CEBT
MEDICAL BENEFITS COMPARISON
(EFFECTIVE JULY 1, 2018)

MEDICAL BASE PLAN	PREFERRED PROVIDER ORGANIZATION (PPO)* OPTION 4	PREFERRED PROVIDER ORGANIZATION (PPO)* OPTION 5	PREFERRED PROVIDER ORGANIZATION (PPO)* OPTION 6
Office Visits	PPO $40 co-pay Non PPO subject to deductible then 60/40	PPO $45 co-pay Non PPO Subject to deductible then 60/40	PPO $50 co-pay Non PPO subject to deductible then 60/40
Lab Charges	PPO $40 co-pay Non PPO subject to deductible then 60/40	PPO $45 co-pay Non PPO Subject to deductible then 60/40	PPO $50 co-pay Non PPO subject to deductible then 60/40
Prescription Drugs Retail - for 30 day supply:	Generic $20 Preferred Brand $40 Non-Preferred Brand $60	Generic $20 Preferred Brand $40 Non-Preferred Brand $60	Generic $20 Preferred Brand $40 Non-Preferred Brand $60
Mail Order - for 90 day supply:	$40 / $80 / $120	$40 / $80 / $120	$40 / $80 / $120
Deductible	$1,500 single $4,500 family	$2,500 single $7,500 family	$3,000 single $9,000 family
Co-insurance	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then PPO 80/20, Non PPO 60/40
Maximum out of Pocket	PPO $4,000 ($8,000 family) Non PPO $8,000 ($16,000 family)	PPO $4,500 ($9,000 family) Non PPO $9,000 ($18,000 family)	PPO $5,000 ($10,000 family) Non PPO $10,000 ($20,000 family)
Hospital Charges	Subject to deductible then PPO 80/20, Non PPO 60/40 Precertification is required for inpatient stays, and for surgeries, whether inpatient or outpatient	Subject to deductible then PPO 80/20, Non PPO 60/40 Precertification is required for inpatient stays, and for surgeries, whether inpatient or outpatient	Subject to deductible then PPO 80/20, Non PPO 60/40 Precertification is required for inpatient stays, and for surgeries, whether inpatient or outpatient
Emergency Care	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then PPO 80/20, Non PPO 60/40
Ambulance	Subject to deductible then PPO 80/20 of "reasonable & customary"	Subject to deductible then PPO 80/20 of "reasonable & customary"	Subject to deductible then PPO 80/20 of "reasonable & customary"

MEDICAL BASE PLAN	PREFERRED PROVIDER ORGANIZATION (PPO)* OPTION 4	PREFERRED PROVIDER ORGANIZATION (PPO)* OPTION 5	PREFERRED PROVIDER ORGANIZATION (PPO)* OPTION 6
Out Patient Surgery	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then PPO 80/20, Non PPO 60/40
Maternity / Prenatal Care	PPO $40 co-pay (applies to the first prenatal care visit) Non PPO subject to deductible then 60/40	PPO $45 co-pay (applies to the first prenatal care visit) Non PPO subject to deductible then 60/40	PPO $50 co-pay (applies to the first prenatal care visit) Non PPO subject to deductible then 60/40
X-Ray Charges	PPO $40 co-pay then 100% in office setting, outpatient subject to deductible 80/20, Non PPO subject to deductible 60/40	PPO $45 co-pay then 100% in office setting, outpatient subject to deductible 80/20, Non PPO subject to deductible 60/40	PPO $50 co-pay then 100% in office setting, outpatient subject to deductible 80/20, Non PPO subject to deductible 60/40
MRI or CT Scan with or without Contrast	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then PPO 80/20, Non PPO 60/40
Pet Scans and SPECT Scans	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then PPO 80/20, Non PPO 60/40
Durable Medical Equipment	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then PPO 80/20, Non PPO 60/40
Physical, Occupational and Speech Therapy	PPO $40 co-pay Non PPO subject to deductible then 60/40; pre-authorization required, 20 visit limit per injury or sickness	PPO $45 co-pay Non PPO Subject to deductible then 60/40; pre-authorization required, 20 visit limit per injury or sickness	PPO $50 co-pay Non PPO subject to deductible then 60/40; pre-authorization required, 20 visit limit per injury or sickness
Chiropractor	PPO/Non PPO $40 co-pay; benefits subject "reasonable & customary" guidelines, 20 visit limit per year	PPO / Non PPO $45 co-pay; benefits subject to "reasonable & customary" guidelines, 20 visit limit per year	PPO/Non PPO $50 co-pay; benefits subject to "reasonable & customary" guidelines, 20 visit limit per year

*Ambulance, chiropractic and out of network charges are all subject to reasonable and customary guidelines (R&C)

ROUTINE SERVICES – will be processed following the Federal Patient Protection and Affordable Care Act.

