**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsil.com/boeing or by calling 1-888-802-8776, refer to group number 7NUS01 when calling.

| 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, deductible does not apply to copayments, prescription drugs, preventive care or vision | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. 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 $4,950 per individual, $7,700 per family for network prescription drug expenses** | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **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**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes, please see contact information below. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**. |

**Questions:** Call 1-888-802-8776, refer to group number 7NUS01 when calling or visit us at www.bcbsil.com/boeing.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 866-473-2016 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Nonnetwork Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **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 | |
| | Specialist visit | 10% after deductible | 40% after deductible | |
| | Other practitioner office visit | 10% after deductible for Chiropractic and Acupuncture | 40% after deductible for Chiropractic and Acupuncture | 26 visits limited per year, network-nonnetwork combined for Chiropractic, covered when medically necessary for a covered illness or in place of covered anesthesia for Acupuncture, office visit copayment may apply |
| | Preventive care/ screening/immunization | No charge | Not covered | According to prescribed guidelines |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% after deductible | 40% after deductible | |
| | Imaging (CT/PET scans, MRIs) | 10% after deductible | 40% after deductible | |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Nonnetwork Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.express-scripts.com/boeing. | Generic drugs | Retail: 10%, member pays minimum $10, maximum $50 per prescription<br>Mail Order: 10%, member pays minimum $25, maximum $130 per prescription | Retail: 10%, member pays minimum $10, maximum $50 per prescription<br>Mail Order: Not covered | Retail: 30 day supply, up to 90 days of maintenance medications at mail copayment at select pharmacies only<br>Mail order: 90 day supply |
| | Preferred brand drugs | Retail: 25%, member pays minimum $35, maximum $125 per prescription<br>Mail Order: 25%, member pays minimum $85, maximum $310 per prescription | Retail: 25%, member pays minimum $35, maximum $125 per prescription<br>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<br>Mail order: 90 day supply, member pay the difference rule applies if generic available |
| | Non-preferred brand drugs | Retail: 35%, member pays minimum $50 (no maximum) per prescription<br>Mail Order: 35%, member pays minimum $125 (no maximum) per prescription | Retail: 35%, member pays minimum $50 (no maximum) per prescription<br>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<br>Mail Order: 90 day supply, member pay the difference rule applies if generic available |
| | 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 |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Nonnetwork Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% after deductible | 40% after deductible | |
| | Physician/surgeon fees | 10% after deductible | 40% after deductible | |
| **If you need immediate medical attention** | Emergency room services | $100 copayment per visit, then no charge after deductible, non-emergent care 40% after deductible and copayment | $100 copayment per visit, then no charge after deductible, non-emergent care 40% after deductible and copayment | 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 | |
| | Urgent care | 10% after deductible | 40% after deductible | |
| **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 | |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Nonnetwork Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 10% after deductible | 40% after deductible |  |
| | Mental/Behavioral health inpatient services | 10% after deductible | 40% after deductible | Preadmission review or preapproval required or penalty is 50% of first $2,000 of eligible charges  |
| | Substance use disorder outpatient services | 10% after deductible | 40% after deductible |  |
| | Substance use disorder 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** | Prenatal and postnatal care | 10% after deductible, unless billed globally | 40% after deductible |  |
| | Delivery and all 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 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  |
| | Habilitation services | Not covered | Not covered |  |
| | 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 |  |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Nonnetwork Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Hospice service | 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** | 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 |
| | 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 |
| | Dental check-up | Coverage offered through separate dental benefit | Coverage offered through separate dental benefit | Not covered under the medical plan, coverage offered through separate dental benefit |

## 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.)**

- Cosmetic surgery (unless reconstructive)
- Dental care (Adult)
- Dental check-up
- Eye exam (Child)
- Glasses (Child)
- Habilitation services
- 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

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

IMPORTANT INFORMATION! The plan document contains important information regarding the items that are listed in this document. It is vital that you review the plan document in order to know if this plan has any limitations, exceptions or exclusions regarding any test, treatment or service. The actual plan document

consists of The Boeing Company Master Welfare Plan, applicable Summary Plan Descriptions (SPDs), insurance contracts and funding vehicles, and other "governing documents." You may submit a written request to receive a copy of these documents; however, unless you specifically request otherwise, you will only receive a copy of the following documents in response to such request: The Boeing Company Master Welfare Plan, this plan's SPD, and any applicable updates to this SPD. In the event of a conflict between this document and the plan document, the terms of the plan document will control.
**Your maximum share of the cost of covered services (including deductible, but otherwise excluding items that don't count toward the out-of-pocket limit) is shown on p. 1. That total amount complies with the maximum amount mandated by the Affordable Care Act.

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-802-8776. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-888-802-8776.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **Note that this information is not applicable for this plan.**

## Language Access Services:

Para obtener asistencia en Español, llame al 866-473-2016.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-473-2016.
如果需要中文的帮助，请拨打这个号码 866-473-2016.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 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:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,240
- **Patient pays** $1,300

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $400 |
| Copays | $0 |
| Coinsurance | $700 |
| Limits or exclusions | $200 |
| **Total** | **$1,300** |

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,420
- **Patient pays** $980

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $400 |
| Copays | $0 |
| Coinsurance | $500 |
| Limits or exclusions | $80 |
| **Total** | **$980** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.