

# SUMMARY OF BENEFITS

THE BOEING COMPANY

## 80/20 PPO PLAN

UAW 952, UAW 1558, UAW 864 ACTIVE

EFFECTIVE JANUARY 2008



# 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 your Summary Plan Description and the contract on file with your group or you may call:**

Boeing Customer Service at **1-800-422-7713** or visit our Web site at [www.wa.regence.com/boeing](http://www.wa.regence.com/boeing)

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

Benefits	Network Provider	Non-Network Provider
<b>Annual Deductible*</b>	\$175 individual per benefit year; 525 family per benefit year	
<b>Preventive Care</b> See your Summary Plan Description for details	100% up to \$200 maximum per exam (deductible does not apply)	not covered
<b>Professional Services</b> Outpatient Office Visits	80% 80% after \$15 copay*	60%
<b>Hospital Facility</b> Emergency Room	80% \$50 copay* (waived if admitted)	60% \$50 copay* (waived if admitted)
<b>Ambulance Services</b>	80%	80%
<b>Hearing Aids</b> \$600 maximum per ear every 3 consecutive benefit years	100%	100%
<b>Home Health</b>	80%	60%
<b>Hospice</b>	80%	100%
<b>Home Medical Equipment, Protheses and Orthotics</b>	80%	60%
<b>Manipulations</b> Limited to 26 spinal and extremity manipulation visits per benefit year	80% After \$15 copay*	60%
<b>Mental Health*</b> (ValueOptions Network) Inpatient	90%** 80%** after \$15 copay	50%** 20 days per benefit year 50%**
Outpatient		20 visits per benefit year
<b>Substance Abuse*</b> (ValueOptions Network) Inpatient 2 courses of treatment lifetime maximum; inpatient/outpatient combined; subject to annual \$250 deductible inpatient, outpatient, network, non-network combined	80% after \$250 deductible**	50%** Maximum benefit \$5,000 per course of treatment
Outpatient 2 courses of treatment lifetime maximum; inpatient/outpatient combined; subject to annual \$250 deductible inpatient, outpatient, network, non-network combined	\$15 copay then 80% after \$250 deductible**	50%** Maximum benefit \$5,000 per course of treatment

(over)

<b>Prescription Drugs</b>		
Retail (30 day supply)	\$5 copay generic \$15 copay brand-name formulary \$30 copay brand-name nonformulary	n/a
Mail Order (Up to 90 day supply)	\$10 copay generic \$30 copay brand-name formulary \$60 copay brand-name nonformulary	n/a
<b>Rehabilitation</b>		
Inpatient	80%	60%
Outpatient	80%	60%
<b>Skilled Nursing Facility</b>	80%	60%
<b>Temporomandibular Joint Disorder (TMJ)*</b> \$3,500 lifetime maximum	80%	60%
<b>Transplants</b> See your Summary Plan Description for specific allowed transplants	80%	60%
<b>Vision Care*</b> Provided by Vision Service Plan Call 1-800-877-7195		

\* Employee costs do not apply to the annual out-of-pocket maximum.

\*\*All care must be coordinated through the Boeing Helpline (ValueOptions) at 1- 800-892-1411. Network benefits available when care is provided by a ValueOptions Network provider.

**Lifetime Maximum:** \$1,500,000 per person.

**Out-of-Pocket Maximum Limit:** The benefits of this plan will be provided until the out-of-pocket maximum has reached \$2,000 per person/\$4,000 per family of three or more, per benefit year. 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 out-of-pocket maximum. The annual deductible, per-visit copays, hearing aids, substance abuse, mental health care, smoking cessation and temporomandibular joint disorder care do not apply to your out-of-pocket maximum.

**Emergency Care:** Emergency benefits will be provided at the level specified for a Network provider. In the event of a medical emergency, treatment by a provider not normally covered under this plan will be recognized for a 24-hour period or for such additional time as is reasonably required to come under the care of a Network provider.

**Network versus Non-Network Providers:** To receive the highest benefit level, you must receive services from a Network or Preferred Provider Organization (PPO) provider. Networks are available in nearly all Boeing locations in the U.S. -- to determine if you are in a network area, call 1-800-810-BLUE. If you receive care where no network is available, benefits will be paid at the network level. Visit the Boeing Health and Welfare Plans Web site at <https://my-ext.boeing.com> or call 1-866-473-2016 or 1-800-810-BLUE for names of Network or 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 noncovered 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.