UNITED

2016 – 2021
Flight Attendant Agreement

Association of
Flight Attendants – CWA

APPENDIX A – PLAN DESIGNS FOR REQUIRED MEDICAL OPTIONS

	Core PPO Option		Core EPO Option	Core HDHP		Traditional Medical PPO	
PLAN DESIGN	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductibles	$300 single/ $600 family	$600 single/ $1200 family	$200 single/ $400 family	$2500 single only/ $5000 true family deductible*		$250 single/ $500 family	
HSA Seed Amount (pro-rated per paycheck)	NA		NA	$750 single / $1500 family		NA	
Medical Annual Out-of-Pocket (OOP) Limits	$2000 single/ $4000 family	$4000 single/ $8000 family	$1,500 single/ $3,000 family	$3000 single only $6000 true family maximum* (includes deductible and coinsurance)	$6000 single only $12000 true family maximum* (includes deductible and coinsurance)	$1,500 single/$3,000 family	
Cross Application Out-of-Network Deductibles and OOP to In-Network	Yes		NA	Yes		Single deductible and OOP Limit for In-Network and Out-of-Network	

	Core PPO Option		Core EPO Option	Core HDHP		Traditional Medical PPO	
PLAN DESIGN	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Office Visit PCP	$25 co-pay	Covered at 60% after deductible	$25 co-pay	Covered at 95% after deductible	Covered at 60% after deductible	Covered at 80% after deductible	Covered at 60% after deductible
Office Visit Specialist	$40 co-pay		$40 co-pay				
Preventive Services (comprehensive array; See Appendix C)	100% preventive		100% preventive	100% preventive		100% preventive	
Laboratory, x-ray and diagnostic testing	Covered at 80% after deductible		Included w/office visit	Covered at 95% after deductible	Covered at 60% after deductible	Covered at 80% after deductible	Covered at 60% after deductible
Hospital/ Inpatient			Covered at 90% after deductible				
Outpatient Facilities /Surgical			Covered at 90% after deductible				
Urgent Care Center	$50		$50 co-pay				
Emergency Room	$200 flat co-pay, waived if admitted		$200 co-pay, waived if admitted			Covered at 80% after deductible	

	Core PPO Option		Core EPO Option	Core HDHP		Traditional Medical PPO	
PLAN DESIGN	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drug Out of Pocket Limit (2016 - as adjusted annually per Affordable Care Act limits)	$4,850 single/ $9,700 family		$5,350 single/ $10,700 family	Consolidated with medical out of pocket maximum		Retail: Consolidated with medical out of pocket maximum Mail Order: $5,350 single/ $10,700 family	
Retail Generic Drugs	$10 co-pay Mandatory Mail – Limit 3 retail fills for maintenance drugs		$10 co-pay Mandatory Mail – Limit 3 retail fills for maintenance drugs	Covered at 100% after deductible		Covered at 80% after deductible. Mandatory Mail – Limit 3 retail fills for maintenance drugs	
Retail Brand Preferred Drugs	$30 co-pay Mandatory Mail – Limit 3 retail fills for maintenance drugs- only if less expensive than retail		$30 co-pay Mandatory Mail – Limit 3 retail fills for maintenance drugs- only if less expensive than retail	Covered at 95% after deductible		Covered at 80% after deductible. Mandatory Mail – Limit 3 retail fills for maintenance drugs	
Retail Brand Non-Preferred Drugs	$50 co-pay Mandatory Mail – Limit 3 retail fills for maintenance drugs - only if less expensive than retail		$50 co-pay Mandatory Mail – Limit 3 retail fills for maintenance drugs - only if less expensive than retail	Covered at 95% after deductible			
Retail Drug Supply Limit	30 day supply		30 day supply	30 day supply		30 day supply	

	Core PPO Option		Core EPO Option	Core HDHP		Traditional Medical PPO	
PLAN DESIGN	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Mail Order Generic Drugs	$25 co-pay		$25 co-pay	Covered at 100% after deductible (plan provides coverage for drugs that are allowed to be covered pre-deductible)		$30 co-pay (2016 rate - subject to 7% annual increase)	
Mail Order Brand Preferred Drugs	$75 co-pay		$75 co-pay	Covered at 95% after deductible		$95 co-pay (2016 rate - subject to 7% annual increase)	
Mail Order Brand Non-preferred	$125 co-pay		$125 co-pay	Covered at 95% after deductible			
Mail Order Drug Supply Limit	90 day supply		90 day supply	90 day supply		90 day supply	

