CEBT
MEDICAL BENEFITS COMPARISON
(EFFECTIVE JULY 1, 2015)

MEDICAL BASE PLAN	PREFERRED PROVIDER ORGANIZATION (PPO)* OPTION 3	PREFERRED PROVIDER ORGANIZATION (PPO)* OPTION 4	KP-DHMO 1500
Office Visits	PPO $35 co-pay Non PPO subject to deductible then 60/40	PPO $40 co-pay Non PPO subject to deductible then 60/40	$40 co-pay
Lab Charges	PPO $35 co-pay Non PPO subject to deductible then 60/40	PPO $40 co-pay Non PPO subject to deductible then 60/40	$0 co-pay
Prescription Drugs	Retail - for 30 day supply: Generic $20 Preferred Brand $40 Non-Preferred Brand $60	Retail - for 30 day supply: Generic $20 Preferred Brand $40 Non-Preferred Brand $60	Retail - for 30 day supply: Generic $20 Preferred Brand $40 Non-Preferred Brand $60 Specialty Drugs 20% coinsurance up to a maximum of $250 per drug fill.
	Mail Order - for 90 day supply: $40 / $80 / $120	Mail Order - for 90 day supply: $40 / $80 / $120	Mail Order - for 90 day supply: $40 / $80 / $120
Deductible	$1,000 (max of 3 per family)	$1,500 (max of 3 per family)	$1,500 Individual $4,500 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	80/20
Maximum out of Pocket	PPO $3,750 ($7,500 family) Non PPO $7,500 ($15,000 family)	PPO $4,000 ($8,000 family) Non PPO $8,000 ($16,000 family)	$4,000 single $8,000 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 80/20 coinsurance
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 80/20 coinsurance

MEDICAL BASE PLAN	PREFERRED PROVIDER ORGANIZATION (PPO)* OPTION 3	PREFERRED PROVIDER ORGANIZATION (PPO)* OPTION 4	KP-DHMO 1500
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 80/20 coinsurance
Maternity / Prenatal Care	PPO $35 co-pay (applies to the first prenatal care visit); Non PPO subject to deductible then 60/40	PPO $40 co-pay (applies to the first prenatal care visit); Non PPO subject to deductible then 60/40	$0 co-pay
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 80/20 coinsurance
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 80/20 coinsurance
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 80/20 coinsurance
Physical, Occupational and Speech Therapy	PPO $35 co-pay; Non PPO subject to deductible then 60/40; **pre-authorization required, 20 visit limit per sickness or injury**	PPO $40 co-pay; Non PPO subject to deductible then 60/40; **pre-authorization required, 20 visit limit per sickness or injury**	$40 co-pay per visit
Chiropractor	PPO/Non PPO $35 co-pay $1,000 annual benefit; benefits subject "reasonable & customary" guidelines	PPO/Non PPO $40 co-pay $1,000 annual benefit; benefits subject "reasonable & customary" guidelines	$40 co-pay, 20 visit limit

Bold items are effective July 1, 2015

*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.

HMO NOTE: The member must use a contracted Kaiser Permanente provider for all care. Out of network providers are only covered if the charges are for emergency treatment. If this is not done, there is no guarantee that the charges will be covered.

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.

01/26/2015

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 benefit per calendar year."

FUNDING

The employer would need to submit a premium deposit of $275.00 per month to CEBT for anyone electing this plan.

01/26/2015

CEBT
PLAN B DENTAL BENEFITS
(FORMERLY VOLUNTARY WITH ORTHODONTICS)
(EFFECTIVE JULY 1, 2015)

ELIGIBLE EXPENSES: Eligible Dental Expenses are the reasonable, necessary and customary charges: If the provider charges above the reasonable, necessary and customary guidelines, 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, space maintainers, 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	$1,500

TYPE IV* Orthodontia Services: Eligible dependent children to age 19. Treatment must be completed prior to age 19.

Coinsurance	50% of R&C
Maximum Lifetime Benefit	$1,500

If moving from a CEBT dental plan, (Plan A) you may not be eligible for the full annual benefit under the dental plans (Plans B or C.)

R&C – Charges that are considered to be above the Reasonable & Customary (R&C) guidelines could be the responsibility of the member.

CEBT PLAN B DENTAL BENEFITS:

1. Employee and dependents can go to any dentist of their choice
2. An employee or dependent may only enroll or drop coverage during the next open enrollment period.
3. An employer must have at least 25% of the eligible employees enroll in the plan in order to have the coverage offered.

LATE ENTRY RESTRICTIONS – If any employee or dependent drops coverage, he or she must wait at least 24 months to enroll or re-enroll, and then may only enroll during open enrollment.

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. 01/26/2015

CEBT
PLAN C VISION SERVICE PLAN (VSP)
(EFFECTIVE JULY 1, 2015)

	12/12/12 UP TO	
MEMBER DOCTOR BENEFITS		
Exam Co-pay	$ 10.00	Once every 12 months
Material Co-pay	$ 10.00	Once every 12 months
Corrective Contact Lenses Allowance	$ 150.00	Once every 12 months
Frame Allowance (retail)	$ 150.00	Once every 12 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

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.

LATE ENTRY RESTRICTIONS – If any employee or dependent drops coverage, he or she must wait at least 24 months to enroll or re-enroll, and then may only enroll during open enrollment.

This summary of benefits is a matter of information only. In all cases the plan document will determine the benefits. 1/26/2015