

BENEFIT SUMMARY
THE BOEING COMPANY
SELECT NETWORK® PLAN



Regence

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

SPEEA

Active and Early Retiree

Effective July 1, 2009 – December 31, 2009

For medically necessary services rendered by a Network or Extended Network provider, the benefits of this plan will be provided at the percentage specified below after the applicable deductible and applicable copays have been met.

This is a brief summary of benefits and exclusions; it is not a certificate of coverage. For full coverage provisions, including a description of limitations and exclusions, refer to the Guide to Benefits 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	Extended Network
Annual Deductible*	\$200 deductible applies only to eligible dependent children living outside the service area.** Copays do not count toward the deductible.	
Annual Out-of-Pocket Maximum	None	None
Alternative Care Naturopaths, Acupuncturists, and Massage Therapists Refer to Guide to Benefits for details	100%; \$10 copay*	Not covered
Ambulance Services	100%	See network provisions
Hearing Aids \$600 maximum limited to one aid per ear every 3 consecutive benefit years; network/non-network combined.	100%	See network provisions
Home Health and Hospice	100%	Not covered
Home Medical Equipment, Protheses and Orthotics	80%	Not covered
Hospital Facility Emergency Room (for true medical emergencies)	100%; \$50 copay* (waived if admitted)	Not covered Non-emergent care is not covered.
Mental Health (ValueOptions Network) Inpatient Outpatient Care must be coordinated through the Boeing Helpline (ValueOptions) at 1 (800) 892-1411.	100%; \$10 copay*	Not covered Not covered
Physical, Occupational and Speech Therapy	100%; \$10 copay*	Not covered
Prescription Drugs* (RegenceRx) Retail (34-day supply) Mail Order (up to 90-day supply) **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.	\$5 copay generic \$15 copay brand-name formulary** \$30 copay non-formulary** \$10 copay generic \$30 copay brand-name formulary** \$60 copay non-formulary**	
Preventive Care Routine exams, immunizations, including flu shots, well child care and routine cancer screenings \$10 copay for routine vision or hearing exam*	100%	Not covered
Professional Services	100%; \$10 copay*	Not covered

Benefits	Network	Extended Network
Outpatient Office Visits		
Skilled Nursing Facility	100%	Not covered
Spinal Manipulations Limited to a combined 26 spinal and extremity manipulation visits per benefit year.	100%; \$10 copay*	Not covered
Substance Abuse (ValueOptions Network) \$10 network outpatient professional copay* Lifetime maximum of 2 courses of treatment Care must be coordinated through the Boeing Helpline (ValueOptions) at 1 (800) 892-1411.	100% Limited to \$7,500 maximum per course of treatment.	Not covered
Transplants	See professional and hospital facility benefits	Refer to Guide to Benefits
Vision Exam One routine eye exam per benefit year.	100%; \$10 copay*	Not covered
Vision Hardware (not subject to deductible) Two pairs of lenses and frames or contacts every two benefit years	Lenses (one pair): Single Vision \$50; Bifocal \$80; Trifocal \$95; Lenticular \$155; Frames \$90 Contacts \$120 (two lenses)	

*Benefits do not apply to the out-of-pocket maximum.

**The dollar amounts reflected are half the normal deductible and OOP amounts due to the six-month benefit period. Effective January 1, 2010, these amounts will reset in full.

Lifetime Maximum:

\$2,000,000 per individual.

Emergency Care:

Emergency room treatment at either a network or extended network facility is paid at the network level if it is a true medical emergency. Care at an extended network facility when the condition is not a true medical emergency will not be covered.

Care Outside the Service Area:

Medical emergencies will be paid at the Select Network Plan level of benefits. If you live inside the service area and are admitted to a hospital while traveling outside the service area, your inpatient care will be covered provided you notify us within 24 hours of admission and move under the care of a Select Network provider when directed by the Company. When you need healthcare outside the United States or its territories, call the BlueCard Worldwide® Service Center at:

1-800-810-BLUE (2583)

or call collect at

1-804-673-1177

Care received by eligible dependent children living outside the service area will be provided at 80% of the allowed

amount after satisfaction of a \$500 annual deductible, subject to all benefit limitations and exclusions.

Limitations and Exclusions to Coverage:

The non-covered services and supplies include, but are not limited to: acupuncture for smoking cessation except as specified; benefits covered by government programs; conditions resulting from military service in the armed forces or any act of war (declared or undeclared); hearing aids, except as specified; myofascial pain syndrome, malocclusions, or other jaw abnormalities, except for temporomandibular joint disorders (TMJ) as specified; investigational services or supplies; surgery (including reversals), treatment, programs or supplies that are intended to result in weight reduction, regardless of diagnosis; occupational injury or disease; over-the counter contraceptive supplies and devices; physical or psychiatric examinations or psychological testing for the purpose of obtaining or continuing employment, licensure, legal proceedings, insurance, school admission, or sports activities, or

which are conducted for purposes of medical research; private duty nursing or hourly nursing charges; services or supplies covered by automobile insurance, personal injury protection insurance, automobile no-fault insurance, homeowner insurance, commercial premises coverage, or similar insurance; services or supplies not medically necessary for illness or injury, except as specified; services or supplies payable under Medicare, when Medicare is primary, if you had properly enrolled when first eligible; surgery or treatment for sexual dysfunction/impotence, except as determined by the Company; transsexualism; treatment for dyslexia, except as specified; certain treatments for infertility, except as specified; visual training; orthoptics and vision hardware, except as specified. This plan does not provide non-network benefits except as specified.