Approved 2-9-88
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by SENATOR ROY M. EHRLICH at
Chairperson

10:00 a.m./~~p.m.~~ on February 4, 1988 in room 526-S of the Capitol.

All members were present except:

Committee staff present:
Emalene Correll, Legislative Research
Bill Wolff, Legislative Research
Norman Furse, Revisors Office
Clarene Wilms, Committee Secretary

Conferees appearing before the committee:
Gene Kermashek, President, Kansas Pharmacy Association, Leavenworth
Ron Erker, Hudson Pharmacies, Wichita
Marily Rhudy, American Pharmaceutical Association
Ron Gaches, Public Affairs, Boeing Military Airplane Company
Written testimony by Jim Gartner, Southwestern Bell Telephone Company
Written testimony by Winston Barton, Secretary, SRS, HB-2504
Written testimony by Debbie Brummer, HB-2504
Written testimony by Wes Brummer, HB-2504
Written testimony by Richard L. Parker, Director, Bureau of Epidemology KDHE SB-445

Bob Williams appeared before the committee in support of SB-524. Mr. Williams stated that there are some employers in Kansas who offer health care plans which require their employees to obtain their prescription medication from mail order groups outside the state of Kansas. Mr. Williams further stated that his organization believed that when possible and economically feasible, businesses, corporations and firms in Kansas should purchase from other businesses in the state. This bill would allow an employee or retiree to purchase their prescription medication from a mail order pharmacy or local pharmacies willing to accept the same reimbursement that the mail order group receives. Copies of correspondence from a consumer having difficulties with a mail order firm were attached as part of Mr. Williams' testimony. Attachment 1

Gene Kermashek, 1988 President of the Kansas Pharmaceutical Association spoke to the committee and presented written testimony concerning SB-524. Mr. Kermashek told the committee some employers required employees to utilize mail order firms. Mr. Kermashek further stated that he supported the tax system where these employees reside and then the employees take their business out of state. Local pharmacists offer the patient consultations not available from mail order businesses. The pharmacists of Kansas need the assistance of Kansas Legislators in order to compete.

Ron Erker, Hudson Pharmacies, Wichita, testified before the committee and presented written testimony stating that SB-524 was important to retail retail pharmacies of Kansas for continued economic stability and competition in the pharmaceutical industry. Mail order causes loss of revenue to the local economy and to the state in the form of consumer spending in our state and loss of tax revenue for our state. Attachment 2

Marily Rhudy, a member of the American Pharmaceutical Association and a pharmacist in business in Topeka appeared before the committee stating that the pharmacists were only asking for an opportunity to compete. Ms. Rhudy stated that she provided a product and she provided a service. Mail order pharmacies provide only a product. Attachment 3

Ron Gaches, Public Affairs, Boeing, appeared in opposition to SB-524. Mr. Gaches stated that Boeing offered health care to almost 23,000 individuals and their families in Wichita and that the plan was one of

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

the most complete and comprehensive available in America. He further stated that the plan is intended to provide employees the greatest possible benefits at a reasonable cost to the company. The prescription drug and medicine coverage is not mandated, controlled or directed by federal or state law. Copies of the health plans were made available to committee members. Attachment 4

Time did not allow the committee to question Mr. Gaches. Therefore, the chairman requested Mr. Gaches to return at 10:00 a.m. on Friday, February 5, 1988, to resume testimony.

Written testimony by Jim Gartner in opposition of SB-524 was presented to the committee. Mr. Gartner stated that failure to continue the mail order prescription plan would constitute an unfair labor practice in the view of the Communication Workers of America and would cause additional expense to Southwestern Bell employees, company, stockholders and their customers. Attachment 5

Written testimony, Winston Barton, Secretary, SRS, addressing concerns expressed by the Public Health and Welfare Committee about HB-2504 was presented to committee members. Mr. Barton further explained the inclusion of third class cities, also that a grandfather clause would not provide desired results. Attachment 6

Written testimony from Debbie Brummer on HB-2504 was presented to the committee to clarify aspects questioned by the committee during testimony given on Monday, February 1, 1988. Attachment 7

Written testimony by Wes Brummer urging that no grandfather clause be added to HB-2504 was presented to the committee members. Attachment 8

Written testimony by Richard L. Parker, Director, Bureau of Epidemiology, was presented to committee members concerning SB-445 and the current process for testing blood for infectious disease. Attachment 9

The meeting adjourned at 11:02 a.m. and will convene at 10:00 a.m. on Friday, February 5, 1988.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE February 4, 1988

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Bill Dean, O.P. KS.	Merrell Dow
Jim Schwartz	KECH
Ron Gaches	Boeing
Jim Gaertner	SW Bell Telephone
Ronald Eckes	Hudson Pharmacy
marily Rhudy	Am Pharm. Assoc
Tom Taylor, Topeka	KPL Gas Service
Tom Hitchcock	Bd. of Pharmacy
Lee W. Gerber	Polson Pharmacy (Wichita)
Joe C Boyle	Consumer (Wichita
STEVE NEELY	GOODYEAR TIRE & RUBBER CO.
Jim Francisco	VISITOR - Boeing
GARY Robbins	Ks Optom Assn
Scott Patterson	Patterson Pharmacy - Clay Center
Dave Henry	Univ of Kansas Medical Center
Jane S. Henry	KPhA/KSHP
Charles Tice	KPhA
Amy Lucas	Intern - Sen. Salisbury
Lela Pasley	ARC/Kansas

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE Feb 4, 1988

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Linda Lubensky	KAHHA
Denny S Koch	SW Bell Tel Co.
Patti Wilkie	G.S.
Tracy Reymaschek	KS Pharmacy Assoc
Ken Bahn	Kaiser Permanente
Tom Bell	Ks. Hosp. Assn.
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
Bob Williams	Ks Pharmacists Assoc
Marily Ruby	" " "
Ron ~~Beer~~ Erker	" " "

THE KANSAS PHARMACISTS ASSOCIATION
1308 WEST 10TH
PHONE (913) 232-0439
TOPEKA, KANSAS 66604
ROBERT R. (BOB) WILLIAMS, M.S., C.A.E.
EXECUTIVE DIRECTOR

SENATE COMMITTEE ON PUBLIC HEALTH & WELFARE

FEBRUARY 4, 1988

TESTIMONY ON SENATE BILL 524

MR. CHAIRMAN, COMMITTEE MEMBERS: Thank you for this opportunity to address the committee.

There are health care plans offered by some employers in Kansas which require their employees to obtain their prescription medication from mail order groups outside the state of Kansas.

In some cases these employees are not allowed to purchase their prescription medication from local pharmacies in Kansas.

In other cases employees can purchase from their local pharmacy but are penalized with a copayment which is not required of those who are using the mail order pharmacy.

This boycott of Kansas pharmacists can mean economic ruin for some pharmacies.

We believe, when possible and economically feasible, businesses, corporations and firms in Kansas should purchase from other businesses within the state. This bill allows an employee or retiree to purchase their prescription medication from a mail order pharmacy or local pharmacies willing to accept the same reimbursement that the mail order group receives.

-over-

An employee would not be required to obtain their prescription medication from a mail order group as a condition of obtaining the employer's payment for prescription drugs: or be subjected to a copayment or other condition not imposed on those using a mail order group.

Harland Priddle, Secretary of the Department of Commerce, has endorsed this concept.

Similar legislation has been passed in Oklahoma and Arkansas. Both Nebraska and Missouri are considering similar legislation in their 1988 Legislative Sessions. Additionally, I would like to note, that this bill does not provide for any type of advantage or preferential treatment for local pharmacies in Kansas. It does, however, allow them the opportunity to compete. Thank you.

Donald P. Briggs
Rt. 4, Box 170
Pittsburg, KS 66762

29 Jan 1988

Lindburg Pharmacy (Attn: Steve)
909 E. Centennial
Pittsburg, KS 66762

Re: Your telephone call of 1/29/88

Regarding the incident that occurred in August, (see enclosed copy of letter to Express Pharmacy Services), I have received several calls from a National Pharmacists publication requesting clarification and additional information about my experience with the mail order pharmacy service. I also received a call from Express Pharmacy Services. The following items will iterate my response and the response from Express Pharmacy.

--Did I ever receive a response from Express Pharmacy?

No, no letter or telephone call. Also did not receive any information from the insurance company. (This answer in regard to my initial letter.) After the Publication started writing the article, they contacted Express Pharmacy; I received a call from Express Pharmacy denying the incident ever happened. I do have the form letter they sent to me at the time of the incident denying me a refill because insufficient time had passed to justify a refill of the drug.

--Do I like the service provided from Express Pharmacy?

No, I do not. The lead time necessary causes an inconvience that causes a certain amount of stress. And if there is something wrong with the order, then there is additional inconvience (and stress). I have not had any trouble in receiving the prescriptions on time, but, the drugs ordered that have arrived by U.S.Mail have had package damage. The last order received was mailed in a cushion envelope and arrived with multiple layers of plastic wrap holding the package together. I figure it is only a matter of time before prescriptions are lost.

In addition, the last order received had one drug (tagamet) that has a strong odor. I have this odor on my breath that repells me and anyone that comes into close contact with me. There is no expiration date of the drug on any of the prescription labels.

--Will I continue to use the Express Pharmacy now that the rules have changed? (I can purchase from the Express Pharmacy or the local pharmacy.)

In 1987, mail order copayment was $7.00. In 1988, mail order copayment will be $7.00 for brand name, and $3.00 for generic drugs. With the drastic increase in premiums this last few years, I have been forced

into looking for the best price for the drugs in an almost futile attempt to decrease my medical expenses. (President Reagon's regime turned the insurance companies loose this last 3 or 4 years, allowing them to increase premiums by leaps and bounds until after the 1988 increases. They were previously restricted to the Cost of Living limit.

--Do I get any information about the drugs from the Express Pharmacy Pharmacists?

No; after the one call when I tried for over 10 minutes to tell the telephone person who answered my call what my call was about; and, being told that a pharmacist (or anyone else) was not available to talk to me, I never called after that. All my orders were sent by mail.

When I want information about the drugs, I talk to you, my local Pharmacist. I do realize that there can be differences in the drugs because of different fillers used, and because of the age of the drugs. Therefore, information received may not be entirely accurate. I also realize that there may be future reluctance to provide information due to the economics of the situation. I know I would hate to be called to provide data about someone elses sales. Too much free time given by the small business man results in bankruptcy.

--How would I like to see the system changed?

I am a Federal Civil Service Retiree, and my health insurance program is administered at the Federal level, therefore, I doubt that anything the State of Kansas does would change my situation. But, I would like to be able to purchase all my drug prescriptions in one location, for my own safety, if for no other reason. But in order to do that without a financial penalty, the local Pharmacist would have to be able to compete against the large volume supplier. The local Pharmacist would have to have the ability and the opportunity to bid against the large volume supplier, and be recognized by the insurance companies as an alternate source of supply.

I have seen my premiums increase from about $10 per month to $150 per month with almost annual decrease in coverage and increase in rules to follow in order to get paid. Doctors' premiums have increased to rediculous levels, and I feel at times that my premiums increase to pay the increase that the Doctors get charged. It seems like the insurance companies are double dipping into the pot. Who is smart enough and has time enough to audit the insurance companies to find out just how much profit the insurance companies are getting? There is probably sufficient paperwork (and smoke) to place the companies budget and expenditures in the same class as the Federal Budget.

Donald P. Briggs

Donald P. Briggs
Route 4, Box 170
Pittsburg, KS 66762
SSN: 509-26-6391
(316) 231-1843

15 Aug 1987

Express Pharmacy Services
8 Queen Ann Court
Langhorne, PA 19047

Re: Ordering error & my phone call of 8/8/1987

On 8/8/1987 I received a memo from your office stating you were unable to fill a prescription because 60 percent of my current supply must be exhausted before reordering. I called your toll free number for information on this memo because I had not ordered any medications since the end of June.

The prescription in question was # 7514 020 984 - Zantac. As stated above, I have not ordered any medicines since June and that order was filled on 1 July 1987. So, one of two things occurred here; either you made a mistake on someone else's order; or, someone obtained by prescription number either here or from the city trash dump and ordered the medication without my knowledge.

As stated, I called and did not receive an answer to my question. I would like to have an answer so I will know whether I need to take any action on securing my files or destroying the old prescription containers. On the other hand, if you made a mistake I would like to know so I can decide whether I should document my orders, (i.e., should I avoid telephone orders at all times).

Please Reply.

Sincerely,

Donald P. Briggs

Copy to:
Aetna Life & Casualty - Group Division
Suite 200, Pioneer Bldg.
4050 Rio Bravo
El Paso, TX 79902

COPY

February 4, 1988

Senate Public Health and Welfare

Re: Senate Bill No. 524

I am Ron Erker, a practicing pharmacist for Hudson Pharmacy in Wichita. I feel that Senate Bill No. 524 is important to retail pharmacy for continued economic stability and competition in the pharmaceutical industry.

Retail pharmacy must compete on a daily basis with deep discounters, chains, and other independent retail pharmacies. This competition and fair trade has been beneficial to the consumer in the form of lower drug prices with increasing services.

The following is an illustration of normal prescription pricing in a retail setting. The medication price is based upon an industry standard known as Average Wholesale Price (AWP). A dispensing fee is then added to this prescription to cover counting , labeling, patient profiles, counseling, delivery, and general overhead. This fee is generally the margin that is used to adjust the price to become more price competitive.

Boeing mail order program for salaried employees which I am the most familiar allows for two ways that a patient may acquire their medications.

The first is by the use of their Blue Cross and Blue Shield of Kansas Major Medical Insurance Plan. A thirty day (30) supply of medication may be purchased from the pharmacy of the patients choice. The patient then submits those charges to Blue Cross of Kansas Insurance. The patient must first meet their deductible of $75.00 per patient, or $225.00 per family to receive any reimbursement. The reimbursement is then paid out at a rate for only eighty percent (80%). Making the other twenty percent (20%) another deductible.

The second means to get a prescription filled is the mail order option. By filling out the proper form and mailing in a written prescription for a ninety (90) day supply to National Prescription Services (a Medco Company) in Las Vegas, Nevada. A patient will receive the prescription in 10 to 14 days (average) at no additional cost or deductible making it a 100% covered service.

Mail order provided by large employer Insurance programs eliminates all competition between retail and mail order. We are simply not allowed to provide our services on an equal basis.

I feel that the disparity between mail order and the Retail pharmacy is causing economic damages to our local pharmacies in the form of loss revenues, employment reductions, and reduction of services. Mail order causes loss of revenue to the local economy and to the state in the form of consumer spending in our state and loss of tax revenue for our state.

Senate Public Healt
February 4, 1988
Attachment 2

Mail-order savings illusory

The federal government will no longer permit mail-order prescription plans to be offered to its employees without deductibles. The reason, a federal official explained, is that "despite our earlier expectations, mail-order programs do not appear to reduce total expenditures for drugs."

Report on pharmacy crimes

During fiscal year 1986 the FBI conducted 46 investigations covering $270,000 worth of controlled substances, the Justice Department recently reported to Congress. The statistics included 15 pharmacy robberies, 26 pharmacy burglaries, two robberies of a drug distributor or manufacturer, four burglaries of a drug distributor or manufacturer and one burglary of a hospital.

Rx activity at record level

The latest *Lilly Digest,* covering independent pharmacy operations in 1986, shows the average pharmacy dispensed 29,106 prescriptions, up from 28,347 Rxs and a record high in the history of the *Digest.* New Rxs, at 16,080, grew 14.2%, while renewals advanced 8.7% to 13,026. With the average Rx charge at $14.36, total prescription sales amounted to $417,895, comprising 64% of total revenues in the average independent.

Female student increase slowing

Analysis of 1986 enrollments for 13 Eastern pharmacy schools showed that female pharmacy student enrollments had stabilized at 58.9%. "This was the first stabilization of the number of women" in student ranks since 1972, researchers noted.

NARD hits M.D. dispensing

NARD intensified its campaign against physician dispensing recently by running 60-second radio ads across the country. The spots featured NARD leader Charles West and Representative Ron Wyden (D., Ore.), who described legislation needed to prevent doctors from selling drugs for profit.

Walgreen has big plans

Walgreen will open 100 new drugstores and do 90 major remodelings in fiscal 1988, ending next August, financed by capital expenditures of $160 million. The financing will also move forward the chainwide rollout of scanning registers. In its latest fiscal year, Walgreen's sales rose 17% to $4.3 billion, while net earnings were virtually stagnant at $103.5 million. The blame goes primarily to operating losses on the 66 Medi Mart drugstores Walgreen acquired 18 months ago.

APhA offers credit card processors

APhA is offering its members a new service called ECAP, which is used to verify and process credit cards. Some 600 members of the association have already applied for a free computer terminal that "reads" credit cards electronically. (ECAP is not to be confused with PCS' RECAP—which uses a similar device to process third-party claims.) Designed by

Senate Public Health & Welfare
February 4, 1988
Attachment 3

American Pharmaceutical Association
APhA
2215 Constitution Avenue, NW
Washington, DC 20037
(202) 628-4410
The National Professional Society of Pharmacists

John F. Schlegel, PharmD
President

D. Stephen Crawford
Chairman of the Board

87 CTL 49 Item 5
87 LL 23 Item 4

August 20, 1987

The Honorable Jim Sasser
Chairman
Senate Subcommittee on Governmental Efficiency,
Federalism, and the District of Columbia
432 Senate Hart Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

The American Pharmaceutical Association (APhA) requests that these comments be included in the subcommittee record of the August 5 and 6 hearing on Federal Employees Health Care Coverage and Mail Order Prescription Drugs. APhA commends you for holding those hearings.

APhA is the national professional society of pharmacists, representing the third largest health profession that comprises more than 150,000 pharmacy practitioners, pharmaceutical scientists and pharmacy students. Since its founding in 1852, APhA has been a leader in the professional and scientific advancement of pharmacy and in safeguarding the well-being of the individual patient.

Historically, APhA, and pharmacists generally, have expressed strong opposition to the current practice of mail-order pharmacy. While the current delivery system used by mail order pharmacies may provide a quality product to patients, it cannot provide the vital communication necessary for quality patient service.

The Standards of Practice for the Profession of Pharmacy, jointly set forth by APhA and The American Association of Colleges of Pharmacy (AACP), in the section titled "Patient Care Functions" outline the responsibilities of every pharmacist in any practice setting. These standards, embraced by the entire profession, state that the pharmacist "clarifies patient's understanding of dosage; integrates drug-related with patient-related information; advises patient of potential drug-related conditions; refers patient to other health care resources; monitors and evaluates therapeutic response of patient; reviews and/or seeks additional drug-related information."

These standards were created to protect the individual patients for whom we provide services. Our view of any pharmacy practice setting must be framed by these standards and we encourage our members to adhere to them. While we acknowledge that not all pharmacists in every case will meet the standard, we also contend that many evaluations and functions occur that are not apparent to the average patient. For example, a brief conversation with a patient may reveal slurred speech, indicative of possible overmedication. There is no opportunity for this type of evaluation when pharmacists receive orders through the mail. Also, visual contact with the patient allows the pharmacist to assess apparent comprehension of instructions, and, in general, the patient's physical and mental status.

2-4-88
3-2

The provision of leaflets and other printed instructions by mail-order pharmacies does not necessarily constitute communication to a degree that can be considered effective. We cannot assume that the information in the printed material is understood or even read by the patient. There is no opportunity to clarify a patient's understanding of dosage without two-way communication. Patient-related information is only available to a mail order pharmacist when the patient chooses to write that information on the prescription order form mailed to the pharmacy. A mail order pharmacist must assume that the information provided is complete. There is no opportunity to evaluate the patient or environmental factors. While most mail order pharmacy firms provide an 800 phone number, experience indicates that patients have a great deal of difficulty with busy signals and unanswered phones.

While mail-order pharmacies say they provide drug interaction information, the completeness of their patient profiles is dependent upon patient-supplied information. The typical patient on multiple drugs uses one pharmacy as provider. When they are forced to split their purchases between mail-order for chronic medications and community pharmacies for acute medications, neither provider can be assured of knowing the entire drug regimen. Thus, neither provider can provide the quality review and evaluation the patient deserves.

The Standards of Practice encourage the pharmacist to refer patients to other health care resources. Since mail-order pharmacies do not know the resources of the community in which a patient resides, this service is not available. A patient cannot always know when referral is warranted. While a patient's physician is the primary judge of therapeutic response, pharmacists play a key role as the most available source of health information. Patients may unwittingly give up a life-saving service because of decisions made by the purchasers of their health care.

We suggest that there are cost containment opportunities that have not been explored by the Office of Personnel Management in their decision to promote mail-order prescriptions for federal employees. The use of improved drug product selection and drug utilization review are just two of these excellent opportunities to achieve real cost savings without sacrificing quality of care. We would be more than happy to discuss these methods at any time.

Sincerely,

John Schlegel

John F. Schlegel, Pharm.D.
President

JFS/kac

APhA testifies on mail-order pharmacy

In testimony submitted to a Senate subcommittee holding hearings on mail order of prescription drugs, APhA said that the delivery system used by mail-order pharmacies cannot provide the vital communication necessary for quality patient service.

APhA pointed out instances when it is difficult for mail-order pharmacies to meet the Standards of Practice for the Profession of Pharmacy that were jointly set forth by APhA and the American Association of Colleges of Pharmacy (AACP).

"For example," noted APhA President John F. Schlegel, "a brief conversation with a patient may reveal slurred speech, indicative of possible overmedication. There is no opportunity for this type of evaluation when pharmacists receive orders through the mail. Also, visual contact with the patient allows the pharmacist to assess apparent comprehension of instructions, and, in general, the patient's physical and mental status.

"The provision of leaflets and other printed instructions by mail-order pharmacies does not necessarily constitute communication to a degree that can be considered effective. We cannot assume that the information in the printed material is understood or even read by the patient."

Schlegel added that no opportunity exists to clarify a patient's understanding of dosage without two-way communication. He said patient-related information is available to a mail-order pharmacist only when the patient chooses to write such information on the prescription order form mailed to the pharmacy. With regard to the toll-free phone number most mail-order pharmacies provide, Schlegel said some patients have had difficulty with busy signals and unanswered phones.

Schlegel noted that the Standards of Practice encourage the pharmacist to refer patients to other health care resources. "Since mail-order pharmacies do not know the resources of the community in which a patient resides, this service is not available....Patients may unwittingly give up a life-saving service because of decisions made by the purchasers of their health care," Schlegel said.

Sen. Jim Sasser (D-TN) chaired two days of hearings on mail order by the Senate Governmental Affairs Subcommittee on Governmental Efficiency, Federalism, and the District of Columbia. The subcommittee reviewed a federal government program offering mail-order drug coverage through Blue Cross/Blue Shield (BC/BS).

Following concerns raised by APhA members and a meeting with staff, BC/BS recently clarified in its membership newsletter that use of its mail-order prescription service is optional, not required, as many subscribers believed. APhA helped prepare the article, which explains that BC/BS subscribers should consult their community pharmacists. In response to APhA, BC/BS also told subscribers that it "encourages you to discuss your choice of pharmacy with your physician or community pharmacists each time you need prescription medication."

Editor's note: Please refer to the worksheet in the August 1987 issue of American Pharmacy *(page 13) to help answer your questions on the use of BC/BS or similar plans.*

Elections *from page 141*

★ APRS Economic, Social, and Administrative Sciences (ESAS) Section chairman-elect: Raymond Jang, Cincinnati, OH, and Marvin D. Shepherd, Austin, TX

★ ESAS Executive Committee member-at-large: Carole Kimberlin, Gainesville, FL, and Linda M. Strand, Salt Lake City, UT

slates of candidates for the **APPM Executive Committee and section offices** are:

★ APPM 1987 chairman-elect: Mark A. Pulido, Carrollton, TX, and Dennis P. Swanson, Whitmore Lake, MI

★ APPM 1988 chairman-elect: M. Ray Hoit, Quantico, VA, and Eugene M. Lutz, Altoona, IA

★ APPM Clinical/Pharmacotherapeutic Practice Section 1988 chairman-elect: Janice A. Gaska, Wilmington, DE, and Nancy J. Wenzloff, Farmington Hills, MI

★ APPM Clinical/Pharmacotherapeutic Practice Section 1988 Executive Committee members-at-large (two to be elected): Janet P. Engle, Chicago, IL; Branton G. Lachman, Corona, CA; Jon J. Tanja, Auburn, AL; and Michael Z. Wincor, Los Angeles, CA

★ APPM Institutional Practice Section 1988 chairman-elect: John M. Hammond, Silver Spring, MD, and Dominic A. Solimando, Jr., W. Lafayette, IN

★ APPM Institutional Practice Section 1988 Executive Committee members-at-large (two to be elected): Gene K. Adams, Garland, TX; Steve C. Firman, Waterloo, IA; Michael A. Pastrick, Concord, CA; and Elizabeth A. Simpson, Grosse Pointe, MI

★ APPM Administrative Practice Section 1988 chairman-elect: W. Ray Burns, Spartanburg, SC, and Ronald Jordan, Providence, RI

★ APPM Administrative Practice Section 1988 Executive Committee members-at-large (two to be elected): Melvin F. Baron, Los Angeles, CA; Kenneth Couch, Spartanburg, SC; Sandra Justice, Montgomery, WV; and Stephen W. Shearer, Spartanburg, SC

★ APPM Specialized Pharmaceutical Services Section 1988 chairman-elect: David L. Laven, Bay Pines, FL, and Stanley L. Mills, Washington, OK

★ APPM Specialized Pharmaceutical Services Section 1988 Executive Committee members-at-large (two to be elected): Stephen G. Arter, Fort Wayne, IN; Barbara Korberly, Philadelphia, PA; and Martha M. Rumore, Ridgewood, NY

★ APPM Community and Ambulatory Practice Section 1988 chairman-elect: Calvin Knowlton, Lumberton, NJ, and John W. Hasty, Hayes, VA

★ APPM Community and Ambulatory Practice Section 1988 Executive Committee members-at-large (two to be elected): Leonard Camp, Titusville, FL; John Murphy, Smyrna, DE; and Hazel M. Pipkin, Bryan, TX

APhA members will also be asked to designate which academy and section they wish to belong to when submitting the ballot. (For an explanation of new APPM sections, see August 7 issue of *Pharmacy Weekly*.)

Chairman and members of the APhA Board of Trustees, also to be elected on the September ballot, comprise the remaining elective offices. The slates of nominees for these offices were listed in last week's *Pharmacy Weekly*.

Welcome back, pharmacy students

With this issue, APhA resumes its bulk mailings of *Pharmacy Weekly* to every school of pharmacy in the country. Welcome back, student members, and our hopes for a productive and rewarding school year.

e.
3-3

February 4, 1988

Testimony Before the

Senate Public Health and Welfare

Regarding SB 524

Presented by

Ron Gaches
Boeing Military Airplane Company

Thank you Mr. Chairman for this opportunity to express our concerns about the unusual protectionist policy contained within SB 524. We hope that after you have had an opportunity to understand the application of the Boeing Prescription Drug and Medicine coverage you will agree that passage of SB 524 is unnecessary.

Boeing offers health care benefits to almost 23,000 individuals and their families employed by the Boeing Military Airplane Company in Wichita. Under the terms of the plan, all Boeing employees and their dependents are automatically covered under the Boeing Medical Plan. This plan is one of the most complete and comprehensive available in America. And its expensive.

For the purposes of defining employee benefits, Boeing employees are divided into two categories, hourly and salaried. The prescription drug and medicine coverage differs slightly for the two groups. The distinctions in the coverage for hourly employees is the result of contract negotiations with the six unions serving Boeing employees.

A detailed explanation of the Prescription Drug and Medicine coverages is found on page 14 of the salaried employees benefits book and pages 14 & 15 of the hourly employees book. I've also distributed a listing of all the pharmacists participating in the PAID Prescriptions Drug Card program. Approximately half of our employees are enrolled in the hourly plan and half in the salaried plan.

Senate Public Health & Welfare
February 4, 1988
Attachment 4

As you can tell by a review of the plans, the financial incentive for an hourly employee to make use of the mail service program for maintenance drugs is very modest, a two dollar savings. The financial incentive for a salaried employee is a bit greater, until the plan's copayment requirement are met and then the incentive is eliminated.

This plan is intended to provide our employees the greatest possible benefits at a reasonable cost to the company. The Prescription Drug and Medicine coverage is not mandated, controlled or directed by federal or state law. To do so now would constitute an unnecessary and ill-advised intervention in the employers' and employees' rights to negotiate a benefit package.

It is interesting to note that our employee benefits manager has not received a single employee complaint about the use of the mail order coverage for maintenance drugs.

In an effort to control the rapidly escalating cost of health care benefits, employers have made use of first dollar deductibles, co-payment requirements, health maintenance organizations, preferred provided agreements and extensive utilization review efforts. The providers of health care services have had to adopt to a rapidly changing environment in order to continue providing affordable health care coverage.

The selection of a single pharmacy service provider to meet the maintenance drug and medicine needs of all 135,000 Boeing employees nationwide provides the company and our employees a tremendous cost savings. Representatives of three Wichita area pharmacies met with our employee benefits manager last spring to discuss their concerns with the mail order program. He promised to evaluate any competitively priced package that they would like to offer the company and our employees. To date no offer has been presented.

Mr Chairman, we appreciate your Committee's attention in listening to our explanation and would try to answer any of your questions.

PAID PRESCRIPTIONS
PHARMACY MASTER
STATE : KANSAS

ABILENE
KOLLING PHARMACY # 2----------205 N BROADWAY

ANDOVER
ANDOVER DRUG----------401 W CENTRAL
MEDICINE CENTER----------528 W ANDOVER RD

ARKANSAS CITY
DILLON PHARMACY 38----------425 NORTH SUMMIT
GRAVES DRUG 11----------212 SO SUMMIT ST
PETERSON MEDICINE CHEST----------200 SOUTH SUMMIT
SAFEWAY PHARMACY 171----------616 N SUMMIT
TAYLORS DRUG----------201 SOUTH SUMMIT

ARMA
ARMA DRUG----------504 E WASHINGTON

ATCHISON
DOMANN DRUG----------504 COMMERCIAL
GIBSON PHARMACY 300----------HWY 73 AT 59

ATTICA
ROGERS PHARMACY----------106 MAIN

AUGUSTA
ALCON CLINIC PHARMACY----------120 WEST JOSEPHINE
AUGUSTA PHARMACY----------215 W 7TH
COOPER DRUG INC----------509 STATE BOX 519
DILLON PHARMACY 18----------1510 OHIO
RIDGWAY DRUG CO----------503 STATE ST

BAXTER SPRINGS
BAXTER REXALL DRUG----------1000 MILITARY
MILO CHEW DRUG CO INC----------1219 MILITARY
WOLKAR DRUG----------2305 MILITARY

BELLE PLAINE
ROYS REXALL DRUGS----------203 WEST FIFTH

BELOIT
S & S DRUG CO----------110 S MILL

BLUE RAPIDS
ILES PHARMACY----------PO BOX 98

BONNER SPRINGS
MILLERS PHARMACY----------207 OAK
WAGGONER PHARMACY----------135 OAK ST
WAL-MART PHCY 4486----------612 SOUTH 130TH ST

CHANUTE
CARDINAL DRUG----------103 E MAIN
REVCO DRUG----------1600 SOUTH SANTA FE

CHETOPA
RIGGS REXALL DRUG----------426 MAPLE ST

CIMARRON
CLARK PHARMACY----------101 S MAIN

CLAY CENTER
PATTERSON FAMILY PHCY----------426 LINCOLN

CLEARWATER
BALES PHCY&TRUE VALUE HDW---130 EAT ROSS PO BOX 459

COFFEYVILLE
COLUMBIA DRUG CO----------131 W 8TH
PRESCRIPTION SHOP----------720 MAPLE STREET
RAUCH MED-ECON PHARMACY----------1205 W 8TH
REVCO DRUG 944----------908 FALL STREET
RX PHARMACY----------1411 W 4TH ST
WAL-MART PHCY 4042----------900 E 8TH ST

COLBY
IPC PHARMACY/COLBY----------175 S RANGE
PFLASTERER & SIMMONDS DR----------470 N FRANKLIN

COLUMBUS
EVANS DRUG INC----------200 WEST PINE

COTTONWOOD FALLS
REED PHARMACY----------321 BROADWAY

DERBY
DAMM PHARMACY----------1412 N WOODLAWN
DORSEY DRUG CO INC----------400 NORTH BALTIMORE
WAL-MART PHCY #4552----------K-15 & 61ST ST
WOLF PHARMACY----------621 N BALTIMORE

DESOTA
DE SOTO DRUGS----------417 E 2ND ST

DODGE CITY
ANDERSON PHARMACY----------2601 CENTRAL VILLAGE SQRE
DILLON PHARMACY 1----------1700 NORTH 14TH
GIBSON PHCY OF DODGE CITY----------2610 N CENTRAL
MEDICAL CENTER PHARMACY----------2020 CENTRAL AVENUE
REVCO DRUG 4109----------W COMANCHE & 14TH
THE PRESCRIPTION CENTER----------2203 CENTRAL

DOUGLAS
WILSON'S PHARMACY----------903 E 1ST

EDWARDSVILLE
MILLER PHARMACY INC----------4TH & BLAKE

EL DORADO
ANDERSON DRUG----------115 N JONES
GRAVES DRUG 1----------107 N MAIN
KELLY DRUG INC.----------115 S. MAIN
MC CARTNEY RX SHOP----------129 E 1ST
REVCO DRUG 4103----------INT MAIN ST & 4TH

EL DORADO
SANDBERG PRES PHARMACY----------115 N JONES

ELKHART
C & R CLINIC PHARMACY----------BOX 962

EMPORIA
ALCO PHARMACY----------6TH + PRAIRIE
BERG & FROST PHARMACY----------1009 W 12TH ST
BERG FROST PHARMACY----------1601 STATE ST
DILLON PHARMACY 52----------1312 INDUSTRIAL RD
GRAVES DRUG 8----------609 COMMERCIAL
HILLS APOTHECARY----------1503 WEST 12TH ST
NICAS PRESCRIPTION CENTER----------WEST HIGHWAY 50
RED X PHARMACY----------624 COMMERCIAL
REVCO DRUG 4116----------2705 W HWY 50
REVCO DRUG 940----------904 EAST 12TH AVE
WAL-MART PHCY----------18TH ST & INDUSTRIAL DR

EUDORA
BYRNES PHARMACY INC----------101 WEST 10TH

EUREKA
CITY RX DRUG----------200 N MAIN
MCMULLEN DRUG INC----------501 NORTH MAIN

FREDONIA
CITY DRUG STORE----------BOX 575

FT SCOTT
CONSUMER PHARMACY----------2322 SOUTH MAIN
VISTA PHARMACY----------24 S NATIONAL

GARDEN CITY
DILLON PHARMACY 5----------1305 EAST KANSAS
DILLONS PHARMACY 60----------1211 JONES AVE
GARDEN PHARMACY----------701 KANSAS PLZ
GIBSONS PHARMACY----------1303 TAYLOR PLAZA
PLAZA PHARMACY INC.----------1127 KANSAS PLAZA
REVCO DRUG CENTER 4122----------2206 E KANSAS

GARDEN PLAIN
MEISTER PHARMACY----------414 N MAIN

GARDNER
BILL BOND PRESCRIPTIONS----------202 E MAIN

GODDARD
GODDARD PHARMACY----------P O BOX 669

GOODLAND
J&L DRUG----------18TH AND CHERRY STS

GREAT BEND
DILLON PHARMACY 51----------4107 10TH ST
FREES PHARMACY----------1420 POLK

GREAT BEND
GIBSON PHARMACY 301----------5320 W 10TH ST
MEDICAL PARK PHARMACY----------3520 LAKIN
REVCO DRUG 948----------4811 TENTH STREET
WAL-MART PHARMACY 4770----------3503 10TH ST
ZARAH PRESCRIPTION SHOP----------3422 BROADWAY

HALSTEAD
HALSTEAD PHARMACY----------227 MAIN

HARPER
HARPER PHCY----------102 W MAIN

HAYS
DILLON PHCY 61----------1902 N VINE
MICHES DRUG CTR----------2937 VINE
PURDYS PHARMACY INC----------2505 CANTERBURY RD
SKAGGS DRUG 75----------2937 VINE ST
WAL-MART PHCY 4664----------3300 VINE ST

HAYSVILLE
CUMMINGS PHARMACY 3----------307 N MAIN
DORSEY HEALTH MART DRUG----------145 N MAIN
STEEN PHARMACY----------207 W GRAND

HOHON
MEDICA PHARMACY----------418 W 5TH

HOISINGTON
CHEYENNE DRUG----------115 N MAIN

HUTCHINSON
CLINIC PHCY----------2101 N MAIN
COBERLY DRUG----------1300 NORTH MAIN
COGHILL DRUG----------510 EAST 17TH
DILLON PHARMACY 10----------725 E 4TH STREET
DILLON PHARMACY 25----------206 WEST FIFTH STREET
DILLONS PHCY #48----------517 E 30TH ST
FRAESE DRUG----------201 NORTH MAIN
GIBSON PHARMACY 302----------1125 E 4TH ST
K MART PHARMACY 3184----------1320 E 30TH AVE
KEY REXALL INC 1----------201 SC MAIN
MEDICAL CENTER PHCY INC----------1100 N MAIN
OSCO #155----------401 E 4TH AVE
SELF SERVICE DRUGS----------25 N MAIN
THE MEDICINE SHOPPEE----------1401 N MAIN ST
WAL-MART PHARMACY 4794----------1500 E 11TH ST

INDEPENDANCE
DEFEVER-OSBORN CLINIC PHY----------800 W CHESTNUT

INDEPENDENCE
DEFEVER OSBORN RX DRUG----------205 N PENN
PIERCE PHARMACY----------720 W LAUREL

IOLA
IOLA PHARMACY INC----------109 E MADISON

JUNCTION CITY
CRAFTS PHARMACY INC----------PO BOX 128
GIBSON PHARMACY 303----------353 GRANT ST
MC COOL PHARMACY----------PO BOX 23

KANSAS CITY
ABRAMS PHARMACY INC----------819 N 7TH ST
BELLAS PHARMACY----------7704 PARALLEL
BOND PHARMACY----------3420 STRONG
BOTTOMLEY PHARMACY----------1420 S 42ND ST
BRUNS PHARMACY----------6013 LEAVENWORTH ROAD
DE GOLER PHCY #3----------4631 CRVILLE
DE GOLERS PHARMACY-WEST---------7735 WASHINGTON AVE
DEGOLER PHARMACY----------1612 WASHINGTON BLVD
DOLGINS PHCY----------7401 STATE AVENUE
E C O PHARMACY----------1806 CENTRAL
FOSTERS BETHEL DRUG----------9201 PARALLEL
HASSIG DRUGS, INC.----------1001 CENTRAL AVE
K MART PHARMACY 4215----------7836 STATE AVE
LASWELL DRUGS----------3017 STRONG AVE
LLOYDS PHARMACY INC----------5902 LEAVENWORTH RD
MC DANELD DRUG STORE---------840 SOUTH 55TH STREET
NELSON PHARMACY----------901 N 9
NORTHS PHARMACY P A-------155 S 18TH STREET STE 106
OSCO #2181----------954 MINNESOTA AVE
OSCO #2189----------8101 STATE AVE
OSCO #2191----------4501 STATE AVE
OSCO DRUG #181----------954 MINNESOTA AVE
PHARMACARE PRESC----------4TH STATE AVE
PHARMACARE PRESCRIPTIONS----------600 NEBRASKA AVE
RENE RYAN PRESC SHOP----------8TH & STATE AVE
RENE RYAN PRESC SHOP----------8919 PARALLEL PWAY
REVCO DRUG----------2737 SOUTH 47TH STREET
REVCO DRUG 930----------3520 STATE AVENUE
REVCO DRUG 935----------PARALLEL S/C
REVCO DRUG 946----------1274 MERRIAM LANE
SHALINSKY DRUG #2----------34TH & GIBBS RD
THE APOTHMAT INC----------1403 SW BLVD
THE MEDICINE SHOPPE----------1709 N 38 STREET
TREASURY DRUG #7884----------7726 STATE AVE
VENTURE PHARMACY----------4301 STATE AVENUE

