

BENEFIT SUMMARY
THE BOEING COMPANY
SELECTIONS® Plus PLAN
 SPFPA Local 255, IBEW Local 271
 Active and Early Retiree
 Effective July 1, 2009



Regence

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

****Mental Health and Substance Abuse Benefit Changes - Effective January 1, 2010.**

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 Naturopaths, acupuncturists, and massage therapists. | 100% after \$10 copay* | 60% |
| Ambulance Services (for true medical emergencies) Ground ambulance maximum of \$2,000 per benefit year. | 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 Inpatient/Outpatient (\$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) **Effective January 1, 2010; Day and visit limitations no longer apply. | | |
| 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 | 100% after \$10 copay* | 60% |
| Prescription Drugs* (RegenceRx) 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 RegenceRx at 1 (800) 322-1737 or visit www.regencerox.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 Manipulations 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) **Effective January 1, 2010: Lifetime maximum and dollar limits no longer apply | | |
| \$10 outpatient copay* | 100% | 60% |
| Care must be coordinated through the Boeing Helpline (ValueOptions) at 1 (800) 892-1411. | | |
| Therapies. Physical, occupational and speech therapy. Outpatient 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. Refer to Summary Plan Description and visit www.regence.com/boeing for details | See Physician Services 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 (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 \$70 Contacts \$105 (two lenses) | |

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

Lifetime Maximum:

\$1,500,000 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 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; 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 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.