CEBT
MEDICAL BENEFITS COMPARISON
(EFFECTIVE JANUARY 1, 2020)

MEDICAL BASE PLAN	PREFERRED PROVIDER ORGANIZATION (PPO)* OPTION 2	PREFERRED PROVIDER ORGANIZATION (PPO)* OPTION 4	EXCLUSIVE PROVIDER ORGANIZATION (EPO) OPTION 4
Office Visits	PPO $30 co-pay; Non PPO subject to deductible then 60/40	PPO $40 co-pay; Non PPO subject to deductible then 60/40	$45 co-pay
Lab Charges	PPO $30 co-pay; Non PPO subject to deductible then 60/40	PPO $40 co-pay; Non PPO subject to deductible then 60/40	$45 co-pay
X-Ray Charges	PPO $30 co-pay then 100% in office setting, outpatient subject to deductible 80/20, Non PPO subject to deductible 60/40	PPO $40 co-pay then 100% in office setting, outpatient subject to deductible 80/20, Non PPO subject to deductible 60/40	$50 co-pay
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	$600 individual $1,800 family	$1,500 individual $4,500 family	Co-pay where indicated
Co-insurance	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then PPO 80/20, Non PPO 60/40	$0
Maximum out of Pocket	PPO $3,500 ($7,000 family) Non PPO $7,000 ($14,000 family)	PPO $4,000 ($8,000 family) Non PPO $8,000 ($16,000 family)	$5,500 single $11,000 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	$1,500 co-pay per admission, Precertification is required for inpatient stays, and for surgeries whether inpatient or outpatient
Emergency Care	Subject to deductible then PPO 80/20	Subject to deductible then PPO 80/20	$50 co-pay / urgent care; $250 co-pay / emergency care (waived if admitted)
Urgent Care Services	**PPO $50 co-pay; Non PPO subject to deductible then 60/40**	**PPO $50 co-pay; Non PPO subject to deductible then 60/40**	$50 co-pay

Medical Base Plan	Preferred Provider Organization (PPO)* Option 2	Preferred Provider Organization (PPO)* Option 4	Exclusive Provider Organization (EPO) Option 4
Ambulance	Subject to deductible then PPO 80/20 of "reasonable & customary"	Subject to deductible then PPO 80/20 of "reasonable & customary"	$250 co-pay per trip
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	$1,000 co-pay per procedure
Maternity / Prenatal Care	PPO $30 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	$45 co-pay (applies to the first prenatal care visit)
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	$750 co-pay per test
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	$750 co-pay per test
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	100% benefit
Physical, Occupational and Speech Therapy	PPO $30 co-pay; Non PPO subject to deductible then 60/40; pre-authorization required, 20 visit limit per injury or sickness	PPO $40 co-pay; Non PPO subject to deductible then 60/40; pre-authorization required, 20 visit limit per injury or sickness	$45 co-pay per visit; pre-authorization required, 20 visit limit per injury or sickness
Chiropractor	PPO/Non PPO $30 co-pay, benefits subject "reasonable & customary", 20 visit limit per year	PPO/Non PPO $40 co-pay, benefits subject "reasonable & customary", 20 visit limit per year	$45 co-pay, benefits subject to "Reasonable & Customary" guidelines, 20 visits limit per year

****Bold items are effective July 1, 2019**

*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.

EPO Note: The member must use a contracted 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. 08/01/2019

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."

08/2019

DELTA DENTAL

CEBT BENEFIT BY TRUST

DELTA DENTAL PPO PLUS PREMIER
CEBT – PLAN B

(EFFECTIVE JANUARY 1, 2020)

MAXIMUM BENEFIT **Calendar Year Maximum**	$1,500 per member, per calendar year
CALENDAR YEAR DEDUCTIBLE **Applies to Basic and Major Services**	Individual Deductible – $50.00 Combination of in and out-of-network Family Deductible – $150.00 Combination of in and out-of-network
PREVENTION FIRST PPO and Premier Networks Only	Diagnostic and Preventive services do not count against the annual maximum when you see a PPO or Premier provider for all services.
RIGHT START 4 KIDS **PPO and Premier Networks Only**	Covers children up to their 13th birthday at 100% with no deductible (for the same services outlined in the plan, up to the annual maximum, and subject to limitations and exclusions). The child must see a Delta Dental PPO or Premier provider to receive the 100% coinsurance. If an out-of-network provider is seen, the adult coinsurance levels will apply. Orthodontics, if selected as part of the group's plan, is not covered at 100% but at the plan's listed coinsurance.

