

BENEFIT SUMMARY
THE BOEING COMPANY
SELECTIONS® PLAN

IUOE 286

Active and Early Retiree

Effective July 1 - December 31, 2010



Regence

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

For medically necessary services rendered by a Selections Plan network provider or an 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. All care must be provided or coordinated by your Primary Care Physician for you to qualify for the highest level of benefits.

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 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	Extended Network
Annual Deductible*	None	\$200 per individual
Annual Out-of-Pocket Maximum	None	\$1,000 per individual; \$2,000 per family of 2 or more
Alternative Care Naturopaths, acupuncturists and massage therapists. Acupuncture limited to 12 visits per benefit year; network/extended network combined.	100% after \$10 copay*	60%
Ambulance Services (for true medical emergencies) Ground ambulance maximum of \$2,000 per benefit year; network/extended network combined.	100%	100%
Hearing Aids Limited to one aid per ear every 3 consecutive benefit years up to \$600 maximum; network/extended network combined.	100%	100%
Home Health Limited to 130 visits per benefit year; network/extended network combined.	100%	60%
Home Medical Equipment	80%	80%
Hospital Facility \$10 outpatient copay* applies	100%	60%
Emergency Room (for true medical emergencies)	100%; \$50 copay* (waived if admitted)	100%; \$50 copay* (waived if admitted)
Mental Health (ValueOptions Network)		
Inpatient	100%	60%
Outpatient	100% after \$10 copay*	60%
Care must be coordinated through the Boeing Helpline (ValueOptions) at 1 (800) 892-1411.		
Physician Services Inpatient/Outpatient \$10 outpatient copay* applies	100%	60%
Prescription Drugs (Medco Health Solutions, Inc.)		
Retail (34-day supply)		\$5 copay* generic \$15 copay* brand-name formulary \$30 copay* non-formulary
Mail Order (up to 90-day supply)		\$10 copay* generic \$30 copay* brand-name formulary \$60 copay* non-formulary
To learn more about your prescription program, contact Medco at 1 (800) 841-2797 or visit www.medco.com .		

Benefits	Network	Extended Network
Preventive Care	100%	Not covered
Includes physical exams, immunizations (including flu shots), well child care and routine cancer screenings. \$10 copay* for routine vision or hearing exam		
Spinal and Extremity Manipulations	100% after \$10 copay*	60%
Limited to a combined total of 26 spinal and extremity manipulation visits per benefit year; network/extended network combined.		
Substance Abuse (ValueOptions Network)		
\$10 outpatient copay* applies	100%	60%
Care must be coordinated through the Boeing Helpline (ValueOptions) at 1 (800) 892-1411.		
Therapies	100% after \$10 copay*	60%
Physical, occupational and speech therapy; Outpatient limited to \$1,000 per benefit year; inpatient limited to \$30,000 per condition; network/extended network combined.		
Transplant	See Physician Services and Hospital Facility benefits	Refer to Guide to Benefits
Blue Distinction Centers for Transplant® programs are available. Refer to Guide to Benefits or visit www.regence.com/boeing for details.		
Vision Hardware	Lenses (per pair): Single Vision \$50; Bifocal \$80; Trifocal \$95; Lenticular \$155 Frames: \$70 Contacts: \$105 (two lenses)	
Two pairs of lenses and frames, or contact lenses, every two benefit years		

*Does not apply to the out-of-pocket maximum and/or deductible

Lifetime Maximum:

\$1,500,000 per individual; network/extended network combined.

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 be paid at the extended network level.

Care Outside the Service Area:

All benefits provided outside the service area will be paid at 80% of the allowed amount (except medical emergencies) after your deductible and any applicable copay have been satisfied. Any additional charges will be your responsibility. If you live in the service area and are admitted to a hospital while traveling outside the service area, your inpatient care will be covered at the higher level of benefits, provided you notify us within 24 hours of the admission and move under the care of a network, Preferred Plan, or participating provider when directed by Regence

BlueShield. When you need health care 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

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; hearing aids, except as specified; investigational services or supplies; myofascial pain syndrome, malocclusions, or other jaw abnormalities, except for temporomandibular joint disorders (TMJ) as specified; 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 Regence BlueShield; 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 extended network benefits except as specified.