BENEFIT SUMMARY

THE BOEING COMPANY

80/20 PPO PLAN

Boeing North America (BNA)
UAW 864 (Texas)
Active
Effective January 1, 2010

Regence

Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

For medically necessary services rendered by a network or non-network provider, the benefits of this plan will be provided at the percentage of the allowed amount as specified below after the copay, deductible, or a combination of the two has been met.

This is a brief summary of benefits, it is not a certificate of coverage. For full coverage provisions, including limitations and exclusions, refer to the Summary Plan Description and the contract on file with your group or:

Call Boeing Customer Service at **1 (800) 422-7713** or visit our Web site at **www.regence.com/boeing**

Use **myRegence.com** for 24-hour access to your health information regarding claims and benefits.

Benefits	Network	Non-Network
Annual Deductible*	$300 per individual $900 per family of 3 or more	$600 per individual $1,800 per family of 3 or more
	Non-network charges apply to the network deductible	
Annual Out-of-Pocket Maximum	$2,000 per individual $6,000 per family of 3 or more	$4,000 per individual $12,000 per family of 3 or more
	Non-network services apply to the network out-of-pocket maximum.	
Acupuncture		
Inpatient	80%	60%
Outpatient	80% after $20 copay*	60%
Limited to 10 visits per benefit year; network/non-network combined.		
Ambulance Services (for true medical emergencies)	80%	80%
Durable Medical Equipment	80%	60%
Hearing Aids	100%	100%
Limited to one aid per ear every 3 consecutive benefit years up to $600 maximum; network/non-network combined.		
Home Health	80%	60%
Home Health is limited to 40 visits per benefit year; network/non-network combined.		
Hospital Facility Inpatient/Outpatient	80%	60%
Emergency Room (for true medical emergencies)	80%; $75 copay* (waived if admitted)	80%; $75 copay* (waived if admitted)
Mental Health (ValueOptions Network)		
Inpatient	90%	60%
Outpatient	80% after $20 copay*	60%
Care must be coordinated through the Boeing Helpline (ValueOptions) at 1 (800) 892-1411.		
Physician Services		
Inpatient	80%	60%
Outpatient	80% after $20 copay*	60%
Prescription Drugs (Medco Health Solutions, Inc.)		
Retail (30 day supply)	$5 copay generic $20 copay brand-name formulary~ $35 copay brand-name non-formulary~	Contact Medco for details of purchasing prescriptions at a non-network pharmacy.
Mail Order (up to 90 day supply)	$10 copay generic $40 copay brand-name formulary~ $70 copay brand-name non-formulary~	n/a

~If the member or physician requests a brand-name drug when a generic equivalent drug is available, the member will pay the generic copay plus the cost of the difference between brand-name and generic drug. To learn more about your prescription program, contact Medco at 1 (800) 841-2797 or visit **www.medco.com**

(over)

Benefits	Network	Non-Network
Preventive Care (ages 2 years and older)	100%	Not covered
Includes physical exams, related lab and x-rays, and flu shots for employees and spouses only as recommended by physician.	deductible does not apply $500 per individual per benefit year	
Children: (ages birth to 24 months)	100%	Not covered
One preventive exam office visit every calendar year. Also includes related lab and x-rays, and immunizations according to prescribed guidelines and doctor recommendations (excluding travel vaccines).	deductible does not apply $500 per individual per benefit year	
Screening Exams:	100%	Not covered
Includes Pap tests, mammograms, prostate and colorectal (including colonoscopy) and related office visits.	deductible does not apply Not subject to preventive care maximum	
Spinal Manipulations	80% after $20 copay*	60%
Limited to 26 spinal manipulation visits per benefit year; network/non-network combined.		
Substance Abuse (ValueOptions Network)		
Inpatient	80%	60%
Outpatient	80% after $20 copay*	60%
Care must be coordinated through the Boeing Helpline (ValueOptions) at 1 (800) 892-1411.		
Therapies (including extremity manipulations)	80%	60%
Physical, occupational and speech therapy. Extremity manipulations apply to the Physical Therapy benefit.		
Transplants	80%	60%
Blue Distinction Centers for Transplant® programs are available. Refer to Summary Plan Description and visit www.regence.com/boeing for details.		
Vision Care This benefit is provided by Vision Service Plan (VSP). Contact VSP at 1 (800) 877-7195 for details.		

*Do not apply to the annual out-of-pocket maximum and/or annual deductible.

Lifetime Maximum:
$2,000,000 per individual

Out-of-Pocket (OOP) Maximum:
The benefits of this plan will be provided until the OOP maximum is reached. Thereafter, this plan will provide benefits at 100% of the allowed amount for the remainder of the benefit year. Any balances of charges not covered by this plan will be your responsibility to pay and do not apply to the OOP maximum. The annual deductible, all copays (including prescriptions and emergency room), tobacco cessation do not apply to your OOP maximum.

Emergency Room:
Emergency room treatment at either a network or non-network facility is paid at the network level if it is a true medical emergency. Care at a non-network facility when the condition is not a true medical emergency, will be paid at the non-network level.

Network versus Non-Network Providers:
To receive the highest benefit level, you must receive services from a Blue Cross Blue Shield Plan Preferred Provider Organization (PPO) provider. Networks are available in nearly all Boeing locations in the U.S. – To find a network provider call **1 (800) 810-BLUE (2583).** If you receive care where no network is available, benefits will be paid at the network level. You may also visit the Boeing Health and Welfare Plans Web site at:

www.boeing.com/express

or call 1 (866) 473-2016

for names of PPO providers with the local Blue Cross and/or Blue Shield plan.

Hospital Preadmission Approval:
All hospital and skilled nursing facility admissions must be medically necessary. Preadmission approval is the responsibility of the member and must be obtained to ensure that full plan benefits will be provided.

Exclusions and Limitations to Coverage:
The non-covered services and supplies include, but are not limited to: acupuncture and temporomandibular joint disorder and except as specified; benefits covered by Medicare, auto insurance or government programs; substance abuse, except as specified; conditions related to military service or war; cosmetic surgery, except as specified; dentistry, dental x-rays or hospitalization for dentistry; intentionally self-inflicted injuries; investigational services or supplies; mental disorders, except as specified; obesity, unless approved in advance by the service representative according to written guidelines; occupational injury or disease; orthoptics, visual analysis, therapy or training, except as specified; prescription drugs, except as specified; private duty nursing or hourly nursing charges; services or supplies not medically necessary for illness or injury, except as specified; surgery or treatment for transsexualism or certain treatments for infertility; treatment of dyslexia, except as specified.