THE MEDICAL PLAN

This chart compares treatments and services under the three medical plan options available to you and your family:

	SELECT EPO PLAN	CHOICE PPO PLAN[1]		VALUE CDH PLAN	
	In-Network Only[2]	In-Network[2]	Out-of-Network[2]	In-Network[2]	Out-of-Network[2]
Aetna network	Aetna Select™ (Open Access) network	Aetna Choice® POS II (Open Access) network		Aetna Choice® POS II (Open Access) network	
Deductible	$ 400/Employee-Only $ 800/Employee + Spouse $ 800/Employee + 1 Child $1,200/Employee + 2+ Children $1,200/Employee + Family	$ 600/Employee-Only $1,200/Employee + Spouse $1,200/Employee + 1 Child $1,800/Employee + 2+ Children $1,800/Employee + Family	$ 900/Employee-Only $ 1,800/Employee + Spouse $ 1,800/Employee + 1 Child $ 2,700/Employee + 2+ Children $ 2,700/Employee + Family	$1,500/Employee-Only $3,000/Employee + Spouse[3] $3,000/Employee + 1 Child[3] $3,000/Employee + 2+ Children[3] $3,000/Employee + Family[3]	
Out-of-pocket maximum	$2,000/Employee-Only $4,000/Employee + Spouse $4,000/Employee + 1 Child $6,000/Employee + 2+ Children $6,000/Employee + Family	$3,000/Employee-Only $6,000/Employee + Spouse $6,000/Employee + 1 Child $9,000/Employee + 2+ Children $9,000/Employee + Family	$ 4,000/Employee-Only $ 8,000/Employee + Spouse $ 8,000/Employee + 1 Child $12,000/Employee + 2+ Children $12,000/Employee + Family	$4,500/Employee-Only $9,000/Employee + Spouse $9,000/Employee + 1 Child $9,000/Employee + 2+ Children $9,000/Employee + Family	
Lifetime maximum benefit	Unlimited	Unlimited		Unlimited	
For the following treatments and services, the medical plan options pay:					
Preventive Care[4]					
Routine physicals (includes labs)	100% — deductible waived	100% — deductible waived	60%	100% — deductible waived	50%
Annual well-woman exam (includes labs)	100% — deductible waived	100% — deductible waived	60%	100% — deductible waived	50%
Mammograms (routine for women ages 39 and over)	100% — deductible waived	100% — deductible waived	60%	100% — deductible waived	50%
Well-child care (includes labs)	100% — deductible waived	100% — deductible waived	60%	100% — deductible waived	50%
Physician Office Visits					
Primary care office visits (surgical & non-surgical)	Preventive: 100% — deductible waived Non-preventive: 100% after $35 copay[5]	Preventive: 100% — deductible waived Non-preventive: 80%	Preventive: 60% Non-preventive: 60%	Preventive: 100% — deductible waived Non-preventive: 70%	Preventive: 50% Non-preventive: 50%
Specialist office visits (surgical & non-surgical)	100% after $50 copay[5]	80%	60%	70%	50%
Teladoc phone or online video consultation[6]	100% after $20 copay — deductible waived	80%	N/A	70%	N/A
Lab & X-ray	Preventive: 100% — deductible waived Non-preventive: 90%[5]	Preventive: 100% — deductible waived Non-preventive: 80%	Preventive: 60% Non-preventive: 60%	Preventive: 100% — deductible waived Non-preventive: 70%	Preventive: 50% Non-preventive: 50%
Maternity care	Prenatal office visits: 100% — deductible waived[7]. All other visits/services covered at 90%[5]	Prenatal office visits: 100% — deductible waived[7]. All other visits/services covered at 80%	60%	Prenatal office visits: 100% — deductible waived[7]. All other visits/services covered at 70%	50%
Emergency Services					
Hospital emergency room	90% after $150 copay (waived if admitted)[8]	80%	80%	70%	70%
Urgent care	100% after $75 copay — deductible waived	80%	60%	70%	50%
Non-emergency use of the emergency room	Not covered	Not covered	Not covered	Not covered	Not covered
Ambulance	100% — deductible waived[8]	80% — deductible waived	80% — deductible waived	70% — deductible waived	70% — deductible waived
Outpatient Services					
Outpatient surgery	90%	80%	60%	70%	50%
Physician/surgeon and related professional fees (non-office visits)	90%	80%	60%	70%	50%
Hospital Services					
Per confinement copay	$250	$250	$250	Not applicable	Not applicable
Inpatient (includes maternity care)	90%	80%	60%	70%	50%
Outpatient	90%	80%	60%	70%	50%

Please see the footnotes on page 2.

