

**BENEFIT SUMMARY**  
**THE BOEING COMPANY**  
**TRADITIONAL MEDICAL PLAN (TMP)**



**Regence**

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

SPEEA WEU

Active & Early Retiree

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](http://www.regence.com/boeing)

Use [myRegence.com](http://myRegence.com) for 24-hour access to your health information regarding claims and benefits

Benefits	Network	Non-Network
<b>Annual Deductible*</b>	Greater of \$225 or 0.225% of annual base salary per individual Greater of \$675 or 0.675% of annual base salary per family of 3 or more	
<b>Annual Out-of-Pocket Maximum</b>	\$2,000 per individual; network/non-network combined. \$4,000 per family, but not more than \$2,000 for any person; network/non-network combined.	
<b>Alternative Care</b>		
Inpatient	95%	60%
Outpatient	100% after \$15 copay*	60%
Includes services rendered by an acupuncturist only. Naturopaths, naturopathic services and massage therapists are not covered.		
<b>Ambulance Services</b> (for true medical emergencies)	95%	95%
<b>Durable Medical Equipment</b>	95%	60%
<b>Hearing Aids</b>	95%	60%
Limited to one aid per ear every 3 consecutive benefit years up to \$800 maximum; network/non-network combined.		
<b>Home Health</b>	100%	100%
Home health limited to 120 visits per benefit year; network/non-network combined.		
<b>Hospital Facility</b> Inpatient/Outpatient	95% or 100%**	60%
<b>Emergency Room</b> (for true medical emergencies)	95% or 100%**, \$50 copay* (waived if admitted)	100% or 95%**, \$50 copay* (waived if admitted)
**For Hospital Safety Incentive facilities: Visit <a href="http://www.regence.com/boeing">www.regence.com/boeing</a> or call 1-800-422-7713.		
<b>Mental Health</b> (ValueOptions Network)		
Inpatient/Outpatient	95% or 100%**	60%
**For Hospital Safety Incentive facilities: Visit <a href="http://www.regence.com/boeing">www.regence.com/boeing</a> or call 1-800-422-7713. Care must be coordinated through the Boeing Helpline (ValueOptions) at 1 (800) 892-1411.		
<b>Physician Services</b> Inpatient	95%	60%
Outpatient	100% after \$15 copay*	60%
<b>Prescription Drugs</b> (Medco)		
Retail (34 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 at 3 <sup>rd</sup> tier)	Contact Medco for details of purchasing prescriptions at a non-network pharmacy.
Mail Order (up to 90 day supply)	\$10 copay generic \$30 copay brand-name formulary \$60 copay brand-name non-formulary	n/a
To learn more about your prescription program, contact Medco at 1 (800) 841-2797 or visit <a href="http://www.medco.com">www.medco.com</a>		

Benefits	Network	Non-Network
<b>Preventive Care</b> (ages 2 and older)		
One preventive exam office visit every calendar year age 2 – 18.	100% deductible does not apply	Not covered
One preventive exam office visit every 3 calendar years age 19 through 34.	\$500 benefit maximum	
One preventive exam office visit every calendar year age 35 and older.	Charges over \$500 are subject to copay, deductible and coinsurance.	
Benefit maximum and time frames also include preventive x-rays and lab charges, and immunizations according to prescribed guidelines and doctor recommendations (excluding travel vaccines).		
<b>Children:</b> (ages birth to 24 months)		
8 routine exams include immunization according to prescribed guidelines and doctor recommendations (excluding travel vaccines).	100% deductible does not apply	Not covered
<b>Screening Exams:</b>		
Includes mammograms, Pap tests, prostate and colorectal screening (including Colonoscopy) and related office visits.	100% deductible does not apply Not subject to preventive care maximum	Not covered
<b>Spinal and Extremity Manipulations</b>		
	100% after \$15 copay*	60%
Limited to a combined 26 spinal and extremity manipulation visits per benefit year; network/non-network combined.		
<b>Substance Abuse</b> (ValueOptions Network)		
Inpatient/Outpatient	95% or 100%**	60%
**For Hospital Safety Incentive facilities: Visit <a href="http://www.regence.com/boeing">www.regence.com/boeing</a> or call 1-800-422-7713. Care must be coordinated through the Boeing Helpline (ValueOptions) at 1 (800) 892-1411.		
<b>Therapies</b>		
	95%	60%
Physical, occupational and speech therapy.		
<b>Transplants</b>		
	See Physician Services and Hospital Facility	60%
Blue Distinction Centers for Transplant® programs are available. Refer to Summary Plan Description and visit <a href="http://www.regence.com/boeing">www.regence.com/boeing</a> for details. Donor procurement costs limited to \$30,000 per organ \$60,000 per lifetime; network/non-network combined.		
<b>Vision Care</b> 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:**

\$2,000,000 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 all retail and mail order prescription costs and emergency room), temporomandibular joint disorder and smoking cessation 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 may also visit the Boeing Health and Welfare Plans Web site at:

[www.boeing.com/express](http://www.boeing.com/express)  
or call **1 (866) 473-2016**

for names of 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 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.