THE MEDICAL PLAN

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

	VALUE CDH PLAN[1]		CHOICE PPO PLAN[1]		SELECT EPO PLAN
	In-Network[2]	Out-of-Network[2]	In-Network[2]	Out-of-Network[2]	In-Network Only[2]
BCBS network	Blue Choice PPO network		Blue Choice PPO network		Blue Choice PPO network
Deductible	$1,500/Employee-Only $3,000/Employee + Spouse[3] $3,000/Employee + Child(ren)[3] $3,000/Employee + Family[3]	$ 2,250/Employee-Only $ 4,500/Employee + Spouse[3] $ 4,500/Employee + Child(ren)[3] $ 4,500/Employee + Family[3]	$ 600/Employee-Only $1,200/Employee + Spouse $1,800/Employee + Child(ren) $1,800/Employee + Family	$ 900/Employee-Only $ 1,800/Employee + Spouse $ 2,700/Employee + Child(ren) $ 2,700/Employee + Family	$ 400/Employee-Only $ 800/Employee + Spouse $1,200/Employee + Child(ren) $1,200/Employee + Family
Out-of-pocket maximum	$4,500/Employee-Only $9,000/Employee + Spouse $9,000/Employee + Child(ren) $9,000/Employee + Family	$ 6,750/Employee-Only $13,500/Employee + Spouse $13,500/Employee + Child(ren) $13,500/Employee + Family	$3,000/Employee-Only $6,000/Employee + Spouse $9,000/Employee + Child(ren) $9,000/Employee + Family	$ 4,000/Employee-Only $ 8,000/Employee + Spouse $12,000/Employee + Child(ren) $12,000/Employee + Family	$2,000/Employee-Only $4,000/Employee + Spouse $6,000/Employee + Child(ren) $6,000/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	50%	100% — deductible waived	60%	100% — deductible waived
Annual well-woman exam (includes labs)	100% — deductible waived	50%	100% — deductible waived	60%	100% — deductible waived
Mammograms (routine for women ages 39 and over)	100% — deductible waived	50%	100% — deductible waived	60%	100% — deductible waived
Well-child care (includes labs)	100% — deductible waived	50%	100% — deductible waived	60%	100% — deductible waived
Physician Office Visits					
Primary care office visits (surgical & non-surgical)	Preventive: 100% — deductible waived Non-preventive: 70%	Preventive: 50% Non-preventive: 50%	Preventive: 100% — deductible waived Non-preventive: 80%	Preventive: 60% Non-preventive: 60%	Preventive: 100% — deductible waived Non-preventive: 100% after $35 copay[5]
Specialist office visits (surgical & non-surgical)	70%	50%	80%	60%	100% after $50 copay[5]
MDLIVE phone or online video consultation	70%	N/A	80%	N/A	100% after $20 copay — deductible waived
Lab & X-ray	Preventive: 100% — deductible waived Non-preventive: 70%	Preventive: 50% Non-preventive: 50%	Preventive: 100% — deductible waived Non-preventive: 80%	Preventive: 60% Non-preventive: 60%	Preventive: 100% — deductible waived Non-preventive: 90%[5]
Maternity care	Prenatal office visits: 100% — deductible waived[6]. All other visits/services covered at 70%	50%	Prenatal office visits: 100% — deductible waived[6]. All other visits/services covered at 80%	60%	Prenatal office visits: 100% — deductible waived[6]. All other visits/services covered at 90%[5]
Emergency Services					
Hospital emergency room	70%	70%	80%	80%	90% after $150 copay (waived if admitted)[7]
Urgent care	70%	50%	80%	60%	100% after $75 copay — deductible waived
Non-emergency use of the emergency room	Not covered	Not covered	Not covered	Not covered	Not covered
Ambulance	70%	70%	80% — deductible waived	80% — deductible waived	100% — deductible waived[7]
Outpatient Services					
Outpatient surgery	70%	50%	80%	60%	90%
Physician/surgeon and related professional fees (non-office visits)	70%	50%	80%	60%	90%
Hospital Services					
Per confinement copay	Not applicable	Not applicable	$250	$250	$250
Inpatient (includes maternity care)	70%	50%	80%	60%	90%
Outpatient	70%	50%	80%	60%	90%

Please see the footnotes on page 2.

(continued)

	VALUE CDH PLAN[1]		CHOICE PPO PLAN[1]		SELECT EPO PLAN
	In-Network[2]	Out-of-Network[2]	In-Network[2]	Out-of-Network[2]	In-Network Only[2]
Other Covered Services					
Spinal manipulation (limits apply)[8]	70%	50%	80%	60%	100% after $50 copay
In vitro fertilization (limits apply)[9]	70%	50%	80%	60%	90%
Sterilization (tubal ligation/ vasectomy)	Tubal ligation, including ancillary services: 100% — deductible waived; vasectomy covered at 70%	50%	Tubal ligation, including ancillary services: 100% — deductible waived; vasectomy covered at 80%	60%	Physician services covered at 100% after $100 copay; other services, such as hospital and lab, covered at 90%
Short-term rehabilitation (limits apply)[10]	70%	50%	80%	60%	100% after $50 copay if received in doctor's office or special rehabilitation facility; otherwise, covered at 90%
Autism treatment (inpatient/ outpatient services, medication management and diagnostic services, and **Applied Behavioral Analysis (ABA)**; speech, occupational and physical therapy, each up to 60 visits/year)	70%	50%	80%	60%	100% after $50 copay
Hearing aids (maximum benefit of $3,000 every 36 months)	70%	50%	80%	60%	90%
Routine eye exam[4]	100% — deductible waived	50%	100% — deductible waived	60%	100% — deductible waived
Routine hearing exam[4]	100% — deductible waived	50%	100% — deductible waived	60%	100% — deductible waived
Gym Membership	One-time $25 enrollment fee and $25/month access charge (per member)	Not covered	One-time $25 enrollment fee and $25/month access charge (per member)	Not covered	One-time $25 enrollment fee and $25/month access charge (per member)
Prescription Drug Coverage					
	For covered prescription drugs, you pay:				
Deductible	N/A — Prescription costs other than the $10/$20 generic preventive drug copays are subject to the *Value CDH Plan* medical deductible		N/A		
Retail (30-day supply)	Generic Preventive Drugs: $10 copay from a designated list of drugs and conditions (deductible waived) Other Preventive Drugs: • Preferred Brand: 20%, $25 min. and $100 max. • Non-Preferred Brand: 30%, $50 min. and $200 max. Other Non-Preventive Drugs (deductible applies): 30%		Generic Preventive Drugs: $10 copay 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%, $50 min. and $200 max.		
Specialty Drugs (30-day supply)	30% (deductible applies)		• Generic: 15%, $10 min. and $50 max. • Preferred Brand: 20%, $25 min. and $100 max. • Non-Preferred Brand: 30%, $50 min. and $200 max.		
Mail-Order and CVS Retail (90-day supply)	Generic Preventive Drugs: $20 copay from a designated list of drugs and conditions (deductible waived) Other Preventive Drugs: • Preferred Brand: $ 68 • Non-Preferred Brand: $125 Other Non-Preventive Drugs (deductible applies): 30%		Generic Preventive Drugs: $20 copay from a designated list of drugs and conditions Other Drugs: • Generic: $ 25 • Preferred Brand: $ 68 • Non-Preferred Brand: $125		

[1] For the *Value CDH Plan* and 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] 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.

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

[8] 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.

[9] In vitro fertilization benefit limited to $10,000/lifetime for medical and $5,000/lifetime for associated prescription drugs.

[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.