

## United Airlines 2010 Active Employee Health & Wellness PPO Benefit Summary

Customer Services 1-800-535-9825  
www.bcbsil.com/united

Benefit Features	2010 Health & Wellness Preferred Provider Organization (PPO) Benefits	
	In-network:	Out-of-network:
Annual Deductibles	\$350 single \$700 family	\$1,050 single \$2,100 family
Annual Out-of-Pocket Limits	\$2,250 single \$4,500 family	\$6,750 single \$13,500 family
<b>PRIMARY CARE</b>		
	In-network:	Out-of-network:
Office Visit	\$25 copay PCP \$50 copay Specialist	Covered up to 60%; Subject to reasonable and customary limits
X-Ray and Laboratory (performed in office)	100% after office visit copay	Covered up to 60%; Subject to reasonable and customary limits
<b>PREVENTIVE SERVICES (Refer to Wellness Chart)</b>		
	In-network:	Out-of-network
Annual PAP Smears and PSA Tests for Men Over 50	100% after office visit copay	Covered up to 60%; Subject to reasonable and customary limits
Screenings	100% after office visit copay	Covered up to 60%; Subject to reasonable and customary limits
Immunizations - Adult and Child	100% after office visit copay	Covered up to 60%; Subject to reasonable and customary limits

**EMERGENCY SERVICES**

In-Area (when not followed by admission)	\$100 copay
Out-of-Area (when not followed by admission)	\$100 copay Subject to reasonable and customary limits

**AMBULANCE**

Covered up to 80%

**HOSPITAL CARE/INPATIENT**

	In-network	Out-of-network
Semi-Private Room and Board	In-network: Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits
Intensive Care	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits
Surgery-Noncosmetic	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits
Surgery-Cosmetic	Not Covered	Not Covered
X-Ray and Laboratory	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits
Anesthesia	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits
Prescribed Care in a Skilled Nursing Facility	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits
Physical Therapy	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits
Physician Hospital Visit	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits

**MATERNITY CARE**

	In-network	Out-of-network
Physician's Office: Initial Visit	\$25 copay	Covered up to 60%; Subject to reasonable and customary limits
All subsequent Physician charges for prenatal	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits

visits

In-Hospital: Physician's Services	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits
Newborn Nursery Services	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits
Covers Birthing Centers, Licensed and Certified	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits
Covers Midwives, Licensed and Certified	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits

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**PRESCRIPTION DRUGS** (Medco 1-800-864-1425)

Retail Drugs	\$8 copay for generic \$25 copay for preferred \$50 copay non preferred 30-day supply
Mail Order / Home Delivery Drugs	\$20 copay for generic \$65 copay for preferred \$130 copay non preferred 90-day supply

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**Member Pays the Difference:** When you or your physician choose to have the brand medication when therapeutically equivalent generic is available, you will be responsible for the difference in cost between the brand and generic medications plus your generic copay.

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Viagra	8 pills per month
Annual Rx Maximum	Unlimited

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**HEARING**

Audiometric Exam	Covered up to 80%
Hardware - Hearing Aid	\$5,000 lifetime maximum

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**MENTAL HEALTH SERVICES BY AN ELIGIBLE PROVIDER**

	In-network:	Out-of-network:
Outpatient	\$25 copay	Covered up to 60%; Subject to reasonable

and customary limits

Inpatient/Partial Inpatient	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits
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**SUBSTANCE ABUSE SERVICES BY AN ELIGIBLE PROVIDER**

Outpatient Detoxification	\$25 copay	Covered up to 60%; Subject to reasonable and customary limits
Inpatient Detoxification	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits
Outpatient Rehabilitation	\$25 copay	Covered up to 60%; Subject to reasonable and customary limits
Inpatient Rehabilitation	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits

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**CHIROPRACTIC SERVICES**

*Limited to a combined 30 visits per benefit year*

\$25 copay

Covered up to 60%;  
Subject to reasonable  
and customary limits

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**THERAPY OUTPATIENT SERVICES**

*Limited to combined 60 visits per benefit year for Physical, Occupation, and Speech Therapy*

	In-network:	Out-of-network:
Physical	\$25 copay	Covered up to 60%; Subject to reasonable and customary limits
Occupational	\$25 copay	Covered up to 60%; Subject to reasonable and customary limits
Speech	\$25 copay	Covered up to 60%; Subject to reasonable and customary limits

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**ACUPUNCTURE BY AN ELIGIBLE PROVIDER**

(16 visits per year)

\$25 copay

\$25 copay

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<b>DURABLE MEDICAL EQUIPMENT</b>	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits
	In-network:	Out-of-network:
<b>OUTPATIENT SURGERY</b>	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits
<b>DENTAL</b>		
	In-network:	Out-of-network:
Implants	Covered up to 80% only if no alternative procedure can be performed	Covered up to 60%; Subject to reasonable and customary limits
Surgical Removal of Tumors, Cysts	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits
<b>TRANSPLANTS</b>		
	In-network:	Out-of-network
Heart	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits
Kidney	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits
Liver	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits
Lung	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits
Cornea	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits
Bone Marrow	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits
<b>OTHER COVERED SERVICES</b>		

	In-network:	Out-of-network:
Blood and blood components, private duty nursing, oxygen and its administration; surgical dressings, casts and splints, prosthetic devices.	Covered up to 80%	Covered up to 60%; Subject to reasonable and customary limits

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This summary is only an overview of your medical benefits. Please refer to the Summary Plan Description (SPD) for details, or call the BlueCross BlueShield customer service unit at 1-800-535-9825.

Medical necessity is required. The deductible must be met before services are paid. Precertification within the U.S. for inpatient stay is required; if no precertification, payment is at 50%. This is only an overview of your benefits.

If either you and/or your Dependent are covered under more than one group health care plan the Maintenance of Benefits provision will be applied. This means that the plan works with other group plans including Medicare to provide you with benefits up to the benefit amount provided by the higher plan.