CEBCO Medical Plan Comparisons – Union County 2025 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 Abuse[2]				
- 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.