

BENEFIT SUMMARY
THE BOEING COMPANY
BASIC INDEMNITY PLAN

UAW 148 and 1482
 Medicare Retiree
 Effective January 1, 2010



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

For medically necessary services, the benefits of this plan will be provided at the percentage of the allowed amount as specified below after the deductible, emergency room copay 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.

Call Medicare at **1 (800) 633-4227** or visit their Web site at www.medicare.gov

Benefits	Covered Services
Annual Deductible* Deductible may be met by 1 person or combination	\$1,500 retiree only \$2,625 retiree plus spouse or child(ren) \$3,750 retiree plus spouse and child(ren)
Annual Out-of-Pocket Maximum	\$1,600 retiree only \$2,800 retiree plus spouse or child(ren) \$4,000 retiree plus spouse and child(ren)
Alternative Care Inpatient/Outpatient Includes services rendered by an acupuncturist only. Naturopaths, naturopathic services and massage therapists are not covered.	90%
Ambulance (for true medical emergencies)	90%
Durable Medical Equipment	90%
Hearing Aids Limited to one aid per ear every 3 consecutive benefit years up to \$600 maximum.	90%
Home Health Home Health limited to 120 visits per benefit year.	90%
Hospital Facility Inpatient/Outpatient	90%
Emergency Room (for true medical emergencies)	90%
Mental Health Inpatient/Outpatient	90%
Physician Services Inpatient/Outpatient	90%
Prescription Drugs (Medco Health Solutions, Inc.) Retail (30 day supply)	\$5 copay generic \$20 copay brand-name formulary~ \$35 copay brand-name non-formulary~*
Mail Order (up to 90 day supply)	\$10 copay generic \$40 copay brand-name formulary~ \$70 copay brand-name non-formulary~
~If you or your physician requests a brand drug when a generic equivalent drug is manufactured, you pay the generic copay plus the difference in cost between generic and brand drug. To learn more about your prescription program, contact Medco at 1 (800) 841-2797 or visit www.medco.com	

Benefits	Covered Services
Preventive Care (ages 2 and older) Includes physical exams, lab and x-ray, immunizations (excluding travel vaccines), flu and pneumonia vaccinations, and preventive hearing exams.	100% deductible does not apply \$500 per individual per benefit year
Children: (ages birth to 24 months) Includes exams and immunizations according to prescribed guidelines and doctor recommendations (excluding travel vaccines).	100% deductible does not apply \$500 per individual per benefit year
Screening Exams: Includes office visits, Pap tests, mammograms, and prostate and colorectal screenings (including colonoscopy).	100% deductible does not apply Not subject to the dollar maximum.
Spinal and Extremity Manipulations Limited to a combined 26 spinal and extremity manipulation visits per benefit year.	90%
Substance Abuse Inpatient/Outpatient	90%
Therapies Physical, occupational and speech therapy; limited to 60 outpatient visits per benefit year for physical, occupational and speech therapy combined.	90%
Transplants Blue Distinction Centers for Transplant® programs are available. Refer to Summary Plan Description and visit www.regence.com/boeing for details.	90%
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 and temporomandibular joint disorder care do not apply to your OOP maximum.

Services Not Covered By Medicare:

For services not covered by Medicare or when Medicare benefits are exhausted, utilize a provider participating with your local Blue Cross and/or Blue Shield plan in order to have claims submitted electronically to Regence on your behalf. Visit the Boeing Health and Welfare Plans Web site at

www.boeing.com/express

or call 1 (866) 473-2016

or

the Blue Cross Blue Shield Association
at 1 (800) 810-BLUE

for names of participating providers in your area.

Exclusions and Limitations to Coverage:

The non-covered services and supplies include, but are not limited to: acupuncture, 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.