

BENEFIT SUMMARY
THE BOEING COMPANY
TRADITIONAL MEDICAL PLAN
NONUNION ACTIVE
EFFECTIVE JANUARY 2008



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. For chemical dependency and mental disorders benefits, contact ValueOptions at 1-800-892-1411 for assessments and referrals. **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 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 Provider	Non-Network Provider
Annual Deductible*	Individual deductible is the greater of \$200 or 0.2% of annual base wage. Family deductible is the greater of \$600 or 0.6% of annual base wage.	
Preventive Care See your Summary Plan Description for details	100% up to \$500 maximum per benefit year Excess of \$500 maximum, subject to the copay, deductible and coinsurance	not covered
Professional Services Outpatient Office Visit	100% after \$15 copay	60%
Hospital Facility Emergency room	100% \$50 copay* (waived if admitted)	100% \$50 copay* (waived if admitted)
Ambulance Services	100%	100%
Hearing Aids \$600 maximum per ear every 3 consecutive benefit years	100%	100%
Home Health	100%	60%
Home Medical Equipment, Protheses and Orthotics	100%	60%
Manipulations Limited to 26 spinal and extremity manipulation visits per benefit year (combined)	100% after \$15 copay	60%
Mental Health (ValueOptions Network) Inpatient	100%** (deductible does not apply)	60%** 20 days per benefit year
Outpatient	100% after \$15 copay** (deductible does not apply)	60%** 20 visits per benefit year
Substance Abuse (ValueOptions Network) Inpatient 2 courses of treatment lifetime maximum; inpatient /outpatient combined	100% Maximum benefit of \$7,500 per course of treatment (deductible does not apply)	60%** Maximum benefit of \$2,500 per course of treatment, accrues towards network maximum.
Outpatient 2 courses of treatment lifetime maximum; inpatient /outpatient combined	100% after \$15 copay Maximum benefit of \$7,500 per course of treatment (deductible does not apply)	60%** Maximum benefit of \$2,500 per course of treatment, accrues towards network maximum.

(over)

Benefits	Network Provider	Non-Network Provider
Prescription Drugs (Medco) Retail (30 day supply)	90% generic \$5 minimum, \$25 maximum 80% brand-name formulary~ \$15 minimum, \$75 maximum 70% brand-name non-formulary~ \$30 minimum, no maximum	See network provisions- (copay is lesser of billed amount or network allowed)
Mail Order (up to 90 day supply)	\$10 copay generic \$30 copay brand-name formulary~ \$60 copay brand-name non-formulary~	n/a
~ If you request a brand drug when a generic equivalent drug is manufactured, you pay the generic copay plus the difference in cost between the generic and brand drug.		
Rehabilitation Inpatient/Outpatient	100%	60%
Skilled Nursing Facility	100%	100%
Temporomandibular Joint Disorder (TMJ) \$3,500 lifetime maximum	50%*	50%*
Transplants See your Summary Plan Description for allowed transplants	100%	60%
Vision Care Provided by Vision Service Plan Call 1-800-877-7195		

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

**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: The benefits of this plan will be provided until the network out-of-pocket maximum has reached \$5,000 per individual/\$15,000 per family per benefit year. Non-network out-of-pocket accumulations apply towards the network out-of-pocket maximum. 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, substance abuse, mental health care and temporomandibular joint disorder care do not apply.

Emergency Care: Emergency room treatment at either a network or non-network facility is paid at the network level if it is a true medical emergency. A patient admitted to a non-network hospital retains emergency status (and benefits are paid at the network level) for 24 hours or until the patient can be transferred safely to a network facility. However, for care at a non-network facility when the condition is not a true medical emergency, covered services are paid at the non-network level.

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 across the U.S. 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 <http://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.