

United Airlines 2010 Active Employee Medical PPO Benefit Summary

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

Benefit Features	2010 Medical Preferred Provider Organization (PPO) Benefits
Annual Deductibles	\$250 single / \$500 family aggregate
Annual Out-of-Pocket Limits	\$1,500 single / \$3,000 family aggregate including deductible

PRIMARY CARE

Office Visit	In-network: Covered up to 80% after deductible Out-of-network: Covered 60%; Subject to reasonable and customary limits
X-Ray and Laboratory	In-network: Covered up to 80% Out-of-network: Covered 60%; Subject to reasonable and customary limits

PREVENTIVE SERVICES

	Refer to Wellness Chart
Annual PAP Smears and Expenses for PSA Tests for Men Over 50	In-network: Covered up to 80% Out-of-network: Covered 60%; Subject to reasonable and customary limits
Screenings	Refer to Wellness Chart
Immunizations - Adult and Child	Refer to Wellness Chart

EMERGENCY SERVICES

In-Area (when not followed by admission)	Covered up to 80%
Out-of-Area (when not followed by admission)	Covered up to 80%; Subject to reasonable and customary limits

AMBULANCE	Covered up to 80%
HOSPITAL CARE/INPATIENT	
Semi-Private Room and Board	In-network: Covered up to 80%
Intensive Care	In-network: Covered up to 80%; Out-of-network: Covered 60%; Subject to reasonable and customary limits
Surgery-Noncosmetic	In-network: Covered up to 80%; Out-of-network: Covered 60%; Subject to reasonable and customary limits
Surgery-Cosmetic	Not Covered
X-Ray and Laboratory	In-network: Covered up to 80%; Out-of-network: Covered 60%; Subject to reasonable and customary limits
Anesthesia	In-network: Covered up to 80%; Out-of-network: Covered 60%; Subject to reasonable and customary limits
Prescribed Care in a Skilled Nursing Facility	Covered up to 80%
Physical Therapy	In-network: Covered up to 80%; Out-of-network: Covered 60%; Subject to reasonable and customary limits
Physician Hospital Visit	In-network: Covered up to 80%; Out-of-network: Covered 60%; Subject to reasonable and customary limits
MATERNITY CARE	
Physician's Office: Pre/Post-Natal Care-Global Billing	In-network: Covered up to 80%; Out-of-network: Covered 60%; Subject to reasonable and customary limits
In-Hospital: Physician's Services	In-network: Covered up to 80%; Out-of-network: Covered 60%; Subject to reasonable and customary limits
Newborn Nursery Services	In-network: Covered up to 80%; Out-of-network: Covered 60%; Subject to reasonable and customary limits
Covers Birthing Centers, Licensed and Certified	In-network: Covered up to 80%; Out-of-network: Covered 60%; Subject to reasonable and customary limits
Covers Midwives, Licensed and Certified	In-network: Covered up to 80%

Out-of-network: Covered 60%;
Subject to reasonable and customary limits

PRESCRIPTION DRUGS

Retail Drugs	Covered up to 80%; limit of 3 fills for maintenance drugs
Mail Order / Home Delivery Drugs	\$22 copay for generic; \$72 copay for brand; 90-day supply; Medco Health 1-800-864-1425
Oral Contraceptives	Covered
Diaphragms	Covered
Viagra	8 pills per month
Annual Rx Maximum	Unlimited

HEARING

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

MENTAL HEALTH SERVICES BY AN ELIGIBLE PROVIDER

Outpatient	In-network: Covered up to 80% Out-of-network: Covered 60%; Subject to reasonable and customary limits
Inpatient	In-network: Covered up to 80% Out-of-network: Covered 60%; Subject to reasonable and customary limits

SUBSTANCE ABUSE SERVICES BY AN ELIGIBLE PROVIDER

Outpatient Detoxification	In-network: Covered up to 80% Out-of-network: Covered 60%; Subject to reasonable and customary limits
Inpatient Detoxification	In-network: Covered up to 80% Out-of-network: Covered 60%; Subject to reasonable and customary limits
Outpatient Rehabilitation	In-network: Covered up to 80% Out-of-network: Covered 60%; Subject to reasonable and customary limits
Inpatient Rehabilitation	In-network: Covered up to 80%

	Out-of-network: Covered 60%; Subject to reasonable and customary limits
CHIROPRACTIC SERVICES	In-network: Covered up to 80%; Maintenance not covered Out-of-network: Covered 60%; Maintenance not covered; Subject to reasonable and customary limits
THERAPY OUTPATIENT SERVICES	
Physical	In-network: Covered up to 80% Out-of-network: Covered 60%; Subject to reasonable and customary limits
Occupational	In-network: Covered up to 80% Out-of-network: Covered 60%; Subject to reasonable and customary limits
Speech	In-network: Covered up to 80% Out-of-network: Covered 60%; Subject to reasonable and customary limits
ACUPUNCTURE BY AN ELIGIBLE PROVIDER	Covered up to 80% up to 15 visits
DURABLE MEDICAL EQUIPMENT	In-network: Covered up to 80% Out-of-network: Covered 60%; Subject to reasonable and customary limits
OUTPATIENT SURGERY	In-network: Covered up to 80% Out-of-network: Covered 60%; Subject to reasonable and customary limits
DENTAL (medically necessary)	
Implants	In-network: Covered up to 80% only if no alternative procedure can be performed Out of network: Covered 60%; Subject to reasonable and customary limits
Surgical Removal of Tumors, Cysts (inpatient/outpatient)	In network: Covered up to 80% Out of network: Covered 60%; Subject to reasonable and customary limits

TRANSPLANTS

Heart	In-network covered up to 80% Out-of-network: Covered 60%; Subject to reasonable and customary limits
Kidney	In-network covered up to 80% Out-of-network: Covered 60%; Subject to reasonable and customary limits
Liver	In-network covered up to 80% Out-of-network: Covered 60%; Subject to reasonable and customary limits
Lung	In-network covered up to 80% Out-of-network: Covered 60%; Subject to reasonable and customary limits
Cornea	In-network covered up to 80% Out-of-network: Covered 60%; Subject to reasonable and customary limits
Bone Marrow	In-network covered up to 80% Out-of-network: Covered 60%; Subject to reasonable and customary limits

OTHER COVERED SERVICES

Blood and blood components, private duty nursing, allergy shots, oxygen and its administration; surgical dressings, casts and splints, durable medical equipment, prosthetic devices.	In-network: Covered up to 80% Out-of-network: Covered 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 both you and/or a Dependent are covered under the Retiree Medical Plan and another group health care plan or Medicare, the Plan includes a provision to coordinate coverage under these Plans. The Plans (including Medicare) work together to provide you with benefits up to the benefit amount provided by the plan with the higher coverage level. If you have coverage under more than one group plan, including Medicare, you must file a claim for all charges with each plan.