PPO Dentist	PREMIER Dentist	NONPAR Dentist	COVERED SERVICES	BENEFIT INFORMATION (subject to Delta Dental guidelines)
DIAGNOSTIC AND PREVENTIVE SERVICES				
100%	100%	100%	Oral Exams and Cleanings	Twice each in a calendar year. Two additional cleanings may be covered for those with a documented Evidence Based Dentistry (EBD) condition.
			Sealants	Once per tooth in a 36-month period for unrestored permanent molars, through age 15
			Bitewing X-Rays	Once in a calendar year
			Full Mouth X-Rays	Once in a 5-year period
			Fluoride	Twice in a calendar year, through age 15
			Space Maintainers	One per quadrant, per lifetime to maintain space for eruption of permanent posterior teeth, through age 13
BASIC SERVICES (including occlusal guards)				
80%	80%	80%	Fillings	Once per tooth in a 12-month period; composite (white) fillings
			Simple Extractions	
			Oral Surgery	
			Endodontics / Periodontics	
MAJOR SERVICES				
50%	50%	50%	Crowns	Once per tooth in 5-year period. Not a benefit under age 12.
			Implants	Once per tooth in a 5-year period. Not a benefit under age 16.
			Dentures, Bridges	Once in a 5-year period, only when existing prosthesis cannot be made serviceable. Fixed bridges or removable partials are not a benefit under age 16.
ORTHODONTICS $1,500 lifetime maximum				
50%	50%	50%	For covered children to age 19	

You are enrolled in a Delta Dental PPO plus Premier plan. You and your family members may visit any licensed dentist, but will enjoy the greatest out-of-pocket savings if you see a Delta Dental PPO dentist. There are three levels of dentists to choose from.

PPO Dentist - Payment is based on the PPO dentist's allowable fee, or the actual fee charged, whichever is less.
Premier Dentist - Payment is based on the Premier Maximum Plan Allowance (MPA), or the fee actually charged, whichever is less.
Non-Participating Dentist – Payment is based on the non-participating Maximum Plan Allowance. Members are responsible for the difference between the non-participating MPA and the full fee charged by the dentist. You will receive the best benefit by choosing a PPO dentist.

Members may add coverage once a year at Open Enrollment. Coverage may only be dropped by an employee or dependent with proof of qualifying event.

This is a brief description of services covered under your dental plan. Please refer to the Plan Document for full plan details. If differences exist between this summary and the Plan Document, the Plan Document will govern.

Your Vision Benefits Summary

Get access to the best in eye care and eyewear with C.E.B.T. and VSP® Vision Care.

Using your VSP benefit is easy.

- **Create an account at vsp.com.** Once your plan is effective, review your benefit information.
- **Find an eye doctor who's right for you.** The decision is yours to make—with the largest national network of private-practice doctors, plus participating retail chains, it's easy to find the in-network doctor who's right for you. Visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Best Eye Care

You'll get the highest level of care, including a WellVision Exam®– the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP provider, you'll get the most out of your benefit, have lower out-of-pocket costs, and your satisfaction is guaranteed.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe, CALVIN KLEIN, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more.[1] Visit **vsp.com** to find a Premier Program location that carries these brands. Plus, save up to 40% on popular lens enhancements.[2] Prefer to shop online? Check out all of the brands at **eyeconic.com®**, VSP's preferred online eyewear store.

Plan Information

VSP Provider Network: VSP Signature

C.E.B.T. and VSP provide you with an affordable eyecare plan.

Visit **vsp.com** or call **800.877.7195** for more details on your vision coverage and exclusive savings and promotions for VSP members.

Plan B

Benefit	Description	Copay
Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness • Every 12 months	$15
Prescription Glasses		$15
Frame	• $160 allowance for a wide selection of frames • $180 allowance for featured frame brands • 20% savings on the amount over your allowance • $80 Costco® frame allowance • Every 24 months	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every 12 months	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancements • Every 12 months	$50 $80 - $90 $120 - $160
Contacts (instead of glasses)	• $160 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 12 months	Up to $60
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.	
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam	
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor	
Your Coverage with Out-of-Network Providers		
Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.		

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

1. Brands/Promotion subject to change.
2. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.