KINGMAN
HOLDER PHARMACY----------232 N MAIN
KINGMAN DRUG STORE----------211 MAIN ST

LANSING
RUSSELL LANSING PHARMACY----------617 N MAIN

LAWRENCE
DILLON PHARMACY 43----------1740 MASS ACHUSETTS
GIBSON PHARMACY----------2525 IOWA ST
GOODSON FAMILY PHARMACY----------500 ROCKLEDGE RD

LAWRENCE
JAYHAWK PHARMACY----------1400 W 6TH ST
K MART PHARMACY 7040----------3106 IOWA ST
MEDICAL ARTS PHARMACY----------346 MAINE ST
RANEY DRUG STORE----------921 MASSACHUSETTS ST
RANEY HILLCREST DRUG----------925 IOWA ST
RANEY PHARMACY----------404 MAINE
ROUND CORNER DG STORE----------801 MASSACHUSETTS
ROUND CORNER DRUG----------801 MASSACHUSETTS
SUPERX DRUG KA-8----------1015 W 23RD STREET
THE MEDICINE SHOPPE----------1901 MASS
THE MEDICINE SHOPPE INC----------1901 MASS
WESTRIDGE DRUG STORE----------601 KASOLD

LEAVENWORTH
CLAUDES REXALL DRUG INC----------429 DELAWARE
GENES PHARMACY INC----------521 N 7
K MART PHARMACY 5647-------4820 S 4TH ST TRAFFICWAY
RUSSELL CLINIC PHARMACY----------500 EISENHOWER RD
RUSSELL DRUGS INC----------104 N BROADWAY
RUSSELL MED ARTS PHARMACY----------520 6TH AVE
RUSSELL PLAZA PHARMACY----------3400 S 4TH
THE CORNER PHARMACY----------429 DELAWARE

LEBO
ALLEGRE REXALL D----------323 BROADWAY PO BOX 25

LENEXA
DAHLS FOOD MARKET----------10900 W 87TH ST
KENNEY HEALTH MART DRUGS----------9580 QUIVIRA ROAD
REVCO DRUG 941----------CCR 79TH ST & QUIVERA RD
THE PRESCRIPTION SHOPPE----------7753 QUIVIRA RD

LECTI
REIFSCHNEIDER DRUG CO----------110 N MAIN

LIBERAL
CLINIC PHCY OF LIBERAL----------1412 N WESTERN
EL-KAN DRUG, INC.----------1033 NORTH KANSAS
GIBSONS PHARMACY----------920 S KANSAS
H & R PHARMACY----------BOX 8
MEDICINE SHOPPE----------1038 N KANSAS
REVCO #4129----------1511 N KANSAS AVE
SAFEWAY PHARMACY 177----------730 N KANSAS
WAL-MART PHARMACY 4799----------1601 N KANSAS AVE

LOUISBURG
MULLEN DRUGS----------BOX 39

MANHATTAN
BARRYS DRUG CENTER----------405 POYNTZ AVE
DUNNES PHARMACY----------2429 CLAFLIN RD
K MART PHARMACY 7037----------401 E POYNTZ AVE
KELLSTROM PHARMACY----------1860 CLAFIN
REVCO DRUG 937----------3013 ANDERSON AVENUE
WAL-MART PHARMACY----------628 TUTTLE CREEK BLVD

MCPHERSON
DILLON PHARMACY 236----------1318 N MAIN
MEDICAL CENTER PHCY----------400 W 4TH
RALEIGHS DRUG STORE----------213 N MAIN

MERRIAM
GEORGETOWN PHCY----------9338 W 75TH

MISSION
REVCO DRUG 931----------4901 JOHNSON DRIVE
SHERIDAN PHARMACY----------5407 JOHNSON DR

MULVANE
MULVANE PHCY INC----------104 E MAIN STREET

NEODESHA
KLAYDER GARRETT PHCY----------503 MAIN ST
PORTER DRUG STORE----------506 MAIN PO BOX 215

NESS CITY
HAMMOND REXALL----------107 SOUTH PENN AVE

NEWTON
CARTER PHARMACY----------1021 WASHINGTON RD
DILLON PHARMACY 24----------1216 N MAIN
GIBSON PHARMACY 315----------401 MERIDIAN ST
HORST PHARMACY----------511 MAIN
HORST PHCY AT AXTELL----------203 EAST BROADWAY
PROFESSIONAL CENTRE PHY----------215 SOUTH PINE
WILSON DRUG STORE----------521 N MAIN
WILSON PHARMACY----------201 SOUTH PINE

NORTON
MOFFET DRUG STORE----------102 SOUTH STATE
STAPLETON DRUG STORE----------108 S KANSAS

OLATHE
DILLON PHARMACY #59----------588 EAST SANTA FE
JACK H KLEE PROF PHCY----------401 CLAIRBORNE
K MART PHARMACY 3322----------200 E SANTA FE
KERRS PHARMACY----------1717 S MUR-LEN RD
KRAMER DOWNTOWN DRUG----------101 S KANSAS
KRAMER TWIN TRAILS DRUG----------1325 E SANTA FE
REVCO DRUG 4127----------877 S PARKER
REVCO DRUG 936----------118 NORTH CLAIRBORNE
TAYLOR DRUG----------405 CLAIRBORNE
THE MEDICINE SHOPPE INC----------600 E SANTA FE
TREASURY DRUG 7721----------2099 E SANTA FE
WAL-MART PHARMACY 4577----------16630 W 135TH ST

OSWEGO
HARTMANN DRUG----------HWY 59 SOUTH
OSWEGO DRUG STORE----------413 COMMERCIAL

OTTAWA
BRISCOE DRUG STORE----------847 SOUTH MAIN STREET
KRAMER DRUG STORE----------134 SOUTH MAIN STREET
REYNOLDS DRUG STORE----------304 SOUTH MAIN
THE CLINIC PHARMACY----------1320 S ASH
WAL-MART PHCY #4382----------2204 PRINCETON CIRCLE

OVERLAND PARK
BRUCE SMITH DRUGS WEST----------8707 W 95TH ST
DAHLS----------6801 W 91 ST
DOLGINS APOTHECARY #2----------8700 FARLEY
FOX HILL MEDICAL PHCY----------4601 W 109TH ST
K MART PHARMACY 4443----------9401 METCALF AVE
KEY REXALL DRUG----------8700 SANTA FE DR
LARRY LEARD PHARMACY----------8820 W 95TH ST
MC DANIELS SUNFLOWER PHY----------7330 W 80TH
OSCO #2186----------7501 METCALF
OSCO #2190----------9605 METCALF
OSCO #2192----------3702 W 95TH ST
OSCO DRUG #192----------3701 WEST 95TH STREET
REVCO DRUG 932----------10370 METCALF STREET
SHALINSKY REXALL DRUG 3----------8025 SANTA FE DR
THE DOCTORS BUILDING PHY----------10550 QUIVIRA RD
TREASURY DRUG #7885----------9624 NALL AVE
VENTURE PHARMACY 5----------9600 METCALF
WYCLIFF PHCY.----------10354 MASTIN

OXFORD
BAGOT DRUG STORE----------100 S. SUMNER BOX 398

PAOLA
ASHER PHARMACY----------19 SOUTH PEARL
MILLER HEALTH MART PHCY----------2 E PECRIA

PARSONS
CONSUMERS PHCY # 17----------300 E MAIN
DAVIDS PRESCRIPTION SHOP----------PO BOX 352
REVCO DRUG 943----------2100 MAIN STREET
SLAYBAUGH DRUG CO INC----------49 PARSONS PLAZA

PEABODY
DONS DRUGS----------126 N WALNUT

PITTSBURG
CROWELL DRUG CO INC----------401 N BROADWAY
DILLONS PHARMACY 108----------2600 N BROADWAY
GUTTERIDGE PHARMACY INC----------606A N BROADWAY
LINDBURG PHARMACY----------2405 S HUCKER
THE PRESCRIPTION CENTER----------3001 N BROADWAY
WAL-MART PHARMACY 07----------HIGHWAY 69 NORTH

PLAINVILLE
UNREIN DRUG INC----------210 W MILL

PRAIRIE VILLAGE
BRUCE SMITH DRUGS----------25 CN THE MALL
MC DANIELS SOUTHGATE PHCY----------7600 STATELINE

PRAIRIE VILLAGE
WOOTEN DRUGS INC----------8262 MISSION RD

PRATT
GIBBONS PHARMACY----------EAST HIWAY 54
MESSER DRUG----------906 E 1ST
PRATT MED CLINIC PHCY INC-----420 COUNTRY CLUB ROAD
SCHREPELS PHCY----------115 S JACKSON

ROELAND PARK
OSCO #2182----------4701 SYCAMORE

ROLAND PARK
VENTURE PHARMACY 22----------4950 ROE BLVD

ROSE HILL
ROSE HILL PHARMACY----------1309 N ROSE HILL RD

SABETHA
GREENS DRUG STORE----------918 MAIN

SALINA
B&K PRESCRIPTIONS SHOP----------601 E IRON
DILLON PHARMACY 41----------1201 W CRAWFORD
FOOD BARN PHARMACY 4139----------1808 S 9TH ST
GIBSON PHARMACY 306----------321 S BROADWAY
JIMS PHARMACY----------737 E CRAWFORD
K MART PHARMACY 7169----------400 S BROADWAY
KEY REXALL CLINIC PHCY----------136 E CLAFLIN
KEY REXALL PHARMACY----------1103 W CRAWFORD
KEY RX DRUGS SOUTHGATE----------2024 SOUTH OHIO
WALGREENS 55-872----------2450 S 9TH STREET

SCOTT CITY
SCOTT CITY PHARMACY----------419 MAIN

SENECA
MEDICAL ARTS PHARMACY----------201 N SIXTH

SHAWNEE
HALLS PHARMACY----------6642 NIEMAN ROAD
RENE RYAN PRESC SHOP----------6301 PFLUMM RD
REVCO DRUG 224----------12100 W 63RD ST
SAFEWAY PHARMACY 801----------12010 W 63RD
SHAWNEE PHARMACY----------5949 NIEMAN ROAD
SWARNERS PHARMACY----------11200 JOHNSON DRIVE
TREASURY DRUG #7883----------7414 NIEMAN RD

SHAWNEE MISSION
K MART PHARMACY 4222----------8703 W 63RD STREET
LINNS PHARMACY----------9119 WEST 74
TREASURY DRUG 7897----------6721 JOHNSON DRIVE

SOUTH HUTCHINSON
ASHCRAFT PHARMACY----------511 N MAIN

SPRING HILL
SPRING HILL PHARMACY INC----------111 S MAIN BOX 426

STOCKTON
STOCKTON PHARMACY----------406 MAIN

TONGANOXIE
MURRAY PHARMACY----------516 E 4TH STREET

TOPEKA
BROOKWOOD JAYHAWK DRUG----------2901 W 29TH STREET
CONTINENTAL PHARMACY----------631 HORNE
DILLIONS PHARMACY #64----------5720 W 21ST ST
FALLEY'S DISC PRESC CTR----------3712 SW BURLINGAME
HUDSON PHCY----------2123 FAIRLAWN PLAZA DR
K MART PHARMACY 7409----------2240 N TYLER ST
MEDICAL ARTS PHARMACY----------10TH & HORNE STREETS
MEDICAL CENTER PHARMACY----------918 WEST 10TH
NORTHSIDE FAMILY RX CTR------2105 NORTH TOPEKA BLVD
OSCO DRUG #157----------115 W 29TH ST
PLATT DRUGS INC----------2913 S TOPEKA
REVCO DRUG 938----------2042 N TOPEKA AVE
REVCO DRUG 939----------5119 W 29TH ST
SCHAFFERT GRIMES DRUG CO--------3931 GAGE CENTER DR
SUPER D DRUGS----------500 W 10TH ST
WALGREENS 01225----------4019 SW 10TH ST
WALGREENS 51-945----------3600 TOPEKA AVE
WALGREENS 51-946----------815 KANSAS
WALGREENS 55-944----------5309 W 21ST STREET

VALLEY CENTER
VALLEY DRUG STORE----------224 WEST MAIN STREET

WAKEENEY
GIBSON DRUG INC----------127 NORTH MAIN ST

WELLINGTON
CHIEF DRUG INC----------116 SO WASHINGTON ST
DILLIONS PHARMACY 63----------1111 WEST 8TH
GLASCO DRUGS----------102 SC WASHINGTON
REVCO DRUG 205----------1108 E 16TH ST
WELLINGTON CLINIC PHCY----------924 S WASHINGTON

WELLSVILLE
HAUSLER PHARMACY----------601 MAIN ST

WICHITA
APOTHECARY SHOP----------1148 S HILLSIDE
CONSUMERS PHCY----------1035 N EMPORIA
CREST PHARMACY----------5025 E KELLOGG
CUMMING PHARMACY 1----------501 N HILLSIDE
CUMMINGS PHARMACY 11----------2816 S HYDRAULIC
CUMMINGS PHARMACY 13----------6217 E 13TH
CUMMINGS PHARMACY 5----------2413 WEST 13TH
CUMMINGS PHARMACY 7----------959 N EMPORIA
CUMMINGS PHARMACY 9----------1610 S BROADWAY

WICHITA
DAMM PHARMACIES----------4127 E KELLOGG
DANDURAND DRUG CO INC----------7732 EAST CENTRAL
DAVIDS PARKLANE PHCY----------1410 S GLENDALE
DILLON PHARMACY 16----------8828 WEST 13TH
DILLON PHARMACY 21----------5500 E HARRY
DILLON PHARMACY 34----------3932 WEST 13TH
DILLON PHARMACY 56----------4858 S BROADWAY
DILLON PHARMACY 62----------1435 N WACO
DILLON PHCY #65----------3211 SOUTH SENECA
FAMILY PRESCRIPTION SHOP----------7111 E 21ST ST
FOOD BARN PHARMACY 4115----------640 N WEST ST
GESSLER DRUG STORE #1----------4701 E DOUGLAS
GESSLER DRUG STORE #3----------6420 E CENTRAL
GESSLER DRUG STORE #4----------8903 W CENTRAL
GESSLER DRUG STORE 2----------126 N WEST ST
HART DRUG #2----------816 S. WOODLAWN
HART PHARMACY INC----------2716 W CENTRAL
HUDSON PHARMACY----------3243 E MURDOCK
HUGH SNELL'S PRESC----------1361 N WEST
HUGH SNELLS PRESCRIPTION---------1515 SOUTH CLIFTON
K MART PHARMACY 3358----------4830 S BROADWAY
K MART PHARMACY 4174----------8600 E KELLOGG
K MART PHARMACY 7117----------5010 E 21ST ST N
K-MART #4171----------4200 W KELLOGG
KEN MAR FAMILY DRUGS----------4728 E 13TH
KILKENNY PRESCRIPTIONS----------4002 W CENTRAL
LINDSAY PHARMACY INC----------7200 W 13TH
MEDI-SAVE PHARMACY 316----------3040 S SENECA
MEDICAL CENTER PHARMACY----------1118 S CLIFTON
NYQUIST PHARMACY----------6157 E HARRY
OSCO #2131----------8109 E KELLOGG
OSCO #2132----------2501 S SENECA
OSCO #2133----------3333 E CENTRAL
OSCO #2134----------2305 N AMIDON
OSCO DRUG #135----------4035 E HARRY
OSCO DRUG #2135----------4035 E HARRY ST
P J PHARMACY----------1010 W PAWNEE
P K PHARMACY----------3305 E HARRY
POLSON PHARMACY----------1855 W 21ST N
PRESTON PHARMACY----------10312 W MAPLE
PRESTON SOCORA PHARMACY-----8200 W CENTRAL SUITE #2
PROFESSIONAL PHARM INC----------429 E MURDOCK AVE
REVCO DRUG 210----------7011 W CENTRAL
REVCO DRUG 225----------501 E PAWNEE AVE
REVCO DRUG 4112----------2601 SOUTH CLIVER
REVCO DRUG 4113----------636 N WEST ST
REVCO DRUG 4114----------2120 N WOODLAWN
REVCO DRUG 934----------NE CORNER 31ST & MERRIDAN
REVCO DRUG 945----------4930 EAST 21ST STREET
RIGG MEDICAL ARTS PHARM----------315 N HILLSIDE
RILEYS PRESC SHOPPE INC----------123 EAST FIRST ST
RUMPLES DRUG STORE----------201 EAST 21ST
SAFEWAY FOOD BARN #4087----------1212 S WOODLAWN
SAFEWAY PHARMACY 720----------3020 E DOUGLAS
SALYER PHARMACY----------102 E 21ST

WICHITA
SELF SERVICE DRUGS----------125 SOUTH MARKET
SELLERS PRESCRIPTION SHOP----------3040 S SENECA
SENECA SQUARE PHCY----------3109 S SENECA
SKAGG ALPHA BETA #4407----------8714 WEST 13TH
SKAGGS ALPHA BETA #4406----------2101 N ROCK RD
SKAGGS ALPHA BETA #4408--------1607 S GEORGETOWN PS
SUPER FOOD BARN #4128----------2220 N AMIDON
T G & Y PHARMACY----------6229 NORTH BROADWAY
T G & Y PHARMACY 1402----------1902 W 21ST STREET
T G Y PHARMACY 95----------600 S TYLER ROAD
TG&Y PHARMACY 123-51----------1919 E PAWNEE
TG&Y PHARMACY 1400----------235 E 47TH ST SOUTH
TOMMY'S PHARMACY----------8032 E KELLOGG
TURNERS CORNER DRUG----------1001 CLEVELAND AVENUE
WALLS IGA PHARMACY----------501 E PAWNEE
WEST STREET PHARMACY----------1301 N WEST ST
WICHITA CLINIC PHARMACY----------3311 E MURDOCK
ZONGKER DRUG CO----------1101 W DOUGLAS

WINFIELD
GRAVES DRUG 10 INC----------905 MAIN ST
THE CLINIC PHARMACY----------1317 WHEAT ROAD
WAL MART PHARMACY----------HIWAY 77 & PIKE RD
WHEELERS PHARMACY----------320 EAST 9TH
WINFIELD PHARMACY----------118 E 9TH

ADA
- DICUS PHARMACY----------312 W 12TH
- DUTCH ROBBINS DRUG CTR----------121 E 14 ST
- REVCO DRUG 253----------BROADWAY & FOURTH
- WAL-MART PHARMACY #4231----------1601 N BROADWAY

ALTUS
- BUNKER HILL UNITED DRUG----------1600 N MAIN
- REVCO DRUG 217----------1114 N MAIN ST
- STREET DRUG INC----------1210 N GRADY

ALVA
- IDEAL DRUG----------927 OKLAHOMA BLVD
- IDEAL DRUG # 621----------927 OKLAHOMA
- SAFEWAY PHARMACY 164----------706 FLYNN

ANADARKO
- STANS PHARMACY INC----------PETREE PLAZA SHP CTR
- WAL-MART PHARMACY 4162----------HIGHWAY 281

ANDARKO
- LOVELLS PHARMACY----------602 W CENTRAL

ANTLERS
- HALLEY DRUGSTORE----------208 N HIGH

ARDMORE
- DAVES PHARMACY----------617 W BROADWAY
- HUMPTY DRUG 431----------617 BROADWAY
- REVCO DRUG 4100----------1201 N COMMERCE
- SAFEWAY PHARMACY 161----------510 N COMMERCE
- WAL-MART PHARMACY----------601 N COMMERCE

BARTLESVILLE
- BOULEVARD PHARMACY----------1117 E&F PHILLIPS BLVD
- GUNTER REXALL DRUG----------414 S DEWEY
- HOEY GIBSON PHARMACY----------102 S E WASHINGTON
- K MART PHARMCY 7041----------501 S E WASHINGTON BLVD
- MAYS DRUG 6----------3920 FRANK PHILLIPS BLVD
- MEDICAL PARK CTR PHCY--------3400 SE FRANK PHILLIPS
- SKAGGS ALPHA BETA 4404-------2501 SE WASHINGTON BLVD
- WAL-MART PHCY----------3901 ADAMS RD

BETHANY
- BETHANY DISCOUNT DRUG-------6736 NW 39TH EXPRESSWAY
- DON COODY PHARMACY----------7530 NW 23RD
- DONS WESTERN OAKS PHCY----------7330 N W 23
- HUMPTY DRUG 459----------7120 N W 23RD
- SKAGGS ALPHA BETA 4248----------7101 N W 23

BIXBY
- ALLEN'S PHARMACY----------PO BOX 774
- DEVINE DRUG----------PO BOX 158
- JOHNSTON DRUG----------PO BOX 446

BLACKWELL
- GRAVES DRUG #9----------123 S MAIN
- HUTTON PHARMACY----------119 NO MAIN
- HUTTON PHARMACY INC----------119 N MAIN
- WILLIS PHCY----------115 SOUTH MAIN ST

BOISE CITY
- BOISE CITY FAMILY PHCY----------318 W MAIN
- LOONEY DRUG COMPANY----------PO BOX 818

BRISTOW
- KEMPS DRUG STORE----------215 NORTH MAIN
- SUPER H PHARMACY----------206 E 7TH ST
- WAL MART PHCY----------123 W 12TH

BROKEN ARROW
- ECKERD DRUG 2090----------1201 E KENOSHA
- ECKERD DRUG 935----------2 ELM PLACE
- ECKERD DRUGS 2650----------816 SOUTH ASPEN
- K MART PHARMACY 7250----------3601 S ELM PLACE
- MAYS DRUG STORE 14----------2039 W HOUSTON
- PETRIK DRUG #2----------3100 S ELM PL SUITE F
- PETRIK DRUGS----------201 SOUTH MAIN
- QUAIL RUN PHARMACY----------620 SOUTH ASPEN
- RON'S PHARMACY----------1639 S MAIN
- ROSS DRUG STORE INC----------202 S MAIN
- ROSS DRUG 2----------1924 SEQUOYAN CENTER
- ROSS DRUGS----------202 S MAIN
- SKAGGS ALPHA BETA 4273----------3612 S ELM PLACE
- WAL MART PHARMACY #4053--------BROKEN ARROW PARK PLZ

CANTON
- PETE HERODS DRUG----------200 W MAIN

CARNEGIE
- LIBERTY DRUGS----------11 WEST MAIN
- PHILS DISCOUNT PHARMACY----------25 W MAIN ST

CATOOSA
- PLEMONS PHARMACY----------HWY. 66 & PINE-BOX 340

CEMENT
- CENTRAL DRUG STORE----------307 N MAIN ST

CHANDLER
- CITY DRUG----------725 MANVEL AVE
- HITE DRUG----------913 MANVEL
- WAL MART PHCY----------1700 E 1ST

CHECOTAH
- WAL MART PHARMACY----------US 266 & US 69

CHICKASHA
- CLINIC PHARMACY----------BOX 703
- GIBSON DISCOUNT PHCY----------805 SOUTH 4TH
- HUMPTY DRUG 452----------759 GRAND AVENUE

CHICKASHA
- MEDICINE SHOPPE PHARMACY----------720 S 4TH ST
- PETTYS PHARMACY----------759 GRAND AVE
- REVCO DRUG 257----------1902 S FOURTH STREET
- WAL-MART PHARMACY 4113-------HIGHWAY 81 & GRAND AVE

CHOCTAW
- CHOCTAW PHARMACY----------PO BOX 1067
- ECKERD DRUGS 2647----------NWC 23RD & HARPER

CHOUTEAU
- CHOUTEAU DRUG STORE----------100 W MAIN

CLAREMORE
- HEALTH CENTER PHARMACY----------113 E BLUE STARR DR
- HUMPTY DRUG #455----------101 W WILL ROGERS
- HUMPTY DRUG 455----------1015 W WILL ROGERS BLVD
- HUMPTY PHARMACY #455----------1015 W WILL ROGERS
- SAFEWAY PHARMACY 555----------332 N LYNN RIGGS
- WAL MART PHARMACY #4012---------680 S LINN RIGGS RD
- WAREHOUSE MARKET PHCY 23----------810 N LYNN RIGGS

CLEVELAND
- CLEVELAND DRUG----------111 S BROADWAY
- PALACE DRUG----------101 N. BROADWAY

CLINTON
- SAFEWAY PHARMACY 148----------1212 CHOCTAW

COLLINSVILLE
- COLLINSVILLE FAMILY PHCY----------PO BOX 82

COWETA
- CITY REXALL DRUG----------113 NORTH BROADWAY
- SEVEN OAKS HEALTH MART PY----1186 SEVEN OAKS CENTER
- THRIFTY WAY PHARMACY INC----------HWY 51 EAST

CUSHING
- REVCO DRUG----------2110 O EAST MAIN
- SNIDER PHARMACY----------1022 E CHERRY
- WAL-MART PHARMACY----------2004 E MAIN

DAWHUSKA
- WAL MART PHCY 4496----------1457 WEST MAIN

DEL CITY
- BEACHLER'S DISCOUNT PHCY------3029 S.E. 44TH STREET
- FARTHINGS DEL CITY----------4401 S E 28TH
- GIBSON PHARMACY----------3405 SE 29TH STREET
- LETT REXALL DRUG INC----------4337 SE 15
- SUNNYLANE DISC PHARMACY----------3912 SUNNYLANE

DEWEY
- POPKESS HEALTHMART PHCY----------524 E DON TYLER

DRUMRIGHT
- LESLIES DRUG----------145 E BROADWAY

DUNCAN
- R & S DRUG #1----------833 MAIN ST
- R & S DRUG #3----------1507 N 81 HWY
- R&S DRUG #2----------101 E MAIN ST
- SAFEWAY PHARMACY 182----------1401 BEECH
- STAR DISCOUNT PHARMACY----------1141 WARD MALL

DURANT
- CORNER DRUG----------145 W MAIN
- CORNER DRUG----------1005 W MAIN
- DURANT DURG INC----------119 N 3RD
- GIBSON PHARMACY----------1410 N FIRST
- MEDICAL CTR PHCY INC----------1301 N WASHINGTON
- MORRISON DRUG----------806 N FIRST ST

EDMOND
- BARRETT DRUG CENTER----------101 E 2ND
- CLINIC PHARMACY INC----------120 N BRYANT
- COVERTS MR DISCOUNT DRUG----------220 S LITTLER
- ECKERD DRUGS #2630----------2201 W EDMOND RD
- EVAN CUT RITE DRUG CTR----------178 SE 33RD
- HOSPITAL DISCOUNT PHCY----------104 SOUTH BRYANT
- HYDE DRUG #6----------745 W DANFORTH
- JIMS PHARMACY----------1 N BROADWAY
- REVCO DRUG CTR 2828----------1327 DANFORTH AVE
- REVCO DRUG 258----------3400 SOUTH BLVD
- REVCO DRUG 4117----------824 N 3RD ST
- SAFEWAY DRUGS #208----------2205 W EDMOND RD
- SAFEWAY PHARMACY 157----------3300 SO BLVD
- WAL MART PHCY----------3200 S BROADWAY
- WESTBROOK PHARMACY----------1208 W 15TH ST

EL RENO
- BEACHLER PHARMACY----------210 W ELM
- CANADIAN VALLEY PHCY----------2001 PARKVIEW
- HUMPTY DRUG 453----------310 WEST ELM
- MEDICINE CHEST PHARMACY----------101 S BICKFORD
- REVCO DRUG 2800----------1512 S W 27TH ST
- RUKES DISCOUNT PHARMACY----------121 S BICKFORD
- WAL-MART PHCY 4227----------1528 SW 27TH STREET

ELK CITY
- AUSTINS GRANDVIEW PHCY----------2406 BELL
- SAFEWAY PHARMACY 170----------412 W THIRD

ENID
- K MART PHARMCY 3128---------4010 OWEN K GARRIOTT RD
- LAMBKE SPRINGS PHARMACY----------615 EAST OKLAHOMA
- REVCO DRUG 218----------SYCAMORE SQUARE
- SAFEWAY PHARMACY 180----------917 E BROADWAY
- SAFEWAY PHARMACY 72----------128 SUNSET SHP CTR
- SCHEFFE PRESCRIPTION----------113 EAST RANDOLPH
- SKAGGS ALPHA BETA 4405--------3828 W OWEN K GARRIOT

ENID
WAL MART PHCY 4499----------4406 W OWEN K GARRIOTT

EUFAULA
EUFAULA PHARMACY----------329 S MAIN
S & H PHARMACY----------134 NORTH MAIN

FAIRVIEW
IDEAL DRUG 607----------820 E STATE RD

FORT GIBSON
BOX PHARMACY #1----------P O BOX 1178

FOX
CAMP PHARMACY----------BOX 98

GLENPOOL
GLENOAK PHARMACY----------BOX 370
GLENPOOL PHCY----------719 E 141ST ST

GROVE
WAL-MART PHARMACY----------HIGHWAY 59 SOUTH

GUTHRIE
LOGSDONS LILLIE DRUG----------P O BOX 848
MURRAY DRUG CO----------101 E OKLA
NEWT'S DISCOUNT PHARMACY----------102 N BROAD
REVCO DRUG 250----------DIVISION ST GUTHRIE PLAZA
SAFEWAY PHARMACY 188----------220 E CLEVELAND

GUYMON
IDEAL DRUG OF GUYMON----------10TH AND QUINN
UNITED DISCOUNT DRUG--------NORTHRIDGE SHOPPING CTR

HARRAH
BOB'S DRUG----------311 N HARRAH RD
THRIFTY PHCY #4----------SE 29TH & HARRAH RD

HARTSHORNE
CAL DRUG----------401 W HWY 270

HEAVENER
T & M PHARMACY----------402 E FIRST ST

HENRYETTA
BERRY PRESCRIPTIONS----------506 WEST MAIN ST
MOODY PHARMACY----------118 SOUTH 4TH ST
TAYLOR PHARMACY----------408 WEST MAIN
WAL MART PHARMACY 4247----------U S HIGHWAY 75

HINTON
HINTON DISCCUNT DRUG----------104 W MAIN
MARSHAS HEALTH MART DRUG----------BOX 332

HOBART
GAINES HEALTHMART DRUG----------104 W 4TH

HOLDENVILLE
STANFORD DRUG----------102 WEST MAIN
WAL-MART PHARMACY 4210----------500 E HIGHWAY 270

HUGO
REVCO DRUGS #2862----------1800 E JACKSON HWY 70E

IDABEL
PALACE DRUG STORE----------411 SOUTH CENTRAL

INOLA
INOLA DRUG----------19 WEST COMMERCIAL

JENKS
JENKS WAL MART PHCY----------220 S ELM
RIVERSIDE PHARMACY----------708 WEST MAIN
WAL-MART PHARMACY 4245----------220 S ELM ST

JONES
JONES DRUG STORE----------101 WEST MAIN

KINGFISHER
PALACE DRUG----------224 N MAIN
TOMS DRUG STORE----------119 W ADMIRE
WAL MART DISCOUNT PHCY----------1213 S MAIN

LANGLEY
LANGLEY DRUG----------BOX 326

LAWTON
BUY FOR LESS DISCOUNT PHY--------1017 S SHERIDAN RD
EARL DRUG----------331 C AVE
EARL DRUG SOUTH----------6C4 LEE BLVD
ECKERD DRUG 2598----------3RD STREET & C AVE
ECKERD DRUGS #2645----------4516 EAST LEE BLVD
GIBSON DISCOUNT PHCY----------1130 SW LEE BLVD
GIBSON DISCOUNT PHCY----------4400 CACHE ROAD
HUMPTY DRUG 414----------10 SOUTH 11TH
HUMPTY DRUG 469----------902 GROVE BLVD
K MART PHARMCY 3044----------1050 N.W. 38TH STREET
KENS RX----------902 GORE
SAFEWAY PHARMACY 194----------616 N W SHERIDAN
WAL MART PHCY----------1822 NORTHWEST 52ND ST
WOLF CREEK PHARMACY----------4417 W GORE

LEXINGTON
WILLIAMS PHARMACY----------111 E BROADWAY

LINDSAY
TABOR DRUG----------225 S MAIN

LOCUST GROVE
FLEMING DRUG----------14 EAST MAIN

LONE GROVE
LONE GROVE DRUG----------PO BOX 209

MADILL
CORNER DRUG----------100 LILLIE BLVD

MANGUM
HOWARD DRUG----------101 E JEFFERSON

MANNFORD
CENTER PHARMACY INC----------WOODCREST PLZ B 971
HEALTHWAY DRUG CORP----------P O BOX 770

MARIETTA
THE PRESCRIPTION SHOP----------100 N HWY 77

MARLOW
MEDICINE CHEST----------201 N BROADWAY

MC ALESTER
GIBSON DISCOUNT PHCY---------6TH & CARL ALBERT PKWY
LEMAC DISCOUNT PHARMACY--------1100 EAST WASHINGTON
WALMART PHARMACY 4151----------US 69 BYPOSS

MCALESTER
BOBS DRUGS CENTER----------1200 S MAIN

MCLOUD
MCLOUD DISCOUNT DRUG----------BOX 393

MEEKER
MEEKER DRUG----------MAIN & FOWLER

MIAMI
GIBSON PHCY----------1500 NORTH MAIN
GIBSONS RX CENTER----------1601 NORTH MAIN
WAL-MART PHARMACY----------2015 NORTH MAIN

MIDWEST CITY
APOTHECARY SHOPPE----------6520 E RENO
BRANNON MOBLY PHCY----------10006 S E 15
BRYANT DRUG----------9213 N E 10
CONRAD MARR DRUG 2----------1215 EAST LOCKHEED
CONRAD-MARR DRUG NO 1----------101 MID AMERICA
CROSS PHARMACY----------2828 PARKLAWN DR SUITE 12
HENDREN PRESC. SHOP----------7221 E RENO
MARKS PRESCRIPTION SHOP----------7221 EAST RENO
MIDWEST CITY MEM HOSPITAL---------2825 PARK LAWN DR
SKAGGS ALPHA BETA 4232----------7520 EAST RENO
THE DRUG STORE----------2801 PARKLAWN SUITE 103
THOMAS WILSON PHARMACY IN-------2820 PARKLAWN DRIVE
TUBB REXALL DRUG #3----------1104 N MIDWEST BLVD
TUBB REXALL DRUG 2----------7501 SOUTHEAST 15TH
VENTURE PHARMACY 78----------5701 E RENO
WAL-MART PHCY 4544----------TOWN & COUNTRY SC
WALKERS HERITAGE PARK PHY-----6908 E RENO SUITE 101

MOORE
BEACHLER PHARMACY----------620 CITY AVE

MOORE
ECKERD DRUG 2141----------404 EASTERN
ECKERD DRUG 940----------1225 SANTE FE
FAIRMOORE DISCOUNT PHCY----------624 N W 5TH
HUMPTY DRUG 471----------620 CITY AVENUE
LEONS PHARMACY----------322 SERVICE RD
MOORE REXALL DRUG----------621 N BROADWAY
MOORE REXALL DRUGS----------621 N BROADWAY
PHILS PHARMACY----------404 N EASTERN
SOUTHGATE DRUG----------431 TELEPHONE ROAD
TOMS PARKVIEW PHARMACY----------1400 SE 4TH
WAL MART DRUG 4277----------I-35 & S E 19TH

MULDROW
MULDROW PHARMACY----------BOX 369

MUSKOGEE
CONSUMERS PHARMACY 41----------105 NORTH YORK
CONSUMERS PHARMACY 9----------911 W BROADWAY
K MART PHARMCY 7003----------4 E SHAWNEE ST
KENS RX DRUG CENTER----------110 N JUNCTION
KIRKS DRUG STORE----------207 N THIRD ST
MUSKOGEE FAMILY PHARMACY----------3520 CHANDLER RD
SAFEWAY PHARMACY 577----------3115 WEST OKMULGEE
THRIFTY DISCOUNT DRUGS----------3RD AND BROADWAY
WAL MART DISCOUNT PHCY----------3208 PHOENIX DR
WAL-MART PHARMACY #4130----------727-32ND ST

MUSTANG
FOOD WORLD PHARMACY----------201 N MUSTANG
MUSTANG DRUG----------115 N MUSTANG RD
MUSTANG MED CTR PHCY----------500 PARK PL
REVCO DRUG 4118----------MUSTANG TRADE CENTER
WAL-MART PHARMACY 4517---------200 NORTH MUSTANG RD

NEWCASTLE
NEWCASTLE DRUG CO----------ROUTE 1 BOX 30
NEWCASTLE FAMILY PHARMACY------HWY 62 & DEAVILLE RD

NEWKIRK
MEDICINE CORNER PHCY----------601 W. SOUTH ST.
SIMONS PHARMACY INC----------106 W 7TH

NICOMA PARK
WESTMINSTER DRUG----------2405 NORTH WESTMINSTER

NOBLE
NOBLE PHARMACY----------PO BOX 615

NORMAN
DOCTORS PARK PHARMACY----------500 E ROBINSON
ECKERD DRUGS 2565----------1000 EAST ALAMEDA
HYDE DRUG #3----------227 EAST MAIN
MEDICAL PLAZA PHARMACY----------1125 N PORTER
MEDICINE CHEST PHARMACY----------1025 N PORTER
MEDICINE CHEST PHCY 2499----------1025 N PORTER

NORMAN
PLAZA WEST PHCY & GIFTS----------114 36TH AVE NW
PROFESSIONAL CTR PHCY INC----------1028 N FLOOD
REVCO DRUG CTR 2857----------153 12TH AVE SE
SAFEWAY PHARMACY 175----------2300 W MAIN
SKAGGS ALPHA BETA 4280----------2600 W ROBINSON
SOONER DISCOUNT PHARMACY----------1225 WEST LINDSEY
TREASURY DRUG #7874----------2280 W MAIN
TREASURY DRUG #7875----------1213 EAST LINDSEY
WAL-MART PHCY #4212----------2211 MAIN ST

OAKLAHOMA CITY
SAFEWAY PHARMACY 192----------415 S W 59TH ST

OKARCHE
KRITTENBRINK PHARMACY----------315 KANSAS

OKLAHOMA CITY
AIRPORT PHARMACY----------3100 SW 59TH
ALMONTE DRUG & HALLMARK----------2944 SW 59TH
AMC PHARMACY----------1001 N PENNSYLVANIA
ASHBY PRESCRIPTION PHAR----------1111 N LEE
BAGGETT PHARMACY----------4517 SOUTH PENNSYLVANIA
BAKER DRUG COMPANY 1----------1900 CLASSEN BLVD
BOBS PHARMACY----------210 SW 89 IH
BRITTON DRUG----------900 W BRITTON RD
CARY'S UNIVERSITY DRUG----------1400 N. LOTTIE
COMMUNITY IGA DRUG CTR----------1425 SW 29TH
COMMUNITY IGA PHARMACY----------3713 S WESTERN
CONNIES PRESCRIP SHOP----------5700 N W GRAND BLVD
CONRAD & MARR #5----------4483 NW 50TH
COUNTRY BOY PHARMACY #5----------2001 N E 23RD
COUNTRY BOY PHARMACY #6----------1124 N E 36
COUNTRY BOY PHARMACY #7----------1801 NW 16TH ST
CROWN PHARMACY----------7501 S WALKER
DOCO BOATMAN PHARMACY INC----------2915 PINE RIDGE RD
DRUGS FOR LESS 2504----------1641 SW 47TH
DRUGS FOR LESS 2505----------6022 S WESTERN
DRUGS FOR LESS 2506----------7301 S SHIELDS
DRUGS FOR LESS 2507----------9320 N PENN
ECKERD DRUG 2161----------12322 N MAY
ECKERD DRUG 854----------4612 S PENNSYLVANIA
ECKERD DRUG 858----------3939 N MACARTHUR
ECKERD DRUG 869----------2103 W BRITTON ROAD
ECKERD DRUG 893----------1421 SOUTH AIR DEPOT BLVD
ECKERD DRUG 896----------4805 NORTH MAY
ECKERD DRUG 897----------3501 CLASSEN BLVD
ECKERD DRUG 945----------4320 S.E. 44
ECKERD DRUG 966----------9208 S WESTERN AVE
ECKERD DRUG 973----------8337 N ROCKWELL AVE
ECKERD DRUGS #2685----------309 W 59TH
ECKERD DRUGS #2743----------3031 NW 23RD ST
ECKERD DRUGS 2618----------11122 N ROCKWELL
EXCHANGE PHARMACY----------2300 EXCHANGE
FAUBION PHARMACY----------3500 S WESTERN
FOOD WORLD PHCY----------2121 W HEFNER RD

