

**BENEFIT SUMMARY**  
 THE BOEING COMPANY  
**TRADITIONAL INDEMNITY PLAN**  
 IAM 725 & IBEW 2295  
 MEDICARE RETIREE  
 EFFECTIVE JANUARY 2008



For medically necessary services the benefits of this plan will be provided at the percentage of the allowed amount as specified below after Medicare benefits have been paid and 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:**

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**

<b>Benefits</b>	<b>Covered Services</b>
<b>Annual Deductible*</b>	\$250 per individual; \$750 per family
<b>Preventive Care</b> See your Summary Plan Description for details	100% up to \$500 maximum per benefit year (deductible does not apply)
<b>Professional Services</b>	90%
<b>Hospital Facility</b> Emergency room	90% after \$50 copay* (waived if admitted)
<b>Ambulance Services</b>	90%
<b>Hearing Aids</b> \$600 maximum per ear every 3 consecutive benefit years	90%
<b>Home Health</b> Limited to 120 visits per benefit year	90%
<b>Hospice</b>	90%
<b>Home Medical Equipment, Protheses and Orthotics</b>	90%
<b>Manipulations</b> Limited to 26 spinal and extremity manipulation visits per benefit year	90%
<b>Mental Health</b> Inpatient and Outpatient (deductible does not apply)	90%
<b>Substance Abuse</b> (deductible does not apply)	90%
Inpatient/Outpatient combined; 2 courses of treatment lifetime maximum	Maximum benefit of \$7,500 per course of treatment

(over)

Benefits	Covered Services
<b>Prescription Drugs (Medco)</b> Retail (30 day supply)  Mail Order (up to 90 day supply)	\$5 copay generic \$15 copay brand-name formulary** \$30 copay brand-name non-formulary**  \$10 copay generic \$30 copay brand-name formulary** \$60 copay brand-name non-formulary**
** 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.	
<b>Rehabilitation</b> Inpatient Outpatient (Limited to 60 visits per benefit year)	90% 90%
<b>Skilled Nursing Facility</b>	90%
<b>Temporomandibular Joint Disorder (TMJ)</b> \$3,500 lifetime maximum	50%*
<b>Transplants</b> See your Summary Plan Description for allowed transplants	90%
<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.

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

**Out-of-Pocket Maximum:** 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, emergency room copays and temporomandibular joint disorder care do not apply.

**Services Not Covered By Medicare:** To reduce your out of pocket expenses, use our Preferred Provider Organization (PPO) for services. PPO networks are available throughout the U.S. 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.

**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.