

BENEFIT SUMMARY
THE BOEING COMPANY
TRADITIONAL INDEMNITY PLAN



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

SCPEA
 Medicare Retiree
 Effective January 1, 2010

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	
Annual Deductible	\$300 per individual \$900 per family of 3 or more
Annual Out-of-Pocket Maximum	\$2,000 per individual \$4,000 per family of 3 or more Deductibles apply toward the out-of-pocket maximum.
Alternative Care Inpatient/Outpatient Includes services rendered by an acupuncturist only. Naturopaths, naturopathic services and massage therapists are not covered.	90%
Ambulance	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%; \$50 copay* (waived if admitted)
Mental Health Inpatient/Outpatient	90%
Physical Services Inpatient/Outpatient	90%
Prescription Drugs (Medco Health Solutions, Inc.) Retail (34 day supply)	\$5 copay generic \$15 copay brand-name formulary~ \$30 copay brand-name non-formulary~
Mail Order (up to 90 day supply)	\$10 copay generic \$30 copay brand-name formulary~ \$60 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

Preventive Care (ages 2 and older)

Includes physical exams and related lab and x-ray, Pap tests, mammograms, prostate and colorectal (including colonoscopy) screenings, immunizations (excluding travel vaccines) and preventive hearing exams.

90%
deductible does not apply
\$500 benefit maximum

Children: (ages birth to 24 months)

Includes exams and immunizations according to prescribed guidelines and doctor recommendations (excluding travel vaccines).

90%
deductible does not apply

Screening Exams:

Includes office visits, Pap tests, mammograms, prostate and colorectal (including colonoscopy) screenings.

See Preventive Care Ages 2 and Older

Spinal 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 deductible.

Lifetime Maximum:

\$1,500,000 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, all copays (including prescriptions and emergency room) 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.

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.

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