OKLAHOMA CITY
GIBSON PHCY 3----------4300 N MC ARTHUR
GILLIAM RX #1----------119 N BROADWAY
HERITAGE HILLS DIS PHCY----------208 NW 13TH
HILLCREST DRUG----------2112 S W 59TH ST
HOME CARE PHARMACY----------425 SW 44
HUMPTY DRUG 417----------9330 N PENNSYLVANIA
HUMPTY DRUG 425----------2001 N E 23RD
HUMPTY DRUG 467----------3713 S WESTERN
HYDE DRUG #5----------7113 NW 10TH
HYDE DRUG #7----------11931 NORTH PENNSYLVANIA
HYDE DRUG CO----------4557 WINDSOR MALL
HYDE DRUG INC----------5108 N SHARTEL
LANGSAM MAYFAIR DRUG----------5012 NORTH MAY
MC CARTNEY PHARMACY #4----------7001 N W EXPRESSWAY
NORTHSIDE PHARMACY----------8920 N. WESTERN
OKLAHOMA ALLERGY CLINIC----------750 NE 13TH ST
PAN MED PHARMACY----------2835 SW 44TH
PARKER PRESC SERVICE INC---4901 SO PENNSYLVANIA AVE
PRO-MED DISCOUNT PHARMACY----------7415 N MAY
PROCTOR PHARMACY----------6517 S WESTERN
QUAIL PLAZA DRUG INC----------10916 N MAY
R-X PRES SHOP #1----------905 S W 29TH
R-X PRES SHOP #2----------5209 S PENNSYLVANIA
RELIABLE DISC PHARMACY----------5900 S PENNSYLVANIA
REVCO DISCOUNT #2858----------11717 S WESTERN
REVCO DRUG CTR 2863----------6000 NW 22ND ST SUITE A
REVCO DRUG 2829----------1646 SW 89TH ST
REVCO DRUG 2856----------3639 NW 39TH EXPRESSWAY
REVCO DRUG 292----------5730 SOUTH MAY ST
SAFEWAY DRUG 554----------PO BOX 25008
SAFEWAY PHARMACY 154----------2016 N W 39TH ST
SAFEWAY PHARMACY 181----------12508 N MAY AVE
SAFEWAY PHARMACY 183----------3020 N W 16TH ST
SAFEWAY PHARMACY 185----------1648 S W 89TH
SAFEWAY PHARMACY 195----------4301 S MAY
SAFEWAY PHARMACY 457----------PO BOX 25008
SAFEWAY PHARMACY 533----------PO BOX 25008
SAFEWAY PHARMACY 537----------PO BOX 25008
SAFEWAY PHARMACY 547----------PO BOX 25008
SAFEWAY PHARMACY 550----------PO BOX 25008
SAFEWAY PHARMACY 561----------PO BOX 25008
SAFEWAY PHARMACY 562----------PO BOX 25008
SAFEWAY PHARMACY 563----------PO BOX 25008
SAFEWAY PHARMACY 564----------PO BOX 25008
SAFEWAY PHARMACY 569----------PO BOX 25008
SAFEWAY PHARMACY 571----------PO BOX 25008
SAFEWAY PHARMACY 573----------PO BOX 25008
SHEEN PHARMACY----------2534 S ROBINSON
SKAGGS ALPHA BETA 4228--------7000 SOUTH MAY STREET
SKAGGS ALPHA BETA 4229--------9500 NORTH MAY STREET
SKAGGS ALPHA BETA 4230----5857 NORTHWEST EXPRESSWAY
SOUTHERN HILLS PHARMACY----------35 S E 33RD
SPRINGDALE MEDIC PACY----------5300 N MERIDIAN
STEWART AND WOOD DRUG----------137 SOUTHEAST 44TH
SUPER FOOD BARN PHCY 4089----------PO BOX 25008

OKLAHOMA CITY
T G Y PHARMACY #1017----------1024 S E 44TH ST
T G Y PHARMACY #1017----------1024 SA E 44TH ST
TG&Y PHARMACY #411----------1600 SW 74TH EXP
THOMPSON DRUG----------4595 S E 29TH
THRIFTY PHARMACY 1----------5808 SOUTH PENNSYLVANIA
THRIFTY PHCY #3----------10706 N MAY
TOWER PHARMACY----------1044 S W 44
TREASURY DRUG # 7877----------2830 N W 63 ST
TREASURY DRUG #7878----------6477 N MACARTHUR
UNITED DISC PHCY 3 INC----------1027 N E 36TH
UNITED DISCOUNT PHARMACY------4001 NORTH MAC ARTHUR
UNITED HEALTH CENTER----------1100 CLASSEN DRIVE
UNITED HEALTH CENTER----------1101 SOUTH WEST 44TH
VENTURE PHARMACY 77----------7401 S SHIELDS
VILLAGE PHARMACY----------2733 NW BRITTON RD
WAL-MART PHARMACY 4564----------6000 NW 23RD ST
WAL-MART PHCY #4622----------7012 NW HWY-ROCKWELL
WAREHOUSE MARKET PHCY 77----------1 S E 59TH ST
WHEELER & STUCKEY PHCY4----------4200 W MEMORIAL RD
WHEELER & STUCKEY RX PHCY----------1215 N WALKER

OKMULGEE
HEALTH CENTER PHCY----------1200 S BELMONT
WAL MART PHARMACY #4121----------HIGHWAY 75 SOUTH

OOLOGAH
TRUMMELS DRUG STORE----------HIGHWAY 169

OWASSO
MAYS DRUG STORE 16----------11640 E 86 ST NO
OWASSO DRUG----------130- SOUTH MAIN
WAL-MART PHCY OF OWASSO----------BOX 297

PAULS VALLEY
SAFEWAY PHARMACY 178----------505 S CHICKASAW

PAWHUSKA
LOVELACE DRUG----------

PERKINS
PERKINS DRUG----------246 S MAIN ST PO BOX 129

POCOLA
MCCUTCHEN HLTH SER WEST----------PO BOX 453

PONCA CITY
EVANS DRUG CO 5----------2005 N 14TH
GRAVES DRUG #10----------209 EAST GRAND
JULIES DRUG INC----------310 FAIR VIEW P O BOX 110
MEDICINE CHEST----------HARTFORD SQUARE
NORTHCUTT REXALL----------819 SOUTH 4TH ST
O'CONNOR PHARMACY INC----------1113 EAST HARTFORD
R T'S FMLY DSCT PHCY INC----------2128 N 14TH ST
RALPHS DRUG----------115 E HIGHLAND
TERRYS DISCOUNT PHCY----------3032 TURNER

PONCA CITY
TONI'S WESTSIDE REXALL----------301 WEST GRAND
WALKER DRUG----------415 N. 14TH ST.

POTEAU
WAL-MART PHARMACY 4031----------HIGHWAY 271

PRAGUE
PRAGUE PHARMACY----------917 BROADWAY

PRYOR
BEGGS DRIVE-IN PHARMACY----------110 SOUTH ADAIR
MEDICAL CENTER PHARMACY----------109 N FAIRLAND
THE PROFESSIONAL PY INC----------422 EAST GRAHAM
WAL MART PHARMACY #4022----------HIGHWAY 69 SOUTH
WAL MART PRESCRIPTIONS----------500 SOUTH MILL

PURCELL
KENNEDY DRUG INC----------200 W MAIN ST
UNITED DRUG----------1600 N GREEN

SAND SPRINGS
FAMILY MARKET PHCY #16----------230 S WILSON
K MART PHARMACY 3067-------1200 E CHARLES PAGE BLVD
MAYS DRUGS STORE #8---------720 E CHARLES PAGE BLVD
SPOON DRUG INC----------540 PLAZA CT

SAPULPA
BELL FAMILY DRUGS----------201 E DEWEY ST
CITY DRUG STORE INC----------1 SO MAIN STREET
FAMILY MARKET PHCY #18----------2020 S MAIN
HUMPTY PHARMACY----------511 E DEWEY
MAYS DRUG STORE 12----------735 S MISSION
MED-WORLD PHCY----------14 S MISSION
PLYMOUTH DRUG CO----------25 SOUTH PARK STREET
SAPULPA DRIVE-IN 1----------219 S MAIN
SAPULPA DRIVE-IN 2----------1029 E CLEVELAND
WAL MART PHARMACY #4073----------TAFT & MAIN STS

SEMINOLE
BESTYET PHARMACY----------600 W STROTHERS
CENTRAL DRUG SEMINOLE----------200 EAST OAK
SEMINOLE DRUG----------1703 N MILT PHILLIPS
WAL-MART PHARMACY----------1600 NORTH MILT PHILLIPS

SHAWNEE
BRZNNON DRUG CENTER----------1924 N KICKAPOO
CLINIC PHARMACY----------2803 NORTH SARATOGA
ECKERD DRUGS #2658----------600 A W INDEPENDENCE
HUMPTY DRUG 464----------1924 NORTH KICKAPOO
MENZ CAMPUS DRUGS----------2311 N KICKAPOO
MISSION HILL PHARMACY---------1902 GORDON COOPER DR
REVCO DRUG 254----------KICKAPOO SPUR & POTTENGER
SAFEWAY #199----------600 W INDEPENDENCE
SHAWNEE DISC DRUG CTR----------9 EAST MAIN
SHAWNEE MEDICAL CTR PHCY--------1104 WEST MACARTHUR

SHAWNEE
- SPARKS DISCOUNT PHCY----------1146 N HARRISON
- STAR DISCOUNT PHCY----------733 E INDEPENDENCE
- THE APOTHECARY PHCY INC----------905 E INDEPENDENCE
- WAL MART PHCY 4103----------800 W AYRES

SILLWATER
- WICKLOW PHARMACY----------724 S WESTERN

SKIATOOK
- JOHNS DRUG----------ROGERS BLVD & A STREET
- KENDALL REXALL----------118 EAST ROGERS

SPENCER
- MARY MAHONEY PHARMACY----------12716 NE 36TH ST
- SPENCER DRUG----------3700 N. SPENCER ROAD

STILLWATER
- CHARLIES DISCOUNT DRUG----------723 S WALNUT
- CONSUMERS I G A PHCY----------909 WEST SIXTH
- CONSUMERS IGA PHARMACY----------909 W 6TH AVE
- RAZOOKS DRUG----------1518 W 9TH
- REVCO DRUG 251----------719 N PERKINS
- TIGER DRUG----------825 S WALNUT
- TREASURY DRUG 7896----------1608 CIMARRON PLAZA

STILWELL
- STILWELL PHARMACY----------116 W DIVISION

STROUD
- HARDING DRUG INC----------PO BOX 416

SULPHUR
- GIBSON PHARMACY----------301 WEST MUSKOGEE
- WAL-MART PHARMACY 4225----------2118 W BROADWAY

TAHLEQUAH
- COX DRUG----------1301 EAST DOWNING
- RED BUD PHARMACY----------200 WEST CHOCTAW
- SUN DRUGS CO----------830 S MUSKOGEE

TECUMSEH
- RALPHS PHARMACY----------211 N BROADWAY

TISHOMINGO
- SOONER PHARMACY----------100 S BYRD

TONKAWA
- HUTTON PHCY #2 INC----------205 E TONKAWA
- M & J DRUGS----------200 E GRAND

TULSA
- BRIARWOOD PHARMACY----------8159 E 31ST ST
- BUDS THRIF-T PRESC #3----------3720 E ADMIRAL PLACE
- BUTLER DRUG----------504 SO. SHERIDAN
- COUCH PHARMACY----------2602 SOUTH HARVARD

TULSA
- DOOLEY PHARMACY----------4120 WEST 25 AVE
- ECKERD DRUG 2071----------2110 S HARVARD
- ECKERD DRUG 2319----------2323 WEST EDISON
- ECKERD DRUG 903----------1330 EAST 51ST STREET
- ECKERD DRUG 906----------1130 SOUTH MEMORIAL
- ECKERD DRUG 920----------3120-B SOUTH GARNETT
- ECKERD DRUG 934----------6539 E 17 ST SC
- ECKERD DRUG 978----------4926 W. SKELLY DRIVE
- ECKERD DRUGS 918----------12009 SOUTH MEMORIAL DR
- FAMILY MARKET PHCY #11----------4915 S UNION
- FAMILY PHARMACY #1 INC----------6465 SO YALE
- FAMILY PHARMACY #2----------6565 SOUTH YALE AVE
- FREELAND - BROWN PHARMACY----------4508 SOUTH PEORIA
- G-S PHARMACY INC----------5930 E 31ST
- GENE GATES PHARMACY INC----------8519 EAST 11TH STREET
- GOODENOW DRUG INC----------301 SOUTH LEWIS
- K MART PHARMCY 3238----------3132 EAST 51 ST
- K MART PHARMCY 3284----------5305 E ADMIRAL PLACE
- K MART PHCY 4473----------10131 E 21ST ST S
- KENS PHARMACY----------3319 W 45
- LAWHORN PHCY----------1615 EAST 15TH STREET
- MARINA PHARMACY----------5902 E 21ST
- MAYS DRUG STORE #4----------2171 GS 129TH E AVE
- MAYS DRUG STORE #9----------1150 SOUTH GARNETT RD
- MAYS DRUG 1----------2625 SO MEMORIAL
- MAYS DRUG 15----------5026 S SHERIDAN RD
- MAYS MAIN PLACE #11----------515 S MAIN
- MED X #14----------1339 E 41
- MED X COPR 6----------307 S UTICA
- MED X CORPORATION #2----------3133 SOUTH HARVARD
- MED X CORPORATION 11----------1714 UTICA SQUARE
- MED X CORPORATION 4----------4237 SOUTHWEST BLVD
- MED X CORPORATION 5----------4941 SOUTH PEORIA
- MED X CORPORATION 7----------1515 NORTH HARVARD
- MED-X CORPORATION #1----------6342 E ADMIRAL PLACE
- MED-X DRUG 3----------5234 N PEORIA
- RALEY PHARMACY----------19296 E ADMIRAL PL
- RANCH ACRES PHCY----------3102 SC HARVARD
- REVCO #1701----------6921 E ADMIRAL PLACE
- SAFEWAY PHCY 502----------2235 EAST 61ST
- SAFEWAY STORE #545----------12572 E 21 ST
- SAFFA PHARMACY----------6933 S SHERIDAN
- SCOTT ROBINSONS PHCY----------4720 S HARVARD AVE
- SERIVCO DISCOUNT DRUG----------1150 S GARNETT
- SKAGGS ALPHA BETA 4113----------3328 EAST 51ST STREET
- SKAGGS ALPHA BETA 4220----------1939 MEMORIAL DRIVE
- SKAGGS ALPHA BETA 4221----------7990 E 51ST ST S
- SKAGGS ALPHA BETA 4227----------11333 EAST 31ST STREET
- SKAGGS ALPHA BETA 4253----------4818 E 80TH ST SOUTH
- SKAGGS DRUG 4113----------3328 E 51ST ST
- SOONER DISCOUNT DRUGS----------2118 SO GARNETT
- STANS PHARMACY----------3115 SOUTH SHERIDAN
- SUMMERS PHARMACY----------6041 S SHERIDAN RD
- THE DRUG WAREHOUSE 7----------3126 S HARVARD
- WAL-MART PHARMACY 4576----------5797 E ADMIRAL PL

TULSA
- WALGREENS 18-954----------1528 N. LEWIS AVE
- WALGREENS 31-956----------4187 S YALE AVE
- WAREHOUSE MARKET PHCY----------6207 S PEORIA
- WESTVIEW PHARMACY----------3606 N CINCINNATI

TUTTLE
- CEDAR SPRINGS PHARMACY----------RT 3 BOX 124-A

VINITA
- BOB HASLETT REXALL DRUG----------116 S WILSON ST
- V & V DRUG----------201 N SCRAPER
- WALMART PHCY----------HIGHWAY 66 EAST

WAGONER
- OWL DRUG----------115 SOUTH MAIN
- SIMMONS HEALTHGARD DRUG----------1202 W CHEROKEE
- WAL MART PHCY 4063--------JCT US 69 & STATE HWAY 51

WEWOKA
- NORMAN DRUG CO----------109 N WEWOKA

WOODWARD
- FAMILY DISCOUNT DRUG CTR----------1218 MAIN
- IDEAL DRUG CENTER----------1414 OKLAHOMA AVE
- SAFEWAY PHARMACY 167----------1310 OKLAHOMA AVE

YUKON
- CONRAD MARR DRUG 6----------334 ELM
- GEORGE KEY PHARMACY----------325 MAIN ST
- HACKNEY DRUG----------12320 N MUSTANG RD
- HYDE DRUG #4----------1111 S CORNWELL
- REVCO DRUG 2802----------VANDAMENT AVE & 11TH ST
- THRIFTY PHARMACY----------1311 S HOLLY
- THRIFTY PHARMACY 2----------1311 SOUTH HOLLY

Employee Benefits

Boeing Health Care Plans

Salaried Employees

1987 Edition

4-4

Foreword

This booklet describes the health care plans that may be available to you and your family if you are an eligible salaried employee of The Boeing Company. The provisions of each of the plans are effective as of January 1, 1987.

The plans described in this booklet have been designed to provide you with financial protection against large out-of-pocket health care expenses. In many cases, you will have a choice among medical and/or dental plans that are available in your area.

The Boeing Medical Plan, which is described beginning on page 4, is available to you and your eligible dependents regardless of where you live or receive your medical care. It offers comprehensive coverage of most medically necessary services and supplies, including prescription drugs and vision care services and supplies. In certain areas of the country, you may elect as an alternative to receive your medical care through an approved health maintenance organization (HMO), as explained on page 22. An HMO generally provides you and your dependents with all covered medical care for a fixed monthly cost, as long as you receive the care from or through the HMO's physicians or facilities.

You may also have a choice between two dental plans. Both cover necessary and appropriate dental care, including specialty care. Under the Prepaid Provider Dental Plan, you select a dentist from a list of those participating in the Plan. The Prepaid Plan then covers the full cost of most dental care that is received through your selected dentist. Under the Scheduled Dental Plan, you may receive your care from any licensed dentist. However, you share part of the cost for all covered dental care, based on the Plan's schedule of benefits. Both dental plans are described beginning on page 23.

You are encouraged to review the information on the following pages and to share it with your family so that you may receive the maximum protection available under each of these plans. Please take special care in reviewing the new medical review program under the Boeing Medical Plan since benefits may be limited or denied under certain circumstances.

If you have questions concerning your coverages, contact the appropriate Boeing Group Insurance Office at the address listed on page 36.

Every effort has been made to provide an accurate summary of the plans described in this booklet. If questions arise about the plans, final determination will be based on the official legal documents and contracts that govern the interpretation and administration of the plans. Copies of these documents and contracts are available from or through the Boeing Group Insurance Office.

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Eligibility

Employees

You are eligible for coverage under the plans described in this booklet if you are an active Boeing salaried employee. This includes employees represented by one of the collective bargaining representatives listed on page 33.

Dependents

Certain family members may also be covered under these plans if you are covered as an employee. Eligible dependents include your spouse and unmarried dependent children who are under the age of 19. Step-children are covered on the same basis as natural and adopted children as long as they live with you and are solely dependent on you for support. In addition, you may request coverage for a minor child who is related to you either directly or through marriage as long as that child is unmarried, solely dependent on you for support, and living with you in a parent-child relationship.

An unmarried child may continue to be eligible between the ages of 19 and 25 if he or she is attending school regularly or is dependent solely on you for support.

Beyond age 25, an unmarried child may continue to be eligible if he or she is unable to earn a living because of a developmental disability or physical handicap. The child must be chiefly dependent on you for support on the date his or her eligibility for benefits would otherwise end. Coverage may continue under the plans described in this booklet for the duration of the incapacity as long as you continue to be an eligible employee under these plans.

If you would like to continue the coverage of a disabled child beyond age 25, you must complete an application form and provide proof of the child's incapacity within 31 days of the child's 25th birthday. You may also be required to verify the incapacity from time to time. Application forms are available from the Boeing Group Insurance Office.

Other Boeing Coverage

No person may be covered both as an employee (active or retired) and as a dependent. This means that eligible dependents do not include another employee who is covered under a Company-sponsored plan providing coverage for medical, vision care, prescription drug, dental or similar services, or one who is covered under an approved health maintenance organization (HMO) plan.

A person will also not be covered as a dependent of more than one employee. A child who would otherwise be eligible as a dependent under more than one Company-sponsored or HMO plan will be covered under the plan of the person considered to be the head of the household. The head of the household is the parent or guardian in the following order:

1. The parent with whom the child lives.
2. The parent who has the greater length of service with the Company based on an hourly employee's seniority or a salaried employee's service date.

If an application is required to begin coverage for the child and an application is not completed, the child will be covered under the plan, if otherwise available, that provides automatic coverage.

How to Enroll

Medical Coverage You and your dependents are automatically covered under the Boeing Medical Plan. However, you must complete a Boeing health care information card before any benefits will be paid by the Plan. You must also update this card if you wish to add or remove dependents at a later date. Payment of benefits is delayed until the health care information card is fully completed, and the information has been entered into the Company's eligibility files.

If you elect the health maintenance organization option (described on page 22), you must complete the necessary enrollment cards for the HMO that you select. You may enroll yourself and your dependents in an approved HMO plan within 30 days of your date of hire or within 30 days after moving into the service area of an HMO. Open enrollment periods are also held during which you may change the plan through which you receive your medical coverage.

If you and another Boeing employee marry after your coverages become effective, the special provisions described above under "Other Boeing Coverage" apply to you and each of your dependents. However, if one of you is covered under the Boeing Medical Plan described in this booklet and the other is enrolled in an approved HMO plan, you or your spouse has 30 days from the date of marriage to change to the plan under which the other is covered if you both wish to be covered under the same plan. The person who elects to change coverage must meet the eligibility requirements of the plan to which he or she is applying.

Dental Coverage If you live in the service area of the Prepaid Provider Dental Plan, you must complete an application to select coverage under either this plan or the Scheduled Dental Plan. Both plans are described beginning on page 23. You may enroll in either plan within 30 days of your date of hire or within 30 days after moving into the service area of the Prepaid Provider Dental Plan. Open enrollment periods are also held during which you may change the plan through which you receive your dental coverage.

No enrollment applications are required for dental coverage if you live outside the service area of the Prepaid Provider Dental Plan. You and your dependents will automatically receive your coverage through the Scheduled Dental Plan.

Other Applications As noted earlier, a special application is required if you wish to continue coverage beyond age 25 for a disabled child or if you wish to request coverage for a minor child that is related to you directly or through marriage. Applications for these purposes are available from the Boeing Group Insurance Office.

Effective Date of Coverage

If you are a newly hired employee, your coverage becomes effective on the first day of the month following one full calendar month of continuous employment provided you have completed any necessary enrollment forms. To complete a full calendar month, you must be on the Company's active payroll from the first regularly scheduled workday of a month through the last regularly scheduled workday of that month.

If you enroll in a plan at a later date or are transferring to the salaried payroll, your coverage becomes effective on the first day of the month following your enrollment or transfer.

If you are on an approved leave of absence on the date coverage is to become effective and the leave has not gone beyond 30 days, you will be considered on the active payroll and your coverage will become effective on that date. However, if the approved leave of absence has gone beyond 30 days, the effective date of your coverage will be the first of the month following your return to active work.

You continue to be eligible for coverage as long as you are on the active payroll on the first day of each calendar month. You are considered on the active payroll if you are on vacation or are absent due to an approved leave that has not then gone beyond 30 days. For coverage during a leave that goes beyond 30 days, see pages 31 and 32.

Coverage of your current dependents becomes effective on the same date your coverage becomes effective. New dependents are covered on the date of marriage or birth, or in the case of adoption, the date the child is legally placed in your home.

If you or a dependent (other than your natural newborn child) is hospitalized on the date coverage is to become effective, the effective date will be delayed until the date the dependent is released as an inpatient from the hospital.

For coverage of new dependents to become effective, you may be required to complete the necessary enrollment or health care information card.

For a description of when coverage terminates under these plans, see page 31.

Contributions

Boeing provides coverage for you and your eligible dependents under the Company-sponsored Medical and Dental Plans at no cost to you.

If you elect the health maintenance organization option described on page 22, the Company contributes toward your HMO coverage up to the greater of: the monthly cost for the Company-sponsored Medical Plan in the current year or the monthly cost for such coverage during 1986.

If the Company's contributions toward an HMO are less than the net HMO dues required for you and your family, you contribute the difference through payroll deductions. Your net HMO dues are the total monthly HMO dues for you and your enrolled family members less any amounts paid by or through other employers toward such coverage.

Under certain circumstances, you may also arrange to pay the full cost of coverage during a period when coverage would otherwise terminate. See the termination of coverage section on page 31 for an explanation of the provisions and procedures related to self-pay arrangements.

Medical Plan

This Plan provides you and your eligible dependents with financial protection against large health care expenses. Although you may receive care from any licensed health care provider that is covered under the Plan, you receive enhanced benefits if you receive your care through a member of the preferred network of health care providers. Use of preferred network providers also offers you certain other advantages, as explained in exhibit 1.

A summary of major plan features is provided in the sections that follow. You are especially encouraged to read the medical review program requirements (explained in exhibit 2) since the regular benefit payment levels under the Plan may be reduced or denied if the program requirements are not met.

Deductible Expenses

You and your eligible dependents are responsible each year for certain expenses, known as deductible expenses, before the Plan will begin paying benefits.

During a calendar year, deductible expenses for each person covered under the Plan are the first $75 of charges for covered medical services and supplies, up to an annual deductible maximum of $225 per family. Charges for all covered services and supplies, except those related to second surgical opinions, vision care and mail service prescription drugs, apply toward the individual and family deductible requirements.

In addition to the individual and family deductible expenses that must be paid once each calendar year, the Plan includes a separate *emergency room deductible.* The separate $25 deductible applies to each visit to a hospital emergency room that does not result in an immediate inpatient admission. If the patient is admitted as an inpatient immediately following treatment in the emergency room, the separate $25 deductible is waived.

Expenses that are included in the $25 emergency room deductible are not applied toward the $75 individual or the $225 family deductible. Instead, when hospital emergency room services are used, expenses will apply first to the $25 emergency room deductible, with any remaining expenses used to meet the individual or family deductible if these have not been satisfied for the calendar year.

Deductible expenses may not be waived by the health care provider.

Benefit Payment Levels

Once the required deductible expenses have been paid, you and your dependents receive benefits under a special plan benefit payment arrangement. Under this arrangement, the amount of the copayment that is your responsibility varies depending on the type of service or supply that is received as well as on the type of health care provider that is used.

The benefit payment levels described below do not generally apply to the mail service prescription drug program or to vision care services and supplies. See exhibit 3 on page 14 for a description of the mail service drug program and exhibit 4 on page 16 for the Plan's vision care schedule and terms.

After you and your dependents have paid the required deductible expenses, the Plan pays benefits according to the following guidelines. Please note that you must contact the medical review program before receiving certain types of care (as explained on pages 6 and 7) or Plan benefit payments may be reduced or denied.

1. *100 percent* payment for most physician and hospital services and supplies when received from a member of a preferred network of health care providers. Exhibit 1 offers more information about the preferred networks that are available under the Plan and the advantages of using network providers. (For special provisions relating to the coverage of specialty care when such care is not available through a preferred network, contact the Boeing Group Insurance Office.)
2. *100 percent* of the usual and customary charges for home health or hospice care or for care in a skilled nursing facility or birthing center, when used in place of hospital inpatient care.
3. *100 percent* of the usual and customary charges related to a second (and third) surgical opinion, including diagnostic, x-ray and laboratory services.

Exhibit 1
PREFERRED NETWORKS OF HEALTH CARE PROVIDERS

Preferred network providers are those physicians, hospitals and other health care providers who have entered into special contracts with the Plan's service representatives to provide efficient, cost effective health care. Although you may receive care from any licensed health care provider that is covered under the Plan, the Plan offers you certain advantages if you use a member of the preferred network.

Special fee arrangements between the service representatives and preferred network providers make it possible for the Plan to cover 100 percent of most physician and hospital services and supplies, after you have paid your deductible expenses. This means that in most cases, your only out-of-pocket expenses when you use a member of a preferred network are deductible expenses, expenses for noncovered services and supplies, and any amounts that exceed Plan maximum benefits.

In addition to greater benefits, use of preferred network providers offers you certain other assurances. For example, preferred network providers have agreed to assist you through the preadmission and prior approval procedures that are required under the Plan's medical review program (explained on pages 6 and 7). If prior approval is required but not obtained because of an oversight by the network provider, you will not be held financially responsible.*

Finally, the contracts with preferred network providers include direct billing and payment systems. This means that no claim form is required whenever you use a preferred network provider. Once you have paid any out-of-pocket expenses such as your deductible expenses, no further paperwork is usually required on your part.

*Although the network provider may assist you through the second surgical opinion requirements, you are solely responsible for obtaining the required second opinion.

Preferred networks are available in the following areas:

Alabama
(all counties)

California
(all counties)

Kansas
(Butler, Cowley, Harvey, Sedgwick & Sumner counties)

New Jersey
(Burlington, Camden, Gloucester & Salem counties)

Oregon
(Clackamas, Multnomah & Washington counties in Oregon; Clark county in Washington state)

Pennsylvania
(Bucks, Chester, Delaware, Montgomery & Philadelphia counties)

Washington, D.C. area
(including Montgomery and Prince Georges counties in Maryland, and Arlington and Fairfax counties in Virginia)

Washington state
(King, Kitsap, Pierce & Snohomish counties)

Since network service areas may change from time to time, you may wish to contact the Boeing Group Insurance Office to see if the above list has been updated. A directory of health care providers in preferred network service areas is available through the Boeing Group Insurance Office.

Exhibit 2
MEDICAL REVIEW PROGRAM REQUIREMENTS

Among the issues that a patient must consider when his or her physician recommends care is whether such care will be covered under the Medical Plan. Recognizing this, the Company has introduced into the Plan a medical review program that provides the patient and physician with information about coverage for certain types of nonemergency care before the patient decides to undergo the care and expense.

The Medical Plan pays its regular benefits for certain types of nonemergency care only if a person covered under the Plan contacts the medical review program before undergoing the care. The following explains the requirements of the review program. Please remember that benefits may be limited or denied if the review program requirements are not followed.

Please note that the medical review program requirements do not apply if care is received outside the service area of a preferred network of health care providers or if a person's primary coverage is provided through another employer's group medical plan.

Preadmission and Prior Approval Requirements

The Plan requires the patient or physician to contact the medical review program before a nonemergency admission to a hospital or skilled nursing facility, or before home health or hospice care is received. The information provided by the patient or physician is then reviewed against established medical criteria to determine the medical necessity of the care that is being recommended.

If care is received through a member of a preferred network of health care providers, the physician will assist the patient through the precertification and prior approval portions of the program. The patient simply presents the Medical Plan ID card and reminds the physician of the program requirements. If the preferred network physician does not contact the program after the patient has been identified as covered under this Plan, the patient will not be held financially responsible if Plan benefits are limited or denied, as explained below.

If care is received through a physician who is not part of a preferred network, the patient or physician should contact the service representative that is indicated on the lower right corner of the Medical Plan ID card. (The telephone number for the service representative's medical review program appears in exhibit 7 on pages 36 and 37.) Under these circumstances, the program should be contacted at least 10 days before the proposed admission.

Under this portion of the review program, benefits are paid as follows:

1. The Plan pays its regular benefits if the hospital, skilled nursing facility, home health or hospice care is approved through the medical review program.
2. Regular Plan benefits are reduced to 50 percent of the usual and customary charges for the care if preadmission or prior approval is required but not obtained, and it is later determined that the care was medically necessary. Under this provision, the patient's out-of-pocket expenses are limited to $1,000 (after deductible expenses have been paid) and include any out-of-pocket expense that may be required under the second surgical opinion requirements.
3. No benefits are paid if the admission or care does not meet the medical necessity criteria under the program.

Although contacting the program before emergency or pregnancy-related admissions is not required, the patient or physician may wish to contact the program shortly after admission to be assured that the remainder of the admission is covered under the Plan.

Second Surgical Opinion Requirements

The Plan also requires each covered person to obtain a second surgical opinion from an approved physician before undergoing certain listed procedures on either an inpatient or outpatient basis. The patient is solely responsible for obtaining a required second opinion under the program.

If one of the surgeries listed below is recommended, the patient should contact the service representative indicated on the lower right corner of the Medical Plan ID card to obtain the names, addresses and telephone numbers of physicians approved to give a second opinion. The patient must then receive a second opinion from an approved physician within six months before the surgery. (Under the provisions of the Plan, the physician who provides the second opinion may not perform the surgery and may not be an associate of the surgeon.)

Expenses related to the second opinion are paid in full. To receive proper credit for the second opinion, the patient should ask his or her physician to specify on the bill that the charges are for a second opinion.

Benefits for the surgery are paid as follows:

1. The Plan pays its regular benefits for the surgery as long as the required second opinion is received, whether or not the second opinion agrees with the original physician's recommendation.
2. Regular Plan benefits are reduced to 50 percent of the usual and customary charges for the surgery if the required second opinion is not received. Under this provision, the patient's out-of-pocket expenses are limited to $1,000 (after deductible expenses have been paid) and include any out-of-pocket expense that may be required under the preadmission and prior approval requirements.

Medical Advisory Services

The review program also offers a medical advisory service. Through this service, you and your dependents may receive information about such things as treatment alternatives and physician referrals. For example, if your physician recommends a surgery that does not require a second opinion, you may nevertheless contact the review program to obtain a list of physicians who would provide a voluntary second opinion.

Second Surgical Opinion Procedures

The codes listed after the following procedures are those listed in the most recent edition of *Current Procedural Terminology*. These CPT codes are subject to change in accordance with recommendations by the American Medical Association.

cholecystectomy—removal of the gall bladder
(CPT 47600-47620)

dilation and curettage—dilation of the cervix and scraping of the uterus
(CPT 58120)

excision (removal) of cataracts
(CPT 66830-66945, 66983, 66984)

hemorrhoidectomy—removal of hemorrhoids
(CPT 46221, 46250-46262, 46934-46936)

inguinal hernia repair—hernia in the groin
(CPT 49500-49525)

hysterectomy—removal of the uterus
(CPT 58150-58285)

knee surgery
(CPT 27330-27365, 27440-27447, 29870-29887)

laminectomy or spinal fusion—removal or welding of parts of the spine
(CPT 62295-63031, 63040-63064)

mastectomy—partial or complete removal of breast tissue
(CPT 19140-19240)

prostate surgery
(CPT 52601, 52612, 52614, 52650, 55801-55845)

septoplasty and/or rhinoplasty—nose surgery for functional improvement
(CPT 30400-30420, 30520 and 30620)

bunionectomy—removal of bunions
(CPT 28290-28299)

tonsillectomy and/or adenoidectomy
(CPT 42820-42836)

varicose vein stripping and ligation—removal and tying of varicose veins
(CPT 36470, 36471, 37700-37787)

coronary artery bypass
(CPT 33510-33528)

For all other expenses, the Plan pays a portion of the charges for covered services and supplies after you and your dependents have paid your deductible expenses. In these instances, the Plan pays:

1. *80 percent* of usual and customary charges for most other health care services and supplies, including those received from health care providers who are in a preferred network service area but who are not members of the network. Under this provision, when a person's copayment reaches $500 or a family's copayment reaches $1,000 in any calendar year, the Plan pays 100 percent of usual and customary charges for the remainder of that year.
2. *90 percent* of usual and customary charges for most physician and hospital services and supplies when received outside the service area of a preferred network. After the $500 individual or $1,000 family copayment limit is reached in a calendar year, the Plan pays 100 percent of usual and customary charges for the remainder of that year.
3. *50 percent* of the usual and customary charges for the outpatient treatment of mental illness, whether or not the health care provider is a member of a preferred network. These expenses do not apply to the individual or family copayment limits explained above.
4. *50 percent* of the usual and customary charges for the treatment of temporomandibular joint disease (TMJ) and myofascial pain-dysfunction syndrome (MPDS), up to a lifetime maximum benefit of $3,500. The 50 percent copayment level applies whether or not the health care provider is a member of the preferred network. In addition, these expenses do not apply to the individual or family copayment limits explained above.

Under the above plan payment levels, *your out-of-pocket expenses* include the amounts not covered under the 80 percent and 90 percent payment levels, and may also include any or all of those listed below. The following out-of-pocket expenses do not apply toward the $500 or $1,000 family copayment limits that are referred to under the 80 percent and 90 percent plan payment levels.

1. Calendar year deductible expenses.
2. The $25 emergency room deductible.
3. The 50 percent copayment amount for the outpatient treatment of mental illness or for the treatment of TMJ or MPDS that is not covered by the Plan.
4. The difference between the usual and customary charges for a service or supply (defined on page 35) and the health care provider's actual charge, when the provider has not agreed to accept usual and customary charges as full payment. (When a member of a preferred network is used, the patient is not responsible for this amount.)
5. Amounts that exceed benefit maximums (summarized on page 9).
6. Expenses that are not covered as a result of a benefit reduction or denial under the medical review program (explained on pages 6 and 7).
7. Expenses for services and supplies that are not covered under the Plan or for services and supplies that are subject to specific exclusions (see page 18).

Any offer by a health care provider to waive all or part of the above expenses will serve to reduce the usual and customary charge level used by the Plan to determine the appropriate benefit payment level.

Benefit Maximums

The following benefit maximums apply to you and each person covered under the Plan. Any benefits that have been paid under this or another Company-sponsored medical plan for active or retired employees are applied against these maximums unless they have been previously reinstated or restored.

A *$1 million lifetime maximum* applies to each person covered under the Plan. Included within this maximum are the following limitations:

1. A maximum of $500 per covered *hearing aid* per ear during any consecutive three years.
2. A maximum of 120 days of covered *skilled nursing facility care* during any calendar year.
3. A maximum of $4,000 for covered *treatment of substance abuse* during any calendar year.
4. A $3,500 lifetime maximum for the covered treatment of *temporomandibular joint disease (TMJ) and myofascial pain dysfuntion syndrome (MPDS).*
5. For covered care in a *private room in a hospital or skilled nursing facility,* a maximum benefit equal to the average charge for a semiprivate room in the facility where the admission occurs. (If that facility does not offer semiprivate rooms, the maximum benefit is equal to the average charge for a semiprivate room in similar facilities in the area.)

Medical Review Program

The medical review program is designed to let you and your physician know whether certain types of nonemergency care are covered under this Plan, before the patient undergoes the care or incurs the expense. The program is available in all preferred network service areas and may be contacted through the telephone numbers listed in exhibit 7 on pages 36 and 37.

The medical review program includes: preadmission certification requirements for inpatient hospital or skilled nursing facility care; prior approval procedures for home health and hospice care; second surgical opinion requirements for certain listed procedures; and medical advisory services. Each of these is explained in exhibit 2 on pages 6 and 7.

You are encouraged to review this information carefully since benefits may be limited or denied if you do not follow the medical review program requirements before undergoing certain types of care.

Covered Medical Services and Supplies

The Plan covers medically necessary services and supplies when they are used to diagnose or treat an accidental injury or illness. Such services and supplies are also covered for certain listed conditions, as explained beginning on page 15.

Coverage of the following services and supplies is subject to general plan provisions, including the exclusions listed on pages 18, 19 and 20 and the definitions that appear beginning on pages 34.

Physician Services The services of a licensed physician (M.D. or D.O.) are covered when they are medically necessary for the diagnosis or treatment of accidental injuries, illnesses or other covered conditions.

