

United Airlines 2009 Retiree Pre-Medicare PPO Medical Plan Benefit Summary

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
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Mail Order / Home Delivery Drugs	<p>Retirees after 7/1/2003 unless otherwise noted: \$21 copay for generic \$67 copay for brand 90-day supply Medco Health 1-800-864-1425</p> <p>Non-AMFA Retirees prior to 7/1/2003: \$16 copay for generic \$48 copay for brand 90-day supply Medco Health 1-800-864-1425</p>
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	<p>In-network: Covered up to 80%</p> <p>Out-of-network: Covered 50%; Subject to reasonable and customary limits</p>
Inpatient	<p>In-network: Covered up to 80%</p> <p>Out-of-network: Covered 60%; 30 days per person per year; Subject to reasonable and customary limits</p>

SUBSTANCE ABUSE SERVICES BY AN ELIGIBLE PROVIDER

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

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

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

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 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.