(continued)

	SELECT EPO PLAN	CHOICE PPO PLAN[1]		VALUE CDH PLAN	
	In-Network Only[2]	In-Network[2]	Out-of-Network[2]	In-Network[2]	Out-of-Network[2]
Other Covered Services					
Spinal manipulation (limits apply)[9]	100% after $50 copay	80%	60%	70%	50%
Sterilization (tubal ligation/ vasectomy)	Physician services covered at 100% after $100 copay; other services, such as hospital and lab, covered at 90%	80%	60%	70%	50%
Short-term rehabilitation (limits apply)[10]	100% after $50 copay if received in doctor's office or special rehabilitation facility; otherwise, covered at 90%	80%	60%	70%	50%
Autism treatment (inpatient/ outpatient services, medication management and diagnostic services; speech therapy up to 60 visits/year)	100% after $50 copay	80%	60%	70%	50%
Hearing aids (maximum benefit of $3,000 every 36 months)	90%	80%	60%	70%	50%
Routine eye exam[4]	100% — deductible waived	100% — deductible waived	60%	100% — deductible waived	50%
Routine hearing exam[4]	100% — deductible waived	100% — deductible waived	60%	100% — deductible waived	50%
Fitness Program	Included	Included	Not covered	Included	Not covered
Vision Discounts Program	Included	Included	Not covered	Included	Not covered
Beginning Right Maternity Management Program	Included	Included	Included	Included	Included
Diabetes America	100% after $10 copay	100% after $10 copay	100% after $10 copay	70%	50%
Prescription Drug Coverage					
For covered prescription drugs, you pay:					
Deductible	N/A	N/A		N/A — Prescription costs other than the $10/$20/$40 preventive drug copays are subject to the *Value CDH Plan* medical deductible	
Retail (30-day supply)	Preventive Drugs: $10 copay for generic or $20 copay for brand-name from a designated list of drugs and conditions Other Drugs: • Generic: 15%, $10 min. and $50 max. • Preferred Brand: 20%, $25 min. and $100 max. • Non-Preferred Brand: 30%, $45 min. and $150 max.	Preventive Drugs: $10 copay for generic or $20 copay for brand-name from a designated list of drugs and conditions Other Drugs: • Generic: 15%, $10 min. and $50 max. • Preferred Brand: 20%, $25 min. and $100 max. • Non-Preferred Brand: 30%, $45 min. and $150 max.		Preventive Drugs: $10 copay for generic or $20 copay for brand-name from a designated list of drugs and conditions (deductible waived) Other Drugs (deductible applies): 30%	
Specialty Drugs (30-day supply)	• Generic: 15%, $10 min. and $50 max. • Preferred Brand: 20%, $25 min. and $100 max. • Non-Preferred Brand: 30%, $45 min. and $150 max.	• Generic: 15%, $10 min. and $50 max. • Preferred Brand: 20%, $25 min. and $100 max. • Non-Preferred Brand: 30%, $45 min. and $150 max.		30% (deductible applies)	
Mail-Order and CVS Retail (90-day supply)	Preventive Drugs: $20 copay for generic or $40 copay for brand-name from a designated list of drugs and conditions Other Drugs: • Generic: $ 25 • Preferred Brand: $ 68 • Non-Preferred Brand: $120	Preventive Drugs: $20 copay for generic or $40 copay for brand-name from a designated list of drugs and conditions Other Drugs: • Generic: $ 25 • Preferred Brand: $ 68 • Non-Preferred Brand: $120		Preventive Drugs: $20 copay for generic or $40 copay for brand-name from a designated list of drugs and conditions (deductible waived) Other Drugs (deductible applies): 30%	

[1] For the *Choice PPO Plan*, in-network expenses don't apply to the out-of-network deductible or out-of-pocket maximum, and out-of-network expenses don't apply to the in-network deductible or out-of-pocket maximum.

[2] Unless otherwise noted, benefits paid at 90%, 80%, 70%, 60% or 50% co-insurance are paid only after the deductible has been met.

[3] For the *Value CDH Plan* only, the deductible is the same whether you and your family sign up for Employee + Spouse, Employee + Child(ren), or Employee + Family coverage, and there are no individual sub-limits for each covered person. The full deductible can be met by one family member or a combination of family members.

[4] For limits, see the Preventive Care Guide on www.mycpchembenefits.com.

[5] For the *Select EPO Plan* only, lab and X-ray charges for services performed at a doctor's office and billed as part of the visit are covered by the office visit copay. When these services are not performed at the time of the office visit, are performed at another facility or are performed by an entity other than the doctor's office, you and/or your family must first meet your deductible, and then the expense will be covered at 90%. The deductible is waived for preventive services regardless of where services are performed.

[6] Due to Teladoc's interpretation of Texas state law, Teladoc allows only phone consultations in the state of Texas.

[7] 100% coverage for prenatal office visits does not include inpatient admissions, high risk specialist visits, ultrasounds, amniocentesis, fetal stress tests, certain diagnostic lab tests or delivery including anesthesia.

[8] In a medical emergency, out-of-network hospital emergency room and ambulance will be covered at the in-network level.

[9] Spinal manipulation includes non-surgical spinal manipulation provided by chiropractor, physical therapist or other applicable licensed provider — up to 20 visits/year. The limit applies to the total of both in-network and out-of-network visits.

[10] The combined maximum for physical, occupational and speech therapy is 60 visits/year. The limit applies to the total of both in-network and out-of-network visits.