

BENEFIT SUMMARY
THE BOEING COMPANY
SELECTIONS® PLUS PLAN
SPEEA



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

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*	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 Refer to Guide to Benefits for details	100%; \$10 copay*	60%
Ambulance Services	100%	See network provisions
Hearing Aids \$600 maximum per ear every 3 consecutive benefit years	100%	See network provisions
Home Health and Hospice	100%	60%
Home Medical Equipment, Protheses and Orthotics	80%	60%
Hospital Facility Emergency Room (for true medical emergencies)	100% 100%; \$50 copay* (waived if admitted)	60% See network provisions
Mental Health (ValueOptions Network) Inpatient: Outpatient: Care must be coordinated through the Boeing Helpline (ValueOptions) at 1 (800) 892-1411.	100% 100%; \$10 copay*	60% 60%
Physical, Occupational and Speech Therapy	100%; \$10 copay*	60%
Prescription Drugs* (RegenceRx) Retail (34-day supply) Mail Order (up to 90-day supply)	\$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

**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 the brand-name and generic drug.

Benefits	Network	Extended Network
Professional Services Outpatient Office Visits	100%; \$10 copay*	60%
Skilled Nursing Facility	100%	60%
Spinal Manipulations Limited to a combined total of 26 spinal and extremity manipulation visits per benefit year; network/extended network combined.	100%; \$10 copay*	60%
Substance Abuse (ValueOptions Network) \$10 network outpatient professional copay* Lifetime maximum of 2 courses of treatment; inpatient/outpatient and network/extended network combined. Care must be coordinated through the Boeing Helpline (ValueOptions) at 1 (800) 892-1411.	100% \$7,500 maximum per course of treatment.	60% \$7,500 maximum per course of treatment.
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.

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, call the BlueCard Worldwide® Service Center at:

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 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.