

BENEFIT SUMMARY
THE BOEING COMPANY
BASIC PPO PLAN

IAM 725 and IBEW 2295
 Early Retiree
 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 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.

Benefits	Network	Non-Network
Annual Deductible*	\$1,000 per individual \$3,000 per family of 3 or more	\$2,000 per individual \$6,000 per family of 3 or more
Non-network charges apply to the network charges.		
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 and supplies apply to the network out-of-pocket maximum.		
Alternative Care		
Inpatient/Outpatient	90%	60%
Includes services rendered by an acupuncturist only. Naturopaths, naturopathic services and massage therapists are not covered.		
Ambulance Services (for true medical emergencies)	90%	90%
Durable Medical Equipment	90%	60%
Hearing Aids	90%	60%
Limited to one aid per ear every 3 consecutive benefit years up to \$800 maximum; network/non-network combined.		
Home Health	90%	60%
Home Health limited to 120 visits per benefit year; network/non-network combined.		
Hospital Facility Inpatient/Outpatient	90%	60%
Emergency Room (for true medical emergencies)	90%; \$75 copay (waived if admitted)	90%; \$75 copay (waived if admitted)
Mental Health (ValueOptions Network)		
Inpatient/Outpatient	90%	60%
Care must be coordinated through the Boeing Helpline (ValueOptions) at 1 (800) 892-1411.		
Physician Services		
Inpatient/Outpatient	90%	60%
Prescription Drugs (Medco Health Solutions, Inc.)	\$5 copay generic	Contact Medco for details of purchasing prescriptions at a non-network pharmacy.
Retail (30 day supply)	\$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 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		

Benefits	Network	Non-Network
Preventive Care (ages 2 years and older) Includes physical exams, related lab and x-rays, preventive hearing exams, and immunizations included according to prescribed guidelines and doctor recommendations (excluding travel vaccines).	100% deductible does not apply \$500 individual per benefit year Charges over \$500 are subject to copay, deductible and coinsurance.	Not covered
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	Not covered
Screening Exams: Includes Pap tests, mammograms, and prostate and colorectal screenings (including colonoscopy).	100% deductible does not apply Not subject to the \$500 preventive care maximum.	Not covered
Spinal and Extremity Manipulations Limited to a combined 26 spinal and extremity manipulation visits per benefit year; network/non-network combined.	90%	60%
Substance Abuse (ValueOptions Network) Inpatient/Outpatient Care must be coordinated through the Boeing Helpline (ValueOptions) at 1 (800) 892-1411.	90%	60%
Therapies Physical, occupational and speech therapy; limited to 60 outpatient visits per benefit year for physical, occupational and speech therapy combined; network/non-network combined.	90%	60%
Transplants Blue Distinction Centers for Transplant® programs are available. Refer to Summary Plan Description and visit www.regence.com/boeing for details.	90%	60%
Vision Care No Vision Coverage		

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

Lifetime Maximum:

\$1,750,000 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, emergency room copays, temporomandibular joint disorder care 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 just 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, 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.