BENEFIT SUMMARY

THE BOEING COMPANY

TRADITIONAL MEDICAL PLAN (TMP)

SPFPA 255

Active

Effective July 1, 2010 – December 31, 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*	$100 per individual; $300 per family of 3 or more; network/ non-network combined.	
Annual Out-of-Pocket Maximum	$1,000 per individual; $2,000 per family of 2 or more; network/non-network combined.	
Alternative Care		
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.		
Ambulance Services (for true medical emergencies)	95%	95%
Hearing Aids	95%	60%
Limited to one aid per ear every 3 consecutive benefit years up to $600 maximum; network/non-network combined.		
Home Health	100%	100%
Durable Medical Equipment	95%	60%
Hospital Facility (Hospital Safety Incentive applies**)		
Inpatient/Outpatient	95% or 100%**	60%
Emergency Room (for true medical emergencies)	95% or 100%;** $50 copay* (waived if admitted)	95% or 100%;** $50 copay* (waived if admitted)
Mental Health (ValueOptions Network)		
Inpatient (Hospital Safety Incentive applies**)	95% or 100%**	60%
Outpatient	95%	60%
Care must be coordinated through the Boeing Helpline (ValueOptions) at 1 (800) 892-1411.		
Physician Services		
Inpatient	95%	60%
Outpatient	100% after $15 copay*	60%
Prescription Drugs		
(Medco Health Solutions, Inc.) Retail (34 day supply)	$5 copay* generic $15 copay* brand-name formulary $30 copay* brand-name non-formulary	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 **www.medco.com.**		

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Benefits	Network	Non-Network
Preventive Care One preventive exam office visit every 3 calendar years for employees and spouses under age 35. One preventive exam office visit every calendar year for employees and spouses age 35 and older.	100% (deductible does not apply) $200 benefit maximum Additional expenses are patient responsibility	Not covered
Benefit maximum and time frames also include preventive lab and x-rays. Routine colorectal screening (including colonoscopy) charges accumulate to the $200 preventive maximum.		
Children: (birth through age 5) 8 routine exams from birth to 24 months; One routine exam per year from ages 2 through 5.	100% (deductible does not apply)	Not covered
Screening Exams: Includes mammograms, Pap tests, prostate and the related office visit.	100% (deductible does not apply) Not subject to preventive care maximum	Not covered
Spinal and Extremity Manipulations	100% after $15 copay* (deductible does not apply)	60%
Limited to a combined 26 spinal and extremity manipulation visits per benefit year; network/non-network combined.		
Substance Abuse (ValueOptions Network)		
Inpatient (Hospital Safety Incentive applies**)	95% or 100%**	60%
Outpatient	95%	60%
Care must be coordinated through the Boeing Helpline (ValueOptions) at 1 (800) 892-1411.		
Therapies	95%	60%
Physical, occupational and speech therapy. Refer to Summary Plan Description for details.		
Transplant	See Physician Services and Hospital Facility benefits	60%
Donor procurement cost limited to $30,000 per organ/ $60,000 per lifetime; network/non-network combined. Distinction Centers for Transplant® programs are available. Refer to Summary Plan Description for details and visit www.regence.com/boeing.		
Vision Care	This benefit is provided by Vision Service Plan (VSP). Contact VSP at 1 (800) 877-7195 for details.	

*Does not apply to the annual out-of-pocket maximum and/or annual maximum.

**For Hospital Safety Incentive details and facilities: visit www.regence.com/boeing or call 1 (800) 422-7713.

Lifetime Maximum:

$1,500,000 per individual;
network/non-network combined.

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 may also visit the Boeing Health and Welfare Plans Web site at:

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:

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; 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.