——————none——————
	Hospice services	10% after **deductible**	10% after **deductible**	Subject to 6 month review, preadmission review or preapproval required or penalty is 50% of first $2,000 of eligible charges
If your child needs dental or eye care	Children's eye exam	Coverage offered through separate vision benefit	Coverage offered through separate vision benefit	Not covered under the medical **plan**, coverage offered through separate vision benefit
	Children's glasses	Coverage offered through separate vision benefit	Coverage offered through separate vision benefit	Not covered under the medical **plan**, coverage offered through separate vision benefit
	Children's dental check-up	Not covered	Not covered	Not covered under the medical **plan**

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Children's dental check-up
- Children's eye exam
- Children's glasses
- Cosmetic surgery (unless reconstructive)
- Dental care (Adult)
- Infertility treatment (limited coverage may apply)
- Long-term care
- Private-duty nursing (limited coverage may apply)
- Routine eye care (Adult)
- Routine foot care (limited coverage may apply)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery (limited coverage may apply)
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.; www.bcbsil.com/boeing/resources/international_travel.html

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

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

Does this Coverage Provide Minimum Essential Coverage? Yes.

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

Does this Coverage Meet the Minimum Value Standard? Yes.

If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a **plan** through the **Marketplace**.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-473-2016.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-473-2016.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-866-473-2016.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-473-2016.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

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

Peg is Having a Baby
(9 months of network pre-natal care and a hospital delivery)

The plan's overall deductible	**$400**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,660**

Managing Joe's type 2 Diabetes
(a year of routine network care of a well-controlled condition)

The plan's overall deductible	**$400**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,660**

Mia's Simple Fracture
(network emergency room visit and follow up care)

The plan's overall deductible	**$400**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Boeing Company
Grievance Procedure under Section 1557 of the Affordable Care Act

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

The Director – Corporate Investigations, Ethics and Business Conduct, The Boeing Company, 6300 James S. McDonnell Blvd, Mail Code 100-1495, Berkley, MO 63134, telephone 888-970-7171, has been designated as the Section 1557 Coordinator to coordinate the efforts of Boeing and the Plans to ensure compliance with Section 1557 by investigating any complaints that the Plans have failed to comply with Section 1557. Any person who believes an eligible employee or eligible dependent under the Plans has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability by the Plans may file a grievance under this procedure. It is against the law for Boeing or the Plans to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the office of the Director – Corporate Investigations, Ethics and Business Conduct, The Boeing Company, 6300 James S. McDonnell Blvd, Mail Code 100-1495, Berkley, MO 63134, telephone 888-970-7171 within sixty (60) days of the date the person filing the grievance becomes aware of the alleged discriminatory action.

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

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

- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, generally within thirty (30) days after its filing (unless the Section 1557 Coordinator informs the complainant of a reasonable extension), including a notice to the complainant of their right to pursue further administrative or legal remedies.

- The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the Vice-President – Ethics and Business Conduct ("VP, EBC"), The Boeing Company, 100 N. Riverside MC 5003-5459, Chicago, IL 60606-1596, telephone 888-970-7171 within fifteen (15) days of receiving the Section 1557 Coordinator's decision. The VP, EBC shall issue a written decision in response to the appeal generally within thirty (30) days after its filing (unless the VP, EBC informs the appellant of a reasonable extension).

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

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

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

Boeing will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements and should be contacted at 888-970-7171 for such assistance.

Resources Available in Languages Other Than English

Spanish

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

Chinese

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

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-473-2016 (người gọi điện khiếm thính nên sử dụng dịch vụ tiếp âm được phục vụ thông qua nhà cung cấp dịch vụ điện thoại của họ).

Korean

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

Tagalog

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

Russian

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

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-473-2016
(ينبغي على ضعاف السمع الذين يودّون عمل مكالمات هاتفية استخدام خدمة المرحّل عبر مزوّد خدمة الهاتف الذي يتعاملون معه).

French-Creole

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

Portuguese

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

French

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

Polish

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-473-2016 (osoby niedosłyszące zechcą skorzystać z pomocy udostępnianej prze swoją firmę telefoniczną).

Japanese

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

Italian

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

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-473-2016 (hörbehinderte Anrufer sollten den Relay-Dienst ihres Telefonanbieters nutzen).

Farsi

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