

BENEFIT SUMMARY
THE BOEING COMPANY
BASIC PPO PLAN

IAM 725 and IBEW 2295
 Early Retiree
 January 1, 2009



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

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 deductible, emergency room copay 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* Copays do not count towards the deductible. Non-network charges apply to network charges	\$1,000 per individual \$3,000 per family of 3 or more	\$2,000 per individual \$6,000 per family of 3 or more
Annual Out-of-Pocket Maximum	\$2,000 per individual \$4,000 per family of 2 or more	\$4,000 per individual \$8,000 per family of 2 or more
Alternative Care Inpatient/Outpatient Includes services received by an Acupuncturist only. Naturopaths, naturopathic services and massage therapists are not covered.	90%	60%
Ambulance Services	90%	See network provisions
Hearing Aids \$600 maximum per ear every 3 consecutive benefit years; network/non-network combined.	90%	60%
Home Health and Hospice Home Health limited to 120 visits per benefit year; network/non-network combined.	90%	60%
Durable Medical Equipment, Prostheses and Orthotics	90%	60%
Hospital Facility Inpatient/Outpatient Emergency Room (for true medical emergencies)	90% 90%; \$50 copay*	60% See network provisions
Mental Health (ValueOptions Network) Inpatient Outpatient Care must be coordinated through the Boeing Helpline (ValueOptions) at 1 (800) 892-1411.	90%; deductible does not apply 90%; deductible does not apply	60%; 20 days per benefit year 60%; 20 visits per benefit year
Physical, Occupational and Speech Therapy Refer to Summary Plan Description for details.	90%	60%
Prescription Drugs (Medco)* Retail (30 day supply) Mail Order (up to 90 day supply)	\$5 copay generic \$15 copay brand-name formulary** \$30 copay brand-name non-formulary** \$10 copay generic \$30 copay brand-name formulary** \$60 copay brand-name non-formulary**	Not covered

**If the member or physician requests a brand-name drug when a generic drug is available, the member will pay the generic copay plus the cost of the difference between brand-name and generic drug.

Benefits	Network	Non-Network
Preventive Care Refer to Summary Plan Description for details.	100% \$500 maximum per individual per benefit year. (deductible does not apply)	Not covered
Professional Services Inpatient/Outpatient	90%	60%
Skilled Nursing Facility	90%	60%
Spinal 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 2 courses of treatment lifetime maximum; inpatient/outpatient maximum combined Care must be coordinated through the Boeing Helpline (ValueOptions) at 1 (800) 892-1411.	90%; deductible does not apply Maximum benefit \$7,500 per course of treatment	60% Maximum benefit \$5,000 per course of treatment
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, emergency room copays, temporomandibular joint disorder care 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, 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.