BENEFIT SUMMARY

THE BOEING COMPANY

Basic PPO Plan

Huntsville (IAM 44)
Decatur (IAM 2766)
Early Retiree
Effective July 1, 2009

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*	$1,000 per individual	$2,000 per individual
Copays do not count toward the deductible	$3,000 per family of 3 or more	$6,000 per family of 3 or more
Non-network charges apply towards network deductible.		
Annual Out-of-Pocket Maximum	$2,000 per individual or $4,000 per family of 2 or more network/non-network combined.	
Alternative Care		
Inpatient/ Outpatient	90%	60%
Acupuncture services only. Naturopaths, naturopathic services and massage therapists are not covered. Refer to Summary Plan Description for details.		
Ambulance Services	90%	See network provisions
Hearing Aids	90%	60%
$800 maximum per ear every 3 consecutive benefit years; network/non-network combined.		
Home Health	90%	60%
Home Health limited to 120 visits per benefit year; network/non-network combined.		
Durable Medical Equipment, Prostheses and Orthotics	90%	60%
Hospital Facility		
Inpatient/Outpatient	90%	60%
Emergency Room (for true medical emergencies)	90%; $50 copay*	See network provisions
Mental Health* (ValueOptions Network)		
Inpatient	90%	60%; 20 days per benefit year
Outpatient	90%	60%; 20 visits per benefit year
Care must be coordinated through the Boeing Helpline (ValueOptions) at 1(800) 892-1411.		
Physical, Occupational and Speech Therapy		
Outpatient visits limited to 60 per benefit year; network/non-network combined.	90%	60%
Physician Services		
Inpatient	90%	60%
Outpatient	90%	60%
Prescription Drugs (Medco)*		
Please refer to Medco at 1-800 841-2797 or visit the Medco Web site at **www.medcohealth.com**.		

(over)

Benefits	Network	Non-Network
Preventive Care (Ages 2 and Older) Refer to Summary Plan Description for details. Includes routine mammogram, Pap smear, prostate, colorectal cancer screenings, related lab and x-ray, preventive hearing exams, and child immunizations.	100% $500 maximum per individual per benefit year. (deductible does not apply)	Not covered
Skilled Nursing Facility and Hospice	90%	60%
Spinal Manipulations Limited to 26 spinal manipulation visits per benefit year. Extremity manipulations apply to the Physical Therapy benefit.	90%	60%
Substance Abuse (ValueOptions Network)		
Inpatient	90%	60%
Outpatient	90%	60%
Lifetime maximum of two courses of treatment; inpatient/outpatient and network/non-network combined.	Maximum benefit $7,500 per course of treatment; network/non-network combined.	Maximum benefit $2,500 per course of treatment; accrues towards the $7,500 network maximum.
Care must be coordinated through the Boeing Helpline (ValueOptions) at 1(800) 892-1411.		
Transplants Refer to Summary Plan Description for details.	90%	60%
Vision Care* Routine vision care services are covered through Vision Service Plan (VSP). Contact VSP at 1-800-877-7195 for details.		

*Employee costs do not apply to the annual out-of-pocket maximum.

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 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:

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 and temporomandibular joint disorder and 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.