Physician services are also covered for the following:

1. Second surgical opinions required under the medical review program as well as voluntary second surgical opinions.
2. Injectable legend drugs (other than preventive injections and immunizations) that are used to treat a covered condition. (Antigen, allergy vaccine, insulin and other drugs and medicines are not covered as a physician service but may be covered under the prescription drug benefit.)
3. An eye examination (including refraction) by a physician if the exam is being provided because of the presence of another medical condition such as diabetes, glaucoma or cataracts. (Routine eye examinations are covered under the vision care benefits as described on page 16.)

4. Diagnostic x-ray and laboratory examinations when required by a physician to diagnose an illness or injury. In addition, the Plan covers such exams when they are used in connection with a required or voluntary second surgical opinion, a routine Papanicolaou's (PAP) test, or a routine screening mammogram. The Plan limits this coverage to one per year for routine PAP tests, and to once every two years for routine screening mammograms for covered persons who are 35 years of age or older.

   Coverage of computerized axial tomography (CAT) scans is limited as explained on page 19.

Other Professional Services The Plan covers certain health care services when provided either by a physician (M.D. or D.O.) or by another type of health care professional. Specifically, the Plan covers the health care professionals that are listed below, for the type of services indicated. All health care professionals must be licensed in the state in which the services are performed and must be acting within the scope of that license. In the absence of licensing requirements, appropriate certification is required.

1. Registered nurses for services that would have been covered if they had been performed by a physician licensed as an M.D. (However, the Plan does not cover such services if the nurse ordinarily lives in your home or is a member of your or your spouse's family.)
2. Clinical psychologists for the treatment of mental illness conditions covered under the Plan. (For the coverage terms related to mental illness treatment, see page 15.)
3. Physical, occupational and speech therapists for the services described on page 12.
4. Dentists for dental work or surgery covered under the Medical Plan. (For coverage of routine dental care, refer to the description of the Boeing dental plans that begins on page 23.)
5. Optometrists providing covered vision care services. (For coverage of routine vision care services, see the vision care schedule and terms that are described on page 16.)
6. Podiatrists providing covered podiatric services.
7. Chiropractors for the necessary adjustment by hand of any articulation of the spine.
8. Christian Science practitioners who are listed in the current Christian Science Journal at the time they provide a service.

Hospital Services and Supplies The Plan covers the charges for a semiprivate room and the medically necessary hospital services and supplies needed to treat an accidental injury, illness or other covered condition. When a nonemergency admission is planned in the service area of a preferred network of health care providers, it must be precertified under the medical review program, as explained on pages 6 and 7.

If a private room is used, you are responsible for the difference between the charge for the private room and the hospital's average charge for a semiprivate room. If the hospital does not provide semiprivate rooms, the Plan pays up to the level being charged for semiprivate rooms in similar facilities in the area.

Covered hospital services and supplies include: operating rooms and equipment; surgical dressings and supplies; x-ray and laboratory services; electrocardiograms; anesthesia, including administration and materials; pathology; drugs (excluding blood and blood derivatives); and the administration of blood.

Other covered services include outpatient surgery at a hospital if the second surgical opinion requirements under the medical review program are met, and emergency room treatment of an accidental injury or illness. (See page 4 for a description of the special $25 emergency room deductible.)

Skilled Nursing Facility Services and Supplies The Plan covers the charges for a semiprivate room in a skilled nursing facility as well as the medically necessary services and supplies for the treatment of an accidental injury, illness or other covered condition only if the skilled nursing facility care is provided in place of hospital inpatient care. When a nonemergency admission is planned in the service area of a preferred network of health care providers, it must be precertified under the medical review program, as explained on pages 6 and 7.

If a private room in a skilled nursing facility 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 does not provide semiprivate rooms, the Plan pays up to the level being charged for semiprivate rooms in similar facilities in the area.

The Plan covers care in a skilled nursing facility for up to 120 days in any calendar year. If additional care is required, you may apply to the service representative for an extension of benefits. Limited extensions may be granted if the service representative determines that the continued care is medically necessary.

Home Health Care Services When provided in the service area of a preferred network of health care providers, home health care requires prior approval under the medical review program, as explained on pages 6 and 7.

The Plan covers medically necessary home health care services if inpatient care in a hospital or skilled nursing facility would otherwise be required. In addition, the patient must be considered "homebound," which means that leaving home involves a considerable and taxing effort and public transportation cannot be used without the help of another.

Before the patient begins receiving home health care, the physician must develop a written treatment plan. Then, at least once every two months, the physician must review the treatment plan and certify that the patient's condition and treatment continue to meet the above criteria.

The Plan covers the following home health care services and supplies if they are provided by employees of an approved home health agency and billed through the agency:

1. Physician services.
2. Nursing services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.).
3. Physical therapy services provided by a physical therapist.
4. Speech therapy services provided by a speech therapist.
5. Occupational therapy services provided by an occupational therapist.
6. Medical social services provided by a person with a master's degree in social work.
7. Home health aide services.
8. Respiratory therapy services provided by an inhalation therapist certified by the National Board of Respiratory Therapists.
9. Medical supplies that would have been provided on an inpatient basis.
10. Nutritional supplements (such as diet substitutes) administered intravenously or through hyperalimentation.

The Plan covers prescription drugs and medicines as well as durable medical equipment for home health care on the same basis as for other types of care.

A list of exclusions that apply to home health care services appears on page 19.

Hospice Care Services Hospice care services are provided to terminally ill patients in an effort to control the pain and other symptoms associated with terminal illness. The Plan provides coverage of these services, according to the following guidelines, for the patient whose life expectancy has been determined to be six months or less.

When provided in the service area of a preferred network of health care providers, hospice care requires prior approval under the medical review program, as explained on pages 6 and 7.

Before the patient begins receiving hospice care, the physician must develop a written treatment plan. Then, at least once every two months, the physician must review the treatment plan and certify that the patient's condition and treatment continue to meet the above criteria.

An approved hospice treatment plan may include both inpatient and outpatient care. If hospital inpatient care is approved, the Plan provides coverage for hospice care on the same basis as it does for other types of care (see page 10). Care in a skilled nursing facility or in a hospital outpatient setting is also covered for the hospice patient on the same basis as for others.

Outpatient hospice care in the home is covered if the physician certifies that the patient is "homebound" and would otherwise require hospital inpatient care or care in a skilled nursing facility. A patient is considered homebound if leaving home involves a considerable and taxing effort and public transportation cannot be used without the help of another.

The Plan covers the following hospice home care services and supplies if they are provided by employees of an approved hospice agency and billed through the agency:

1. Physician services.
2. Nursing services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.), within the limitations described below.
3. Physical therapy services provided by a physical therapist.
4. Speech therapy services provided by a speech therapist.
5. Occupational therapy services provided by an occupational therapist.
6. Medical social services provided by a person with a master's degree in social work.
7. Home health aide services, within the limitations described below.
8. Respiratory therapy services provided by an inhalation therapist certified by the National Board of Respiratory Therapists.
9. Medical supplies that would have been provided on an inpatient basis.
10. Nutritional supplements (such as diet substitutes) administered intravenously or through hyperalimentation.
11. Respite care services (to provide temporary relief of family members or friends from the duty of caring for the patient), within the limitations described below.

The Plan covers prescription drugs and medicines as well as durable medical equipment for hospice care on the same basis as for other types of care.

Visits by a registered nurse, licensed practical nurse or home health aide to provide skilled care are covered if they are for a minimum of four or more hours, up to a total of 120 hours. Similarly, respite care visits are covered if they are for a minimum period of four or more hours per day, up to a total of 120 hours per three-month period.

Under certain circumstances, the Plan may extend hospice benefits beyond the skilled and respite care maximums described above. If your physician recommends an extension, you should apply to the appropriate service representative at the address listed on page 36 or 37.

A list of exclusions that apply to hospice care services appears on page 19.

Christian Science Sanatorium Services and Supplies The Plan covers the charges for a semiprivate room in a sanatorium if the patient is admitted for the process of healing (not rest or study) and is 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 does not provide semiprivate rooms, the Plan pays up to the level being charged for semiprivate rooms in similar facilities in the area.

Physical, Occupational and Speech Therapy Services The Plan covers certain types of therapy only to the extent that the therapy will significantly restore function. The services of a physical therapist are covered for the administration of physical therapy (but not other types of therapy) to restore function. In addition, the Plan covers an occupational therapist's services for occupational therapy that is for physical restoration, and a speech therapist's services to restore function when prescribed by a physician as to type and duration.

All such therapy services must be provided under a physician's supervision, and the patient must continue under the care of the attending physician during the time the therapy is being provided. The attending physician must evaluate the therapy treatment at least once every three months and certify that continuing therapy is required.

Physical, occupational and speech therapists must meet licensing or certification requirements, as explained in the definitions that begin on page 34.

Ambulance Services The Plan covers professional ambulance services when the ambulance is used to transport the patient from the place where he or she is injured or becomes ill to the first hospital where treatment is given. Such services are also covered when the physician requires the use of an ambulance to transport the patient from a hospital to the patient's area of residence for the protection of the patient's health or life.

Ambulance service from one hospital to another, including return, is covered only in situations where evidence clearly establishes that the institution to which a patient is being transferred is the nearest one having appropriate regional specialized treatment facilities, equipment or staff physicians. No other expenses in connection with travel are covered.

Prescription Drugs and Medicines The Plan covers only those drugs and medicines that legally require a physician's prescription. The only exceptions to the prescription requirement are insulin when provided for known diabetes, and digitalis and nitroglycerin for known heart conditions.

The Plan offers you and your dependents two coverage options for prescription drugs and medicines. Under the first option, you and your dependents may receive a covered prescription drug or medicine through any licensed pharmacist, and have it covered under the general terms of the Plan. As an alternative, you may use a mail service program to obtain maintenance prescription drugs that are taken on an ongoing basis for a chronic medical condition. Maintenance prescription drugs obtained through the mail service program are covered at 100 percent and are not subject to the Plan's deductible.

Exhibit 3 further explains your prescription drug coverage under these two options.

Vision Care Services and Supplies The Plan covers vision care services and supplies as explained in exhibit 4. The deductible requirements and general benefit payment levels of the Plan do not apply.

Hemodialysis The Plan covers hemodialysis treatment in the patient's home when it is repetitive and for chronic, irreversible kidney disease. Covered services and supplies include the rental or lease of hemodialysis equipment.

Under certain conditions, the Plan may cover the purchase of major hemodialysis equipment and supplies as well as the necessary training for the operation of the dialyzer. For purchased supplies to be covered in these instances, the items must be of no real use to the patient in the absence of the disease and must be of no value to other household members. The specific conditions, including an amortization period, that apply to the purchase of the equipment are established by the service representative.

Hearing Aids The Plan covers up to $500 toward the cost and installation of a hearing aid when recommended in writing by a physician who is certified as an otolaryngologist. The number of hearing aids for each covered person is limited to one per ear during any consecutive three-year period, including any time covered under another Company-sponsored medical plan.

The Plan does not cover: hearing or audiometric examinations, unless disease is present; replacement of lost, broken or stolen hearing aids unless the three-year time period has been exhausted; replacement parts, including batteries, for the repair of hearing aids; hearing aids that do not meet professionally accepted standards, including any services and supplies that are experimental in nature; eyeglass-type hearing aids if the charge exceeds the covered amount for one hearing aid; hearing aids ordered before a person becomes eligible for coverage or after coverage terminates; and hearing aids ordered before termination of coverage but delivered more than 60 days after coverage terminates.

Other Covered Services and Supplies The Plan also covers the following types of services and supplies:

1. X-ray, radium and radioactive isotope therapy.
2. Anesthesia and oxygen.
3. The rental (or purchase when approved by the service representative) of durable medical or surgical equipment when manufactured and used exclusively for the therapeutic treatment of the patient.
4. Artificial limbs, eyes and other prostheses, including the necessary repair and replacement required by normal usage or change in the patient's condition.
5. Orthopedic appliances and braces, including necessary repair and replacement required by normal usage or change in the patient's condition.

Exhibit 3
PRESCRIPTION DRUG AND MEDICINE COVERAGE

The Medical Plan offers two coverage options for prescription drugs and medicines. Under the regular terms of the Plan, you and your dependents may obtain a covered prescription through any licensed pharmacist. Or as an alternative, you may use the mail service program to order maintenance prescription drugs that are taken on an ongoing basis to control a chronic medical condition. Each of these options is described below.

Medical Plan Coverage

The Medical Plan covers medically necessary prescription drugs and medicines that are required by federal law to be prescribed in writing by a physician or dentist and to be dispensed by a licensed pharmacist.

When you or a dependent receives a covered prescription through your pharmacist, you are responsible for the full cost of the drug or medicine. You must then submit a claim to the Medical Plan's service representative for reimbursement.

Under this option, coverage is subject to all Plan provisions. This means that any expenses for covered drugs and medicines are applied to your individual and family deductible requirements. Once you have paid your applicable deductible expenses in a calendar year, the Plan's 80 percent copayment level applies until you reach the Plan's $500 individual or $1,000 family copayment limits. (See page 4 for additional information about Plan payment levels.) Coverage is also subject to the general exclusions and limitations of the Plan.

Mail Service Program

This option is provided as an alternative for people who must take maintenance drugs on an ongoing basis for a chronic medical condition. There are no deductibles or copayments. As a result, you may receive covered prescription drugs and medicines at no cost to you through this program.

As with the other option, you receive coverage for medically necessary prescription drugs and medicines that are required by federal law to be prescribed in writing by a physician or dentist and to be dispensed by a licensed pharmacist. This includes insulin when prescribed by a physician as well as needles and syringes when prescribed along with insulin.

This program covers up to a 90-day supply per prescription or refill, if prescribed by your physician. Authorized refills are covered only after the initial order has been used. Certain controlled substances are subject to quantity limitations.

Unless your physician indicates otherwise, you will receive a generic equivalent of the prescribed drug when available and permissible under the law.

Forms for ordering prescription drugs through this program are available from the Boeing Group Insurance Office.

Exclusions that apply to this program are listed below.

Mail Service Program Exclusions The following items are not covered under the mail service program:

1. All contraceptives, whether medication or device, regardless of intended use.
2. Appliances, devices and other non-drug items, including but not limited to contraceptive devices, therapeutic devices and artificial appliances. However, this does not apply to needles and syringes when prescribed along with insulin.
3. Any charges for the administration or injection of any drug.
4. 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 municipality, state or federal program, including Medicare.
5. Any prescription filled in excess of the number prescribed by the physician or any refill after one year from the date of the physician's order.
6. Immunizing agents, except allergy serum (antigen).
7. Drugs dispensed during an inpatient admission by a hospital, skilled nursing facility, sanatorium or other facility.
8. Experimental drugs or ones used for investigational purposes.
9. Drugs that are not medically necessary for the treatment of an illness, injury or other covered condition, including vitamins.

Covered Conditions

The Plan covers the services and supplies described in the preceding section when they are for the treatment of accidental injuries and illnesses. These services and supplies are also covered for certain specific conditions. The following is a summary of the coverage provisions related to these conditions.

Pregnancy-Related Conditions Medically necessary services and supplies are covered for pregnancy-related conditions for employees and dependent wives if they are provided while the patient is covered under this Plan. Services and supplies are considered for the treatment of a pregnancy-related condition if they are specifically related to the pregnancy, and if they are provided during the pregnancy or within 90 days following the termination of the pregnancy.

Covered pregnancy-related conditions include normal delivery, spontaneous abortion (miscarriage), legal abortion and complications of pregnancy. In addition, if the mother is eligible for benefits, the following services and supplies are covered for the newborn child:

1. Routine hospital services and supplies for the first 10 days of nursery care for a healthy child.
2. Physician services during the first two days following birth.

For a newborn child that is ill, injured or born prematurely, the Plan covers the above hospital and physician services and supplies. In addition, if the child is an eligible dependent and is enrolled in the Plan, coverage is provided for all other services and supplies that are normally covered under this Plan. This includes treatment for hereditary complications and congenital abnormalities.

Coverage of a newborn child continues as long as the child remains an eligible dependent and is enrolled in the Plan.

Coverage of the services of an approved birthing center are covered if such services would be covered if received in a hospital.

Congenital Abnormalities and Hereditary Complications The Plan covers medically necessary services and supplies that are required for the treatment of congenital abnormalities and hereditary complications. This coverage applies to newborn children, as noted under pregnancy-related conditions, as well as to all other persons covered under the Plan.

Substance Abuse Treatment The Plan pays up to $4,000 per covered person in any calendar year for the effective treatment of alcoholism and other types of substance abuse. This includes coverage of treatment at an approved treatment facility or hospital as well as physician services and prescription drugs when provided in connection with a specific treatment plan prepared by your physician. If treatment is provided at an approved treatment facility, coverage is limited to the intensive inpatient treatment and outpatient counseling services that have been prescribed by your physician.

The Plan does not cover: recovery houses that provide an alcohol- or drug-free residential setting; alcohol or drug information and referral services; school programs; emergency service patrols; or detoxification unless immediately followed by a rehabilitation program.

To receive coverage of substance abuse treatment, the patient must complete the prescribed course of treatment.

Mental Illness Treatment The Plan covers inpatient services and supplies for the treatment of mental illness on the same basis as other medical conditions. This includes the services of a physician and hospital, as well as those provided by a licensed community mental health agency with an inpatient facility when approved by the service representative.

The Plan also covers the services of a physician, licensed day or night care center, and licensed mental health agency approved by the service representative when provided for outpatient treatment of mental illness. The Plan payment level for such outpatient treatment is 50 percent of the usual and customary charges for the treatment.

If the mental illness is related to, accompanies or results from substance abuse, coverage of the treatment will be provided solely under the substance abuse provisions explained above.

Oral Surgery The Plan covers certain services and supplies provided by a physician or dentist for oral surgery to the extent that they are not covered under your Company-sponsored dental plan. The Plan also covers hospital services and supplies (as described on page 10) and general anesthesia when medically necessary.

The Medical Plan covers such services and supplies when provided for the prompt repair of natural teeth or other body tissues as a result of an accidental injury. This may include surgical procedures of the jaw, cheek, lips, tongue or other parts of the mouth as well as treatment of fractures of the facial bones (maxilla or mandible).

Exhibit 4
VISION CARE BENEFITS

The Medical Plan covers the following vision care services and supplies:

1. Eye examinations, which must include refraction, when performed by a legally qualified ophthalmologist or optometrist.
2. Prescription lenses and frames required for such lenses.
3. Contact lenses when elected in place of conventional lenses and frames.

Benefit Payment Levels

Coverage of vision care services and supplies is subject to all Plan provisions except the deductible and copayment features. The Plan pays benefits according to the following schedule:

Services & Supplies	*Maximum Benefit*
Eye examination	$ 45 paid-in-full when performed by a preferred network provider
Lenses:	
single vision (two lenses)	$ 45
bifocal (two lenses)	74
trifocal (two lenses)	87
lenticular (two lenses)	140
Frames	$ 35
Contact lenses (two lenses) covered in place of conventional lenses and frames	$ 95

Benefit Limitations

The Plan covers up to one eye examination and two sets of lenses and frames during each consecutive 24-month period that you or an eligible dependent is covered under this or another Company-sponsored plan. A 24-month period begins for each covered person on the date the person receives prescribed lenses and/or frames. The repair or replacement of lost, stolen or broken lenses and/or frames is considered part of the two-set limitation.

Exclusions

The Plan does not cover the following vision care services and supplies:

1. Special supplies, such as nonprescription sunglasses and subnormal vision aids.
2. Special lens treatment, such as seamless lenses (e.g., Varilux and Ultra-vue), anti-reflective coatings and tinting, when such treatment is provided for an extra charge.
3. Services and supplies that are not specifically listed as covered. (Coverage may, however, be provided under the general terms of the Medical Plan.)
4. Services and supplies that are received while the person is not covered under the Plan, or lenses and frames that are furnished or ordered before the date the person becomes covered. However, lenses and frames that are ordered within 30 days after coverage terminates are covered under the general terms of the Plan if the person receives a complete eye examination, including refraction before coverage ends, and the examination results in a new prescription or a change in the person's prescription.

To be covered, the injury must occur while the patient is covered under the Plan, and treatment must be provided in the same calendar year or the calendar year following the date of the accident. In addition, any teeth being repaired must have been free from decay, or in good repair, and have been firmly attached at the time of the accident. If crowns, dentures, bridgework or in-mouth appliances are installed as a result of the accident, the Plan covers only the first denture or bridgework to replace lost teeth, the first crown to repair each damaged tooth, or the in-mouth appliance that is installed as the first course of orthodontic therapy following the injury.

In addition to the coverage of oral surgery related to an accidental injury, the Plan covers medically necessary services for medical conditions if such services are not covered under your Company-sponsored dental plan and they are not related to the correction of the gums, teeth or tissues of the mouth for dental purposes. This includes the following medical conditions:

1. Excision of a tumor or cyst of the jaw, cheek, lips, tongue, or roof or floor of the mouth.
2. Excision of exostoses of the jaw and hard palate.
3. Incision and drainage of cellulitis.
4. Incision of accessory sinuses, salivary glands or ducts.

The Plan also covers services in connection with the correction of developmental abnormalities of the jaw or malocclusion of the jaw by osteotomy (the surgical cutting of the bone or bony tissue) with or without bone grafting performed by either a physician or dentist.

The Plan does not cover services and supplies related to the correction of the gum, teeth or tissues of the mouth for dental purposes. This includes services and supplies related to the removal, repair, replacement, restoration or repositioning of teeth lost or damaged in the course of biting or chewing.

When any of the above services and supplies are related to the diagnosis or treatment of TMJ or MPDS, coverage is provided as follows.

Temporomandibular Joint Disease (TMJ) and Myofascial Pain Dysfunction Syndrome (MPDS) Treatment The Plan covers the following surgical and nonsurgical services and supplies for the treatment of TMJ and MPDS when provided by a physician or dentist:

1. Initial diagnostic examinations and x-rays.
2. Follow-up office visits.
3. Surgical procedures and related hospitalization.
4. Appliances, including nightguards, bite plates, orthopedic repositioning devices, or mandibular orthopedic devices.
5. Appliance management, including kinesiotherapy, physical therapy, biofeedback therapy, joint manipulation, prescription drugs, injections of muscle relaxants, and therapeutic drugs or agents.

As explained on page 8, the Plan payment level for TMJ and MPDS treatment is 50 percent of the usual and customary charges, up to a maximum lifetime benefit of $3,500 per covered person.

The Plan does not cover: restorative techniques to build occlusion unless the tooth is diseased or accidentally damaged; nonsurgical orthodontic treatment, except as noted above; and banding treatment.

Human Organ Donor If you or a covered dependent receives a human organ or tissue transplant that is covered by the Plan, certain donor expenses may also be covered. Specifically, physician and hospital services and supplies are covered under this Plan for the surgical removal of the organ or tissue if the donor is a hospital inpatient. Coverage is provided from the day of surgery and continues for up to a maximum of ten additional consecutive days, as long as the donor remains a hospital inpatient.

The Plan does not cover: organ selection, transportation or storage costs; non-human organ or tissue transplants; services and supplies for the donor when the donor is covered under another group benefit plan; donor expenses when government funding is available.

Donor expenses that are covered under this Plan are applied against the maximum benefit limits (described on page 9) for the recipient covered under this 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 that occurs while the person is covered under the Plan.

Reconstructive Breast Surgery The Plan also covers necessary services and supplies for reconstructive breast surgery following or coinciding with a mastectomy that is performed as a result of an illness or injury. Also covered is the first external as well as the first permanent internal breast prosthesis.

Vasectomy or Tubal Ligation The Plan covers services and supplies that are required for a vasectomy or tubal ligation, but not those related to a reversal.

Surgical Treatment for Morbid Obesity The Plan covers the medically necessary services and supplies required for the surgical treatment of morbid obesity only if all of the following criteria are met:

1. The patient is 100 or more pounds overweight based on life insurance tables and has been for at least five years.
2. Use of a prolonged, guided medical treatment program for at least one year has failed to resolve the condition.
3. The patient has been given an adequate medical workup to show that there is an absence of any correctable endocrine problem that could be causing the obesity, and the workup shows that the patient suffers from an abnormal calcium metabolism or malabsorption state.
4. The patient has other conditions that are severely aggravated by the obesity, e.g., hypercholesterolemia, hypertension, coronary artery disease, diabetes mellitus or respiratory insufficiency.
5. The patient has received a psychologic evaluation and, if necessary, a formal consultation.
6. There are adequate persons and facilities available to perform careful surgical and medical follow-up after the surgery.

If all of the above conditions are met, the patient should apply to the service representative for certification of the surgery. Prior approval is recommended.

Medical Plan Exclusions

The Plan does not cover the items listed below. Charges for these items are deducted from a health care provider's bill before the Plan pays its benefits for covered services and supplies.

1. Expenses during the first 12 months of a person's coverage to the extent that they are in connection with a preexisting condition (as defined on page 35).

   The continuous time spent by a covered person under another Company-sponsored medical plan or an approved health maintenance organization (HMO) that is not federally qualified will be credited against the 12-month requirement if such coverage was in effect immediately before coverage under this Plan became effective.

   This exclusion does not apply to the coverage of hearing aids or routine vision care expenses. It also does not apply to a person who transfers to this Plan directly from an approved, federally qualified HMO provided the person was covered under the HMO as a Boeing employee or dependent.
2. Expenses in connection with an occupational accident or illness covered by a workers' compensation law.
3. Expenses related to an intentionally self-inflicted injury.
4. Expenses related to services and supplies that are not medically necessary for the treatment of an accidental injury, illness or other condition covered under the Plan. This applies to routine physical examinations, immunizations, and other preventive services and supplies, except PAP tests and screening mammograms (as explained on page 10).

   Inpatient hospital care 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 the patient's physical condition. Examples of care that should generally be provided in an outpatient setting include: observation and/or diagnostic studies; surgery that can be performed on a same-day basis; and psychiatric care that is primarily aimed at controlling or changing the patient's environment.
5. Expenses for services or supplies that are not recommended and approved by a physician or other covered health care professional (see page 9), or that are provided before the person becomes covered under this Plan.
6. Expenses for experimental or investigational services and supplies (as defined on page 34), and related complications.
7. Expenses for custodial care.

8. Expenses for skilled nursing facility services when the services are not usually provided by such facilities or when the services 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.
9. Charges for the following home health care services:
   - homemaker or housekeeping services.
   - services provided by volunteers, household members, family or friends.
   - unnecessary and inappropriate services, food, clothing, housing or transportation.
   - supportive environmental services or equipment such as but not limited to wheelchair ramps or support railings.
   - social services.
   - psychiatric care.
   - maintenance or custodial care.
   - supplies or services that are not included in the written treatment plan or not otherwise specifically covered.
10. Charges for the following hospice services:
   - volunteer services or spiritual counseling.
   - services to other family members, including bereavement counseling.
   - financial or legal counselor services.
   - homemaker or housekeeper services.
   - services provided by household members, family or friends.
   - unneccessary and inappropriate services, food, clothing or transportation.
   - supportive environmental services or equipment such as but not limited to wheelchair ramps or support railings.
   - social services.
   - psychiatric care.
   - maintenance or custodial care.
   - services or supplies not included in the written treatment plan or not otherwise specifically covered.
11. Expenses for services or supplies for a prosthesis in connection with impotency, or for services or supplies that are required in connection with a sex transformation.
12. Expenses related to the reversal of a sterilization procedure, or in connection with in-vitro fertilization, artificial insemination or embryo transfer procedures.
13. Expenses for services and supplies to the extent that they are covered under another Company-sponsored plan that has been discontinued or to the extent that they are covered under any federal, state or other governmental plan. This does not apply to Medicare coverage at any time when compliance with federal law requires that this Plan provide primary coverage for the person before Medicare will pay its benefits.
14. Expenses to the extent that coverage is available under any automobile medical, personal injury protection (PIP), automobile no-fault, automobile uninsured or underinsured motorist, homeowner, or commercial premises medical contracts. Any benefits paid by this Plan before benefits are paid under one of these other types of contracts or insurance are provided to assist the patient, and do not indicate that the service representative is acting as a volunteer or that the representative is waiving any right to reimbursement or subrogation (see page 20).
15. Expenses related to inpatient care in a U.S. government hospital or for any other type of care received from such a hospital, except as required by federal law.
16. Expenses for services or supplies for which there is no charge made to the employee or dependent or for charges that the employee or dependent is not required to pay.
17. Expenses for dyslexia, visual analysis therapy or training related to muscular imbalance of the eye, or for orthoptics. However, such expenses are covered for up to six months when the care is required to correct a muscle imbalance (strabismus squint, esotropia or exotropia), and treatment begins before the person's 12th birthday.
18. Expenses in connection with radial keratotomy or other eye surgery to correct refractive errors, except when preoperative visual acuity is 20/50 or less with a lens.
19. Expenses in connection with the use of a computerized axial tomography (CAT) scanner for a full body scan other than at or in a hospital or at an institution that has an agreement with a hospital to supply such services. However, expenses are covered under other circumstances if: the services are required and certified by the physician as requiring the immediate use of the equipment to diagnose a potentially life threatening condition; or the services are provided at a physician's office, clinic or other institution approved by the Company for other than emergency use.

20. Expenses for the treatment of anorexia nervosa, bulimia or any similar condition, except when covered as treatment of mental illness under the terms described on page 15.
21. Expenses for services and supplies related to the following: cosmetic surgery (except as described on page 17); obesity (except for the surgical treatment of morbid obesity as a last resort as described on page 18); substance abuse treatment (except as described on page 15); TMJ and MPDS treatment (except as described on page 17).
22. Charges for services and supplies for a pregnancy-related condition for dependent children unless otherwise required by law.
23. Charges for services or supplies that are required by law to be provided by any school system.
24. Charges for education, special education or job training whether or not provided by a facility that also provides medical or psychiatric care.
25. Charges in connection with marriage counseling, family or child counseling, career counseling, social adjustment counseling, pastoral counseling or financial counseling.
26. Charges to the extent that they exceed usual and customary amounts.
27. Charges for the completion of claim forms.

When an Injury is Caused by the Negligence of Another

If a third party is legally liable for an injury to a person covered under this Plan, regular Plan benefits will be paid if the injured person agrees to cooperate with the service representative in the administration of the Plan's subrogation rights by providing all necessary and requested information and by submitting bills related to the injury to any applicable insurer. The injured person must also agree to reimburse the Plan if he or she recovers from the liable party or any other source.

Coordination of Benefits

If you or your dependents have group medical, dental or other health care coverage in addition to being covered under the Boeing Medical Plan, the benefits from the other group plans are taken into account before benefits are paid under this Plan. Other group coverage includes another employer's group benefit plan or other arrangement of coverage for individuals in a group, whether insured or uninsured.

The group plan that pays its benefits first is considered the primary plan of coverage and will pay its benefits without regard to benefits that may be payable under other plans. When another group plan is the primary plan for medical coverage, the Boeing Medical Plan will pay the difference between the benefits paid by the primary plan and what would have been paid had the Boeing Plan been primary.

The following rules are used to determine which group plan will be considered the primary plan.

1. A plan that does not contain coordination of benefits provisions will pay its benefits before a plan that includes such provisions.
2. A plan that covers a person other than as a dependent will pay before a plan that covers the person as a dependent.
3. If a dependent child is covered under both parents' group plans, the child's primary coverage will be provided through the parent whose birthday comes first in the calendar year, with secondary coverage being provided through the parent whose birthday comes later in the calendar year. If the other group plan does not rely on this "birthday rule" but rather relies on gender to determine benefit coordination, then the "gender rule" used by the other plan will determine the order by which the plans will pay benefits.

4. If a dependent child's parents are divorced or separated, the following guidelines will be used:

   a. The plan of the parent with custody will pay its benefits first if that parent has not remarried. The plan of the parent without custody will pay second.

   b. If the parent with custody has remarried, then the plans will pay in the following order: the plan of the parent with custody, the plan of the spouse of the parent with custody, the plan of the parent without custody, and the plan of the spouse of the parent without custody.

   c. If a court decree establishes financial responsibility for the health care coverage of the child, the plan of the parent with such financial responsibility will be the primary plan of coverage.

5. If none of the above rules is able to establish which group plan should pay first, then the plan that has covered the person for the longest period of time will be considered the primary plan of coverage.

Benefits under the Boeing Medical Plan will not be coordinated with benefits paid under any another group plan offered by or through Boeing.

The service representative has the right to obtain and release any information or recover any payment it considers necessary to administer these provisions.

The exclusion of governmental benefits and services is described in the exclusions section of the Plan.

How to File a Claim

The Boeing Medical Plan is administered by a national network of Blue Cross and Blue Shield service representatives. The service representative for your area is indicated on the front of your Boeing Medical Plan ID card. In addition, a list of the representatives across the country and their addresses appears in exhibit 7 on pages 36 and 37.

In most instances, your physician or other health care provider will bill the Plan directly. Simply present your Boeing Medical Plan ID card to identify yourself as covered under this Plan. (For a description of how to claim benefits under the prescription drug coverage options, please refer to exhibit 3 on page 14.)

Most physicians and hospitals who are members of an approved network of health care providers have agreed to submit their itemized bills directly to the Plan's service representative. Many health care providers who are not members of an approved network will also bill the service representative for you. Under these circumstances, no claim form is required.

If direct billing is not available to you, you should submit the appropriate claim form along with an itemized bill to the service representative indicated below, based on the area where the care is received.

1. *In Alabama, California, Kansas, Oregon, Pennsylvania, the Washington, D.C. area (including Virginia and Maryland) or Washington state,* submit the claim form and itemized bill to the Blue Cross or Blue Shield service representative in that state or area.
2. *In New Jersey and Delaware,* submit the claim form and itemized bill to the service representative for Pennsylvania.
3. *In all other areas,* submit the claim form and itemized bill to the service representative identified on the front of your ID card.

All claim forms are available from or through the Boeing Group Insurance Office.

Health Maintenance Organization Option

Approved health maintenance organizations (HMOs) offer you and your family an alternative to the Boeing Medical Plan described on pages 4 through 21. An HMO is an organization of physicians and other health care providers that offers a total health care program for a fixed monthly cost. In most cases, all care (except certain types of emergency care) must be received through the HMO's physicians and facilities.

You may elect to receive coverage through one of the approved HMOs listed below if you live in the HMO's service area. For a description of an approved HMO's service area, contact the Boeing Group Insurance Office.

1. Group Health Cooperative of Puget Sound
2. HealthPlus
3. Virginia Mason MedCenters
4. Kaiser Foundation Health Plan of the Northwest
5. Equicor Health Care Plan (formerly Health Care Plus)
6. Prudential Health Care Plan
7. Kaiser Foundation Health Plan of the Mid-Atlantic States
8. Network Health Plan Corporation
9. Health Maintenance Organization of Pennsylvania/ New Jersey
10. Maxicare of Philadelphia
11. Greater Delaware Valley Health Care
12. HIP of New Jersey
13. Total Health Plus
14. HMO of Delaware

If you are a newly hired employee who meets the eligibility requirements explained on page 2, you may enroll in one of these HMOs during the first 30 days of your employment. You and your eligible dependents must all be enrolled in the same plan.

After the initial 30-day enrollment period, transfer between plans is permitted only during an authorized annual open enrollment period or if you move into or out of an HMO's service area. Following a change in your residence, you have 30 days to select from among the alternate benefit plans that are available in your new location.

If you elect coverage through an approved HMO, you may be required to contribute toward the cost of such coverage. The amount of your contribution, if any, is determined as explained on page 3.

Since the cost of coverage under an HMO is determined by the number of people in your family who are covered, you must complete a new enrollment card if you have a change in your family as a result of marriage, birth, divorce, marriage of a child, or other event. The new card should be completed within 30 days of the change. HMO enrollment cards are available from the Boeing Group Insurance Office.

A summary comparison of medical plan options, including the Boeing Medical Plan and all approved HMOs in your area, is available from the Boeing Group Insurance Office. In addition, you may request from an HMO specific information about the HMO's program of coverage, including the nature of the services provided by the HMO, conditions under which you and your family are eligible to receive such services, the circumstances under which services may be denied, the procedures to follow to obtain services, and the procedures for a review of when services are denied.

Dental Plan Options

Most salaried employees and their dependents have a choice between two Company-sponsored dental plans: the Prepaid Provider Dental Plan and the Scheduled Dental Plan. Both plans cover all necessary and appropriate dental care, including specialty care. The major differences are in the level of copayments that are your responsibility under each plan and in your selection of dentists.

Your Choices

If you live in the Seattle, Portland or Wichita area, you may choose between the Prepaid Provider Dental Plan or the Scheduled Dental Plan for your dental coverage. To receive coverage under either plan, you must complete the appropriate enrollment card.

All covered family members must be enrolled in the same plan. In addition, if you elect the Prepaid Provider Dental Plan, your eligible dependents must receive their dental care from or through the participating dentist you select.

Transfer between dental plans is permitted only during authorized open enrollment periods. However, if you or one of your dependents moves into or out of the service area of the Prepaid Plan or if your selected dentist terminates his or her participation in the Prepaid Plan, you may elect to transfer between plans by completing a new enrollment card within 30 days.

If you live outside the service area of the Prepaid Plan, you and your dependents are automatically enrolled in the Scheduled Dental Plan. No special enrollment forms are required.

The Prepaid Provider Dental Plan is described on pages 23 through 26, and the Scheduled Dental Plan is described on pages 27 through 30.

Prepaid Provider Dental Plan

The Prepaid Provider Dental Plan is currently available in the Seattle, Portland and Wichita areas. Through special contracts between the service representative and participating dentists, the Plan offers you and your dependents the opportunity to receive all necessary covered dental care, except orthodontia, at no cost to you. Your share of the cost for orthodontia care is explained below under the Benefit Payment Levels section.

If you choose coverage under this Plan, you must select a participating dentist to provide or arrange for the dental care needs of you and your family. Your selection will be approved as long as the dentist has an opening for patients. If you do not make a selection, the service representative will assign you to a participating dentist. A list of participating dentists in your area is available from the Boeing Group Insurance Office.

You may change dentists under the Prepaid Plan by completing a new enrollment card and submitting it to the Boeing Group Insurance Office. The change will be automatically approved as long as the participating dentist you are requesting has available openings. An approved transfer is effective the first day of the second month after the Group Insurance Office receives your request.

Covered dental treatment for you and your dependents must be provided by or arranged through your selected or assigned dentist, with two exceptions. The first is covered orthodontia treatment, which may be provided by any qualified licensed dentist.

The second exception is out-of-area emergency care. If you or a dependent requires emergency dental care and is more than 50 miles from your selected dentist, the Plan covers the usual and customary charges for out-of-area care, up to a maximum of $50, if the care is provided by a licensed dentist under the conditions listed below. Under these conditions, no prior approval by your selected dentist is required.

1. The care is required for an acute condition and is provided solely for the immediate relief of that condition.
2. The care would have been covered under the Plan had it been provided by your selected dentist.
3. The patient could not have been reasonably expected to go to his or her selected dentist for such care.
4. The care is provided outside the service area of the Plan.

Benefit Payment Levels and Maximums

For a fixed monthly fee paid by the Company, your participating dentist provides or arranges for necessary dental care to you and your dependents. You pay nothing for covered dental services and supplies, with the following exceptions:

1. The Plan covers 50 percent of the usual and customary charges of any qualified licensed dentist for covered orthodontia care, up to a lifetime maximum benefit of $1,200. You pay any remaining charges.
2. The Plan covers the usual and customary charges for out-of-area emergency care, up to a maximum of $50, under the conditions described above. You pay any remaining charges.

Covered Dental Services and Supplies

The Prepaid Provider Dental Plan covers the following dental services and supplies that in the opinion of the participating dentist are necessary for the patient's dental health.

Diagnostic Services and Supplies The Plan covers routine examinations once in a six-month period; complete mouth or panographic x-rays once in a three-year period; supplementary bitewing x-rays once in a six-month period; and emergency examinations.

Examinations by a specialist are only covered if the dentist is in a specialty field recognized by the American Dental Association and the patient has been referred by the patient's selected dentist.

The Plan does not cover a review of a proposed treatment plan or case presentation by the attending dentist. In addition, study and diagnostic models and caries susceptibility tests are not covered.

