Boeing: IAM 837 Medicare Retiree Traditional Indemnity Plan

BlueCross BlueShield of Illinois

Coverage Period: 01/01/2014 - 12/31/2014

This is a brief summary of benefits, it is not a certificate of coverage. If there is any conflict between the information in this benefits summary and the official Plan document, the official Plan document will govern. 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 Member Services at **888-802-8776** or visit our Website at **bcbsil.com/boeing**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $350/ind, $1,050/fam; Nonnetwork: $0; deductible does not apply to prescription drugs and preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Is there an out–of–pocket limit on my expenses?	Yes. $2,000/ind, $6,000/fam, network-nonnetwork combined**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, penalties for failing to obtain preauthorization, deductibles	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	No.	This plan treats **providers** the same in determining payment for the same services.

Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference.
This plan may encourage you to use in network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

*! IMPORTANT INFORMATION ! The plan document contains important information regarding the items that are listed in this document. It is vital that you review the plan document in order to know if this plan has any limitations, exceptions or exclusions regarding any test, treatment or service. The actual plan document consists of The Boeing Company Master Welfare Plan, applicable Summary Plan Descriptions (SPDs), insurance contracts and funding vehicles, and other "governing documents." You may submit a written request to receive a copy of these documents; however, unless you specifically request otherwise, you will only receive a copy of the following documents in response to such request: The Boeing Company Master Welfare Plan, this plan's SPD, and any applicable updates to this SPD. In the event of a conflict between this document and the plan document, the terms of the plan document will control.

**Your maximum share of the cost of covered services (including deductible, but otherwise excluding items that don't count toward the out-of-pocket limit) is shown on p. 1. That total amount complies with the maximum amount mandated by the Affordable Care Act for 2014.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% after deductible	10% after deductible	*!
	Specialist visit	10% after deductible	10% after deductible	*!
	Other practitioner office visit	10% after deductible for Chiropractic	10% after deductible for Chiropractic	26 visits limited/year, spinal and extraspinal manipulations*!
	Preventive care/screening/immunization	No charge	No charge	According to prescribed guidelines*!
If you have a test	Diagnostic test (x-ray, blood work)	10% after deductible	10% after deductible	*!
	Imaging (CT/PET scans, MRIs)	10% after deductible	10% after deductible	*!
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	RETAIL: 10%/prescription, member pays min $5/prescription, max $25/prescription; MAIL ORDER: $10 copay/prescription	Not covered	RETAIL: 31 day supply; MAIL ORDER: 90 day supply*!
	Preferred brand drugs	RETAIL: 20%/prescription, member pays min $20/prescription, max $75/prescription; MAIL ORDER: $50 copay/prescription	Not covered	RETAIL: 31 day supply; MAIL ORDER: 90 day supply*!
	Non-preferred brand drugs	RETAIL: 30%/prescription, member pays min $35/prescription, max $275/prescription; MAIL ORDER: $85 copay/prescription	Not covered	Same as Preferred brand drug limitation above*!
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% after deductible	10% after deductible	*!
	Physician/surgeon fees	10% after deductible	10% after deductible	*!
If you need immediate medical attention	Emergency room services	$75 copay/visit, then 10% after deductible, including non-emergent care	$75 copay/visit, then 10% after deductible, including non-emergent care	*!
	Emergency medical transportation	10% after deductible	10% after deductible	*!

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Urgent care	10% after deductible	10% after deductible	*!
If you have a hospital stay	Facility fee (e.g., hospital room)	10% after deductible	10% after deductible	*!
	Physician/surgeon fee	10% after deductible	10% after deductible	*!
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% after deductible	10% after deductible	*!
	Mental/Behavioral health inpatient services	10% after deductible	10% after deductible	*!
	Substance use disorder outpatient services	10% after deductible	10% after deductible	*!
	Substance use disorder inpatient services	10% after deductible	10% after deductible	*!
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	10% coinsurance after deductible	Limited to 120 visits/benefit year, network-nonnetwork combined*!
	Rehabilitation services	Inpatient/Outpatient: 10% after deductible	Inpatient/Outpatient: 10% after deductible	60 visits limited/year for all therapies combined, network-nonnetwork combined*!
	Habilitation services	Not covered	Not covered	*!
	Skilled nursing care	10% after deductible	10% after deductible	*!
	Durable medical equipment	10% after deductible	10% after deductible	*!
	Hospice service	10% after deductible	10% after deductible	6-month max*!

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery (unless medically necessary)
- Cosmetic surgery (limited coverage may apply)
- Dental care (Adult) (limited coverage may apply)
- Dental check-up (child)
- Eye exam
- Glasses
- Habilitation services
- Infertility treatment (limited coverage may apply)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (limited coverage may apply)
- Weight loss programs