BENEFIT SUMMARY

THE BOEING COMPANY

BASIC INDEMNITY PLAN

UAW 148 and 1482
Medicare Retiree
January 1, 2009

For medically necessary services, 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.

Call Medicare at **1-800-633-4227** or visit their Web site at **www.medicare.gov**

Benefits	
Annual Deductible*	$1,500 retiree only $2,625 retiree plus spouse or child(ren) $3,750 retiree plus spouse and child(ren)
Annual Out-of-Pocket Maximum Refer to Summary Plan Description for details.	$1,600 retiree only $2,800 retiree plus spouse or child(ren) $4,000 retiree plus spouse and child(ren)
Alternative Care Inpatient/Outpatient Includes services received by an Acupuncturist only. Naturopaths, naturopathic services and massage therapists are not covered.	90%
Ambulance	90%
Hearing Aids $600 maximum per ear every 3 consecutive benefit years.	90%
Home Health and Hospice Home Health limited to 120 visits per benefit year.	90%
Durable Medical Equipment, Prostheses and Orthotics	90%
Hospital Facility	
Inpatient/Outpatient	90%
Emergency Room (for true medical emergencies)	90%
Mental Health	
Inpatient/Outpatient	90% (deductible does not apply)
Physical, Occupational and Speech Therapy Refer to Summary Plan Description for details.	90%
Prescription Drugs (Medco)*	
Retail (30 day supply)	$5 copay generic $20 copay brand-name formulary** $35 copay brand-name non-formulary**
Mail Order (up to 90 day supply)	$10 copay generic $40 copay brand-name formulary** $70 copay brand-name non-formulary**

**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.

(over)

Benefits	
Preventive Care Refer to Summary Plan Description for details.	100% $500 maximum per individual, per benefit year. (deductible does not apply)
Professional Services Inpatient/Outpatient	90%
Skilled Nursing Facility	90%
Spinal Manipulations	90%
Limited to a combined 26 spinal and extremity manipulation visits per benefit year; network/non-network combined.	
Substance Abuse Inpatient/Outpatient 2 courses of treatment lifetime maximum; inpatient/outpatient maximum combined.	90% (deductible does not apply) Maximum benefit $7,500 per course of treatment
Transplants Refer to Summary Plan Description for details.	90%
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:

$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 reminder 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 and temporomandibular joint disorder care do not apply to your OOP maximum.

Services Not Covered By Medicare:

For services not covered by Medicare or when Medicare benefits are exhausted, utilize a provider participating with your local Blue Cross and/or Blue Shield plan in order to have claims submitted electronically to Regence on your behalf. Visit the Boeing Health and Welfare Plans web site at **http://my-ext.boeing.com or call 1-866-473-2016 or the Blue Cross Blue Shield Association at 1-800-810-BLUE** for names of participating providers in your area.

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.