The Summary of Benefits and Coverage (SBC) is posted on the www.cebt.org website.

PPO NOTE: Combination of PPO and Non PPO out of pocket limit will never exceed the Non PPO out of pocket limit.

This comparison of coverages is intended only as a general description for the principle features of the benefit plans. Please refer to the plan document for details.

02/01/2018

CEBT'S HOSPITAL REIMBURSEMENT PLAN

PURPOSE

For CEBT Employer groups who would like to allow employees the option to choose other coverage as their primary health plan (i.e. spouse's medical plan) CEBT offers a Hospital Reimbursement Plan (HRP). This plan design allows employees to file claims under the other plan as primary and CEBT's HRP plan would be considered secondary coverage.

PLAN DESIGN

All eligibility, exclusions and conditions of CEBT's other plans would apply. The Schedule of Benefits states:

> "The plan will pay up to $1,000 per day for otherwise un-reimbursed eligible medical expenses for hospital confinement. This may include expenses for visits to the plan participant from a provider when confined.
>
> The reimbursement will be paid directly to the plan participant. There is a $30,000 maximum hospital benefit per plan year."

CEBT
PLAN C DENTAL BENEFITS
(EFFECTIVE JULY 1, 2018)

EXPENSES: Eligible Dental Expenses are the reasonable, necessary and customary charges: If the provider charges above the reasonable, necessary and customary guidelines (R&C), the member may be responsible for the difference.

TYPE I Preventive Services: Routine exams & cleaning are covered 2 times per calendar year; bitewing x-rays, 4 slides per year, performed on the same date. Full mouth x-rays are eligible once every 36 months.

Deductible	Waived
Coinsurance	100% of R&C

TYPE II Basic Services: Emergency treatment, simple extractions, anesthesia and restorative fillings, oral surgery, endodontics, periodontics, root canal.

Deductible	$50 Single / $150 Family
Coinsurance	80% of R&C

TYPE III Major Services: Crowns, dentures, bridges, prosthetic repairs, implants and other prosthetic devices.

Deductible	Combined with Basic
Coinsurance	50% of R&C

ANNUAL MAXIMUM Types I, II, III $1,500

If moving from CEBT Dental Plan A you may not be eligible for the full annual benefit under the Dental Plans B or C.

EXCLUSIONS – Expenses incurred for any procedure which began before the individual became covered: Prosthetic devices to replace teeth missing (congenitally or otherwise, except if a cleft palate or cleft lip condition), lost or extracted before the member's effective date of coverage.

CEBT DENTAL PLAN BENEFITS:

1. Employee and dependents can go to any dentist of their choice.
2. An employee may only enroll or drop coverage during open enrollment period. If an employee drops coverage, he or she must wait at least 2 open enrollment periods to re-enroll.
3. A dependent may drop coverage at any time, but must wait at least 2 open enrollment periods to re-enroll.
4. An employer must have at least 25% of the eligible employees enrolled in the plan in order to have the coverage offered.

Minimum participation requirements apply. This is a brief description of the program. Certain covered services are subject to other limitations described in the policy. Final interpretation and complete listing and description of any and all benefits, limitations and exclusions are found in, and are governed by, the Master Policy issued to CEBT and the Participation Agreement. Read the Certificate of Coverage carefully. This is only intended to highlight some of the pertinent provisions of the Group Plan; such Plan will control in all instances. 02/1/2018

CEBT
PLAN B VISION SERVICE PLAN (VSP)
(EFFECTIVE JULY 1, 2018)

	12/12/24	
MEMBER DOCTOR BENEFITS	UP TO	
Exam Co-pay	$ 15.00	Once every 12 months
Material Co-pay	$ 15.00	Once every 12 months
Corrective Contact Lenses Allowance	**$160.00**	Once every 12 months
Frame Allowance (retail)	**$160.00**	Once every 24 months

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for 12 months.

NON-MEMBER DOCTOR BENEFITS	
Exam	$ 35.00
Single Lens	$ 25.00
Bifocal Lens	$ 40.00
Trifocal Lens	$ 55.00
Elective Contact Lenses	$120.00
Frame	$ 45.00

****Bold items are effective July 1, 2018**

ASSUMPTIONS

1. An employee or dependent may only enroll or drop coverage during the next open enrollment period.

2. An employer must have at least 25% of the eligible employees enrolled in the plan in order to have the coverage offered.

ENROLLMENT RESTRICTIONS – If any employee or dependent drops coverage, he or she must wait at least 2 open enrollment periods to enroll or re-enroll.

This summary of benefits is a matter of information only. In all cases the plan document will determine the benefits. 02/01/2018