BENEFIT SUMMARY

THE BOEING COMPANY

TRADITIONAL MEDICAL PLAN

SPEEA WTPU EARLY RETIREE

JULY 2008

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 your 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	$200 per individual; $600 per family of 3 or more	
Annual Out-of-Pocket Maximum	$2,000 per person; $4,000 per family of 2 or more	
Preventive Care See Summary Plan Description for details Routine exams (1 exam every 3 calendar years for employee/spouse under age 35; 1 exam every calendar year for employee/spouse age 35 and older) Well child exams (ages birth through age 5 only), childhood immunizations (not subject to preventive dollar maximum) Routine mammogram, Pap Smear, prostate cancer screenings (not subject to preventive dollar maximum)	100% $200 maximum per exam (deductible does not apply)	Not covered
Professional Services	95% (inpatient) 100%; $15 copay* (outpatient)	60% 60%
Alternative Care Acupuncture services only. Naturopaths, Naturopathic services and Massage Therapists are not covered.	95% (inpatient) 100%; $15 copay* (outpatient)	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%; $50 copay * (waived if admitted)
**For Hospital Safety Incentive facilities: Visit www.regence.com/boeing or call 1-800-422-7713		
Ambulance Services	95%	95%
Hearing Aids $600 maximum per ear every 3 consecutive benefit years; network/non-network combined	95%	60%
Home Health and Hospice Home Health limited to 120 visits per benefit year; network/non-network combined	100%	100%
Home Medical Equipment, Prostheses and Orthotics	95%	60%
Spinal and Extremity Manipulations Limited to 26 visits per benefit year; network/non-network combined	100%; $15 copay*	60%

(over)

Benefits	Network	Non-Network
Mental Health* (ValueOptions Network)		
Inpatient	95%	50%; 20 days per benefit year
Outpatient	80%	50%; 20 visits per benefit year
Care must coordinated through the Boeing Helpline (ValueOptions) at 1-800-892-1411.		
Prescription Drugs (Medco)*		
Retail (34 day supply)	90% generic 80% brand-name formulary 70% brand-name non-nonformulary	See network provisions
Mail Order (up to 90 day supply)	$10 copay generic $30 copay brand-name formulary $60 copay brand-name non-nonformulary	n/a
Substance Abuse* (ValueOptions Network)		
Inpatient	95%	50%; limited to $5,000 per course of treatment
Outpatient	95%	50%; limited to $5,000 per course of treatment
2 courses of treatment lifetime maximum; inpatient/outpatient combined		
Care must coordinated through the Boeing Helpline (ValueOptions) at 1-800-892-1411.		
Physical, Occupational and Speech Therapy	95%	60%
Skilled Nursing Facility	100%	100%
Transplants See your Summary Plan Description for specific allowed transplants	See professional and hospital facility benefits	60%
Vision Care* Call Vision Service Plan at 1-800-877-7195		

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

Lifetime Maximum: $1,500,000 per person

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, copays, substance abuse, mental health care and 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 Network or Preferred Provider Organization (PPO) provider. Networks are available in nearly all Boeing locations in the U.S. -- to determine if you are in a network area, call **1-800-810-BLUE (2583)**. If you receive care where no network is available, benefits will be paid at the network level. Visit the Boeing Health and Welfare Plans Web site at **https://my-ext.boeing.com or call 1-866-473-2016 or 1-800-810-BLUE or collect at 1-804-673-1177** for names of Network or 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.

Limitations and Exclusions to Coverage: The noncovered 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.