

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

Benefit Features	2009 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	
Annual PAP Smears and Expenses for PSA Tests for Men Over 50	Refer to Wellness Chart 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	
Semiprivate 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	\$21 copay for generic; \$67 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

VISION

Routine Exam	Not covered
Hardware-Regular Lenses and Frames	Not covered
Hardware-Contact Lenses	Not covered

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 50%; Subject to reasonable and customary limits
Inpatient	In-network: Covered up to 80% Out-of-network: Covered 60%; 30 days per person per year; 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 50%; Subject to reasonable and customary limits
Inpatient Detoxification	In-network: Covered up to 80% Out-of-network: Covered 60%; 30 days per person per year; Subject to reasonable and customary limits
Outpatient Rehabilitation	In-network: Covered up to 80% Out-of-network: Covered 50%; Subject to reasonable and customary limits
Inpatient Rehabilitation	In-network: Covered up to 80% Out-of-network: Covered 60%; 30 days per person per year; 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

OTHER 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

Implants	Covered up to 80% only if no alternative procedure can be performed
Surgical Removal of Tumors, Cysts	Tumors, cysts-inpatient/outpatient: Covered up to 80%

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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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 UAL benefits. Please refer to your Summary Plan Description for more details on benefits, or call the Customer Full Service Unit. See the telephone number at the top of the page-1-800-535-9825.

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.