Preventive Services and Supplies The Plan covers prophylaxis (cleaning) once in a six-month period; topical application of fluoride once in a six-month period when performed with prophylaxis for dependent children under age 19; and fissure sealants for dependent children under age 14.

Fissure sealants are topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in the child's teeth to prevent dental decay. The Plan only covers sealants applied to permanent molar teeth that have intact occlusal surfaces, no decay and no prior restorations. The repair or replacement of a sealant on any tooth within three years of its initial placement is considered part of the original service.

The Plan does not cover home fluoride kits, cleaning of prosthetic appliances, plaque control, oral hygiene, or dietary instructions.

Restorative Services and Supplies The Plan covers the restoration of a hard tooth surface that is visibly decayed (known as a carious lesion) to a state of functional acceptability. Restorations may be accomplished through either the use of such filling materials as amalgam, silicate or plastic or through the use of crowns, inlays or onlays.

Restorations on the same surface or surfaces of a tooth are covered once in a two-year period. Crowns, inlays and onlays (whether gold, porcelain, plastic, gold substitute casting or a combination of these materials) are covered on the same tooth once in a five-year period. Stainless steel crowns are covered once in a two-year period.

If a composite or plastic restoration is placed on a posterior tooth, the Plan covers up to the amount allowed for an amalgam restoration. If a tooth can be adequately restored with a filling material but a crown, inlay or onlay is elected instead, the Plan covers the restoration as if a filling material had been used.

The Plan covers the use of a crown as an abutment to a partial denture only when the tooth is decayed to the extent that a crown would be required whether or not a partial denture is required.

The Plan does not cover appliances or restorations that are needed to correct vertical dimension or that are for the purpose of restoring occlusion, overhang removal, or recontouring or polishing a restoration.

Oral Surgery The Plan covers surgical and nonsurgical extractions; preparation of the alveolar ridge and soft tissues of the mouth for the insertion of dentures; ridge extension for the insertion of dentures; treatment of pathological conditions and traumatic facial injuries; and general anesthesia when administered by a dentist in connection with a covered oral surgery procedure.

The Plan does not cover extraoral grafts (grafts from tissues outside the mouth or using artificial materials) or tooth transplants.

Periodontic Services and Supplies The Plan covers services and supplies for the following surgical and nonsurgical procedures when used for the treatment of tissues that support the teeth: root planing; subgingival curettage; gingivectomy; and limited adjustments to occlusion (eight teeth or less) such as the smoothing of teeth or reducing cusps.

The Plan covers either root planing or subgingival curettage (but not both) once in a 12-month period.

The Plan does not cover: periodontal splinting, or any crown or bridgework that is provided with periodontal splinting; major (complete) occlusal adjustment; and periodontal appliances.

Endodontic Services and Supplies In covering pulpal and root canal therapy, the Plan covers pulp exposure treatment, pulpotomy and apicoectomy. The Plan covers root canal treatment on the same tooth once in a two-year period. Tooth bleaching, whether vital or nonvital, is not covered.

Pedodontic Services and Supplies The Plan covers space maintainers only when used to maintain space for the eruption of permanent teeth. No coverage is provided for the replacement of a space maintainer that was previously covered under either of the dental plans.

Prosthodontic Services and Supplies The Plan covers dentures, bridges, partial dentures (including abutment crowns) and related items as well as the adjustment or repair of an existing prosthetic device within the following limitations.

1. The Plan allows for a full, immediate or overdenture. If you elect any other service or supply, such as a personalized restoration or specialized treatment, the Plan covers up to the appropriate amount for a full, immediate or overdenture. Coverage of root canal therapy performed in conjunction with overdentures is limited to two teeth per arch.
2. When a partial denture is required, the Plan allows for a cast chrome or acrylic partial denture. This allowance also applies toward the cost of any other procedure that may be provided, such as a more elaborate or precision device used to restore the case.
3. If you elect to receive implants and related appliances that are attached to the implants, your plan allows up to the amount that would have been provided for a full or partial denture.

The Plan also limits the frequency that certain prosthodontic services and supplies are covered, as follows:

1. The Plan covers the replacement of an existing prosthetic device once in a five-year period and only then if it is unserviceable and cannot be made serviceable. Expenses related to making the device serviceable are covered.
2. The Plan covers denture adjustments and relines if these services are provided more than six months after the initial placement occurs. Later relines and jump rebases (but not both) are covered once in a 12-month period.
3. If implants are covered within the terms explained above, the Plan covers replacements only if placed five or more years after the initial placement.

The Plan does not cover: duplicate dentures; the cleaning of prosthetic appliances; temporary dentures; surgical placement or removal of implants or attachments to implants; and crowns and copings that are provided in conjunction with overdentures.

Orthodontia Services and Supplies The Plan covers orthodontia treatment, including the correction or prevention of malocclusion, according to the payment level described on page 24.

Prepaid Provider Dental Plan Exclusions

The following items are not covered under the Prepaid Provider Dental Plan.

1. Injuries or conditions that are covered under a workers' compensation or employer liability law; or services that are provided by any federal, state or provincial government agency, or by any municipality, county or other political subdivision or community agency at no charge to the covered person.
2. Procedures, appliances or restorations that are primarily for cosmetic purposes. Cosmetic services include but are not limited to laminates and tooth bleaching.
3. Charges for services and supplies that are received while the person is not covered under the Plan, except as explained on page 26 under the Coverage Following Termination of Employment section.
4. Analgesics (such as nitrous oxide or intravenous sedation) or any other euphoric drugs, injections or prescription drugs.
5. Hospitalization charges.
6. Full mouth reconstruction.
7. Charges for the failure to keep a scheduled dental appointment.

8. Charges in excess of the $1,200 lifetime maximum benefit that applies to covered orthodontia care for each eligible person.
9. Experimental services and supplies (and related complications), the use of which are not generally recognized by the American Dental Association as tested and accepted dental practice. This also applies to items requiring approval by the Federal Drug Administration or other governmental agency if such approval was not granted at the time the service or supply was ordered.
10. Services with respect to the treatment of temporomandibular joints (jaw joints).
11. Charges for the laboratory examination of a tissue specimen.
12. Charges for habit-breaking appliances.
13. Charges for patient management problems.
14. Charges for completing claim forms.
15. Services or treatment that in the opinion of the participating dentist are not necessary for the patient's dental health.
16. Replacement of missing posterior teeth with a fixed bridge when the patient has at least 12 posterior teeth in occlusion (three-quarters of the masticatory table).
17. Application of desensitizing medications.
18. All other items that are not specified as covered dental services and supplies under the section that begins on page 24.

Coverage Following Termination of Employment

This Plan generally does not cover care that you or an eligible dependent receives while not covered under the Plan. However, the Plan will cover services and supplies that are provided during the three calendar months following termination of your employment if your dentist has determined the need for the treatment before your employment ends.

The Plan covers necessary services and supplies related to a prosthetic appliance, including abutment crowns of a partial denture, if the denture impressions were taken while you were still an active employee and the patient was covered under the Plan. However, the appliance must be delivered and installed within three calendar months after termination of your employment. If the impressions were taken after your employment terminates, coverage will be provided according to the requirements listed in the paragraph above. No coverage is provided if the denture impressions are taken before a person became eligible for Plan benefits.

The Plan covers necessary services and supplies in connection with a crown that is required for the restoration of a tooth (independent of the use of a crown in connection with a partial denture) if the tooth was prepared for the crown before employment terminates. Otherwise, the crown must be installed according to the requirements described in the first paragraph of this section.

For other coverage continuation options following the termination of your employment, see page 32.

How to File a Claim

No claim forms are generally required under the Prepaid Provider Dental Plan. The exceptions are for covered orthodontia care, out-of-area emergency care, and certain specialty care. Special claim forms for these exceptions are available through the Boeing Group Insurance Office.

Scheduled Dental Plan

As an alternative to the Prepaid Provider Dental Plan, you may elect the Boeing Scheduled Dental Plan. This Plan offers you and your dependents the opportunity to receive your dental care from any licensed dentist on a fee-for-service basis. Your share of the cost will vary, depending on the type of treatment you receive and, in many cases, on the level of your dentist's fees.

Deductible Expenses

You and your dependents are responsible for the first $50 of covered charges for most necessary dental services and supplies during each period of your continuous service with Boeing. The deductible requirement, which must be met by each person covered under the Plan, applies to all covered services and supplies except examinations, x-rays, prophylaxis (cleaning), fluoride treatments and fissure sealants.

Benefit Payment Levels

After you and your dependents have paid your deductible expenses, the Plan covers the usual and customary charges for necessary dental services and supplies, up to the amounts listed in the schedule of benefits in exhibit 5.

Certain dental treatment may be covered even though it is not listed in the schedule. The service representative determines the benefit allowance for such treatment by taking into account the nature and complexity of the treatment. The allowance will be consistent with those listed in the schedule.

If your dentist recommends a plan of treatment that includes services and supplies that are not listed in the schedule, you may ask your dentist to complete a claim form before treatment begins and submit it to the service representative for a predetermination review. Based on the information provided by your dentist, the service representative will advise you as to the Plan's coverage for the proposed treatment. You may also contact the service representative about the reasonableness of charges quoted by your dentist for a proposed treatment plan.

Benefit Maximums

During each calendar year, the Plan pays up to $1,000 for you and each of your dependents for all covered services and supplies except those related to orthodontia. For covered services and supplies related to orthodonitia, the Plan pays up to $1,200 per covered person during all periods the person is covered under this Plan.

Covered Dental Services and Supplies

The Plan covers the necessary dental services and supplies that are listed in the schedule of benefits in exhibit 5. In addition, certain other dental treatment may be covered even though it is not listed in the schedule.

For such nonlisted items, the service representative determines coverage by taking into account the nature and complexity of the treatment. All coverage is subject to the general terms of the Plan, including the exclusions listed below.

Benefit Limitations The Plan places certain limits on the coverage of necessary dental services and supplies. These limits are generally included in the schedule of benefits.

With regard to the replacement of dentures and bridgework, the Plan covers such replacement within the terms of the schedule only if you can present satisfactory evidence that the existing denture or bridgework was installed at least five years earlier and cannot be made serviceable. Similarly, the Plan covers the replacement of an immediate temporary denture or bridgework with a permanent denture or bridgework only if the replacement is required and takes place within 12 months from the date the temporary denture or bridgework is installed.

Scheduled Dental Plan Exclusions

The following items are not covered under the Scheduled Dental Plan.

1. Treatment provided by other than a dentist or licensed dental hygienist when provided under the supervision and direction of the dentist.
2. Services and supplies that are partially or wholly for cosmetic purposes. Cosmetic services include but are not limited to personalization or characterization of dentures.
3. Charges for services and supplies that are received while the person is not covered under the Plan, except as explained under on page 28 under the Coverage Following Termination of Employment section.
4. Charges for the replacement of a lost or stolen prosthetic appliance.
5. Orthodontic treatment, including correction or prevention of malocclusion, except as specifically provided for under the Plan.
6. Injuries or conditions that are in connection with an occupational accident or covered under a workers' compensation law.
7. Charges for prophylaxis more often than once in each six-month period.
8. Separate charges for anesthetics or the administration thereof, anesthetic supplies or drugs, except general anesthesia when medically necessary.
9. The portion of a charge that exceeds the usual and customary charge or that exceeds the maximum covered expenses listed in the schedule.
10. Periodontal services and supplies, including periodontal splinting and bridgework, except as specifically listed in the schedule.

11. Treatment of temporomandibular joint disease and myofascial pain-dysfunction syndome.
12. Charges that would not have been made if no dental plan existed, or charges that neither you nor your dependents are required to pay.
13. Services or supplies that are furnished or paid for by reason of the past or present service of any person in the armed forces of a government.
14. Services or supplies that are paid or otherwise provided for under any law of a government. However, to the extent that benefits are provided by the government as an employer to its own employees and their dependents, coverage of dental services and supplies is not excluded but rather is subject to the coordination of benefits provisions explained on page 30.
15. Services and supplies that are not necessary for the treatment of an injury or disease or that are not recommended by the attending dentist; or charges that are unreasonable.
16. Charges for the failure to keep a scheduled dental appointment.
17. Charges for completing claim forms.

Coverage Following Termination of Employment

This Plan generally does not cover care that you or an eligible dependent receives while not covered under the Plan. However, the following exceptions apply.

The Plan covers necessary services and supplies related to a prosthetic appliance, including abutment crowns of a partial denture, if the denture impressions were taken while you were still an active employee and the patient was covered under the Plan. However, the appliance must be delivered and installed within two calendar months after termination of your employment. No coverage is provided if the denture impressions are taken before a person became eligible for Plan benefits.

The Plan covers necessary services and supplies in connection with a crown that is required for the restoration of a tooth (independent of the use of a crown in connection with a partial denture) if the tooth was prepared for the crown before employment terminates. However, the crown must be placed within two calendar months after your employment ends.

For other coverage continuation options following the termination of your employment, see page 32.

Exhibit 5
SCHEDULE OF COVERED DENTAL SERVICES

The following schedule lists the maximum dollar amounts that are covered under the Scheduled Dental Plan as of January 1, 1987. To encourage the regular use of dental services, these maximums are intended to cover a large percentage of most dentists' charges for diagnostic and preventive care and lower percentages for the other categories of care.

Benefits are paid according to the schedule, based on the date the service or supply is received.

Diagnostic	
Examinations (one per course of treatment)	
initial oral exam	$ 18.00
periodic oral exam	14.00
emergency oral exam	18.00
Complete Mouth X-rays (limit once in a two-year period)	
intraoral series (including bitewings)	40.00
panoramic	32.00
Intraoral Periapical X-rays	
single, first film	7.00
each additional film	5.00
Bitewings (limit once in a six-month period)	
single film	10.00
two films	12.00
four films	16.00
Preventive	
Prophylaxis (limit once in a six-month period)	
age 14 and over	$ 31.00
to age 14	20.00
Fluoride Treatment	
topical application of fluoride (limit once per year)	12.00
Fissure Sealants (to age 14)	
topical applications (per quadrant)	12.00
Minor Restorations	
Amalgam Restorations	
primary—one surface	$ 25.00
primary—two surfaces	34.00
primary—three surfaces	45.00
permanent—one surface	27.00
permanent—two surfaces	38.00
permanent—three surfaces	49.00
permanent—four surfaces	60.00
pin retention—exclusive of amalgam	13.00
Other Minor Restorations	
silicate cement	27.00

acrylic	33.00
composite resin—one surface	31.00
composite resin—two surfaces	45.00
composite resin—three surfaces.	70.00

Major Restorations

Inlays and Onlays	
gold inlay—one surface	$118.00
gold inlay—two surfaces	136.00
gold inlay—three surfaces	148.00
onlay—per tooth (in addition to inlay)	32.00
re-cement inlay	21.00
Crowns	
plastic (acrylic)	135.00
plastic with metal (gold)	215.00
porcelain	215.00
porcelain with metal (gold)	215.00
gold (full cast)	215.00
gold (3/4 cast)	215.00
stainless steel	70.00
temporary (fractured tooth)	43.00
crown buildup (pin retained)	60.00
re-cement crown	23.00

Endodontics

Pulp Treatment (excluding final restoration)	
pulp cap	$ 16.00
vital pulpotomy	36.00
Root Canal Therapy (includes treatment plan, clinical procedures and follow-up care; excludes final restoration)	
single rooted	150.00
bi-rooted	195.00
tri-rooted	275.00
apicoectomy (performed as a separate surgical procedure)	150.00

Periodontics

Nonsurgical Services	
periodontal exam	$ 48.00
periodontal prophylaxis (once in a six-month period)	40.00
occlusal adjustment (limited)	44.00
occlusal adjustment (complete)	180.00
periodontal scaling and/or root planing (entire mouth)	43.00
periodontal scaling and/or root planing (fewer than 12 teeth)	38.00
Surgical Services	
osseous surgery (per quadrant)	305.00
free soft tissue grafts	155.00
gingivectomy (per quadrant)	100.00
gingival curettage	50.00
vestibuloplasty	200.00

Prosthodontics

Dentures (includes six months post-delivery care)	
complete upper or lower	$ 300.00
immediate upper or lower	300.00
partial upper or lower (no clasps, acrylic base)	275.00
partial upper or lower (two gold or chrome clasps, acrylic base)	300.00
partial upper or lower with gold/chrome lingual or palatal bar (two gold or chrome clasps, acrylic base)	310.00
partial upper or lower with gold/chrome lingual or palatal bar (two gold or chrome clasps, cast base)	310.00
Related Denture Services	
denture adjustment (complete or partial)	30.00
repair broken denture (no teeth damage)	40.00
replace missing or broken tooth (per tooth)	40.00
denture conversion	105.00
reline denture	105.00
Bridgework	
cast gold pontic	210.00
porcelain fused to gold pontic	215.00
re-cement bridge	34.00

Oral Surgery

Extractions (includes local anesthesia and routine postoperative care)	
single tooth (uncomplicated)	$ 28.00
each additional tooth (uncomplicated)	25.00
erupted tooth	55.00
impacted tooth—soft tissue	73.00
impacted tooth—partially bony	100.00
impacted tooth—completely bony	120.00
root recovery (per tooth)	58.00
Related Oral Surgical Procedures	
alveolplasty (per quadrant)	50.00
incision and drainage of abscess (intraoral)	38.00
frenectomy (separate procedure).	91.00
oral antral fistula closure	80.00
general anesthesia (not provided at a hospital)	
first 30 minutes	68.00
each additional 15 minutes (or major fraction thereof)	25.00

Orthodontia

50% of usual and customary charges up to a lifetime maximum benefit of	$1,200.00

Other Expenses

Certain procedures not listed above may be covered under the Dental Plan. The service representative will determine the allowance for such a procedure by taking into account the nature and complexity of the procedure. The amount will be consistent with those listed in the schedule.

Coordination of Benefits

If you or your dependents have other group medical or dental coverage in addition to being covered under the Scheduled Dental Plan, the benefits from the other group plans are taken into account before benefits are paid under this Plan. Other group coverage includes another employer's group benefit plan or other arrangement of coverage for individuals in a group, whether insured or uninsured.

The group plan that pays its benefits first is considered the primary plan of coverage and will pay its benefits without regard to benefits that may be payable under other plans. When another group plan is the primary plan for dental coverage, the Boeing Scheduled Dental Plan will pay an amount that, when added to the benefits paid under the other plan or plans, does not exceed 100 percent of allowable expenses.

Allowable expenses are any necessary, usual and customary charges, part or all of which are covered under any of the other plans, that are made to a person during a calendar year while that person is covered under this Plan.

The following rules are used to determine which group plan will be considered the primary plan.

1. A plan that does not contain coordination of benefits provisions will pay its benefits before a plan that includes such provisions.
2. A plan that covers a person other than as a dependent will pay before a plan that covers the person as a dependent.
3. If a dependent child is covered under both parents' group plans, the child's primary coverage will be provided through the parent whose birthday comes first in the calendar year, with secondary coverage being provided through the parent whose birthday comes later in the calendar year. If the other group plan does not rely on this "birthday rule" but rather relies on gender to determine benefit coordination, then the "gender rule" used by the other plan will determine the order by which the plans will pay benefits.
4. If a dependent child's parents are divorced or separated, the following guidelines will be used:

   a. The plan of the parent with custody will pay its benefits first if that parent has not remarried. The plan of the parent without custody pays second.

   b. If the parent with custody has remarried, then the plans will pay in the following order: the plan of the parent with custody, the plan of the spouse of the parent with custody, the plan of the parent without custody, and the plan of the spouse of the parent without custody.

   c. If a court decree establishes financial responsibility for the health care coverage of the child, the plan of the parent with such financial responsibility will be the primary plan of coverage.
5. If none of the above rules is able to establish which group plan should pay first, then the plan that has covered the person for the longest period of time will be considered the primary plan of coverage.

Benefits under the Scheduled Dental Plan will not be coordinated with benefits paid under any another group plan offered by or through Boeing. When dental services performed by a licensed dentist are also covered under the Boeing Medical Plan, the Scheduled Dental Plan will pay its benefits first.

The service representative has the right to obtain and release any information or recover any payment it considers necessary to administer these provisions.

How to File a Claim

Aetna Life Insurance Company is the service representative that administers the Scheduled Dental Plan for Boeing. The addresses where Aetna may be reached are found in exhibit 7 on page 37.

You must submit a separate claim form for each eligible person who receives covered dental services and supplies. A claim form should always be submitted within 90 days of the completion of a plan of treatment, or the claim may be denied.

Two benefit claim forms are provided under this Plan. One is for all covered dental services and supplies except orthodontia. This form includes an automatic assignment of benefits section that allows you to instruct the service representative to pay your dentist directly. If you wish to pay the dentist, you should cross out the assignment as indicated on the claim form.

The orthodontia claim form is exclusively for reporting orthodontic expenses. The special billing and benefit payment arrangements that are available for these services are explained on the form.

Claim Review Procedure

Claim forms for the plans described in this booklet are available from the Boeing Group Insurance Office. Claims should be filed as soon as possible after receiving a covered service or supply to avoid a delay or loss of benefits.

If a claim for benefits is denied or partially denied, you will be notified in writing within 90 days of receipt of your claim and given an opportunity for appeal. The notice will give the specific reason(s) for the denial.

You or a person appointed by you may request a review of your denied or partially denied claim within 60 days after you have received the written notice. Make the request by writing to the appropriate service representative indicated in exhibit 7 on pages 36 and 37.

You or a person appointed by you may examine pertinent documents relating to the denial and may submit issues and comments in writing. A decision by the service representative will be made promptly, usually within 60 days of the date your request for review is received unless special circumstances require more time. In no event will you receive a decision more than 120 days after your request is received. The decision will be in writing and will include the specific reasons for the decision by referring to the applicable plan provisions.

Exhibit 6
HOW TO AVOID CLAIM PROBLEMS

In many cases, your physician or other health care provider will send a bill directly to the Plan's service representative. If you are required to submit a claim, the following tips should help you avoid delays and other claim filing problems.

1. Complete all the information that is requested on the form, including your full name, address, Social Security number, the patient's name and birth date, the date of the service, the diagnosis, and the type of service(s) received.
2. Always attach an itemized bill that includes the health care provider's name, address and tax identification number. A notice from the provider that payment is overdue generally will not provide adequate information for benefit determination and payment.
3. If additional information is requested, be sure that the follow-up information includes the patient's full name, your name and your full Social Security number.
4. If you or a dependent is eligible for coverage under another employer's group benefit plan, file a claim first with the plan providing primary coverage.

When that plan sends you a written explanation of your benefits, send a copy of the explanation along with the appropriate claim form and an itemized bill to the second plan. If you are not sure which plan provides primary coverage, file a claim with both plans at the same time.

To avoid having a benefit claim inappropriately denied, you should also file a new Boeing health care information card if you add or lose a dependent.

Termination of Coverage

Termination Dates

Coverage for you and your eligible dependents under the plans described in this booklet generally ends on the last day of the month in which you are employed.

If earlier, coverage for an eligible dependent will end on the last day of the month in which the person no longer meets the dependent eligibility requirements explained on page 2.

Coverage may be continued beyond these normal termination dates under special circumstances, as explained below.

Disability If you or an eligible dependent is totally disabled on the termination date indicated above, the Company will continue coverage under the Boeing Medical Plan for that person for up to 12 months, at no cost to you. Under this special extension, coverage will cease before the end of the 12-month period if the person becomes covered under any other plan (as an employee or dependent) or is no longer totally disabled.

Death In the event of your death, coverage under the Boeing Medical Plan continues for your eligible dependents at no cost to them until the earlier of twelve months after the date of your death or they become covered as an employee or dependent under another employer's medical plan.

Layoff If you are laid off, medical coverage for you and your dependents will continue for up to three months after your date of layoff or, if earlier, until the date you become covered by another employer's medical plan either as an employee or dependent.

If you and your dependents are covered through an approved HMO at the time you are laid off, you must continue to make any contributions that are required for HMO coverage. See page 3 for an explanation of HMO contributions.

Leave of Absence If you are on an approved leave of absence from the Company, you are considered an active employee and covered under the plans described in this booklet during the first 30 days of your leave. Any payroll deductions for HMO coverage will continue if you were contributing before your leave began.

If you are on an approved medical leave of absence that is the result of a continuous disability, your contributions for the plans described in this booklet will be waived for up to five calendar months following the initial 30-day leave period. A waiver of contributions for dependent medical and dental plan coverage starts on the same date as it does for you.

During all other approved leaves of absence and approved medical leaves that go beyond six months, your Company-sponsored medical and dental coverages will continue at no cost to you as long as you draw pay from the Company. (Coverage under an approved HMO plan may be continued during this time if you make the required payroll deductions.) Once you stop drawing pay, you may be eligible to continue coverage under a self-pay arrangement, as explained in the following section.

Other Continuation Options

When coverage under the plans described in this booklet would otherwise end, you and/or your dependents may be eligible to continue your group coverage under a self-pay option if the loss of coverage is the result of the termination of your employment (for reasons other than gross misconduct on your part) or a reduction in your hours, such as an approved leave of absence. Your eligible dependents may also have a choice of options if they would otherwise lose coverage as the result of your death or in the event of divorce or a child's loss of eligibility under the plans.

Under these continuation options, you or your dependent must pay the full contribution for group coverage.

Coverage may be continued for up to a total of three years if coverage would otherwise end because of your death, divorce or a child's loss of eligibility. If coverage would otherwise end because of termination or a reduction in hours, the maximum continuation period is 18 months. (For medical leaves of absence, the plans include an alternate option that permits you to continue coverage under your entire package of benefits for an extended period of time.)

Any extension of coverage that is provided under another provision of the medical or dental plans is considered part of the three-year or 18-month continuation period.

The continuation period may end sooner if: the required contribution is not paid within the allowed payment period; the person covered under the option becomes covered under another group health plan either as an employee or a dependent or becomes entitled to Medicare; or the Company no longer provides health care benefits to any of its employees.

If you do not pay the required monthly contributions during the allowed payment period, coverage will end as of the end of the month for which the last contribution was received. If you then return to the active payroll following an approved leave of absence, your coverage will be reinstated on the first of the month following your return, subject to all Plan provisions.

Should you or your spouse wish to continue coverage following divorce or a child's loss of eligibility, one of you must notify the Company within 60 days of your interest in the continuation option. Following this notification, the Company will provide you with additional information, including your cost for the coverage and the payment procedures and requirements under the plans. The Company will automatically provide this information following your termination, reduction in hours, or death.

For more information about the continuation options that may be available to you, contact the Boeing Group Insurance Office.

Conversion of Your Medical Plan Coverage

If coverage terminates for you or an eligible dependent, that person may convert to an individual medical policy offered by the service representative for group conversion purposes. The benefits provided under the individual policy will not duplicate the benefits provided under the Boeing Medical Plan.

To convert to an individual policy, you must complete an application and submit it to the service representative within 31 days of the date coverage under the Medical Plan would otherwise terminate. You will then be billed for the applicable premium. Conversion applications are available from the Boeing Group Insurance Office or the service representative.

No evidence of insurability will be required. However, if the individual policy includes a waiting period, any credit for time covered under the Boeing Medical Plan will be based on the provisions of the individual policy.

Retiree Coverage

If you are an employee retiring from the service of the Company with 10 or more years of credited service under a Company-sponsored retirement plan, you may be eligible to enroll yourself and your eligible dependents in the Company's retired salaried employees medical plan. Additional information about this plan is available through either the Boeing Group Insurance Office or the Boeing Retirement Office.

Please note that if you or your spouse is near age 65 when you retire, you must apply to Medicare for coverage within 60 days of your retirement, or you may experience a lapse in coverage.

Liability for Plan Benefits

The Boeing Medical Plan and the Scheduled Dental Plan are self-funded by Boeing, which means that all benefits under these plans are paid from the assets of the Company.

The Company has entered into administrative contracts with the service representatives for these plans. Under these contracts, the service representatives agree to make all benefit determinations and payments under the Company-sponsored plans.

Washington Dental Service has liability for the Prepaid Provider Dental Plan, in accordance with the policy it has issued to Boeing.

Special Disclosure Information

Plan Sponsor The plans described in this booklet are sponsored by The Boeing Company, 7755 East Marginal Way S., Seattle, Washington.

Plan Administrator and Agent for Service of Legal Process The Plan Administrator is the Welfare Benefit Plans Committee which may be reached through the above address or by telephone at 206-655-2391. Legal process may be served upon the Committee at the above address.

Type of Administration The plans are administered in accordance with the terms of the applicable administrative agreements and insurance contracts that the Company has with the service representative for each plan.

Type of Plan The plans in this booklet are welfare benefit plans that provide coverage of medical and dental services and supplies.

Funding and Contributions The cost of coverage under these plans is paid by the Company as explained on page 3. The cost is based on claims experience. Benefit payments are made by the service representatives, in accordance with the provisions of the applicable administrative agreements and insurance contracts.

Plan Records Fiscal records are kept on a calendar year basis. The plan year for each plan begins on January 1 and ends on December 31 of each year.

Plan Number and Employer Identification Number The plan number assigned by Boeing pursuant to instructions by the U.S. Department of Labor for the Boeing Medical Plan and the Scheduled Dental Plan is 503. The plan number for the Prepaid Provider Dental Plan is 533. Boeing's employer identification number is 91-0425694.

Collective Bargaining Representatives The plans described in this booklet are provided in accordance with agreements with the collective bargaining representatives listed below.

Seattle Professional Engineering Employees Association
Engineering Unit
Technical Unit
Wichita Engineering Association

Participant Protections Under ERISA The Employee Retirement Income Security Act of 1974 (ERISA) guarantees certain rights and protections to participants of welfare benefit plans such as the plans described in this booklet. As in the past, the Company fully intends to support your rights. Nevertheless, federal law and regulations require that a statement of ERISA rights be included in this description of your plans.

You have the following rights as a participant in the plans described in this booklet:

1. You may examine, without charge, all plan documents including any insurance contracts, collective bargaining agreements, annual reports, summary plan descriptions, and other documents filed with the Department of Labor.
2. If you want a personal copy of plan documents or related material, you should send a written request to the Plan Administrator. You will be charged only the actual cost of reproduction of these copies.
3. Each year, the Company will provide plan participants with a summary of each plan's annual financial report. Copies of previous years' reports are available for viewing at the Boeing Group Insurance Office. In accordance with ERISA, these summary annual reports will be sent automatically to all participants, shortly after midyear.

Under ERISA, the people responsible for operating the plans are called fiduciaries. These individuals have an obligation to administer the plans prudently and to act in the interest of plan participants and beneficiaries. No one may discriminate against you in any way to prevent you from receiving benefits or exercising your rights under ERISA.

When you become eligible for payments from a plan, you should follow the appropriate steps for filing a claim. In case of claim denial in whole or in part, you will receive a written explanation of the reasons for the denial. Then, if you wish, you may request the Administrator to review and reconsider your claim.

If you feel that your ERISA rights have been violated, you may file suit. Among the violations for which you may file suit are the following:

1. Improper denial of benefits. (You may file suit in either a state or federal court.)
2. Misuse of plan funds by a fiduciary or discrimination against you for asserting your rights. (In either case, you may seek assistance from the Labor Department or file suit in federal court.)
3. Failure of the Plan Administrator to provide materials within 30 days after receiving your written request unless due to reasons beyond the Administrator's control. (You may file suit in a federal court. If a violation exists, the court may require the Plan Administrator to provide the materials and to pay up to $100 for each day's delay.)

The court will decide who should pay court costs and legal fees. For example, if you are successful, the court may order the person you sued to pay these costs and fees. If you lose or if the court finds your suit to be frivolous, you may be ordered to pay these costs and fees.

If you have any questions about your plan, you should contact the Plan Administrator at P.O. Box 3707, M/S 13-56, Seattle, WA 98124 (telephone 206-655-2391). For questions regarding this explanation of your rights under ERISA, contact the nearest area office of the U.S. Labor Management Services Administration, Department of Labor.

Definitions

An approved *birthing center* under the Boeing Medical Plan is a facility for the normal delivery of a child, that operates under the direction and control of the appropriate licensing or regulatory agency of the jurisdiction in which the facility is located.

A *chiropractor* is a person who is duly licensed in the area where his or her services are performed and who is practicing within the scope of such license. (For coverage of a chiropractor's services, see page 10.)

A *Christian Science sanatorium* is a facility that is operated (or listed) and certified by the First Church of Christ, Scientist, in Boston, Massachusetts, at the time of the healing treatment.

A *Company-sponsored plan* is a group health care plan sponsored by Boeing or one of its subsidiaries or affiliates for its employees and dependents. A health maintenance organization (HMO) is not included as a Company-sponsored plan. (To find out whether a particular plan is Company-sponsored, contact the Boeing Group Insurance Office.)

Custodial care is care that does not require the continuing services of skilled medical or allied health professionals and that is designed primarily to assist the patient in activities of daily living. This includes institutional care that primarily supports self-care and provides room and board. Types of custodial care include, but are not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparation of special diets, and the supervision of medications that are ordinarily self-administered.

A *day or night care center* is a facility that is associated with a hospital or is otherwise approved by the service representative and that has a professional staff whose primary purpose is to provide a planned program of psychiatric services for patients with mental illnesses who do not require inpatient hospitalization on a full-time basis. It does not include facilities that are primarily engaged in providing services that are custodial, recreational, social or educational in nature.

A *dentist* is a legally qualified dentist practicing within the scope of his or her license. Under the Prepaid Provider Dental Plan, a participating dentist is a licensed dentist who has agreed to the terms and conditions of the written participating provider dental agreement with the service representative. Under the Scheduled Dental Plan, a dentist may include a legally qualified physician authorized by license to perform the particular dental services that are provided.

An *experimental or investigational service or supply* is one that meets at least one of the following:

1. Is under clinical investigation by health professionals and is not generally recognized by the medical profession as tested and accepted medical practice.
2. Requires approval by the Federal Drug Administration or other governmental agency, and such approval has not been granted at the time the service or supply is ordered.
3. Has been classified by the national Blue Cross and Blue Shield Association as experimental or investigational.

An approved *home health agency* is a public or private agency or organization that administers and provides home health care, and is either a Medicare-approved agency or is operating under the direction and control of the appropriate licensing or regulatory agency of the jurisdiction in which it is located.

A *home health aide* is an individual employed by an approved home health agency or an approved hospice agency who, under the supervision of a registered nurse or physical or speech therapist, provides part-time or intermittent personal care that may include: ambulation and exercise; household services essential to home health care; assistance with medications that are normally self-administered; reporting changes in a patient's condition and needs; and completing appropriate records.

A *home health or hospice treatment plan* is a program for continued care and treatment established in writing by the patient's attending physician.

An approved *hospice agency* is a public or private agency or organization that administers and provides hospice care, and is either a Medicare-approved agency or is operating under the direction and control of the appropriate licensing or regulatory agency of the jurisdiction in which it is located.

A *hospital* is a facility that is an accredited general hospital licensed by the Joint Commission on Accreditation of Hospitals (JCAH).

A *medically necessary* service or supply is one that the service representative has determined meets the criteria listed below. A service or supply may be medically necessary in part only. The fact that 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:

1. It is required to diagnose or treat the patient's condition, and the condition could not have been diagnosed or treated without it.
2. It is consistent with the symptom or diagnosis and the treatment of the condition.
3. It is the most appropriate service or supply that is essential to the patient's needs.
4. It is appropriate as good medical practice.
5. It is professionally and broadly accepted as the usual, customary and effective means of diagnosing or treating the illness, injury or condition.
6. When applied to inpatient care, it cannot be safely provided on an outpatient basis.

A registered *nurse* is a person who is duly licensed in the area where his or her services are performed and who is practicing within the scope of such license. (For coverage of a registered nurse's services, see page 10.)

An *occupational therapist* is a person who is duly licensed in the area where his or her services are performed and who is practicing within the scope of such license. In the absence of such licensing requirements, the therapist must be certified by the American Occupational Therapy Association. (For coverage of an occupational therapist's services, see page 12.)

An *optometrist* is a person who is duly licensed in the area where his or her services are performed and who is practicing within the scope of such license. (For coverage of an optometrist's services, see page 10.)

A *physical therapist* is a person who is duly licensed in the area where his or her services are performed and who is practicing within the scope of such license. In the absence of such licensing requirements, the therapist must be certified as a registered physical therapist by the American Physical Therapy Association. (For coverage of a physical therapist's services, see page 12.)

A *physician* is a person who is licensed as an M.D. or D.O. and who is duly licensed to prescribe and administer all drugs and to perform all surgery. (For coverage of a physician's services, see page 9.)

A *podiatrist* is a person who is duly licensed in the area where his or her services are performed and who is practicing within the scope of such license. (For coverage of a podiatrist's services, see page 10.)

Preadmission review and prior approval under the medical review program includes the review and evaluation of proposed elective hospital and skilled nursing facility admissions as well as proposed home health and hospice care. Such review and evaluation is performed by qualified health care professionals using accepted medical standards and criteria for determining the medical necessity of the admission or care.

In addition to certifying the appropriate length of stay for an admission, the program includes the ongoing (or concurrent) review of the admission as well as discharge planning at the completion of the admission.

A *preexisting condition* is any illness, injury or other condition, whether or not diagnosed, for which a person has received medical treatment, consultation, a diagnostic test or prescribed medicines during the three-month period before his or her coverage becomes effective. See page 18 for the Medical Plan exclusion related to preexisting conditions.

A *preferred network of health care providers* is health care professionals and facilities that have entered into a special contract with the service representative for the Medical Plan to provide cost effective, appropriate care to employees and dependents covered under the Plan. For a further description of preferred networks, see page 5.

For the purposes of the dental plans, a *prosthetic appliance* is a denture, partial denture, fixed or removable bridge, crown when used as a bridge abutment, and other related items.

A *psychologist* is a person who is duly licensed in the area where his or her services are performed and who is practicing within the scope of such license. (For coverage of a psychologist's services, see page 10.)

A *service representative* is an agent that has agreed to make benefit determinations and administer benefit payments under a Company-sponsored plan. A list of service representatives for the plans described in this booklet appears in exhibit 7 on pages 36 and 37.

A *skilled nursing facility* is an institution recognized as such by Medicare and approved by Medicare for payment.

A *speech therapist* is a person who is duly licensed in the area where his or her services are performed and who is practicing within the scope of such license. In the absence of such licensing requirements, the therapist must be certified as a registered speech therapist by the American Speech and Hearing Association. (For coverage of a speech therapist's services, see page 12.)

Substance abuse means alcohol and/or drug dependency under the terms of ICD-9 CM categories 303.0 through 305.9.

An approved *substance abuse treatment facility* is a facility that provides treatment for chronic alcoholism and/or drug abuse and that is operating under the direction and control of the appropriate licensing or regulatory agency of the jurisdiction in which the facility is located.

For the purposes of the Boeing Medical Plan, *usual and customary charges* are the lesser of:

1. The health care provider's actual charge to the patient after any discounts or other reductions.
2. The charge that is most frequently made by the provider to all other patients for comparable services and supplies.
3. The charge that is most frequently made by providers with similar professional qualifications for comparable services or supplies within the same geographic area.

When an unusual or complicated service or supply is provided, the usual and customary charge will be determined by taking into consideration charges for treatment of a comparable nature or complexity.

For the purposes of the Boeing dental plans, *usual and customary charges are the lesser of*:

1. The usual fee charged by your dentist for a given service or supply to all private patients.
2. The customary fee for a given service or supply which means that it is within the range of usual fees charged by dentists in the same limited geographic area who have similar training and experience.
3. The reasonable fee for a given service or supply which means that the charge is usual and customary, and in the opinion of the review committee of the responsible dental society, is justifiable in view of the special circumstances of the particular case in question.

