



CEBCO Medical Plan Comparisons – Union County Benefit Offerings

Benefit Description:	PPO “Core”		PPO “Basic”	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (Single/Family) (Applies only to percent (%) copayments)	\$1,000/\$2,000	\$2,000/\$4,000	\$1,500/\$3,000	\$3,000/\$6,000
Out-of-pocket Maximum (Single/Family) (Includes Medical Deductible & Medical Copays)	\$2,500/\$5,000	\$5,000/\$10,000	\$4,500/\$9,000	\$9,000/\$18,000
Physician Office Services (PCP/SCP) Including Office Surgeries, allergy serum and injections ¹	\$15	40%	\$30/\$60	40%
- Allergy testing	20%	40%	20%	40%
Preventive Care - Medical History - Mammography ¹ , Pelvic Exams, and PAP testing, PSA tests - Immunizations ¹ - Annual diabetic eye exam - Annual Vision and Hearing exams	Covered in Full	40%	Covered in Full	40%
Outpatient Physical Medicine Therapies - (combined Network & Non-Network limits apply) - Physical/Occupational therapy: 30/30 visit limit - Spinal Manipulation: 12 visit limit - Speech Therapy: 20 visit limit	\$15	40%	\$60	40%
Inpatient Services - Unlimited days except for: * 30 days Network/Non-Network combined for physical medicine /rehab * 90 days Network/Non-Network combined for skilled nursing facility	20%	40%	20%	40%
Outpatient Surgery Hospital / Alternative Care Facility	20%	40%	20%	40%
Other Outpatient Services Hospital / Alternative Care Facility	20%	40%	20%	40%
Inpatient and Outpatient Professional Charges	20%	40%	20%	40%
Home Care Services 90 visits annual limit Network/Nonnetwork combined for Home Care, excluded IV therapy	20%	40%	20%	40%
Hospice Services	20%	40%	20%	40%
Emergency Care in Emergency Room (covers all services, copayment waived if admitted)	\$200	Covered as In-Network	\$300	\$300
Urgent Care Facility	\$35	40%	\$75	40%
Ambulance Services	20%	Covered as In-Network	20%	20%
Maternity Services	20%	40%	20%	40%
Mental Health and Substance Abuse²				
- Inpatient:	20%	40%	20%	40%
- Outpatient: OV PCP copay applies	20%	40%	20%	40%
Lifetime Maximum (combined Network and Non-Network)	Unlimited	Unlimited	Unlimited	Unlimited
Human Organ Transplants - Except Kidney and Cornea transplants ⁽³⁾	20%	40%	20%	40%
Medical Supplies, Equipment and Appliances	20%	40%	20%	40%

1 These covered services are covered in full if you have a flat dollar copayment and if rendered without an office visit.

2 Mental health/substance abuse must be authorized by the mental health administrator for services to be covered at the highest benefit level. Refer to schedule of benefits for limitations.

3 Kidney and Cornea transplants are treated the same as any other illness and subject to the medical benefits and lifetime maximum.

* This chart is intended to provide a summary of each plan design. Refer to the Anthem plan booklet for specifics. If there is a discrepancy, the information contained in the program booklet and certificate shall prevail.