

BENEFIT SUMMARY
THE BOEING COMPANY
SELECTIONS® PLUS PLAN

SPEEA

Active and Early Retiree

Effective January 1, 2010



Regence

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

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*	None	\$400 per individual
Annual Out-of-Pocket Maximum	None	\$2,000 per individual \$4,000 per family of 2 or more
Alternative Care Outpatient Office Visits Includes 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 \$2,000 per benefit year; per network/extended network combined.	100%	100%
Hearing Aids Limited to one aid per ear every 3 consecutive benefit years up to \$600 maximum; network/non-network combined.	100%	100%
Home Health Home Health limited to 130 visits per benefit year; network/extended network combined.	100%	60%
Home Medical Equipment	80%	60%
Hospital Facility (\$10 outpatient copay)*	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: Outpatient: Care must be coordinated through the Boeing Helpline (ValueOptions) at 1 (800) 892-1411.	100% 100% after \$10 copay*	60% 60%
Physician Services Outpatient Office Visits	100% after \$10 copay*	60%
Prescription Drugs (Medco Health Solutions, Inc.) Retail (34 day supply) Mail Order (up to 90 day supply)	\$5 copay generic \$15 copay brand-name formulary~ \$30 brand-name nonformulary~ \$10 copay generic \$30 copay brand-name formulary~ \$60 copay brand-name non-formulary~	Contact Medco for details of purchasing prescriptions at a non-network pharmacy. n/a

~If the member or physician requests a brand-name drug when a generic equivalent drug is available, the member will pay the generic copay plus the cost of the difference between brand-name and generic drug. 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 Routine exams, immunizations, (including flu shots), well child care and routine cancer screenings \$10 copay for routine vision or hearing exam	100%	Not covered
Spinal and Extremity Manipulations Outpatient Office Visits Limited to a combined total of 26 spinal and extremity manipulation visits per benefit year; network/extended network combined.	100% after \$10 copay*	60%
Substance Abuse (ValueOptions Network) \$10 outpatient copay* Care must be coordinated through the Boeing Helpline (ValueOptions) at 1 (800) 892-1411.	100%	60%
Therapies Outpatient Office Visits Physical, occupational and speech therapy; limited to \$1,000 per benefit year. Inpatient limited to \$30,000 per condition; network/extended network combined.	100% after \$10 copay*	60%
Transplants Blue Distinction Centers for Transplant® programs are available at www.regence.com/boeing. Refer to Guide to Benefits for details.	See physician and hospital facility benefits	Refer to Guide to Benefits
Vision Exam One routine eye exam per benefit year.	100% after \$10 copay*	Not covered
Vision Hardware 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)	

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

Lifetime Maximum:
 \$2,000,000 per individual

call the BlueCard Worldwide® Service Center at:

1 (800) 810-BLUE (2583)
 or call collect at
1 (804) 673-1177

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 non-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,

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; 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 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 non-network benefits except as specified.