Exhibit 7
WHERE TO GET INFORMATION

Boeing Group Insurance Offices

Puget Sound Area

Location:	7755 East Marginal Way S. Seattle, WA
Mailing Address:	The Boeing Company Group Insurance Office P.O. Box 3707, M/S 13-56 Seattle, WA 98124-2207
Telephone Number:	206-655-2391

Wichita Area

Location:	3801 S. Oliver Wichita, KS
Mailing Address:	Boeing Military Airplane Co. Employee Benefits Office P.O. Box 7730, M/S K66-14 Wichita, KS 67277-7730
Telephone Number:	316-526-2274

Pennsylvania Area

Location:	Industrial Highway, Route 291 Ridley Township, PA
Mailing Address:	Boeing Helicopter Company Boeing Center Employee Benefits Office P.O. Box 16858, M/S P28-13 Philadelphia, PA 19142
Telephone Number:	215-591-3056

Medical Plan Service Representatives

Alabama

Address:	Blue Cross & Blue Shield of Alabama P. O. Box 995 Birmingham, AL 35298
Claims Questions:	205-988-2200 1-800-292-8868
Medical Review Program:	1-800-248-2342
Network Service Area:	all counties

California

Address:	Blue Shield of California Turlock Service Center P. O. Box 2881 Turlock, CA 95381
Claims Questions:	1-800-331-2001
Medical Review Program:	1-800-343-1691
Network Service Area:	all counties

Kansas

Address:	Blue Cross & Blue Shield of Kansas P. O. Box 239 Topeka, KS 66629
Claims Questions:	1-800-223-0529
Medical Review Program:	316-269-4427 316-269-4426
Network Service Area:	Butler, Cowley, Harvey, Sedgwick and Sumner counties

Oregon

Address:	Blue Cross & Blue Shield of Oregon P. O. Box 1271 Portland, OR 97207
Claims Questions:	503-220-5883
Medical Review Program:	503-220-4795 1-800-824-8563 1-800-228-7309 (if calling from outside Oregon)
Network Service Area:	Clackamas, Multnomah and Washington counties in Oregon; Clark county in Washington state

Pennsylvania, New Jersey and Delaware

Address: Blue Cross of Greater Philadelphia
P. O. Box 13109
Philadelphia, PA 19101-3109

Claims Questions: 215-448-2484
1-800-338-0022

Medical Review Program: 1-800-792-7925

Network Service Area: Bucks, Chester, Delaware, Montgomery and Philadelphia counties in Pennsylvania; Burlington, Camden, Gloucester, and Salem counties in New Jersey; preferred network not currently available in Delaware

Washington, D.C. area (including Virginia and Maryland)

Address: Blue Cross & Blue Shield of the National Capital Area
550 12th SW
Washington, D.C.
20065-5540

Claims Questions: 202-479-1727
1-800-424-7474, ext. 1727

Medical Review Program: 202-637-0247
1-800-553-8700

Network Service Area: Washington, D.C. area, including Montgomery and Prince Georges counties in Maryland, and Arlington and Fairfax counties in Virginia

Washington State

Address: King County Medical Blue Shield
P. O. Box 21065
Seattle, WA 98111

Claims Questions: 206-464-0255
1-800-422-7713

Medical Review Program: 206-464-3743
1-800-367-2766

Network Service Area: King, Kitsap, Pierce and Snohomish counties

Mail Service Prescription Drug Program

Address: National Rx Services, Inc.
P. O. Box 18100
Las Vegas, NV 89114

Telephone Number: 1-800-628-8881

Prepaid Provider Dental Plan Service Representatives

Puget Sound Area

Address: Washington Dental Service
P.O. Box C-75983
Northgate Station
Seattle, WA 98125

Telephone Number: 206-522-2300

Wichita Area

Address: Delta Dental Plan of Kansas
P.O. Box 781410
Wichita, KS 67278-1410

Telephone Number: 316-686-0605

Portland Area

Address: Oregon Dental Service
315 SW 5th Avenue
Portland, OR 97204

Telephone Number: 503-228-6554

Scheduled Dental Plan Service Representatives

Puget Sound Area

Address: Aetna Life Insurance Company
P.O. Box 21645
Seattle, WA 98111

Telephone Number: 206-441-2666

Wichita Area

Address: Aetna Life Insurance Company
P.O. Box 6610
Leawood, KS 66206

Telephone Number: 1-800-221-7371

Pennsylvania Area

Address: Aetna Life Insurance Company
P.O. Box 1738
Reading, PA 19603

Telephone Number: 215-372-1650

Employee Benefits

Boeing Health Care Plans

Hourly Employees
(excluding Vertol)

1987 Edition

Foreword

This booklet describes the health care plans that may be available to you and your family if you are an eligible hourly employee of The Boeing Company. The provisions of each of the plans are effective as of January 1, 1987.

The plans described in this booklet have been designed to provide you with financial protection against large out-of-pocket health care expenses. In many cases, you will have a choice among medical and/or dental plans that are available in your area.

The Boeing Medical Plan, which is described beginning on page 4, is available to you and your eligible dependents regardless of where you live or receive your medical care. It offers comprehensive coverage of most medically necessary services and supplies, including prescription drugs and vision care services and supplies. In certain areas of the country, you may elect as an alternative to receive your medical care through an approved health maintenance organization (HMO), as explained on page 22. An HMO generally provides you and your dependents with all covered medical care for a fixed monthly cost, as long as you receive the care from or through the HMO's physicians or facilities.

You may also have a choice between two dental plans. Both cover necessary and appropriate dental care, including specialty care. Under the Prepaid Provider Dental Plan, you select a dentist from a list of those participating in the Plan. The Prepaid Plan then covers the full cost of most dental care that is received through your selected dentist. Under the Dental Incentive Plan, you may receive your care from any licensed dentist. However, you share part of the cost for all covered dental care, based on the type of care you receive. Both dental plans are described beginning on page 23.

You are encouraged to review the information on the following pages and to share it with your family so that you may receive the maximum protection available under each of these plans. Please take special care in reviewing the new medical review program under the Boeing Medical Plan since benefits may be limited or denied under certain circumstances.

If you have questions concerning your coverages, contact the appropriate Boeing Group Insurance Office at the address listed on page 36.

Every effort has been made to provide an accurate summary of the plans described in this booklet. If questions arise about the plans, final determination will be based on the official legal documents and contracts that govern the interpretation and administration of the plans. Copies of these documents and contracts are available from or through the Boeing Group Insurance Office.

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Eligibility

Employees

You are eligible for the plans described in this booklet if you are represented by one of the collective bargaining agreements listed on page 33.

Dependents

Certain family members may also be covered under these plans if you are covered as an employee. Eligible dependents include your spouse and unmarried dependent children who are under the age of 19. Step-children are covered on the same basis as natural and adopted children as long as they live with you and are solely dependent on you for support. In addition, you may request coverage for a minor child who is related to you either directly or through marriage as long as that child is unmarried, solely dependent on you for support, and living with you in a parent-child relationship.

An unmarried child may continue to be eligible between the ages of 19 and 25 if he or she is attending school regularly or is dependent solely on you for support.

Beyond age 25, an unmarried child may continue to be eligible if he or she is unable to earn a living because of a developmental disability or physical handicap. The child must be chiefly dependent on you for support on the date his or her eligibility for benefits would otherwise end. Coverage may continue under the plans described in this booklet for the duration of the incapacity as long as you continue to be an eligible employee under these plans.

If you would like to continue the coverage of a disabled child beyond age 25, you must complete an application form and provide proof of the child's incapacity within 31 days of the child's 25th birthday. You may also be required to verify the incapacity from time to time. Application forms are available from the Boeing Group Insurance Office.

Other Company Coverage

No person may be covered both as an employee (active or retired) and as a dependent. This means that eligible dependents do not include another employee who is covered under a Company-sponsored plan providing coverage for medical, vision care, prescription drug, dental or similar services, or one who is covered under an approved health maintenance organization (HMO) plan.

A person will also not be covered as a dependent of more than one employee. A child who would otherwise be eligible as a dependent under more than one Company-sponsored or HMO plan will be covered under the plan of the person considered to be the head of the household. The head of the household is the parent or guardian in the following order:

1. The parent with whom the child lives.
2. The parent who has the greater length of service with the Company based on an hourly employee's seniority date or a salaried employee's service date.

If an application is required to begin coverage for the child and an application is not completed, the child will be covered under the plan, if otherwise available, that provides automatic coverage.

How to Enroll

Medical Coverage You and your dependents are automatically covered under the Boeing Medical Plan. However, you must complete a Boeing health care information card before any benefits will be paid by the Plan. You must also update this card if you wish to add or remove dependents at a later date. Payment of benefits is delayed until the health care information card is fully completed, and the information has been entered into the Company's eligibility files.

If you elect the health maintenance organization option (described on page 22), you must complete the necessary enrollment cards for the HMO that you select. You may enroll yourself and your dependents in an approved HMO plan within 30 days of your date of hire or within 30 days after moving into the service area of the HMO. Open enrollment periods are also held during which you may change the plan through which you receive your medical coverage.

If you and another Boeing employee marry after your coverages become effective, the special provisions described above under "Other Company Coverage" apply to you and each of your dependents. However, if one of you is covered under the Company-sponsored Medical Plan described in this booklet and the other is enrolled in an approved HMO plan, you or your spouse has 30 days from the date of marriage to change to the plan under which the other is covered if you both wish to be covered under the same plan. The person who elects to change coverage must meet the eligibility requirements of the plan to which he or she is applying.

Dental Coverage If you live in the service area of the Prepaid Provider Dental Plan, you must complete an application to select coverage under either this plan or the Dental Incentive Plan. Both plans are described beginning on page 23. You may enroll in either plan within 30 days of your date of hire or within 30 days after moving into the service area of the Prepaid Provider Dental Plan. Open enrollment periods are also held during which you may change the plan through which you receive your dental coverage.

No enrollment applications are required for dental coverage if you live outside the service area of the Prepaid Provider Dental Plan. You and your dependents will automatically receive your coverage through the Dental Incentive Plan.

Other Applications As noted earlier, a special application is required if you wish to continue coverage beyond age 25 for a disabled child or if you wish to request coverage for a minor child that is related to you directly or through marriage. Applications for these purposes are available from the Boeing Group Insurance Office.

Effective Date of Coverage

If you are a newly hired employee, your coverage becomes effective on the first day of the month following one full calendar month of continuous employment. To complete a full calendar month, you must be on the Company's active payroll from the first regularly scheduled work day of the month through the last regularly scheduled work day of that month.

If you enroll in a plan at a later date or are transferring to the hourly payroll, your coverage becomes effective on the first day of the month following your enrollment or transfer.

If you are on an approved leave of absence on the date coverage is to become effective and the leave has not gone beyond 30 days, you will be considered on the active payroll and your coverage will become effective on that date. However, if the approved leave of absence has gone beyond 30 days, the effective date of your coverage will be the first of the month following your return to active work.

You continue to be eligible for coverage as long as you are on the active payroll on the first day of each calendar month. You are considered on the active payroll if you are on vacation or are absent due to an approved leave that has not then gone beyond 30 days. For coverage during a leave that goes beyond 30 days, see page 31.

Coverage of your current dependents becomes effective on the same date your coverage becomes effective. New dependents are covered on the date of marriage or birth, or in the case of adoption, the date the child is legally placed in your home. If any person (other than your natural newborn child) is hospitalized on the date coverage is to become effective, the effective date will be delayed until the date the dependent is released as an inpatient from the hospital.

For coverage of new dependents to become effective, you may be required to complete the necessary enrollment or health care information card.

For a description of when coverage terminates under these plans, see page 31.

Contributions

Boeing provides coverage for you and your eligible dependents under the Company-sponsored Medical and Dental Plans at no cost to you.

If you elect the health maintenance organization option described on page 22, the Company contributes toward your HMO coverage up to the greater of: the monthly cost for the Company-sponsored Medical Plan in the current year or the monthly cost for such coverage during 1986.

If the Company's contributions toward an HMO are less than the net HMO dues required for you and your family, you contribute the difference through payroll deductions. Your net HMO dues are the total monthly HMO dues for you and your enrolled family members less any amounts paid by or through other employers toward such coverage.

Under certain circumstances, you may also arrange to pay the full cost of coverage during a period when coverage would otherwise terminate. See the termination of coverage section on page 31 for an explanation of the provisions and procedures related to self-pay arrangements.

Medical Plan

This Plan provides you and your eligible dependents with financial protection against large health care expenses. Although you may receive care from any licensed health care provider that is covered under the Plan, you receive enhanced benefits if you receive your care through a member of the preferred network of health care providers. Use of preferred network providers also offers you certain other advantages, as explained in exhibit 1 on page 6.

A summary of major plan features is provided in the sections that follow. You are especially encouraged to read the medical review program requirements (explained in exhibit 2) since the regular benefit payment levels under the Plan may be reduced or denied if the program requirements are not met.

Deductible Expenses

You and your eligible dependents are responsible each year for certain expenses, known as deductible expenses, before the Plan will begin paying benefits.

During a calendar year, deductible expenses for each person covered under the Plan are the first $75 of charges for covered medical services and supplies, up to an annual deductible maximum of $225 per family. Charges for all covered services and supplies, except those related to second surgical opinions, vision care and prescription drugs, apply toward the individual and family deductible requirements. (See page 14 for an explanation of the separate deductible that applies to prescription drugs under the prescription drug card program.)

In addition to the individual and family deductible expenses that must be paid once each calendar year, the Plan includes a separate *emergency room deductible.* The separate $25 deductible applies to each visit to a hospital emergency room that does not result in an immediate inpatient admission. If the patient is admitted as an inpatient immediately following treatment in the emergency room, the separate $25 deductible is waived.

Expenses that are included in the $25 emergency room deductible are not applied toward the $75 individual or the $225 family deductible. Instead, when hospital emergency room services are used, expenses will apply first to the $25 emergency room deductible, with any remaining expenses used to meet the individual or family deductible if these have not been satisfied for the calendar year.

Deductible expenses may not be waived by the health care provider.

Benefit Payment Levels

Once the required deductible expenses have been paid, you and your dependents receive benefits under a special benefit payment arrangement. Under this arrangement, the amount of the copayment that is your responsibility varies depending on the type of service or supply that is received as well as on the type of health care provider that is used.

The benefit payment levels described below do not generally apply to prescription drugs or to vision care services and supplies. See exhibit 3 on page 14 for an explanation of your prescription drug coverage and exhibit 4 on page 16 for the Plan's vision care schedule and terms.

After you and your dependents have paid the required deductible expenses, the Plan pays benefits according to the following guidelines. Please note that you must contact the medical review program before receiving certain types of care (as explained on pages 8 and 9) or Plan benefit payments may be reduced or denied.

1. *100 percent* payment for most physician and hospital services and supplies when received from a member of a preferred network of health care providers. Exhibit 1 offers more information about the preferred networks that are available under the Plan and the advantages of using network providers. (For special provisions relating to the coverage of specialty care when such care is not available through a preferred network, contact the Boeing Group Insurance Office.)
2. *100 percent* of the usual and customary charges for home health or hospice care or for care in a skilled nursing facility or birthing center, when used in place of hospital inpatient care.
3. *100 percent* of the usual and customary charges related to a second (and third) surgical opinion, including diagnostic, x-ray and laboratory services.

For all other expenses, the Plan pays a portion of the charges for covered services and supplies after you and your dependents have paid your deductible expenses. In these instances, the Plan pays:

1. *80 percent* of usual and customary charges for most other health care services and supplies, including those received from health care providers who are in a preferred network service area but who are not members of the network. Under this provision, when a person's copayment reaches $500 or a family's copayment reaches $1,000 in any calendar year, the Plan pays 100 percent of usual and customary charges for the remainder of that year.
2. *90 percent* of usual and customary charges for most physician and hospital services and supplies when received outside the service area of a preferred network. After the $500 individual or $1,000 family copayment limit is reached in a calendar year, the Plan pays 100 percent of usual and customary charges for the remainder of that year.
3. *50 percent* of the usual and customary charges for the outpatient treatment of mental illness, whether or not the health care provider is a member of a preferred network. These expenses do not apply to the individual or family copayment limits explained above.
4. *50 percent* of the usual and customary charges for the treatment of temporomandibular joint disease (TMJ) and myofascial pain-dysfunction syndrome (MPDS), up to a lifetime maximum benefit of $3,500. The 50 percent copayment level applies whether or not the health care provider is a member of the preferred network. In addition, these expenses do not apply to the individual or family copayment limits explained above.

Under the above plan payment levels, *your out-of-pocket expenses* may include any or all of the following. These out-of-pocket expenses do not apply toward the $500 individual or $1,000 family copayment limits that are referred to under the 80 percent and 90 percent benefit payment levels.

1. Calendar year deductible expenses.
2. The $25 emergency room deductible.
3. The 50 percent copayment amount for the outpatient treatment of mental illness or for the treatment of TMJ or MPDS that is not covered by the Plan.
4. The difference between the usual and customary charges for a service or supply (defined on page 35) and the health care provider's actual charge when a nonnetwork provider is used. (When a member of a preferred network is used, the patient is not responsible for this amount.)
5. Amounts that exceed benefit maximums (summarized on page 7).
6. Expenses that are not covered as a result of a benefit reduction or denial under the medical review program (explained on pages 8 and 9).
7. Expenses for services and supplies that are not covered under the Plan or for services and supplies that are subject to specific exclusions (see page 18).

Any offer by a health care provider to waive all or part of these expenses will reduce the usual and customary charge level used by the Plan to determine the appropriate benefit payment level.

Exhibit 1
PREFERRED NETWORKS OF HEALTH CARE PROVIDERS

Preferred network providers are those physicians, hospitals and other health care providers who have entered into special contracts with the Plan's service representatives to provide efficient, cost effective health care. Although you may receive care from any licensed health care provider that is covered under the Plan, the Plan offers you certain advantages if you use a member of the preferred network.

Special fee arrangements between the service representatives and preferred network providers make it possible for the Plan to cover 100 percent of most physician and hospital services and supplies, after you have paid your deductible expenses. This means that in most cases, your only out-of-pocket expenses when you use a member of a preferred network are deductible expenses, expenses for noncovered services and supplies, and any amounts that exceed Plan maximum benefits.

In addition to greater benefits, use of preferred network providers offers you certain other assurances. For example, preferred network providers have agreed to assist you through the preadmission and prior approval procedures that are required under the Plan's medical review program (explained on pages 8 and 9). If prior approval is required but not obtained because of an oversight by the network provider, you will not be held financially responsible.*

Finally, the contracts with preferred network providers include direct billing and payment systems. This means that no claim form is required whenever you use a preferred network provider. Once you have paid any out-of-pocket expenses such as your deductible expenses, no further paperwork is usually required on your part.

Preferred networks are available in the following areas:

Alabama
(all counties)

California
(all counties)

Kansas
(Butler, Cowley, Harvey, Sedgwick & Sumner counties)

New Jersey
(Burlington, Camden, Gloucester & Salem counties)

Oregon
(Clackamas, Multnomah & Washington counties in Oregon; Clark county in Washington state)

Pennsylvania
(Bucks, Chester, Delaware, Montgomery & Philadelphia counties)

Washington, D.C. area
(including Montgomery and Prince Georges counties in Maryland, and Arlington and Fairfax counties in Virginia)

Washington state
(King, Kitsap, Pierce & Snohomish counties)

Since network service areas may change from time to time, you may wish to contact the Boeing Group Insurance Office to see if the above list has been updated. A directory of health care providers in preferred network service areas is available through the Boeing Group Insurance Office.

*Although the network provider may assist you through the second surgical opinion requirements, you are solely responsible for obtaining the required second opinion.

Benefit Maximums

The following benefit maximums apply to you and each person covered under the Plan. Any benefits that have been paid under this or another Company-sponsored medical plan for active or retired employees are applied against these maximums unless they have been previously reinstated or restored.

A *$1 million lifetime maximum* applies to each person covered under the Plan. Included within this maximum are the following limitations:

1. A maximum of $500 per covered *hearing aid* per ear during any consecutive three years.
2. A maximum of 120 days of covered *skilled nursing facility care* during any calendar year.
3. A maximum of $4,000 for covered *treatment of substance abuse* during any calendar year.
4. A $3,500 lifetime maximum for the covered treatment of *temporomandibular joint disease (TMJ) and myofascial pain dysfuntion syndrome (MPDS).*
5. For covered care in a *private room in a hospital or skilled nursing facility,* a maximum benefit equal to the average charge for a semiprivate room in the facility where the admission occurs. (If that facility does not offer semiprivate rooms, the maximum benefit is equal to the average charge for a semiprivate room in similar facilities in the area.)

Medical Review Program

The medical review program is designed to let you and your physician know whether certain types of nonemergency care are covered under this Plan, before the patient undergoes the care or incurs the expense. The program is available in all preferred network service areas and may be contacted through the telephone numbers listed in exhibit 7 (on pages 36 and 37).

The medical review program includes: preadmission certification requirements for inpatient hospital or skilled nursing facility care; prior approval procedures for home health and hospice care; second surgical opinion requirements for certain listed procedures; and medical advisory services. Each of these is explained in exhibit 2 on pages 8 and 9.

You are encouraged to review this information carefully since benefits may be limited or denied if you do not follow the medical review program requirements before undergoing certain types of care.

Covered Medical Services and Supplies

The Plan covers medically necessary services and supplies when they are used to diagnose or treat an accidental injury or illness. Such services and supplies are also covered for certain listed conditions, as explained beginning on page 13.

Coverage of the following services and supplies is subject to general plan provisions, including the exclusions that begin on page 18 and the definitions that begin on page 34.

Physician Services The services of a licensed physician (M.D. or D.O.) are covered when they are medically necessary for the diagnosis or treatment of accidental injuries, illnesses or other covered conditions.

Physician services are also covered for the following:

1. Second surgical opinions required under the medical review program as well as voluntary second surgical opinions.
2. Injectable legend drugs (other than preventive injections and immunizations) that are used to treat a covered condition. (Antigen, allergy vaccine, insulin and other drugs and medicines are not covered as a physician service but may be covered under the prescription drug benefit described on pages 14 and 15.)
3. An eye examination (including refraction) by a physician if the exam is being provided because of the presence of another medical condition such as diabetes, glaucoma or cataracts. (Routine eye examinations are covered under the vision care benefits as described on pages 13 and 16.)
4. Diagnostic x-ray and laboratory examinations when required by a physician to diagnose an illness or injury. In addition, the Plan covers such exams when they are used in connection with a required or voluntary second surgical opinion, a routine Papanicolaou's (PAP) test, or a routine screening mammogram. The Plan limits this coverage to one per year for routine PAP tests, and to once every two years for routine screening mammograms for covered persons who are 35 years of age or older.

   Coverage of computerized axial tomography (CAT) scans is limited as explained on page 20.

Exhibit 2
MEDICAL REVIEW PROGRAM REQUIREMENTS

Among the issues that a patient must consider when his or her physician recommends care is whether such care will be covered under the Medical Plan. Recognizing this, the Company has introduced into the Plan a medical review program that provides the patient and physician with information about coverage for certain types of nonemergency care before the patient decides to undergo the care and expense.

The Medical Plan pays its regular benefits for certain types of nonemergency care only if a person covered under the Plan contacts the medical review program before undergoing the care. The following explains the requirements of the review program. Please remember that benefits may be limited or denied if the review program requirements are not followed.

Please note that the medical review program requirements do not apply if care is received outside the service area of a preferred network of health care providers or if a person's primary coverage is provided through another employer's group medical plan.

Preadmission and Prior Approval Requirements

The Plan requires the patient or physician to contact the medical review program before a nonemergency admission to a hospital or skilled nursing facility, or before home health or hospice care is received. The information provided by the patient or physician is then reviewed against established medical criteria to determine the medical necessity of the care that is being recommended.

If care is received through a member of a preferred network of health care providers, the physician should assist the patient through the precertification and prior approval portions of the program. The patient simply presents the Medical Plan ID card and reminds the physician of the program requirements. If the preferred network physician does not contact the program after the patient has been identified as covered under this Plan, the patient will not be held financially responsible if Plan benefits are limited or denied.

If care is received through a physician who is not part of a preferred network, the patient or physician should contact the service representative that is indicated on the lower right corner of the Medical Plan ID card. (The telephone number for the service representative's medical review program appears in exhibit 7 on pages 36 and 37.) Under these circumstances, the program should be contacted at least 10 days before the proposed admission.

Under this portion of the review program, benefits are paid as follows:

1. The Plan pays its regular benefits if the hospital, skilled nursing facility, home health or hospice care is approved through the medical review program.
2. Regular Plan benefits are reduced to 50 percent of the usual and customary charges for the care if preadmission or prior approval is required but not obtained, and it is later determined that the care was medically necessary. Under this provision, the patient's out-of-pocket expenses are limited to $1,000 (after deductible expenses have been paid) and include any out-of-pocket expense that may be required under the second surgical opinion requirements.
3. No benefits are paid if the admission or care does not meet the medical necessity criteria under the program.

Although contacting the program before emergency or pregnancy-related admissions is not required, the patient or physician may wish to contact the program shortly after admission to be assured that the remainder of the admission is covered under the Plan.

Second Surgical Opinion Requirements

The Plan also requires each covered person to obtain a second surgical opinion from an approved physician before undergoing certain listed procedures on either an inpatient or outpatient basis. The patient is solely responsible for obtaining a required second opinion under the program.

If one of the surgeries listed below is recommended, the patient should contact the service representative listed on the lower right corner of the Medical Plan ID card to obtain the names, addresses and telephone numbers of physicians approved to give a second opinion. The patient must then receive a second opinion from an approved physician within six months before the surgery. (Under the provisions of the Plan, the physician who provides the second opinion may not perform the surgery and may not be an associate of the surgeon.)

Expenses related to the second opinion are paid in full. To receive proper credit for the second opinion, the patient should ask his or her physician to specify on the bill that the charges are for a second opinion.

Benefits for the surgery are paid as follows:

1. The Plan pays its regular benefits for the surgery as long as the required second opinion is received, whether or not the second opinion agrees with the original physician's recommendation.
2. Regular Plan benefits are reduced to 50 percent of the usual and customary charges for the surgery if the required second opinion is not received. Under this provision, the patient's out-of-pocket expenses are limited to $1,000 (after deductible expenses have been paid) and include any out-of-pocket expense that may be required under the preadmission and prior approval requirements.

Medical Advisory Services

The review program also offers a medical advisory service. Through this service, you and your dependents may receive information about such things as treatment alternatives and physician referrals. For example, if your physician recommends a surgery that does not require a second opinion, you may nevertheless contact the review program to obtain a list of physicians who would provide a voluntary second opinion.

Second Surgical Opinion Procedures

The codes listed after the following procedures are those listed in the most recent edition of *Current Procedural Terminology.* These CPT codes are subject to change in accordance with recommendations by the American Medical Association.

cholecystectomy—removal of the gall bladder
(CPT 47600-47620)

dilation and curettage—dilation of the cervix and scraping of the uterus
(CPT 58120)

excision (removal) of cataracts
(CPT 66830-66945, 66983, 66984)

hemorrhoidectomy—removal of hemorrhoids
(CPT 46221, 46250-46262, 46934-46936)

inguinal hernia repair—hernia in the groin
(CPT 49500-49525)

hysterectomy—removal of the uterus
(CPT 58150-58285)

knee surgery
(CPT 27330-27365, 27440-27447, 29870-29887)

laminectomy or spinal fusion—removal or welding of parts of the spine
(CPT 62295-63031, 63040-63064)

mastectomy—partial or complete removal of breast tissue
(CPT 19140-19240)

prostate surgery—(CPT 52601, 52612, 52614, 52650, 55801-55845)

septoplasty and/or rhinoplasty—nose surgery for functional improvement
(CPT 30400-30420, 30520, 30620)

bunionectomy—removal of bunions
(CPT 28290-28299)

tonsillectomy and/or adenoidectomy
(CPT 42820-42836)

varicose vein stripping and ligation—removal and tying of varicose veins
(CPT 36470, 36471, 37700-37787)

coronary artery bypass
(CPT 33510-33528)

Other Professional Services The Plan covers certain health care services when provided either by a physician (M.D. or D.O.) or by another type of health care professional. Specifically, the Plan covers the health care professionals that are listed below, for the type of services indicated. All health care professionals must be licensed in the state in which the services are performed and must be acting within the scope of that license. In the absence of licensing requirements, appropriate certification is required.

1. Registered nurses for services that would have been covered if they had been performed by a physician licensed as an M.D. (However, the Plan does not cover such services if the nurse ordinarily lives in your home or is a member of your or your spouse's family.)
2. Clinical psychologists for the treatment of mental illness conditions covered under the Plan. (For the coverage terms related to mental illness treatment, see page 17.)
3. Physical, occupational and speech therapists for the services described on page 12.
4. Dentists for dental work or surgery covered under the Medical Plan. (For coverage of routine dental care, refer to the description of the Boeing dental plans that begins on page 23.)
5. Optometrists providing covered vision care services. (For coverage of routine vision care services, see the vision care schedule and terms that are described on page 16.)
6. Podiatrists providing covered podiatric services.
7. Chiropractors for the necessary adjustment by hand of any articulation of the spine.
8. Christian Science practitioners who are listed in the current Christian Science Journal at the time they provide a service.

Hospital Services and Supplies The Plan covers the charges for a semiprivate room and the medically necessary hospital services and supplies needed to treat an accidental injury, illness or other covered condition. When a nonemergency admission is planned in the service area of a preferred network of health care providers, it must be precertified under the medical review program, as explained on page 8.

If a private room is used, you are responsible for the difference between the charge for the private room and the hospital's average charge for a semiprivate room. If the hospital does not provide semiprivate rooms, the Plan pays up to the level being charged for semiprivate rooms in similar facilities in the area.

Covered hospital services and supplies include: operating rooms and equipment; surgical dressings and supplies; x-ray and laboratory services; electrocardiograms; anesthesia, including administration and materials; pathology; drugs (excluding blood and blood derivatives); and the administration of blood.

Other covered services include outpatient surgery at a hospital if the second surgical opinion requirements under the medical review program are met (see page 9), and emergency room treatment of an accidental injury or illness. (See page 4 for a description of the special $25 emergency room deductible.)

Skilled Nursing Facility Services and Supplies The Plan covers the charges for a semiprivate room in a skilled nursing facility as well as the medically necessary services and supplies for the treatment of an accidental injury, illness or other covered condition only if the skilled nursing facility care is provided in place of hospital inpatient care. When a nonemergency admission is planned in the service area of a preferred network of health care providers, it must be precertified under the medical review program, as explained on page 8.

If a private room in a skilled nursing facility 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 does not provide semiprivate rooms, the Plan pays up to the level being charged for semiprivate rooms in similar facilities in the area.

The Plan covers care in a skilled nursing facility for up to 120 days in any calendar year. If additional care is required, you may apply to the service representative for an extension of benefits. Limited extensions may be granted if the service representative determines that the continued care is medically necessary.

Home Health Care Services When provided in the service area of a preferred network of health care providers, home health care requires prior approval under the medical review program, as explained on page 8.

The Plan covers medically necessary home health care services if inpatient care in a hospital or skilled nursing facility would otherwise be required. In addition, the patient must be considered "homebound," which means that leaving home involves a considerable and taxing effort and public transportation cannot be used without the help of another.

Before the patient begins receiving home health care, the physician must develop a written treatment plan. Then, at least once every two months, the physician must review the treatment plan and certify that the patient's condition and treatment continue to meet the above criteria.

The Plan covers the following home health care services and supplies if they are provided by employees of an approved home health agency and billed through the agency:

1. Physician services.
2. Nursing services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.).
3. Physical therapy services provided by a physical therapist.
4. Speech therapy services provided by a speech therapist.
5. Occupational therapy services provided by an occupational therapist.
6. Medical social services provided by a person with a master's degree in social work.
7. Home health aide services.
8. Respiratory therapy services provided by an inhalation therapist certified by the National Board of Respiratory Therapists.
9. Medical supplies that would have been provided on an inpatient basis.
10. Nutritional supplements (such as diet substitutes) administered intravenously or through hyperalimentation.

The Plan covers prescription drugs and medicines as well as durable medical equipment for home health care on the same basis as for other types of care.

A list of exclusions that apply to home health care services appears on page 19.

Hospice Care Services Hospice care services are provided to terminally ill patients in an effort to control the pain and other symptoms associated with terminal illness. The Plan provides coverage of these services, according to the following guidelines, for the patient whose life expectancy has been determined to be six months or less.

When provided in the service area of a preferred network of health care providers, hospice care requires prior approval under the medical review program, as explained on page 8.

Before the patient begins receiving hospice care, the physician must develop a written treatment plan. Then, at least once every two months, the physician must review the treatment plan and certify that the patient's condition and treatment continue to meet the above criteria.

An approved hospice treatment plan may include both inpatient and outpatient care. If hospital inpatient care is approved, the Plan provides coverage for hospice care on the same basis as it does for other types of care (see page 10). Care in a skilled nursing facility or in a hospital outpatient setting is also covered for the hospice patient on the same basis as for others.

Outpatient hospice care in the home is covered if the physician certifies that the patient is "homebound" and would otherwise require hospital inpatient care or care in a skilled nursing facility. A patient is considered homebound if leaving home involves a considerable and taxing effort and public transportation cannot be used without the help of another.

The Plan covers the following hospice home care services and supplies if they are provided by employees of an approved hospice agency and billed through the agency:

1. Physician services.
2. Nursing services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.), within the limitations described below.
3. Physical therapy services provided by a physical therapist.
4. Speech therapy services provided by a speech therapist.
5. Occupational therapy services provided by an occupational therapist.
6. Medical social services provided by a person with a master's degree in social work.
7. Home health aide services, within the limitations described below.
8. Respiratory therapy services provided by an inhalation therapist certified by the National Board of Respiratory Therapists.
9. Medical supplies that would have been provided on an inpatient basis.
10. Nutritional supplements (such as diet substitutes) administered intravenously or through hyperalimentation.
11. Respite care services (to provide temporary relief of family members or friends from the duty of caring for the patient), within the limitations described below.

The Plan covers prescription drugs and medicines as well as durable medical equipment for hospice care on the same basis as for other types of care.

Visits by a registered nurse, licensed practical nurse or home health aide to provide skilled care are covered if they are for a minimum of four or more hours, up to a total of 120 hours. Similarly, respite care visits are covered if they are for a minimum period of four or more hours per day, up to a total of 120 hours per three-month period.

Under certain circumstances, the Plan may extend hospice benefits beyond the skilled and respite care maximums described above. If your physician recommends an extension, you should apply to the appropriate service representative at the address listed on pages 36 or 37.

A list of exclusions that apply to hospice care services appears on page 19.

Christian Science Sanatorium Services and Supplies The Plan covers the charges for a semiprivate room in a sanatorium if the patient is admitted for the process of healing (not rest or study) and is 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 does not provide semiprivate rooms, the Plan pays up to the level being charged for semiprivate rooms in similar facilities in the area.

Physical, Occupational and Speech Therapy Services The Plan covers certain types of therapy only to the extent that the therapy will significantly restore function. The services of a physical therapist are covered for the administration of physical therapy (but not other types of therapy) to restore function. In addition, the Plan covers an occupational therapist's services for occupational therapy that is for physical restoration, and a speech therapist's services to restore function when prescribed by a physician as to type and duration.

All such therapy services must be provided under a physician's supervision, and the patient must continue under the care of the attending physician during the time the therapy is being provided. The attending physician must evaluate the therapy treatment at least once every three months and certify that continuing therapy is required.

Physical, occupational and speech therapists must meet licensing or certification requirements, as explained in the definitions on page 35.

Ambulance Services The Plan covers professional ambulance services when the ambulance is used to transport the patient from the place where he or she is injured or becomes ill to the first hospital where treatment is given. Such services are also covered when the physician requires the use of an ambulance to transport the patient from a hospital to the patient's area of residence for the protection of the patient's health or life.

Ambulance service from one hospital to another, including return, is covered only in situations where evidence clearly establishes that the institution to which a patient is being transferred is the nearest one having appropriate regional specialized treatment facilities, equipment or staff physicians. No other expenses in connection with travel are covered.

Prescription Drugs and Medicines The Plan covers prescription drugs and medicines under two programs. You and your dependents may obtain any covered prescription drug through the prescription drug card program. As an alternative, you may use the mail service program to obtain maintenance prescription drugs that are taken on an ongoing basis for a chronic medical condition.

As noted earlier, prescription drugs and medicines are not subject to the Plan's deductible requirements or to its general benefit payment levels. Exhibit 3 explains your coverage under each of these programs.

Vision Care Services and Supplies The Plan covers vision care services and supplies as explained in exhibit 4. The deductible requirements and general benefit payment levels of the Plan do not apply.

Hemodialysis The Plan covers hemodialysis treatment in the patient's home when it is repetitive and for chronic, irreversible kidney disease. Covered services and supplies include the rental or lease of hemodialysis equipment.

Under certain conditions, the Plan may cover the purchase of major hemodialysis equipment and supplies as well as the necessary training for the operation of the dialyzer. For purchased supplies to be covered in these instances, the items must be of no real use to the patient in the absence of the disease and must be of no value to other household members. The specific conditions, including an amortization period, that apply to the purchase of the equipment are established by the service representative.

Hearing Aids The Plan covers up to $500 toward the cost and installation of a hearing aid when recommended in writing by a physician who is certified as an otolaryngologist. The number of hearing aids for each covered person is limited to one per ear during any consecutive three-year period, including any time covered under another Company-sponsored medical plan.

The Plan does not cover: hearing or audiometric examinations, unless disease is present; replacement of lost, broken or stolen hearing aids unless the three-year time period has been exhausted; replacement parts, including batteries, for the repair of hearing aids; hearing aids that do not meet professionally accepted standards, including any services and supplies that are experimental in nature; eyeglass-type hearing aids if the charge exceeds the covered amount for one hearing aid; hearing aids ordered before a person becomes eligible for coverage or after coverage terminates; and hearing aids ordered before termination of coverage but delivered more than 60 days after coverage terminates.

Other Covered Services and Supplies The Plan also covers the following types of services and supplies:

1. X-ray, radium and radioactive isotope therapy.
2. Anesthesia and oxygen.
3. The rental (or purchase when approved by the service representative) of durable medical or surgical equipment when manufactured and used exclusively for the therapeutic treatment of the patient.
4. Artificial limbs, eyes and other prostheses, including the necessary repair and replacement required by normal usage or change in the patient's condition.
5. Orthopedic appliances and braces, including necessary repair and replacement required by normal usage or change in the patient's condition.

Covered Conditions

The Plan covers the services and supplies described in the preceding section when they are for the treatment of accidental injuries and illnesses. These services and supplies are also covered for certain specific conditions. The following is a summary of the coverage provisions related to these conditions.

Pregnancy-Related Conditions Medically necessary services and supplies are covered for pregnancy-related conditions for employees and dependent wives if they are provided while the patient is covered under this Plan. Services and supplies are considered for the treatment of a pregnancy-related condition if they are specifically related to the pregnancy, and if they are provided during the pregnancy or within 90 days following the termination of the pregnancy.

Covered pregnancy-related conditions include normal delivery, spontaneous abortion (miscarriage), legal abortion and complications of pregnancy. In addition, if the mother is eligible for benefits, the following services and supplies are covered for the newborn child:

1. Routine hospital services and supplies for the first 10 days of nursery care for a healthy child.
2. Physician services during the first two days following birth.

Exhibit 3
PRESCRIPTION DRUG AND MEDICINE COVERAGE

The Medical Plan covers prescription drugs and medicines under two different programs. You and your dependents may obtain any covered prescription through the prescription drug card program. Or as an alternative, you may use the mail service program to order maintenance prescription drugs that are taken on an ongoing basis to control a chronic medical condition. Each of these programs is described below.

PAID Prescriptions Drug Card Program

Under this program, you and each of your dependents must pay the first $2 for each prescription you receive, including refills.

Once you have paid this deductible, the level of benefits that are paid depends on whether or not you use a pharmacy that participates in the card program. Participating pharmacies generally display the PAID prescriptions decal, or you may contact the Boeing Group Insurance Office to find out how to locate a participating pharmacy in your area.

When using a participating pharmacy, present your special PAID prescriptions ID card to the pharmacist. The pharmacist will bill the PAID prescription program for any amounts that exceed the $2 per prescription deductible.

If you use a nonparticipating pharmacy or if you do not have your ID card with you when you purchase a prescription at a participating pharmacy, you are responsible for paying the pharmacist for your prescription drugs. You must then file a special PAID prescriptions claim form to receive reimbursement for covered expenses. (Claim forms, including a special form for allergy serum, are available through the Boeing Group Insurance Office.)