APPENDIX B – PLAN DESIGN FOR CORE DENTAL PLAN

Benefit Features	Core PPO Dental Benefits	
	In-network:	Out-of-network:
Annual Deductibles		
Individual	$50	$50
Family (2 members of family must each satisfy individual deductible)	$100	$100
Annual Benefit Maximum	$2,000	$2,000
Orthodontics Lifetime Maximum	$2,000	$2,000
Office Visit Copay	$0	$0
PREVENTIVE SERVICES and DIAGNOSTIC SERVICES		
Dental cleaning, Topical Application of Fluoride, Sealants and Space Maintainers	100% Covered frequency may apply to these services	100% Covered frequency may apply to these services
MINOR RESTORATIVE SERVICES		
Fillings, Endodontics, Periodontics, Oral Surgery	Covered up to 80%; after deductible	Covered up to 80%; after deductible; Subject to reasonable and customary limits

Benefit Features	Core PPO Dental Benefits	
	In-network:	Out-of-network:
MAJOR RESTORATIVE AND PROSTHODONTICS		
Initial placement of Dentures or Bridges to one or more natural teeth which are lost while covered by the Plan. Inlays and Crowns (Porcelain or Stainless Steel)	Covered up to 50%; after deductible; frequency may apply to these services	Covered up to 50% after deductible; Subject to reasonable and customary limits; frequency may apply to these services
ORTHODONTICS		
Exams, X-Rays, Models, Appliances (Adult and Child)	Covered up to 50%; after deductible; frequency may apply to these services	Covered up to 50% after deductible; Subject to reasonable and customary limits; frequency may apply to these services

APPENDIX C – PREVENTIVE SERVICES

Preventive Exams and Screenings – Adult Male

Physical Exam	100% annually
Prostate-Specific Antigen (PSA)	100% annually
Lipid Panel	100% annually
Glucose Testing	100% annually
Colorectal Screening	100% annually
Complete Blood Count (CBC)	100% annually

Immunizations – Adult Male

Tetanus Injections (with or without diphtheria)	100% as often as recommended by physician
Meningitis	100%
Herpes Zoster	100%
Influenza Vaccine	100% annually
Pneumococcal Vaccine	100%
Travel Vaccinations	100% as often as recommended by physician
Measles, Mumps, Rubella (MMR) for Adults	100%

Preventive Exams and Screenings – Adult Female

Physical Exams	100%, one general and one well-woman exam annually
Lipid Panel	100% annually
Glucose Testing	100% annually
Colorectal Screening	100% annually
Chlamydia Infection Screening	100% annually
Mammogram	100% annually
Bone Density	100% annually
Pap Test	100% annually
Complete Blood Count (CBC)	100% annually

Immunizations – Adult Female

Tetanus Injections (with or without diphtheria)	100% as often as recommended by physician
Meningitis	100%
Herpes Zoster	100%
Influenza Vaccine	100% annually
Human Papillomavirus (HPV)	100%

Pneumococcal Vaccine	100%
Travel Vaccinations	100% as often as recommended by physician
Measles, Mumps, Rubella (MMR) for Adults	100%

Preventive Exams and Screenings – Children Birth to 18 (Covered as Well-Child Care)

Office Visits; Examinations Includes: • Physical and medical history • Height and weight • Head circumference (<1 year) • Ocular prophylaxis (at birth) • Hemoglobin (<1 year) • Preventive health counseling, injury prevention and education • Dental health • Subjective assessment of vision and hearing 0–4 years) • Vision and hearing screen • (4–18 years) • Developmental screening • (up to 4 years) • Blood pressure (>1 year) • Administration of immunizations as indicated below	100%, as often as recommended by physician up to age 2, annually as of age 2

Immunizations – Children Birth to 18 (Covered as Well-Child Care)

Hepatitis B Series	100%, as often as recommended by physician
Hepatitis A Series	100%, as often as recommended by physician
Diptheria/Tetanus/Pertussis (DTaP)	100%, as often as recommended by physician
Adult Tetanus/Diphtheria (Td)	100%, as often as recommended by physician
Haemophilus Influenza (Hib) Series	100%, as often as recommended by physician
Influenza Vaccine	100%, as often as recommended by physician
Rotavirus	100%, as often as recommended by physician
Polio Series (IPV)	100%, as often as recommended by physician

Pneumococcal Conjugate (PCV)	100%, as often as recommended by physician
Measles/Mumps/Rubella (MMR)	100%, as often as recommended by physician
Chickenpox Vaccine (VZV)	100%, as often as recommended by physician
Human Papillomavirus (HPV)	100%
Travel Vaccinations	100% as often as recommended by physician