CEBT
MEDICAL BENEFITS COMPARISON
(EFFECTIVE JULY 1, 2018)

Medical Base Plan	PREFERRED PROVIDER ORGANIZATION (PPO)* OPTION 6	KP-DHMO 1500
Office Visits	PPO $50 co-pay Non PPO Subject to deductible then 60/40	$40 co-pay
OB/GYN	PPO $50 co-pay Non PPO Subject to deductible then 60/40	$40 co-pay
Specialty Care	PPO $50 co-pay Non PPO Subject to deductible then 60/40	$40 co-pay
Lab Charges	PPO $50 co-pay Non PPO Subject to deductible then 60/40	$0 co-pay
X-ray Charges	PPO $50 co-pay then 100% in office setting, outpatient subject to deductible 80/20, Non PPO subject to deductible 60/40	Subject to deductible then 80/20 coinsurance
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 Specialty Drugs 20% coinsurance up to a maximum of $250 per drug fill.
Mail Order for 90 day supply	$40 / $80 / $120	$40 / $80 / $120
Deductible	$3,000 individual $9,000 family	$1,500 individual $4,500 family
Coinsurance	Subject to deductible then PPO 80/20, Non PPO 60/40	80/20
Maximum Out of Pocket	PPO $5,000 ($10,000 family) Non PPO $10,000 ($20,000 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 80/20 coinsurance
Emergency Care	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then 80/20 coinsurance
Ambulance	Subject to deductible then PPO 80/20 of “reasonable & customary”	80/20 coinsurance, not subject to the deductible or maximum out of pocket

Medical Base Plan	PREFERRED PROVIDER ORGANIZATION (PPO)* OPTION 6	KP-DHMO 1500
Outpatient Surgery	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then 80/20 coinsurance
Maternity / Prenatal Care	PPO $50 co-pay (applies to the first prenatal care visit) Non PPO subject to deductible then 60/40	$0 co-pay
Physical, Occupational and Speech Therapy	PPO $50 co-pay, Non PPO Subject to deductible then, 60/40; pre-authorization required, 20 visit limit per injury or sickness	$40 co-pay per visit up to 20 visits per year for each type of therapy
CT Scans, MRIs	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then 80/20 coinsurance
MRI CT Scan with Contrast	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 80/20 coinsurance
Durable medical Equipment	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then 80/20 coinsurance
Chiropractor	PPO / Non PPO $50 co-pay benefits subject to "reasonable & customary" guidelines, 20 visits limit per year	$40 co-pay, 20 visit limit

*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. 02/01/2018

CEBT

PLAN A 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 Dental Treatment: 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 $1,750

TYPE IV Orthodontics: (coverage for dependent children only, completed by age 19)

Coinsurance	50% of R&C
Maximum Lifetime Benefit	$2,000

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