VEBA UNITED HEALTH CARE PLANS

Plan Features	VEBA PHMO Network 1	VEBA PHMO Network 2	VEBA PHMO Network 3	VEBA UHC HMO SVA (SignatureValue Advantage)	VEBA UHC PPO Select Plus (In Network)	VEBA UHC PPO Select Plus (Out of Network)
Calendar Year Deductible						
Individual	None	None	None	$500	$500	
Family				$1,500	$1,000	
Calendar Year Co-Pay Max (excluding Prescription Drug)						
Individual	$3,000	$3,000	$3,000	$3,000	$2,000	$4,000
Family	$6,000	$6,000	$6,000	$6,000	$4,000	$8,000
Hospital						
Inpatient Copay (per admission)	No charge	No charge	$250 copay	$500 copay	20% after deductible	50% after deductible
Outpatient Facility / Surgery Services	No charge	No charge	No charge	$100 copay	20% after deductible	50% after deductible
Emergency Services						
Emergency Room	$100 copay	$100 copay	$200 copay	$100 copay	$100 copay	
Ambulance	No charge	No charge	No charge	No charge	20% after deductible	
Physician Services (Includes Mental Health and Substance Abuse)						
Office Visits - Primary	$10 copay	$20 copay	$35 copay	$20 copay	$20 copay	50% after deductible
Office Visits - Specialist	$10 copay	$20 copay	$35 copay	$30 copay	$20 copay	50% after deductible
Urgent Care Visits (Part of Medical Group)	$10 copay	$20 copay	$35 copay	$20 copay	$50 copay	50% after deductible
Urgent Care Visits (Out of service area)	$50 copay	$50 copay	$50 copay	$50 copay	N/A	
Diagnostic X-Ray/Lab						
Lab and X-Ray	No charge	No charge	No charge	No charge	No charge	50% after deductible
Advanced Imaging (CT, MRI, PET)	No charge	No charge	No charge	$200 copay	20% after deductible	50% after deductible
Prescription Drugs						
***Retail Pharmacy ($5 extra pharmacy co-pay when filled at a non Express Advantage Network Pharmacy)**						
Generic	$15 copay*	$15 copay*	$15 copay*	$20 copay*	$15 copay	
Brand - Formulary	$30 copay*	$30 copay*	$30 copay*	$35 copay*	$30 copay	
Non-Formulary	50%	50%	50%	50%	50% * no out of network Rx	
Mail Order Pharmacy (90 day supply)						
Generic	$30 copay	$30 copay	$30 copay	$40 copay	$30 copay	
Brand - Formulary	$60 copay	$60 copay	$60 copay	$70 copay	$60 copay	
Non-Formulary	50%	50%	50%	50%	50% copay	
Durable Medical Equipment						
DME	No charge	No charge	No charge	No charge	20% after deductible	50% after deductible
Infertility Testing/Treatment						
Infertility Services	Not covered	Not covered	Not covered	Not covered	Not covered	
Chiropractic *No Acupuncture on HMO Plans*					$20 copay per visit (24 visits per year)	50% coinsurance after deductible is met
Office Visit	$10 copay	$20 copay	$30 copay	$30 copay		
# of visits per year (max)	Unlimited	Unlimited	Unlimited	Unlimited		
Tenthly rates: Deductions : Jan.—Dec 2018						
Single:	**$705.00**	**$775.00**	**$809.00**	**$591.00**	**$1,062.00**	
Employee + Spouse	**$1,419.00**	**$1,563.00**	**$1,632.00**	**$1,187.00**	**$2,14100**	
Employee + Child(ren)	**$1,341.00**	**$1,476.00**	**$1,541.00**	**$1,121.00**	**$1,977.00**	
Family	**$2,030.00**	**$2,236.00**	**$2,335.00**	**$1,696.00**	**$3,066.00**	

VEBA KAISER PERMANENTE PLANS

Plan Features	VEBA Kaiser Standard $20	VEBA Kaiser Standard $30
Calendar Year Deductible		
Individual	None	None
Family		
Calendar Year Co-Pay Max (excluding Prescription Drug)		
Individual	$1,500	$1,500
Family	$3,000	$3,000
Hospital		
Inpatient Copay (per admission)	No charge	No charge
Outpatient Facility / Surgery Services	$20 copay	$30 copay
Emergency Services		
Emergency Room	$50 copay	$100 copay
Ambulance	No charge	$150 copay
Physician Services (Includes Mental Health and Substance Abuse)		
Office Visits - Primary & Specialist	$20 copay	$30 copay
Urgent Care	$20 copay	$30 copay
Diagnostic X-Ray/Lab		
Lab and X-Ray	No charge	No charge
Prescription Drugs Retail Pharmacy		
Generic	$15-30 day $30-60 day $45-100 day	$15-30 day $30-60 day $45-100 day
Brand - Formulary	$30-30 day $60-60day $90-100 day	$30-30 day $60-60 day $90-100 day
Mail Order Pharmacy		
Generic	$15-30 day $30-100 day	$15-30 day $30-100 day
Brand - Formulary	$30-30 day $60-100 day	$30-30 day $60-100 day
Durable Medical Equipment		
DME	No charge	20%
Infertility Testing/Treatment		
Infertility Services	$20 copay	50%
Chiropractic *No Acupuncture*		
Office Visit	$20 copay	$30 copay
# of visits per year (max)	Unlimited	Unlimited
Tenthly rates: Deductions Jan – Dec 18		
Single:	**$699.60**	**$681.60**
Employee + Spouse	**$1,476.00**	**$1,441.20**
Employee + Child(ren)	**$1,347.60**	**$1,323.60**
Family	**$1,893.60**	**$1,849.20**

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