

# 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 <sup>1</sup>		VALUE CDH PLAN <sup>1</sup>	
	In-Network Only <sup>2</sup>	In-Network <sup>2</sup>	Out-of-Network <sup>2</sup>	In-Network <sup>2</sup>	Out-of-Network <sup>2</sup>
Aetna network	Aetna Select <sup>TM</sup> (Open Access) network	Aetna Choice <sup>®</sup> POS II (Open Access) network		Aetna Choice <sup>®</sup> 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 <sup>3</sup> \$3,000/Employee + 1 Child <sup>3</sup> \$3,000/Employee + 2+ Children <sup>3</sup> \$3,000/Employee + Family <sup>3</sup>	\$2,250/Employee-Only \$4,500/Employee + Spouse <sup>3</sup> \$4,500/Employee + 1 Child <sup>3</sup> \$4,500/Employee + 2+ Children <sup>3</sup> \$4,500/Employee + Family <sup>3</sup>
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	\$6,750/Employee-Only \$13,500/Employee + Spouse \$13,500/Employee + 1 Child \$13,500/Employee + 2+ Children \$13,500/Employee + Family
Lifetime maximum benefit	Unlimited	Unlimited		Unlimited	
<i>For the following treatments and services, the medical plan options pay:</i>					
<b>Preventive Care<sup>4</sup></b>					
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%
<b>Physician Office Visits</b>					
Primary care office visits (surgical & non-surgical)	Preventive: 100% — deductible waived Non-preventive: 100% after \$35 copay <sup>5</sup>	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 <sup>5</sup>	80%	60%	70%	50%
Teladoc phone or online video consultation	100% after \$20 copay — deductible waived	80%	N/A	70%	N/A
Lab & X-ray	Preventive: 100% — deductible waived Non-preventive: 90% <sup>5</sup>	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 <sup>6</sup> . All other visits/services covered at 90% <sup>5</sup>	Prenatal office visits: 100% — deductible waived <sup>6</sup> . All other visits/services covered at 80%	60%	Prenatal office visits: 100% — deductible waived <sup>6</sup> . All other visits/services covered at 70%	50%
<b>Emergency Services</b>					
Hospital emergency room	90% after \$150 copay (waived if admitted) <sup>7</sup>	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 <sup>7</sup>	80% — deductible waived	80% — deductible waived	70% — deductible waived	70% — deductible waived
<b>Outpatient Services</b>					
Outpatient surgery	90%	80%	60%	70%	50%
Physician/surgeon and related professional fees (non-office visits)	90%	80%	60%	70%	50%
<b>Hospital Services</b>					
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 <sup>1</sup>		VALUE CDH PLAN <sup>1</sup>	
	In-Network Only <sup>2</sup>	In-Network <sup>2</sup>	Out-of-Network <sup>2</sup>	In-Network <sup>2</sup>	Out-of-Network <sup>2</sup>
<b>Other Covered Services</b>					
Spinal manipulation (limits apply) <sup>8</sup>	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%	Tubal ligation, including ancillary services: 100% — deductible waived; vasectomy covered at 80%	60%	Tubal ligation, including ancillary services: 100% — deductible waived; vasectomy covered at 70%	50%
Short-term rehabilitation (limits apply) <sup>9</sup>	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 <sup>4</sup>	100% — deductible waived	100% — deductible waived	60%	100% — deductible waived	50%
Routine hearing exam <sup>4</sup>	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
<b>Prescription Drug Coverage</b>					
<i>For covered prescription drugs, you pay:</i>					
Deductible	N/A		N/A — Prescription costs other than the \$10/\$20 generic preventive drug copays are subject to the <i>Value CDH Plan</i> medical deductible		
Retail (30-day supply)	Generic Preventive Drugs: \$10 copay from a designated list of drugs and conditions  Other Drugs: <ul style="list-style-type: none"> <li>• Generic: 15%, \$10 min. and \$50 max.</li> <li>• Preferred Brand: 20%, \$25 min. and \$100 max.</li> <li>• Non-Preferred Brand: 30%, \$50 min. and \$200 max.</li> </ul>		Generic Preventive Drugs: \$10 copay from a designated list of drugs and conditions (deductible waived)  Other Preventive Drugs: <ul style="list-style-type: none"> <li>• Preferred Brand: 20%, \$25 min. and \$100 max.</li> <li>• Non-Preferred Brand: 30%, \$50 min. and \$200 max.</li> </ul> Other Non-Preventive Drugs (deductible applies): 30%		
Specialty Drugs (30-day supply)	<ul style="list-style-type: none"> <li>• Generic: 15%, \$10 min. and \$50 max.</li> <li>• Preferred Brand: 20%, \$25 min. and \$100 max.</li> <li>• Non-Preferred Brand: 30%, \$50 min. and \$200 max.</li> </ul>		30% (deductible applies)		
Mail-Order and CVS Retail (90-day supply)	Generic Preventive Drugs: \$20 copay from a designated list of drugs and conditions  Other Drugs: <ul style="list-style-type: none"> <li>• Generic: \$ 25</li> <li>• Preferred Brand: \$ 68</li> <li>• Non-Preferred Brand: \$125</li> </ul>		Generic Preventive Drugs: \$20 copay from a designated list of drugs and conditions (deductible waived)  Other Preventive Drugs: <ul style="list-style-type: none"> <li>• Preferred Brand: \$68</li> <li>• Non-Preferred Brand: \$125</li> </ul> Other Non-Preventive Drugs (deductible applies): 30%		

<sup>1</sup> For the *Choice PPO Plan* and the *Value CDH 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.

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

<sup>3</sup> 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.

<sup>4</sup> For limits, see the Preventive Care Guide on [www.mycpchembenefits.com](http://www.mycpchembenefits.com).

<sup>5</sup> 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.

<sup>6</sup> 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.

<sup>7</sup> In a medical emergency, out-of-network hospital emergency room and ambulance will be covered at the in-network level.

<sup>8</sup> 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.

<sup>9</sup> 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.