When using a nonparticipating pharmacy, the Plan pays 75 percent of the usual and customary charges for the prescription drugs after you have paid deductible expenses, if you receive your prescription in your state of residence. If you receive your prescription outside your state of residence, the Plan pays 100 percent of the usual and customary charges for the prescription, after you pay deductible expenses. Whether you receive the prescription in or out of state, you are responsible for any amounts that exceed the usual and customary charge level of the program.

This program covers medically necessary prescription drugs and medicines that are required by federal law to be prescribed in writing by a physician or dentist and to be dispensed by a licensed pharmacist. This includes allergy serum (antigen) as well as insulin when prescribed by a physician.

The program restricts each prescription or refill to a 34-day supply or to units of 100, whichever is greater.

Prescription drugs and medicines that are not covered under this program are listed below under the exclusions section.

Mail Service Program

This program is provided as an alternative to the PAID prescriptions card program for people who must take maintenance drugs on an ongoing basis for a chronic medical condition. There are no deductibles or copayments. As a result, you may receive covered prescription drugs at no cost to you through this program.

As with the other program, you receive coverage for medically necessary prescription drugs and medicines that are required by federal law to be prescribed in writing by a physician or dentist and to be dispensed by a licensed pharmacist. This includes insulin when prescribed by a physician as well as needles and syringes when prescribed along with insulin.

This program covers up to a 90-day supply per prescription or refill, if prescribed by your physician. Authorized refills are covered only after the initial order has been used. Certain controlled substances are subject to quantity limitations.

Unless your physician indicates otherwise, you will receive a generic equivalent of the prescribed drug when available and permissible under the law.

Forms for ordering prescription drugs through this program are available from the Boeing Group Insurance Office.

Exclusions that apply to this program are listed below.

The following items are excluded under both the PAID prescriptions card program and the mail service program:

1. All contraceptives, whether medication or device, *regardless of intended use.*
2. Appliances, devices and other non-drug items, including but not limited to contraceptive devices, therapeutic devices and artificial appliances. However, this does not apply to needles and syringes when prescribed along with insulin under the mail service program.
3. Any charges for the administration or injection of any drug.
4. 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 municipality, state or federal program, including Medicare.
5. Any prescription filled in excess of the number prescribed by the physician or any refill after one year from the date of the physician's order.
6. Immunizing agents, except allergy serum (antigen).
7. Drugs dispensed during an inpatient admission by a hospital, skilled nursing facility, sanatorium or other facility.
8. Experimental drugs or ones used for investigational purposes.
9. Drugs that are not medically necessary for the treatment of an illness, injury or other covered condition, including vitamins.
10. Delivery charges under the mail service program.

For a newborn child that is ill, injured or born prematurely, the Plan covers the hospital and physician services and supplies listed on page 13. In addition, if the child is an eligible dependent and is enrolled in the Plan, coverage is provided for all other services and supplies that are normally covered under this Plan. This includes treatment for hereditary complications and congenital abnormalities.

Coverage of a newborn child continues as long as the child remains an eligible dependent and is enrolled in the Plan.

Coverage of the services of an approved birthing center are covered if such services would be covered if received in a hospital.

Congenital Abnormalities and Hereditary Complications The Plan covers medically necessary services and supplies that are required for the treatment of congenital abnormalities and hereditary complications. This coverage applies to newborn children, as noted under pregnancy-related conditions, as well as to all other persons covered under the Plan.

Substance Abuse Treatment The Plan pays up to $4,000 per covered person in any calendar year for the effective treatment of alcoholism and other types of substance abuse. This includes coverage of treatment at an approved treatment facility or hospital as well as physician services and prescription drugs when provided in connection with a specific treatment plan prepared by your physician. If treatment is provided at an approved treatment facility, coverage is limited to the intensive inpatient treatment and outpatient counseling services that have been prescribed by your physician.

The Plan does not cover: recovery houses that provide an alcohol or drug-free residential setting; alcohol or drug information and referral services; school programs; emergency service patrols; or detoxification unless immediately followed by a rehabilitation program.

To receive coverage of substance abuse treatment, the patient must complete the prescribed course of treatment.

Exhibit 4
VISION CARE BENEFITS

The Medical Plan covers the following vision care services and supplies:

1. Eye examinations, which must include refraction, when performed by a legally qualified ophthalmologist or optometrist.
2. Prescription lenses and frames required for such lenses.
3. Contact lenses when elected in place of conventional lenses and frames.

Benefit Payment Levels

Coverage of vision care services and supplies is subject to all Plan provisions except the deductible and copayment features. The Plan pays benefits according to the following schedule:

Services & Supplies	*Maximum Benefit*
Eye examination	$ 45 paid-in-full when performed by a preferred network provider
Lenses:	
single vision (two lenses)	$ 45
bifocal (two lenses)	74
trifocal (two lenses)	87
lenticular (two lenses)	140
Frames	$ 35
Contact lenses (two lenses) covered in place of conventional lenses and frames	$ 95

Benefit Limitations

The Plan covers up to one eye examination and two sets of lenses and frames during each consecutive 24-month period that you or an eligible dependent is covered under this or another Company-sponsored plan. A 24-month period begins for each covered person on the date the person receives prescribed lenses and/or frames. The repair or replacement of lost, stolen or broken lenses and/or frames is considered part of the two-set limitation.

Exclusions

The Plan does not cover the following vision care services and supplies:

1. Special supplies, such as nonprescription sunglasses and subnormal vision aids.
2. Special lens treatment, such as seamless lenses (e.g., Varilux and Ultra-vue), anti-reflective coatings and tinting, when such treatment is provided for an extra charge.
3. Services and supplies that are not specifically listed as covered. (Coverage may, however, be provided under the general terms of the Medical Plan.)
4. Services and supplies that are received while the person is not covered under the Plan, or lenses and frames that are furnished or ordered before the date the person becomes covered. However, lenses and frames that are ordered within 30 days after coverage terminates are covered under the general terms of the Plan if the person receives a complete eye examination, including refraction, before coverage ends and the examination resulted in a new prescription or a change in the person's prescription.

Mental Illness Treatment The Plan covers inpatient services and supplies for the treatment of mental illness on the same basis as other medical conditions. This includes the services of a physician and hospital, as well as those provided by a licensed community mental health agency with an inpatient facility when approved by the service representative.

The Plan also covers the services of a physician, licensed day or night care center, and licensed mental health agency approved by the service representative when provided for outpatient treatment of mental illness. The Plan payment level for such outpatient treatment is 50 percent of the usual and customary charges for the treatment.

If the mental illness is related to, accompanies or results from substance abuse, coverage of the treatment will be provided solely under the substance abuse provisions.

Oral Surgery The Plan covers certain services and supplies provided by a physician or dentist for oral surgery to the extent that they are not covered under your Company-sponsored dental plan. The Plan also covers hospital services and supplies (as described on page 10) and general anesthesia when medically necessary.

The Medical Plan covers such services and supplies when provided for the prompt repair of natural teeth or other body tissues as a result of an accidental injury. This may include surgical procedures of the jaw, cheek, lips, tongue or other parts of the mouth as well as treatment of fractures of the facial bones (maxilla or mandible).

To be covered, the injury must occur while the patient is covered under the Plan, and treatment must be provided in the same calendar year or the calendar year following the date of the accident. In addition, any teeth being repaired must have been free from decay, or in good repair, and have been firmly attached at the time of the accident. If crowns, dentures, bridgework or in-mouth appliances are installed as a result of the accident, the Plan covers only the first denture or bridgework to replace lost teeth, the first crown to repair each damaged tooth, or the in-mouth appliance that is installed as the first course of orthodontic therapy following the injury.

In addition to the coverage of oral surgery related to an accidental injury, the Plan covers medically necessary services for medical conditions if such services are not covered under your Company-sponsored dental plan and they are not related to the correction of the gums, teeth or tissues of the mouth for dental purposes. This includes the following medical conditions:

1. Excision of a tumor or cyst of the jaw, cheek, lips, tongue, or roof or floor of the mouth.
2. Excision of exostoses of the jaw and hard palate.
3. Incision and drainage of cellulitis.
4. Incision of accessory sinuses, salivary glands or ducts.

The Plan also covers services in connection with the correction of developmental abnormalities of the jaw or malocclusion of the jaw by osteotomy (the surgical cutting of the bone or bony tissue) with or without bone grafting performed by either a physician or dentist.

The Plan does not cover services and supplies related to the correction of the gum, teeth or tissues of the mouth for dental purposes. This includes services and supplies related to the removal, repair, replacement, restoration or repositioning of teeth lost or damaged in the course of biting or chewing.

When any of the above services and supplies are related to the diagnosis or treatment of TMJ or MPDS, coverage is provided as follows.

Temporomandibular Joint Disease (TMJ) and Myofascial Pain Dysfunction Syndrome (MPDS) Treatment The Plan covers the following surgical and nonsurgical services and supplies for the treatment of TMJ and MPDS when provided by a physician or dentist:

1. Initial diagnostic examinations and x-rays.
2. Follow-up office visits.
3. Surgical procedures and related hospitalization.
4. Appliances, including nightguards, bite plates, orthopedic repositioning devices, or mandibular orthopedic devices.
5. Appliance management, including kinesiotherapy, physical therapy, biofeedback therapy, joint manipulation, prescription drugs, injections of muscle relaxants, and therapeutic drugs or agents.

As explained on page 5, the Plan payment level for TMJ and MPDS treatment is 50 percent of the usual and customary charges, up to a maximum lifetime benefit of $3,500 per covered person.

The Plan does not cover: restorative techniques to build occlusion unless the tooth is diseased or accidentally damaged; nonsurgical orthodontic treatment, except as noted above; and banding treatment.

Human Organ Donor If you or a covered dependent receives a human organ or tissue transplant that is covered by the Plan, certain donor expenses may also be covered. Specifically, physician and hospital services and supplies are covered under this Plan for the surgical removal of the organ or tissue if the donor is a hospital inpatient. Coverage is provided from the day of surgery and continues for up to a maximum of ten additional consecutive days, as long as the donor remains a hospital inpatient.

The Plan does not cover: organ selection, transportation or storage costs; non-human organ or tissue transplants; services and supplies for the donor when the donor is covered under another group benefit plan; donor expenses when government funding is available.

Donor expenses that are covered under this Plan are applied against the maximum benefit limits (described on page 7) for the recipient covered under this 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 that occurs while the person is covered under the Plan.

Reconstructive Breast Surgery The Plan also covers necessary services and supplies for reconstructive breast surgery following or coinciding with a mastectomy that is performed as a result of an illness or injury. Also covered is the first external as well as the first permanent internal breast prosthesis.

Vasectomy or Tubal Ligation The Plan covers services and supplies that are required for a vasectomy or tubal ligation, but not those related to a reversal.

Surgical Treatment for Morbid Obesity The Plan covers the medically necessary services and supplies required for the surgical treatment of morbid obesity only if all of the following criteria are met:

1. The patient is 100 or more pounds overweight based on life insurance tables and has been for at least five years.
2. Use of a prolonged, guided medical treatment program for at least one year has failed to resolve the condition.
3. The patient has been given an adequate medical workup to show that there is an absence of any correctable endocrine problem that could be causing the obesity, and the workup shows that the patient suffers from an abnormal calcium metabolism or malabsorption state.
4. The patient has other conditions that are severely aggravated by the obesity, e.g., hypercholesterolemia, hypertension, coronary artery disease, diabetes mellitus or respiratory insufficiency.
5. The patient has received a psychologic evaluation and, if necessary, a formal consultation.
6. There are adequate persons and facilities available to perform careful surgical and medical follow-up after the surgery.

If all of the above conditions are met, the patient should apply to the service representative for certification of the surgery. Prior approval is recommended.

Medical Plan Exclusions

The Plan does not cover the items listed below. Charges for these items are deducted from a health care provider's bill before the Plan pays its benefits for covered services and supplies.

1. Expenses during the first 12 months of a person's coverage to the extent that they are in connection with a preexisting condition (as defined on page 35).

   The continuous time spent by a covered person under another Company-sponsored medical plan or an approved health maintenance organization (HMO) that is not federally qualified will be credited against the 12-month requirement if such coverage was in effect immediately before coverage under this Plan became effective.

   This exclusion does not apply to the coverage of hearing aids or routine vision care expenses. It also does not apply to a person who transfers to this Plan directly from an approved, federally qualified HMO provided the person was covered under the HMO as a Boeing employee or dependent.
2. Expenses in connection with an occupational accident or illness covered by a workers' compensation law.

3. Expenses related to an intentionally self-inflicted injury.
4. Expenses related to services and supplies that are not medically necessary for the treatment of an accidental injury, illness or other condition covered under the Plan. This applies to routine physical examinations, immunizations, and other preventive services and supplies, except PAP tests and screening mammograms (as explained on page 7).

   Inpatient hospital care 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 the patient's physical condition.

   Examples of care that should generally be provided in an outpatient setting include: observation and/or diagnostic studies; surgery that can be performed on a same-day basis; and psychiatric care that is primarily aimed at controlling or changing the patient's environment.
5. Expenses for services or supplies that are not recommended and approved by a physician or other covered health care professional (see pages 7 and 10), or that are provided before the person becomes covered under this Plan.
6. Expenses for experimental or investigational services and supplies (as defined on page 34), and related complications.
7. Expenses for custodial care.
8. Expenses for skilled nursing facility services when the services are not usually provided by such facilities or when the services 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.
9. Charges for the following home health care services:
   - homemaker or housekeeping services.
   - services provided by volunteers, household members, family or friends.
   - unnecessary and inappropriate services, food, clothing, housing or transportation.
   - supportive environmental services or equipment such as but not limited to wheelchair ramps or support railings.
   - social services.
   - psychiatric care.
   - maintenance or custodial care.
   - supplies or services that are not included in the written treatment plan or not otherwise specifically covered.
10. Charges for the following hospice services:
    - volunteer services or spiritual counseling.
    - services to other family members, including bereavement counseling.
    - financial or legal counselor services.
    - homemaker or housekeeper services.
    - services provided by household members, family or friends.
    - unneccessary and inappropriate services, food, clothing or transportation.
    - supportive environmental services or equipment such as but not limited to wheelchair ramps or support railings.
    - social services.
    - psychiatric care.
    - maintenance or custodial care.
    - services or supplies not included in the written treatment plan or not otherwise specifically covered.
11. Expenses for services or supplies for a prosthesis in connection with impotency, or for services or supplies that are required in connection with a sex transformation.
12. Expenses related to the reversal of a sterilization procedure, or in connection with in-vitro fertilization, artificial insemination or embryo transfer procedures.
13. Expenses for services and supplies to the extent that they are covered under another Company-sponsored plan that has been discontinued or to the extent that they are covered under any federal, state or other governmental plan. This does not apply to Medicare coverage at any time when compliance with federal law requires that this Plan provide primary coverage for the person before Medicare will pay its benefits.

14. Expenses to the extent that coverage is available under any automobile medical, personal injury protection (PIP), automobile no-fault, automobile uninsured or underinsured motorist, homeowner, or commercial premises medical contracts. Any benefits paid by this Plan before benefits are paid under one of these other types of contracts or insurance are provided to assist the patient, and do not indicate that the service representative is acting as a volunteer or that the representative is waiving any right to reimbursement or subrogation.
15. Expenses related to inpatient care in a U.S. government hospital or for any other type of care received from such a hospital, except as required by federal law.
16. Expenses for services or supplies for which there is no charge made to the employee or dependent or for charges that the employee or dependent is not required to pay.
17. Expenses for dyslexia, visual analysis therapy or training related to muscular imbalance of the eye, or for orthoptics. However, such expenses are covered for up to six months when the care is required to correct a muscle imbalance (strabismus squint, esotropia or exotropia), and treatment begins before the person's 12th birthday.
18. Expenses in connection with radial keratotomy or other eye surgery to correct refractive errors, except when preoperative visual acuity is 20/50 or less with a lens.
19. Expenses in connection with the use of a computerized axial tomography (CAT) scanner for a full body scan other than at or in a hospital or at an institution that has an agreement with a hospital to supply such services. However, expenses are covered under other circumstances if: the services are required and certified by the physician as requiring the immediate use of the equipment to diagnose a potentially life threatening condition; or the services are provided at a physician's office, clinic or other institution approved by the Company for other than emergency use.
20. Expenses for the treatment of anorexia nervosa, bulimia or any similar condition, except when covered as treatment of mental illness under the terms described on page 17.
21. Expenses for services and supplies related to the following: cosmetic surgery (except as described on page 18); obesity (except for the surgical treatment of morbid obesity as a last resort as described on page 18); substance abuse treatment (except as described on page 15); TMJ and MPDS treatment (except as described on page 17).
22. Charges for services and supplies for a pregnancy-related condition for dependent children unless otherwise required by law.
23. Charges for services or supplies that are required by law to be provided by any school system.
24. Charges for education, special education or job training whether or not provided by a facility that also provides medical or psychiatric care.
25. Charges in connection with marriage counseling, family or child counseling, career counseling, social adjustment counseling, pastoral counseling or financial counseling.
26. Charges to the extent that they exceed usual and customary amounts.

When an Injury is Caused by the Negligence of Another

If a third party is legally liable for an injury to a person covered under this Plan, regular Plan benefits will be paid if the injured person agrees to cooperate with the service representative in the administration of the Plan's subrogation rights by providing all necessary and requested information and by submitting bills related to the injury to any applicable insurer. The injured person must also agree to reimburse the Plan if he or she recovers from the liable party or any other source.

Coordination of Benefits

If you or your dependents have group medical, dental or other health care coverage in addition to being covered under the Boeing Medical Plan, the benefits from the other group plans are taken into account before benefits are paid under this Plan. Other group coverage includes another employer's group benefit plan or other arrangement of coverage for individuals in a group, whether insured or uninsured.

The group plan that pays its benefits first is considered the primary plan of coverage and will pay its benefits without regard to benefits that may be payable under other plans. When another group plan is the primary plan for medical coverage, the Boeing Medical Plan will pay the difference between the benefits paid by the primary plan and what would have been paid had the Boeing Plan been primary.

The following rules are used to determine which group plan will be considered the primary plan.

1. A plan that does not contain coordination of benefits provisions will pay its benefits before a plan that includes such provisions.
2. A plan that covers a person other than as a dependent will pay before a plan that covers the person as a dependent.
3. If a dependent child is covered under both parents' group plans, the child's primary coverage will be provided through the parent whose birthday comes first in the calendar year, with secondary coverage being provided through the parent whose birthday comes later in the calendar year. If the other group plan does not rely on this "birthday rule" but rather relies on gender to determine benefit coordination, then the "gender rule" used by the other plan will determine the order by which the plans will pay benefits.
4. If a dependent child's parents are divorced or separated, the following guidelines will be used:

   a. The plan of the parent with custody will pay its benefits first if that parent has not remarried. The plan of the parent without custody will pay second.

   b. If the parent with custody has remarried, then the plans will pay in the following order: the plan of the parent with custody, the plan of the spouse of the parent with custody, the plan of the parent without custody, and the plan of the spouse of the parent without custody.

   c. If a court decree establishes financial responsibility for the health care coverage of the child, the plan of the parent with such financial responsibility will be the primary plan of coverage.
5. If none of the above rules is able to establish which group plan should pay first, then the plan that has covered the person for the longest period of time will be considered the primary plan of coverage.

Benefits under the Boeing Medical Plan will not be coordinated with benefits paid under any other group plan offered by or through Boeing.

The service representative has the right to obtain and release any information or recover any payment it considers necessary to administer these provisions.

The exclusion of governmental benefits and services is described in the exclusions section of the Plan.

How to File a Claim

The Boeing Medical Plan is administered by a national network of Blue Cross and Blue Shield service representatives. The service representative for your area is indicated on the front of your Boeing Medical Plan ID card. In addition, a list of the representatives across the country and their addresses appears in exhibit 7 on pages 36 and 37.

In many instances, your physician or other health care provider will bill the Plan directly. Simply present your Boeing Medical Plan ID card to identify yourself as covered under this Plan. (For a description of how to claim benefits under either of the Plan's prescription drug programs, please refer to exhibit 3 on page 14.)

Most physicians and hospitals who are members of an approved network of health care providers have agreed to submit their itemized bills directly to the service representative. Under these circumstances, no claim form is required. Health care providers who are not members of an approved network may also agree to bill the service representative for you.

If direct billing is not available to you, you should submit the appropriate claim form along with an itemized bill to the service representative indicated below, based on the area where the care is received.

1. *In Alabama, California, Kansas, Oregon, Pennsylvania, the Washington, D.C. area (including Virginia and Maryland) or Washington state,* submit the claim form and itemized bill to the Blue Cross or Blue Shield service representative in that state or area.
2. *In New Jersey and Delaware,* submit the claim form and itemized bill to the service representative for Pennsylvania.
3. *In all other areas,* submit the claim form and itemized bill to the service representative identified on the front of your ID card.

All claim forms are available from or through the Boeing Group Insurance Office.

Health Maintenance Organization Option

Approved health maintenance organizations (HMOs) offer you and your family an alternative to the Boeing Medical Plan described on pages 4 through 21. An HMO is an organization of physicians and other health care providers that offers a total health care program for a fixed monthly cost. In most cases, all care (except certain types of emergency care) must be received through the HMO's physicians and facilities.

You may elect to receive coverage through one of the approved HMOs listed below if you live in the HMO's service area.

1. Group Health Cooperative of Puget Sound
   Seattle, Washington
2. HealthPlus
   Seattle, Washington
3. Virginia Mason MedCenters
   Seattle, Washington
4. Kaiser Foundation Health Plan of the Northwest
   Portland, Oregon
5. Equicor Health Care Plan (formerly Health Care Plus)
   Wichita, Kansas

If you are a newly hired employee who meets the eligibility requirements explained on page 2, you may enroll in one of these HMOs during the first 30 days of your employment. You and your eligible dependents must all be enrolled in the same plan.

After the initial 30-day enrollment period, transfer between plans is permitted only during an authorized annual open enrollment period or if you move into or out of an HMO's service area. Following a change in your residence, you have 30 days to select from among the alternate benefit plans that are available in your new location.

If you elect coverage through an approved HMO, you may be required to contribute toward the cost of such coverage. The amount of your contribution, if any, is determined as explained on page 3.

Since the cost of coverage under an HMO is determined by the number of people in your family who are covered, you must complete a new enrollment card if you have a change in your family as a result of marriage, birth, divorce, marriage of a child, or other event. The new card should be completed within 30 days of the change. HMO enrollment cards are available from the Boeing Group Insurance Office.

A summary comparison of medical plan options, including the Boeing Medical Plan and all approved HMOs in your area, is available from the Boeing Group Insurance Office. In addition, you may request from an HMO specific information about the HMO's program of coverage, including the nature of the services provided by the HMO, conditions under which you and your family are eligible to receive such services, the circumstances under which services may be denied, the procedures to follow to obtain services, and the procedures for a review of when services are denied.

Dental Plan Options

Most hourly employees and their dependents have a choice between two Company-sponsored dental plans: the Prepaid Provider Dental Plan and the Dental Incentive Plan. Both plans cover all necessary and appropriate dental care, including specialty care. The difference is in the level of copayments that are your responsibility under each plan and in your selection of dentists.

Your Choices

Prepaid Provider Dental Plan This Plan is currently available in the Puget Sound, Portland and Wichita areas. Through special contracts between the service representative and participating dentists, the Plan offers you and your dependents the opportunity to receive all necessary covered dental care, except orthodontia, at no cost to you. Your share of the cost for covered orthodontia care is explained on page 24 under the benefit payment level section.

If you elect coverage under this Plan, you must select a participating dentist to provide or arrange for the dental care needs of you and your family. Your selection will be approved as long as the dentist has an opening for patients. If you do not make a selection, the service representative will assign you to a participating dentist.

You may change dentists under the Prepaid Plan by completing a new enrollment card and submitting it to the Boeing Group Insurance Office. The change will be automatically approved as long as the participating dentist you are requesting has available openings. An approved transfer is effective the first day of the second month after the Group Insurance Office receives your request.

Covered dental treatment for you and your dependents must be provided by or arranged through your selected or assigned dentist, with two exceptions. The first is covered orthodontia treatment, which may be provided by any qualified licensed dentist.

The second exception is out-of-area emergency care. If you or a dependent requires emergency dental care and is more than 50 miles from your selected dentist, the Plan covers the usual and customary charges for out-of-area care, up to a maximum of $50, if the care is provided by a licensed dentist under the conditions listed below. Under these conditions, no prior approval by your selected dentist is required.

1. The care is required for an acute condition and is provided solely for the immediate relief of that condition.
2. The care would have been covered under the Plan had it been provided by your selected dentist.
3. The patient could not have been reasonably expected to go to his or her selected dentist for such care.
4. The care is provided outside the service area of the Plan.

Dental Incentive Plan As an alternative to the Prepaid Plan, you may elect the Boeing Dental Incentive Plan. This Plan offers you and your dependents the opportunity to receive your dental care from any licensed dentist on a fee-for-service basis. Your share of the cost will vary, depending on the type of treatment you receive and, in many cases, on the level of your dentist's fees.

Under the Dental Incentive Plan, you are required to have benefits predetermined for certain dental procedures and services. Predetermination of benefits provides you and your dentist with information about the extent of coverage that is available under the Plan for the proposed treatment, before you undergo the care and expense. Exhibit 5 explains the Plan's predetermination requirements.

Although you and your dependents may receive your care from any licensed dentist, the Plan offers you certain advantages if you select a dentist who is a member of the Delta Dental Plan in your state. As explained in the Benefit Payment Levels and Maximums section, member dentists have agreed to accept certain fees as full payment for covered services and supplies. In addition, they have agreed to assist you with the Plan's benefit predetermination requirements. For a list of member dentists in your area, contact the Boeing Group Insurance Office.

Enrollment

If you live in the service area of the Prepaid Plan, you may choose between the Prepaid Provider Dental Plan or the Dental Incentive Plan. To receive coverage under either plan, you must complete the appropriate enrollment card.

All covered family members must be enrolled in the same plan. In addition, if you elect the Prepaid Provider Dental Plan, your eligible dependents must receive their dental care from the participating dentist you select.

Transfer between dental plans is permitted only during authorized open enrollment periods. However, if you or one of your dependents moves into or out of the service area of the Prepaid Plan or or if your selected dentist terminates his or her participation in the Prepaid Plan, you may elect to change to the Dental Incentive Plan by completing a new enrollment card within 30 days.

If you live outside the service area of the Prepaid Plan, you and your dependents are automatically enrolled in the Dental Incentive Plan. No special enrollment forms are required.

Benefit Payment Levels and Maximums

Prepaid Provider Dental Plan If you elect this Plan, your participating dentist receives a fixed monthly fee for providing necessary dental care to you and your dependents. In most cases, you pay nothing for covered dental services and supplies under this Plan. The following summarizes Plan payment levels:

1. The Plan covers most dental care at no cost to you, when provided by your selected dentist according to the guidelines in the "Covered Dental Services and Supplies" section that begins on page 26. You pay any charges that exceed the covered amounts or that are related to noncovered services and supplies.
2. The Plan covers 50 percent of the usual and customary charges of any qualified licensed dentist for covered orthodontia care provided to dependent children under age 19, up to a lifetime maximum benefit of $1,000. You pay any remaining charges.
3. The Plan covers the usual and customary charges for out-of- area emergency care, up to a maximum of $50, under the conditions described on page 23. You pay any remaining charges.

Dental Incentive Plan This Plan pays benefits according to the following four classes of covered services and supplies. A further description of covered services and supplies is provided in the section that follows.

1. Class I includes covered services and supplies related to diagnostic care, preventive care, restorations using filling materials, oral surgery, periodontics, endodontics and pedodontics. Through increasing benefit payment levels for Class I services and supplies, the Plan offers you and your dependents incentives to receive regular dental care.

   More specifically, each person covered under the Plan establishes the level of benefits that he or she will receive for Class I services and supplies during an incentive period. An incentive period is a calendar year that starts each January 1.

   During a person's first incentive period, the Plan pays 70 percent of recognized fees for Class I services and supplies. If the person uses benefits during the next successive incentive period, the Plan pays 80 percent of recognized fees for Class I services and supplies for that person. In the third successive incentive period, the maximum Plan payment level of 90 percent is paid for recognized fees for Class I services and supplies.

The Dental Incentive Plan requires you or your dentist to request a predetermination of benefits for certain procedures and services. Although you and your dependents may receive your dental care from any licensed dentist under this Plan, certain dentists in your area who are members in your state's Delta Dental Plan have agreed to help you through the predetermination procedures. The following summarizes these procedures, based on whether you receive care from a member dentist or a nonmember dentist.

Member Dentist Services

When you visit a member dentist, he or she will examine your mouth and complete a claim form by indicating the services that are required. A separate form is required for you and each of your dependents. The form will include the dentist's estimate of the total cost for any proposed treatment that requires predetermination. The patient (or in the case of a minor, you or your spouse) must sign the form before it is submitted to the service representative.

The service representative will advise you of the total benefit allowance that is available under the Plan, before treatment begins, for any proposed treatment that requires predetermination. Since the Plan covers only treatment that is professionally adequate and does not cover certain types of elective treatments and materials, you should discuss any proposed treatment and its cost with your dentist before you receive the treatment.

If your member dentist does not predetermine a dental procedure that requires predetermination and a less expensive procedure is professionally adequate, the member dentist has agreed to charge you no more than the cost of the less expensive procedure. In addition, if the service representative has advised the dentist that the Plan will only cover the cost of the less expensive procedure and the dentist performs the more expensive procedure without your consent, the dentist has agreed to charge you no more than the cost of the less expensive procedure.

When the course of treatment is completed, your dentist will bill the service representative directly. The service representative will advise you of the amount paid to the dentist and will indicate any remaining amount that you owe for the treatment.

Exhibit 5
PREDETERMINATION REQUIREMENTS UNDER THE DENTAL INCENTIVE PLAN

Nonmember Dentist Services

When you or a dependent visits a nonmember dentist, you must obtain a claim form from the Boeing Group Insurance Office. The form includes instructions for its completion. A separate form is required for you and each of your dependents. The patient (or in the case of a minor, you or your spouse) must sign the form before it is submitted to the service representative.

Benefits for all procedures and services, except those listed below, must be predetermined. After receipt of a completed form, the service representative will advise you of the total benefit allowance that is available under the Plan for any proposed treatment that requires predetermination. You must pay for any amounts that exceed this benefit allowance.

If you receive treatment or services that require predetermination from a nonmember and benefits are not predetermined, the Plan does not cover any charges for such treatment or services. You are solely responsible.

When treatment is completed, your dentist must complete the claim form, indicating that the services have been provided. The form must then be sent to the service representative within six months of the last date of treatment.

When a nonmember dentist is used, benefit payments are made directly to you as a cosignature check that requires endorsement by you and the dentist. Along with the payment you will receive an explanation of the benefits that are paid under the Plan.

As indicated, benefits for all procedures and services must be predetermined when a nonmember dentist is used, except those listed below. Although the following do not require that benefits be predetermined, they are subject to all other coverage provisions under the Plan. See page 26 for an explanation of covered dental services and supplies.

Diagnostic

Initial or periodic oral examination. However, benefits for x-rays must be predetermined unless indicated below.

Radiodontics

Intraoral periapical, complete or panographic series
Intraoral periapical, all other
Intraoral occlusal, maxillary or mandibular, single film
Extraoral maxillary or mandibular, up to two films
Bitewings

Preventive

Dental prophylaxis
Topical application of fluoride

Restorative

Amalgam, one or more surfaces, primary
Amalgam, one or more surfaces, permanent
Restoration, acrylic or plastic (anterior teeth only)
Recementing, inlay or crown
Crown, stainless steel
Temporary crown for a fractured tooth

Endodontics

Pulp capping
Pulpotomy

Prosthodontics

Repair of broken dentures
Replacement of broken teeth
Denture duplication, upper or lower dentures

Oral Surgery

Simple extraction with local anesthesia. However, if all remaining teeth in either the upper or lower dental arch must be extracted, predetermination is required.

Orthodontia

Other Services

Palliative (emergency) treatment of pain

If the person continues to use benefits during successive incentive periods, he or she continues to receive coverage at the 90 percent payment level. The payment level goes down 10 percent during any incentive period that the person does not use benefits. However, the payment level will never fall below the starting 70 percent.

2. Class II includes certain covered services and supplies for restorations using crowns, inlays or onlays. The Plan pays a constant 70 percent of recognized fees for these covered services and supplies.
3. Class III includes most covered services and supplies related to prosthodontics (dentures, bridges and related items). The Plan pays a constant 50 percent of recognized fees for these covered services and supplies.
4. Class IV includes services and supplies for orthodontia care. The Plan covers such care for dependent children under age 19 at a constant 50 percent of usual and customary charges.

The maximum benefit for all Class I, II and III services and supplies is $1,000 per person per calendar year. When multiple treatment dates are required, the charges are applied toward this annual maximum in the year in which the procedure or service is completed. A prosthesis is considered complete on the date it is seated or delivered.

The lifetime maximum benefit for Class IV orthodontia services and supplies for dependent children under age 19 is $1,000. This lifetime maximum applies to all periods that the child is covered under the Plan.

Under the Dental Incentive Plan, the maximum fees recognized for a member dentist are the fees filed by the dentist with the service representative. The member dentist may not charge more than these filed fees. This means that when you use a member dentist, you will be responsible only for the copayment amounts that apply to Class I, II, III and IV services and supplies, and for any amounts for noncovered services and supplies.

For a nonmember dentist, the maximum fees recognized by the Plan are the filed fees charged by 51 percent of the member dentists in that state. However, the maximum fees for a nonmember dentist are increased to the usual and customary charge level under the following circumstances:

1. You receive services from a dentist that is practicing in a state that does not have a Delta Dental Plan.
2. You receive services from a dentist that is practicing in a state where there is not an adequate number of member dentists available. An adequate number of member dentists is available when 80 percent or more of the dentists practicing close to where the majority of Boeing employees live are member dentists.
3. In Kansas, you receive services from a dentist located within a five-mile radius of your home when there are no member dentists within the same five-mile radius.

When a nonmember dentist is used, you are responsible for the regular copayment amounts for Class I, II, III and IV services and supplies. In addition, you are responsible for any amounts that exceed the maximum fees recognized by the Plan as well as charges for noncovered services and supplies.

Whenever there are alternative procedures, the Dental Incentive Plan pays up to the amount charged for the least expensive one. However, if the dentist submits satisfactory evidence to the service representative that the more expensive procedure is the only professionally adequate procedure for the patient, the Plan will cover the more expensive procedure according to the appropriate benefit payment level.

Covered Dental Services and Supplies

Both the Prepaid Provider Dental Plan and the Dental Incentive Plan cover the following services and supplies. Coverage is subject to the benefit payment levels explained above as well as the exclusions and other provisions of each plan.

Diagnostic Services and Supplies The plans cover the following diagnostic services and supplies. For the purpose of determining the appropriate benefit payment level under the Dental Incentive Plan, these covered services and supplies are considered Class I services and supplies.

1. Routine examinations once in a six-month period.
2. Complete mouth or panographic x-rays are covered once in a three-year period. Supplementary bitewing x-rays are covered once in a six-month period.
3. Emergency examinations.

The plans do not cover a review of a proposed treatment plan or case presentation by the attending dentist. In addition, study and diagnostic models and caries susceptibility tests are not covered.

Under the Prepaid Provider Dental Plan, examinations by a specialist are only covered if the dentist is in a specialty field recognized by the American Dental Association and the patient has been referred by the patient's selected dentist.

Preventive Services and Supplies The plans cover the following preventive services and supplies. Under the Dental Incentive Plan, these are covered as Class I services and supplies for the purpose of determining the benefit payment level.

1. Prophylaxis (cleaning) once in a six-month period.
2. The topical application of flouride once in a six-month period when performed with prophylaxis for dependent children under age 19.
3. Fissure sealants for dependent children under age 14. Fissure sealants are topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in the child's teeth to prevent dental decay. The Plan only covers sealants applied to permanent molar teeth that have intact occlusal surfaces, no decay and no prior restorations. The repair or replacement of a sealant on any tooth within three years of its initial placement is considered part of the original service.

The plans do not cover home flouride kits, cleaning of prosthetic appliances, plaque control, oral hygiene, or dietary instructions.

Restorative Services and Supplies The plans cover the restoration of a hard tooth surface that is visibly decayed (known as a carious lesion) to a state of functional acceptability. Restorations may be accomplished through either the use of such filling materials as amalgam, silicate or plastic or through the use of crowns, inlays or onlays.

Restorations on the same surface or surfaces of a tooth are covered once in a two-year period. Crowns, inlays and onlays (whether gold, porcelain, plastic, gold substitute casting or a combination of these materials) are covered on the same tooth once in a five-year period. Stainless steel crowns are covered once in a two-year period.

If a composite or plastic restoration is placed on a posterior tooth, the plans cover up to the amount allowed for an amalgam restoration. If a tooth can be adequately restored with a filling material but a crown, inlay or onlay is elected instead, the plans cover the restoration as if a filling material had been used.

The plans cover the use of a crown as an abutment to a partial denture only when the tooth is decayed to the extent that a crown would be required whether or not a partial denture is required.

The plans do not cover appliances or restorations that are needed to correct vertical dimension or that are for the purpose of restoring occlusion, overhang removal, or recontouring or polishing a restoration.

For the purpose of determining the appropriate benefit payment level for restorative services and supplies under the Dental Incentive Plan, restorations using filling materials are considered Class I services and supplies, while restorations using crowns, inlays or onlays are considered Class II services and supplies.

Oral Surgery Both dental plans cover the following surgical procedures. For the purpose of determining the appropriate benefit payment level under the Dental Incentive Plan, services and supplies related to covered oral surgery are considered Class I services and supplies.

1. Surgical and nonsurgical extractions.
2. Preparation of the alveolar ridge and soft tissues of the mouth for the insertion of dentures.
3. Ridge extension for the insertion of dentures (vestibuloplasty).
4. Treatment of pathological conditions and traumatic facial injuries.
5. General anesthesia when administered by a dentist in connection with a covered oral surgery procedure.

The plans do not cover extraoral grafts (grafts from tissues outside the mouth or using artificial materials) or tooth transplants.

Periodontic Services and Supplies The plans covers services and supplies for the following surgical and nonsurgical procedures when used for the treatment of tissues that support the teeth. For the purpose of determining the appropriate benefit payment level under the Dental Incentive Plan, services and supplies related to covered periodontic treatment are considered Class I services and supplies.

1. Root planing.
2. Subgingival curettage.
3. Gingivectomy.
4. Limited adjustments to occlusion (eight teeth or less) such as the smoothing of teeth or reducing cusps.

The plans cover either root planing or subgingival curettage (but not both) once in a 12-month period.

The plans do not cover: periodontal splinting, or any crown or bridgework that is provided with periodontal splinting; major (complete) occlusal adjustment; and periodontal appliances.

Endodontic Services and Supplies In covering pulpal and root canal therapy, the plans cover pulp exposure treatment, pulpotomy and apicoectomy. The plans cover root canal treatment on the same tooth once in a two-year period. Tooth bleaching, whether vital or nonvital, is not covered.

For the purpose of determining the appropriate benefit payment level under the Dental Incentive Plan, services and supplies related to covered endodontic care are generally considered Class I services and supplies. However, if root canal treatment is provided in conjunction with an overdenture, the Dental Incentive Plan pays benefits for such treatment as part of Class III services and supplies.

Pedodontic Services and Supplies The plans cover space maintainers only when used to maintain space for the eruption of permanent teeth. No coverage is provided for the replacement of a space maintainer that was previously covered under either of the plans.

For the purpose of determining the appropriate benefit payment level under the Dental Incentive Plan, pedodontic services and supplies are considered Class I services and supplies.

Prosthodontic Services and Supplies The plans cover dentures, bridges, partial dentures (including abutment crowns) and related items as well as the adjustment or repair of an existing prosthetic device within the following limitations. For the purpose of determining the appropriate benefit payment level under the Dental Incentive Plan, prosthodontic services and supplies are considered Class III services and supplies.

