

BENEFIT SUMMARY
THE BOEING COMPANY
TRADITIONAL MEDICAL PLAN (TMP)



Regence

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Boeing Aerospace Operation (BAO)
 TDAS (a.k.a. Seymour Johnson) – IAM 2296
 T-38 (IAM 92 and 161)
 Active
 Effective January 1, 2010

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 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*	\$350 per individual \$1,050 per family of 3 or more	\$700 per individual \$2,100 per family of 3 or more
	Non-network deductible applies to the network deductible.	
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 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	80%	80%
Hearing Aids	90%	90%
Limited to one aid per ear every 3 consecutive benefit years up to \$800 maximum; network/non-network combined.		
Home Health	90%	60%
Hospital Facility		
Inpatient/Outpatient	90%	60%
Emergency Room (for true medical emergencies)	90%; \$50 copay* (waived if admitted)	90%; \$50 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.)		
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	Contact Medco for details of purchasing prescriptions at a non-network pharmacy.
Mail Order (up to 90 day supply)	\$10 copay generic \$40 copay-brand-name formulary~ \$70 copay-brand-name non-formulary~	n/a

~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 and older) One preventive exam office visit every calendar year age 2 – 18. One preventive exam office visit every 3 calendar years age 19 through 34. One preventive exam office visit every calendar year age 35 and older. Benefit maximum and time frames also include preventive lab and x-ray charges and immunizations according to prescribed guidelines and doctor recommendations (excluding travel vaccines).	100%; deductible does not apply \$500 benefit maximum Charges over \$500 are subject to deductible and coinsurance	Not covered
Children: (ages birth to 24 months) 8 routine exams including 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) and related office visits.	100%; deductible does not apply Not subject to \$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 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 annual 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 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 must 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 can contact the BAO Human Resource Administrator at 1-800-864-3318 for more information.

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.