1. The plans allow for a full, immediate or overdenture. If you elect any other service or supply, such as a personalized restoration or specialized treatment, your plan covers up to the appropriate amount for a full, immediate or overdenture. Coverage of root canal therapy performed in conjunction with overdentures is limited to two teeth per arch.
2. When a partial denture is required, the plans allow for a cast chrome or acrylic partial denture. This allowance also applies toward the cost of any other procedure that may be provided, such as a more elaborate or precision device used to restore the case.
3. If you elect to receive implants and related appliances that are attached to the implants, your plan allows up to the amount that would have been provided for a full or partial denture.

The plans also limit the frequency that certain prosthodontic services and supplies are covered, as follows:

1. The plans cover the replacement of an existing prosthetic device once in a five-year period and only then if it is unserviceable and cannot be made serviceable. Expenses related to making the device serviceable are covered.
2. The plans cover denture adjustments and relines if these services are provided more than six months after the initial placement occurs. Later relines and jump rebases (but not both) are covered once in a 12-month period.
3. If implants are covered within the terms explained above, the plans cover replacements only if placed five or more years after the initial placement.

The plans do not cover: duplicate dentures; the cleaning of prosthetic appliances; temporary dentures; surgical placement or removal of implants or attachments to implants; and crowns and copings that are provided in conjunction with overdentures.

Orthodontia Services and Supplies The plans cover orthodontia treatment for dependent children under age 19. Orthodontia treatment includes the correction or prevention of malocclusion.

For the purpose of determining the appropriate benefit payment level under the Dental Incentive Plan, orthodontia services and supplies are considered Class IV services and supplies.

Dental Plan Exclusions

The following items are not covered under either the Prepaid Provider Dental Plan or the Dental Incentive Plan.

1. Injuries or conditions that are covered under a workers' compensation or employer liability law; or services that are provided by any federal, state or provincial government agency, or by any municipality, county or other political subdivision or community agency at no charge to the covered person. However, to the extent that payments by a governmental agency are insufficient to cover the charges for covered services or supplies or if benefits are provided by a governmental agency as an employer to its employees, coverage of dental services and supplies is not excluded but rather is subject to the coordination of benefits provisions explained on page 30.

2. Procedures, appliances or restorations that are primarily for cosmetic purposes. Cosmetic procedures include laminates and tooth bleaching.
3. Charges for services and supplies that are received while the person is not covered under either plan, except as explained under the Coverage Following Termination of Employment section.
4. Analgesics (such as nitrous oxide or I.V. sedation) or any other euphoric drugs, injections or prescription drugs.
5. Hospitalization charges.
6. Full mouth reconstruction.
7. Charges for the failure to keep a scheduled dental appointment.
8. Charges in excess of the $1,000 calendar year benefit maximum for Class I, II and III services and supplies under the Dental Incentive Plan, and charges in excess of the $1,000 lifetime benefit maximum that applies under both plans to covered orthodontia care for a dependent child under age 19.
9. Experimental services and supplies (and related complications), the use of which are not generally recognized by the American Dental Association as tested and accepted dental practice. This also applies to items requiring approval by the Federal Drug Administration or other governmental agency if such approval was not granted at the time the service or supply was ordered.
10. Services with respect to the treatment of temporomandibular joints (jaw joints).
11. Charges for the laboratory examination of a tissue specimen.
12. Charges for habit-breaking appliances.
13. Charges for patient management problems.
14. Charges for completing claim forms.
15. All other items that are not specified as covered dental services and supplies under the section that begins on page 26.
16. Application of desensitizing medications.

In addition to the above exclusions that apply to both plans, the following items are excluded under the Prepaid Provider Dental Plan.

1. Services or treatment that in the opinion of the participating dentist are not necessary for the patient's dental health.
2. Replacement of missing posterior teeth with a fixed bridge when the patient has at least 12 posterior teeth in occlusion (three-quarters of the masticatory table).

Coverage Following Termination of Employment

The plans generally do not cover care that you or an eligible dependent receives while not covered under the plan. However, both plans cover certain services and supplies during the three calendar months following termination of your employment if your dentist has determined the need for the treatment before your employment ends. If predetermination is required under the Dental Incentive Plan, you or your dentist must have submitted a predetermination form for the treatment.

Services in connection with a prosthetic device, including the abutment crowns of a partial denture, are covered if the denture impressions were taken while you were actively employed and covered under the plan. However, the prosthetic device must be installed or delivered to the eligible person within the three calendar months following termination of employment. Services are not covered if the denture impressions were taken before the date coverage became effective. If the impressions were taken after employment terminated, they must meet the requirements described in the preceding paragraph.

Services in connection with a crown required for the restoration of a tooth (independent of the use of the crown in connection with a partial denture) are covered if the tooth was prepared for the crown before employment terminated. Otherwise, the crown must be installed according to the requirements described in the first paragraph of this section.

The plans cover services and supplies in connection with covered orthodontia care if such services and supplies are provided during the three calendar months following termination of your employment.

For other coverage continuation options following the termination of your employment, see page 32.

Coordination of Benefits

If you or your dependents have other group dental coverage in addition to being covered under the Boeing Dental Incentive Plan, the benefits from the other group plans are taken into account before benefits are paid under this Plan. Other group coverage includes another employer's group benefit plan or other arrangement of coverage for individuals in a group, whether insured or uninsured.

The group plan that pays its benefits first is considered the primary plan of coverage and will pay its benefits without regard to benefits that may be payable under other plans. When another group plan is the primary plan for dental coverage, the Boeing Dental Incentive Plan will pay an amount that, when added to the benefits paid under the other plan or plans, does not exceed 100 percent of allowable expenses.

Allowable expenses are any necessary, usual and customary charges, part or all of which are covered under any of the other plans, that are made to a person during a calendar year while that person is covered under this Plan.

The following rules are used to determine which group plan will be considered the primary plan.

1. A plan that does not contain coordination of benefits provisions will pay its benefits before a plan that includes such provisions.
2. A plan that covers a person other than as a dependent will pay before a plan that covers the person as a dependent.
3. If a dependent child is covered under both parents' group plans, the child's primary coverage will be provided through the parent whose birthday comes first in the calendar year, with secondary coverage being provided through the parent whose birthday comes later in the calendar year. If the other group plan does not rely on this "birthday rule" but rather relies on gender to determine benefit coordination, then the "gender rule" used by the other plan will determine the order by which the plans will pay benefits.
4. If a dependent child's parents are divorced or separated, the following guidelines will be used:

   a. The plan of the parent with custody will pay its benefits first if that parent has not remarried. The plan of the parent without custody will pay second.

   b. If the parent with custody has remarried, then the plans will pay in the following order: the plan of the parent with custody, the plan of the spouse of the parent with custody, the plan of the parent without custody, and the plan of the spouse of the parent without custody.

   c. If a court decree establishes financial responsibility for the health care coverage of the child, the plan of the parent with such financial responsibility will be the primary plan of coverage.
5. If none of the above rules is able to establish which group plan should pay first, then the plan that has covered the person for the longest period of time will be considered the primary plan of coverage.

Benefits under the Dental Incentive Plan will not be coordinated with benefits paid under any other group plan offered by or through Boeing. When dental services performed by a licensed dentist are also covered under the Boeing Medical Plan, the Dental Incentive Plan will pay its benefits first.

The service representative has the right to obtain and release any information or recover any payment it considers necessary to administer these provisions.

The exclusion of governmental benefits and services is described in the exclusions sections.

How to File a Claim

No claim forms are generally required under the Prepaid Provider Dental Plan. The exceptions are for covered orthodontia care, out-of-area emergency care, and certain specialty care. Special claim forms for these exceptions are available through the Boeing Group Insurance Office.

Under the Dental Incentive Plan, no claim form is usually required if you receive services from a member dentist. The service representative provides each member dentist with such claim forms.

If the services of a nonmember dentist are used or if one of your dependent children receives covered orthodontia care under the Dental Incentive Plan, you will need to obtain a claim form from the Boeing Group Insurance Office. Since many types of dental care require predetermination (as explained in exhibit 5 on pages 24 and 25), you should take a claim form with you on your first visit to a nonmember dentist.

When you are required to submit a claim form to receive benefits, you should submit the form within six months of the last date of treatment or coverage may be denied.

Claim Review Procedure

Claim forms for the plans described in this booklet are available from the Boeing Group Insurance Office. Claims should be filed as soon as possible after receiving a covered service or supply to avoid a delay or loss of benefits.

If a claim for benefits is denied or partially denied, you will be notified in writing within 90 days of receipt of your claim and given an opportunity for appeal. The notice will give the specific reason(s) for the denial.

You or a person appointed by you may request a review of your denied or partially denied claim within 60 days after you have received the written notice. Make the request by writing to the appropriate claims service representative indicated in exhibit 7 on page 36.

You or a person appointed by you may examine pertinent documents relating to the denial and may submit issues and comments in writing. A decision by the service representative will be made promptly, usually within 60 days of the date your request for review is received unless special circumstances require more time. In no event will you receive a decision more than 120 days after your request is received. The decision will be in writing and will include the specific reasons for the decision by referring to the applicable plan provisions.

Termination of Coverage

Termination Dates

Coverage for you and your eligible dependents under the plans described in this booklet generally ends on the last day of the month in which you are employed.

If earlier, coverage for an eligible dependent will end on the last day of the month in which the person no longer meets the dependent eligibility requirements explained on page 2.

Coverage may be continued beyond these normal termination dates under special circumstances, as explained below.

Disability If you or an eligible dependent is totally disabled at the time coverage would otherwise terminate, the Company will continue coverage under the Boeing Medical Plan for the disabled person for up to 12 months, at no cost to you. Under this special extension, coverage will cease before the end of the 12-month period if the disabled person becomes covered, either as an employee or as a dependent, under any other group plan or he or she is no longer totally disabled. You should apply to the service representative for this continuation coverage within 60 days of the date coverage would otherwise terminate.

Leave of Absence If you are on an approved leave of absence from the Company, you are considered an active employee during the first 30 days of your leave, and you and your dependents continue to be covered under the plans described in this booklet during this 30-day period.

If you are on an approved medical leave of absence that is the result of a continuous disability, your contributions for the plans described in this booklet will be waived for up to five calendar

Exhibit 6
HOW TO AVOID CLAIM PROBLEMS

In many cases, your physician or other health care provider will send a bill directly to the Plan's service representative. If you are covered under the Boeing Medical Plan, simply present your Boeing Medical Plan ID card.

If you are required to submit a claim, the following tips should help you avoid delays and other claim filing problems.

1. Complete all the information that is requested on the form, including your full name, address, Social Security number, the patient's name and birth date, the date of the service, the diagnosis, and the type of service(s) received.
2. Always attach an itemized bill that includes the health care provider's name, address and tax identification number. A notice from the provider that payment is overdue generally will not provide adequate information for benefit determination and payment.
3. If additional information is requested, be sure that the follow-up information includes the patient's full name, your name and your full Social Security number.
4. If you or a dependent is eligible for coverage under another employer's group benefit plan, file a claim first with the plan providing primary coverage (as determined under the coordination of benefits provisions described on page 30). When that plan sends you a written explanation of your benefits, send a copy of the explanation along with the appropriate claim form and an itemized bill to the second plan. If you are not sure which plan provides primary coverage, file a claim with both plans at the same time.

To avoid having a benefit claim inappropriately denied, you should also file a new Boeing health care information card if you add or lose a dependent.

months following the initial 30-day leave period. A waiver of contributions for dependent medical and dental plan coverage starts on the same date as it does for you.

Coverage Continuation Options

When coverage under the plans described in this booklet would otherwise end, you and/or your dependents may be eligible to continue your group coverage under a self-pay option if the loss of coverage is the result of the termination of your employment (for reasons other than gross misconduct on your part) or a reduction in your hours, such as an approved leave of absence. Your eligible dependents may also have a choice of options if they would otherwise lose coverage as the result of your death or in the event of divorce or a child's loss of eligibility under the plans.

Under these continuation options, you or your dependent must pay the full contribution for group coverage.

Coverage may be continued for up to a total of three years if coverage would otherwise end because of your death, divorce or a child's loss of eligibility. If coverage would otherwise end because of termination or a reduction in hours, the maximum continuation period is 18 months. (For approved leaves of absence, the plans include an alternate option that permits you to continue coverage under your entire package of benefits for an extended period of time.)

Any extension of coverage that is provided under another provision of the medical or dental plans is considered part of the three-year or 18-month continuation period.

The continuation period may end sooner if: the required contribution is not paid within the allowed payment period; the person covered under the option becomes covered under another group health plan either as an employee or a dependent or becomes eligible for Medicare; or the Company no longer provides health care benefits to any of its employees.

If you do not pay the required monthly contributions during the allowed payment period, coverage will end as of the end of the month for which the last contribution was received. If you then return to the active payroll following an approved leave of absence, your coverage will be reinstated on the first of the month following your return, subject to all Plan provisions.

Should you or your spouse wish to continue coverage following divorce or a child's loss of eligibility, one of you must notify the Company within 60 days of your interest in the continuation option. Following this notification, the Company will provide you with additional information, including your cost for the coverage and the payment procedures and requirements under the plans. The Company will automatically provide this information following your termination, reduction in hours, or death.

For more information about the continuation options that may be available to you, contact the Boeing Group Insurance Office.

Conversion of Your Medical Plan Coverage

If coverage terminates for you or an eligible dependent, that person may convert to an individual medical policy offered by the service representative for group conversion purposes. The benefits provided under the individual policy will not duplicate the benefits provided under the Boeing Medical Plan.

To convert to an individual policy, you must complete an application and submit it to the service representative within 31 days of the date coverage under the Medical Plan would otherwise terminate. You will then be billed for the applicable rate. Conversion applications are available from the Boeing Group Insurance Office or the service representative.

No evidence of insurability will be required. However, if the individual policy includes a waiting period, any credit for time covered under the Boeing Medical Plan will be based on the provisions of the individual policy.

Retiree Coverage

If you are an employee retiring from the service of the Company with 10 or more years of credited service under a Company-sponsored retirement plan, you may be eligible to enroll yourself and your eligible dependents in the Company's retired hourly employees medical plan. Additional information about this plan is available through either the Boeing Group Insurance Office or the Boeing Retirement Office.

Liability for Plan Benefits

The Boeing Medical Plan and the Dental Incentive Plan are self-funded by Boeing, which means that all benefits under these plans are paid from the assets of the Company.

The Company has entered into administrative contracts with the service representatives for these plans, as listed on pages 36 and 37. Under these contracts, the service representatives agree to make all benefit determinations and administer all benefit payments under the Company-sponsored plans.

Washington Dental Service has liability for the Prepaid Provider Dental Plan, in accordance with the policy it has issued to Boeing.

Special Disclosure Information

Plan Sponsor The plans described in this booklet are sponsored by The Boeing Company, 7755 East Marginal Way S., Seattle, Washington.

Plan Administrator and Agent for Service of Legal Process The Plan Administrator is the Welfare Benefit Plans Committee which may be reached through the above address or by telephone at 206-655-2391. Legal process may be served upon the Committee at the above address.

Type of Administration The plans are administered in accordance with the terms of the applicable administrative agreements and insurance contracts with the service representatives for each plan.

Type of Plan The plans in this booklet are welfare benefit plans that provide coverage of medical and dental services and supplies.

Funding and Contributions The cost of coverage under these plans is paid by the Company as explained on page 3. The cost is based on claims experience. Benefit payments are administered by the service representatives, in accordance with the provisions of the applicable administrative agreements and insurance contracts.

Plan Records Fiscal records are kept on a calendar year basis. The plan year for each plan begins on January 1 and ends on December 31 of each year.

Plan Numbers and Employer Identification Number The plan number assigned by Boeing pursuant to instructions by the U.S. Department of Labor are 505 for the Medical Plan, 507 for the Dental Incentive Plan, and 533 for the Prepaid Provider Dental Plan. Boeing's employer identification number is 91-0425694.

Collective Bargaining Representatives The plans described in this booklet are provided in accordance with agreements with the collective bargaining representatives listed below.

International Association of Machinists and Aerospace Workers, AFL-CIO
- Aerospace Industrial District Lodge No. 751
- District Lodge No. 70
- Willamette Lodge No. 63

International Union, United Plant Guard Workers of America and Certain Affiliated Amalgamated Locals
- Local No. 5 UPGWA
- Local No. 255 UPGWA

International Union of Operating Engineers
- Local No. 286
- Local No. 286W

International Brotherhood of Electrical Workers, AFL-CIO
- Local No. 271

Participant Protections Under ERISA The Employee Retirement Income Security Act of 1974 (ERISA) guarantees certain rights and protections to participants of welfare benefit plans such as the plans described in this booklet. As in the past, the Company fully intends to support your rights. Nevertheless, federal law and regulations require that a statement of ERISA rights be included in this description of your plans.

You have the following rights as a participant in the plans described in this booklet:

1. You may examine, without charge, all plan documents including any insurance contracts, collective bargaining agreements, annual reports, summary plan descriptions, and other documents filed with the Department of Labor.
2. If you want a personal copy of plan documents or related material, you should send a written request to the Plan Administrator. You will be charged only the actual cost of reproduction of these copies.
3. Each year, the Company will provide plan participants with a summary of each plan's annual financial report. Copies of previous years' reports are available for viewing at the Boeing Group Insurance Office. In accordance with ERISA, these summary annual reports will be sent automatically to all participants, shortly after midyear.

Under ERISA, the people responsible for operating the plans are called fiduciaries. These individuals have an obligation to administer the plans prudently and to act in the interest of plan participants and beneficiaries. No one may discriminate against you in any way to prevent you from receiving benefits or exercising your rights under ERISA.

When you become eligible for payments from a plan, you should follow the appropriate steps for filing a claim. In case of claim denial in whole or in part, you will receive a written explanation of the reasons for the denial. Then, if you wish, you may request the Administrator to review and reconsider your claim.

If you feel that your ERISA rights have been violated, you may file suit. Among the violations for which you may file suit are the following:

1. Improper denial of benefits. (You may file suit in either a state or federal court.)
2. Misuse of plan funds by a fiduciary or discrimination against you for asserting your rights. (In either case, you may seek assistance from the Labor Department or file suit in federal court.)
3. Failure of the Plan Administrator to provide materials within 30 days after receiving your written request unless due to reasons beyond the Administrator's control. (You may file suit in a federal court. If a violation exists, the court may require the Plan Administrator to provide the materials and to pay up to $100 for each day's delay.)

The court will decide who should pay court costs and legal fees. For example, if you are successful, the court may order the person you sued to pay these costs and fees. If you lose or if the court finds your suit to be frivolous you may be ordered to pay these costs and fees.

If you have any questions about your plan, you should contact the Plan Administrator at P.O. Box 3707, M/S 13-56, Seattle, WA 98124 (telephone 206-655-2391). For questions regarding this explanation of your rights under ERISA, contact the nearest area office of the U.S. Labor Management Services Administration, Department of Labor.

Definitions

An approved *birthing center* under the Boeing Medical Plan is a facility for the normal delivery of a child, that operates under the direction and control of the appropriate licensing or regulatory agency of the jurisdiction in which the facility is located.

A *chiropractor* is a person who is duly licensed in the area where his or her services are performed and who is practicing within the scope of such license. (For coverage of a chiropractor's services, see page 10.)

A *Christian Science sanatorium* is a facility that is operated (or listed) and certified by the First Church of Christ, Scientist, in Boston, Massachusetts, at the time of the healing treatment.

A *Company-sponsored plan* is a group health care plan sponsored by Boeing or one of its subsidiaries or affiliates for its employees and dependents. A health maintenance organization (HMO) is not included as a Company-sponsored plan. (To find out whether a particular plan is Company-sponsored, contact the Boeing Group Insurance Office.)

Custodial care is care that does not require the continuing services of skilled medical or allied health professionals and that is designed primarily to assist the patient in activities of daily living. This includes institutional care that primarily supports self-care and provides room and board. Types of custodial care include, but are not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparation of special diets, and the supervision of medications that are ordinarily self-administered.

A *day or night care center* is a facility that is associated with a hospital or is otherwise approved by the service representative and that has a professional staff whose primary purpose is to provide a planned program of psychiatric services for patients with mental illnesses who do not require inpatient hospitalization on a full-time basis. It does not include facilities that are primarily engaged in providing services that are custodial, recreational, social or educational in nature.

A *dentist* is a legally qualified dentist practicing within the scope of his or her license. Under the Prepaid Provider Dental Plan, a participating dentist is a licensed dentist who has agreed to the terms and conditions of the written participating provider dental agreement with the service representative. Under the Dental Incentive Plan, a member dentist is a licensed dentist who has agreed to the terms and conditions of the written member dentist agreement with the Delta Dental Plan in that state.

An *experimental or investigational service or supply* is one that meets at least one of the following:

1. Is under clinical investigation by health professionals and is not generally recognized by the medical profession as tested and accepted medical practice.
2. Requires approval by the Federal Drug Administration or other governmental agency, and such approval has not been granted at the time the service or supply is ordered.
3. Has been classified by the national Blue Cross and Blue Shield Association as experimental or investigational.

An approved *home health agency* is a public or private agency or organization that administers and provides home health care, and is either a Medicare-approved agency or is operating under the direction and control of the appropriate licensing or regulatory agency of the jurisdiction in which it is located.

A *home health aide* is an individual employed by an approved home health agency or an approved hospice agency who, under the supervision of a registered nurse or physical or speech therapist, provides part-time or intermittent personal care that may include: ambulation and exercise; household services essential to home health care; assistance with medications that are normally self-administered; reporting changes in a patient's condition and needs; and completing appropriate records.

A *home health or hospice treatment plan* is a program for continued care and treatment established in writing by the patient's attending physician.

An approved *hospice agency* is a public or private agency or organization that administers and provides hospice care, and is either a Medicare-approved agency or is operating under the direction and control of the appropriate licensing or regulatory agency of the jurisdiction in which it is located.

A *hospital* is a facility that is an accredited general hospital licensed by the Joint Commission on Accreditation of Hospitals (JCAH).

A *medically necessary* service or supply is one that the service representative has determined meets the criteria listed below. A service or supply may be medically necessary in part only. The fact that 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:

1. It is required to diagnose or treat the patient's condition, and the condition could not have been diagnosed or treated without it.
2. It is consistent with the symptom or diagnosis and the treatment of the condition.
3. It is the most appropriate service or supply that is essential to the patient's needs.
4. It is appropriate as good medical practice.
5. It is professionally and broadly accepted as the usual, customary and effective means of diagnosing or treating the illness, injury or condition.
6. When applied to inpatient care, it cannot be safely provided on an outpatient basis.

A registered *nurse* is a person who is duly licensed in the area where his or her services are performed and who is practicing within the scope of such license. (For coverage of a registered nurse's services, see page 10.)

An *occupational therapist* is a person who is duly licensed in the area where his or her services are performed and who is practicing within the scope of such license. In the absence of such licensing requirements, the therapist must be certified by the American Occupational Therapy Association. (For coverage of an occupational therapist's services, see page 12.)

An *optometrist* is a person who is duly licensed in the area where his or her services are performed and who is practicing within the scope of such license. (For coverage of an optometrist's services, see page 10.)

A *physical therapist* is a person who is duly licensed in the area where his or her services are performed and who is practicing within the scope of such license. In the absence of such licensing requirements, the therapist must be certified as a registered physical therapist by the American Physical Therapy Association. (For coverage of a physical therapist's services, see page 12.)

A *physician* is a person who is licensed as an M.D. or D.O. and who is duly licensed to prescribe and administer all drugs and to perform all surgery. (For coverage of a physician's services, see page 7.)

A *podiatrist* is a person who is duly licensed in the area where his or her services are performed and who is practicing within the scope of such license. (For coverage of a podiatrist's services, see page 10.)

Preadmission review and prior approval under the medical review program described on pages 8 and 9 includes the review and evaluation of proposed elective hospital and skilled nursing facility admissions as well as proposed home health and hospice care. Such review and evaluation is performed by qualified health care professionals using accepted medical standards and criteria for determining the medical necessity of the admission or care. In addition to certifying the appropriate length of stay for an admission, the program includes the ongoing (or concurrent) review of the admission as well as discharge planning at the completion of the admission.

A *preexisting condition* is any illness, injury or other condition, whether or not diagnosed, for which a person has received medical treatment, consultation, a diagnostic test or prescribed medicines during the three-month period before his or her coverage becomes effective. See page 18 for the Medical Plan exclusion related to preexisting conditions.

A *preferred network of health care providers* is health care professionals and facilities that have entered into a special contract with the service representative for the Medical Plan to provide cost effective, appropriate care to employees and dependents covered under the Plan. For a further description of preferred networks, see page 6.

For the purposes of the dental plans, a *prosthetic appliance* is a denture, partial denture, fixed or removable bridge, crown when used as a bridge abutment, and other related items.

A *psychologist* is a person who is duly licensed in the area where his or her services are performed and who is practicing within the scope of such license. (For coverage of a psychologist's services, see page 10.)

A *service representative* is an agent that has agreed to make benefit determinations and administer benefit payments under a Company-sponsored plan. A list of service representatives for the plans described in this booklet appears in exhibit 7 on pages 36 and 37.

A *skilled nursing facility* is an institution recognized as such by Medicare and approved by Medicare for payment.

A *speech therapist* is a person who is duly licensed in the area where his or her services are performed and who is practicing within the scope of such license. In the absence of such licensing requirements, the therapist must be certified as a registered speech therapist by the American Speech and Hearing Association. (For coverage of a speech therapist's services, see page 12.)

Substance abuse means alcohol and/or drug dependency under the terms of ICD-9 CM categories 303.0 through 305.9.

An approved *substance abuse treatment facility* is a facility that provides treatment for chronic alcoholism and/or drug abuse and that is operating under the direction and control of the appropriate licensing or regulatory agency of the jurisdiction in which the facility is located.

For the purposes of the Boeing Medical Plan, *usual and customary charges* are the lesser of:

1. The health care provider's actual charge to the patient after any discounts or other reductions.
2. The charge that is most frequently made by the provider to all other patients for comparable services and supplies.
3. The charge that is most frequently made by providers with similar professional qualifications for comparable services or supplies within the same geographic area.

When an unusual or complicated service or supply is provided, the usual and customary charge will be determined by taking into consideration charges for treatment of a comparable nature or complexity.

For the purposes of the Boeing dental plans, *usual and customary charges* are the lesser of:

1. The usual fee charged by your dentist for a given service or supply to all private patients.
2. The customary fee for a given service or supply which means that it is within the range of usual fees charged by dentists in the same limited geographic area who have similar training and experience.
3. The reasonable fee for a given service or supply which means that the charge is usual and customary, and in the opinion of the review committee of the responsible dental society, is justifiable in view of the special circumstances of the particular case in question.

Exhibit 7
WHERE TO GET INFORMATION

Boeing Group Insurance Offices

Puget Sound Area

Location:	7755 East Marginal Way S. Seattle, WA
Mailing Address:	The Boeing Company Group Insurance Office P.O. Box 3707, M/S 13-56 Seattle, WA 98124-2207
Telephone Number:	206-655-2391

Wichita Area

Location:	3801 S. Oliver Wichita, KS
Mailing Address:	Boeing Military Airplane Co. Employee Benefits Office P.O. Box 7730, M/S K66-14 Wichita, KS 67277-7730
Telephone Number:	316-526-2274

Medical Plan Service Representatives

Alabama

Address:	Blue Cross & Blue Shield of Alabama P.O. Box 995 Birmingham, AL 35298
Claims Questions:	205-988-2200 1-800-292-8868
Medical Review Program:	1-800-248-2342
Network Service Area:	all counties

California

Address:	Blue Shield of California Turlock Service Center P.O. Box 2881 Turlock, CA 95381
Claims Questions:	1-800-331-2001
Medical Review Program:	1-800-343-1691
Network Service Area:	all counties

Kansas

Address:	Blue Cross & Blue Shield of Kansas P.O. Box 239 Topeka, KS 66629
Claims Questions:	1-800-223-0529
Medical Review Program:	316-269-4427 316-269-4426
Network Service Area:	Butler, Cowley, Harvey, Sedgwick and Sumner counties

Oregon

Address:	Blue Cross & Blue Shield of Oregon P.O. Box 1271 Portland, OR 97207
Claims Questions:	503-220-5883
Medical Review Program:	503-220-4795 1-800-824-8563 1-800-228-7309 (if calling from outside Oregon)
Network Service Area:	Clackamas, Multnomah and Washington counties in Oregon; Clark county in Washington state

Pennsylvania, New Jersey and Delaware

Address:	Blue Cross of Greater Philadelphia P.O. Box 13109 Philadelphia, PA 19101-3109
Claims Questions:	215-448-2484 1-800-338-0022
Medical Review Program:	1-800-792-7925
Network Service Area:	Bucks, Chester, Delaware, Montgomery and Philadelphia counties in Pennsylvania; Burlington, Camden, Gloucester, and Salem counties in New Jersey; preferred network not currently available in Delaware

Washington, D.C. area (including Virginia and Maryland)

Address:	Blue Cross & Blue Shield of the National Capital Area 550 12th SW Washington, D.C. 20065-5540
Claims Questions:	202-479-1727 1-800-424-7474, ext. 1727
Medical Review Program:	202-637-0247 1-800-553-8700
Network Service Area:	Washington, D.C. area, including Montgomery and Prince Georges counties in Maryland, and Arlington and Fairfax counties in Virginia

Washington State

Address:	King County Medical Blue Shield P.O. Box 21065 Seattle, WA 98111
Claims Questions:	206-464-0255 1-800-422-7713
Medical Review Program:	206-464-3743 1-800-367-2766
Network Service Area:	King, Kitsap, Pierce and Snohomish counties

PAID Prescriptions Drug Card Program

Address:	PAID Prescriptions P.O. Box 6121 Fair Lawn, NJ 07410-0998
Telephone Number:	1-800-631-1679

Mail Service Prescription Drug Program

Address:	National Rx Services, Inc. P.O. Box 18100 Las Vegas, NV 89114
Telephone Number:	1-800-628-8881

Prepaid Provider Dental Plan Service Representatives

Puget Sound Area

Address:	Washington Dental Service P.O. Box C-75983 Northgate Station Seattle, WA 98125
Telephone Number:	206-522-2300

Wichita Area

Address:	Delta Dental Plan of Kansas 9235 E. Harry P.O. Box 781410 Wichita, KS 67278-1410
Telephone Number:	316-686-0605

Portland Area

Address:	Oregon Dental Service 315 SW 5th Avenue Portland, OR 97204
Telephone Number:	503-228-6554

Dental Incentive Plan Service Representatives

Puget Sound Area

Address:	Washington Dental Service P.O. Box C 75983 Northgate Station Seattle, WA 98125
Telephone Number:	206-522-2300

Wichita Area

Address:	Delta Dental Plan of Kansas 9235 E. Harry P.O. Box 781410 Wichita, KS 67278-1410
Telephone Number:	316-686-0605

Portland Area

Address:	Oregon Dental Service 315 SW 5th Avenue Portland, OR 97204
Telephone Number:	503-228-6554

2-4-88

Mr. Chairman, members of the committee.

My name is Jim Gartner and I represent Southwestern Bell Telephone Company.

Southwestern Bell Telephone appears in opposition to S.B. 524.

August 10, 1986, Southwestern Bell Telephone Company and the Communication Workers of America agreed to a contract containing a medical plan after extensive collective bargaining. Part of the very comprehensive medical plan for all employees is an optional mail service prescription drug program. Employees may order, for $5.00, up to a 90-day supply of prescription and non-prescription drugs through National RX Services, Inc. located in Columbus, Ohio. The prescription is filled by a registered pharmasist within 48 hours of receipt and shipped to the employee within fourteen days.

Various other medical plan options offer employees the option to purchase prescription drugs locally, and the plan reimburses the employee at 80% after fulfilling certain annual deductibles.

Southwestern Bell Telephone concerns are:

1. The bargained agreement with the Communication Workers of America is a three year contract, which Southwestern Bell Telephone is not at liberty to deviate from until rebargaining.

2. The contract covers 59,733 employees in five states (Kansas, Oklahoma, Arkansas, Texas and Missouri).

3. If Senate Bill 524 passes, Southwestern Bell would be guilty of a misdemeanor if we continue our current plan.

4. If Southwestern Bell would refuse to provide the benefits agreed to in our current collective bargaining agreement, we would commit breach of contract and an unfair labor practice.

In summary, failure to continue our mail order prescription plan would constitute an unfair labor practice in the view of the Communication Workers of America and would cause additional expense to our employees, company, stockholders and our customers.

Senate Public Health & Welfare
February 4, 1988
Attachment 5

STATE OF KANSAS
MIKE HAYDEN, *GOVERNOR*

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

OFFICE OF THE SECRETARY

WINSTON BARTON, *SECRETARY*

DOCKING STATE OFFICE BUILDING
TOPEKA, KANSAS 66612-1570
(913) 296-3271
KANS-A-N 561-3271

February 3, 1988

The Honorable Roy L. Ehrlich, Chairman
Senate Committee on Public Health and Welfare
Room 138-N, State Capital Building
Topeka, Kansas 66612

Dear Senator Ehrlich:

The Department of Social and Rehabilitation Services has been requested to address concerns about House Bill 2504 that were expressed by members of the Committee on February 1, 1988. The request was made by Debra Brummer, who presented testimony at the hearing on February 1 and is president of the Randolph-Sheppard Vendors of Kansas.

Third class cities have been included to make K.S.A. 75-3337, et. seq. uniform to all cities in Kansas. Under the current law, first class cities may invoke home rule to opt out of the legislation due to its non-uniformity.

A grandfather clause applicable only to third class cities would render the bill non-uniform which in turn would continue to allow first class cities to opt out of the legislation. A grandfather clause applicable to all cities would hinder establishment of new opportunities for blind vendors in large cities, because existing private contractors could continue to be awarded food service contracts.

The Randolph-Sheppard Vendors of Kansas, Inc. wish to be able to exercise the priority for blind vendors called for in House Bill 2504 when current food service contracts expire, thereby to expand vending facility opportunities for the blind in large metropolitan areas. The Department has no intention of establishing facilities in third class cities, because facilities in cities of that size would not provide adequate remunerative employment opportunities for blind persons.

Thank you for considering this information in your deliberations. If you need additional information, please let me know.

Sincerely yours,

Winston Barton

Winston Barton
Secretary

WB/SS/RS/lm

Senate Public Health & Welfare
February 4, 1988
Attachment 6

February 2, 1988

Roy Ehrlich, Chairman
Senate Committee of Public Health and Welfare
Room # 138 North
State Capital Building
Topeka, KS 66604

Dear Senator Ehrlich:

I am writing this letter to follow up my testimony in suppor of House Bill # 2504 which I presented to you and your committee yesterday. I hope that you might be able to share this with other members of your committee before a final decision is made on this bill.

I would ask that your committee consider the very reason that the Randolph-Sheppard act was inacted and why Kansas as well as many other states subsequently also passed similar laws. This reason being to give blind persons an opportunity to operate food service establishments in buildings which are controlled by Governmental agencies. In some cases these laws might even give these blind persons an edge over other persons or groups.

However, it is important to remember that in Kansas, the number of Government buildings in which this law may give blind persons an edge only represents a very small percentage of the total number of food service opportunities which exist state-wide if ther were to be a person who was replaced by a blind person in one of these buildings. Also the reality is, that no matter how bad the economy might be, it will without a doubt be easier for an experienced sighted person to get another job in the food service industry than an equally experienced blind person.

I believe that the passage of this bill is essential to insure the continued success of the Business Etnterprise Program in Kansas.

If the law is not consistant and uniform with regard to all cities, there is the opportunity for a first class city to invoke "Home Rule" and ignore the law, because it does not apply to cities of the third class.

Senate Public Health & Welfare
February 4, 1988
Attachment 7

It is my opinion that if a "grandfather clause" is added which only affects cities of the third class, the law will still not be uniform. Furthermore, if a clause is added to affect all cities, it may in fact weaken the current law by restricting the Business Enterprise Program from bidding on locations where there is already an existing operator, even if the contract is up for renewal.

It is not my intention, nor do I believe that it is anyone's intention to remove people from their jobs just so that a blind person might have that job. However it is my intention to do all that I can do to insure that proper consideration should continue to be given in government buildings to blond persons for the operation of food service establishments. This employment thus makes these people self supporting tax payers.

For these reasons I urge you to pass HB # 2504 without any "grandfather clauses. "

Thank you very much for your consideration in this matter. If I can answer any further questions please call me at 232-1806.

Sincerely,

Debra Brummer

2-3-88

Wes Brummer
2841 SW Hillcrest
Topeka KS 66614
work 296-6600 ext 455

Sen Ray Ehrich
Senate Public Health & Welfare
Room #138 North
State Capitol Building

Dear Sen Ehrlich:

I am in favor of the passage of HB #2504 by your committee without a "grandfather clause" restricting bidding rights by the Business Enterprise Program.

Facilities operated by food service managers who happen to be blind have dropped over the past years. This is especially true in commercial locations. Two examples include the KPL Building in Topeka which terminated the BEP (Business Enterprise Program administered by SRS) facility & took it over as office space & the St. Francis Hospital location in Wichita which was taken over by the hospital itself. No where has SRS, who has final authority over program actions, kicked out another food service operator with a less competitive bid.

Senate Public Health & Welfare
February 4, 1988
Attachment 8

2) Considering the past record of SRS & their efforts to want to perserve a good image with city and county buildings, it is doubtful that this State agency will attempt to usurp another food Service operator out of a job.

3) When a food service contract comes up for renewal, other contractors besides SRS may bid on the governmental building in question. A "grand-father Clause" may give these other competitors more of an edge in bidding on a facility then the Business Enterprise Program. Such a clause may make this bill more restrictive then the current ineffectual law.

4) The reality is this – it is hard to get a job in the competitive market if you're blind. This law just helps a few food service managers who happen to be blind to get a break. These managers can join any local or state-wide food service organizations, go to food shows, & be a part of the mainstream. It's better then living off disability benefits. Thanks for your time Wes Brunner

STATE OF KANSAS

DEPARTMENT OF HEALTH AND ENVIRONMENT
Forbes Field
Topeka, Kansas 66620-0001
Phone (913) 296-1500

Mike Hayden, *Governor*

Stanley C. Grant, Ph.D., *Secretary*
Gary K. Hulett, Ph.D., *Under Secretary*

January 29, 1988

Senator Roy M. Ehrlich
Chairman, Committee on Public Health
and Welfare
Statehouse
Topeka, Kansas 66612

Dear Senator Ehrlich:

At the time of my testimony on Senate Bill 445 (January 26, 1988) the Committee on Public Health and Welfare raised several questions regarding the current testing of blood for infectious agents. I hope the following will clarify the issue for your committee.

For many years the U.S. Food and Drug Administration (FDA) has required "blood banks" to test all units of blood for evidence of infection with hepatitis B virus and the organism causing syphilis. More recently, by memorandum, testing for evidence of human immunodeficiency virus (HIV) has been required. Earlier this month the HIV testing requirements was included in 21CFR part 600-799 by publication in the Federal Register, to become effective February, 1988 (the exact dates are not available to me at this time).

In addition, the American Association of Blood Banks has similar and more stringent requirements.

The FDA imposes their regulations on strictly intrastate blood banks using such arguements as "some of the materials, for example anticoagulants, most probably have been utilized following interstate shipment".

The present legal climate makes it very unlikely that any blood bank would consider not adhering to standards of practice as outlined above.

Office Location: Suite 605, Mills Bldg., 109 S.W.

Senate Public Health & Welfare
February 4, 1988
Attachment 9

Notwithstanding the foregoing, I feel that it would be of potential benefit for Kansas to require testing for evidence of infection with hepatitis B, HIV and syphilis for donors of blood and tissues should the Federal regulations be changed for any reason or held invalid.

Sincerely,

Richard L. Parker, DVM, MPH
Director, Bureau of Epidemiology

bd
cc: Dr. Schloesser
Director, Div. of Health

Dr. Stanley Grant
Secretary