

# PBT PPO Value Plans

	Plan 1		Plan 2	
	In-Network Provider	Out-of-Network Provider	In-Network Provider	Out-of-Network Provider
<b>Calendar year Deductibles</b>	<b>\$1,000 Per Person \$2,000 Per Family</b>	<b>\$2,000 Per Person \$4,000 Per Family</b>	<b>\$2,000 Per Person \$4,000 Per Family</b>	<b>\$3,000 Per Person \$6,000 Per Family</b>
<b>Coinsurance Percentage</b>	<b>Individual</b> PBT pays 70% of next \$10,000 eligible charges, then 100%  <b>Family</b> PBT pays 70% of next \$20,000 eligible charges, then 100%	<b>Individual</b> PBT pays 50% of next \$20,000 eligible charges, then 100%  <b>Family</b> PBT pays 50% of next \$40,000 eligible charges, then 100%	<b>Individual</b> PBT pays 70% of next \$10,000 eligible charges, then 100%  <b>Family</b> PBT pays 70% of next \$20,000 eligible charges, then 100%	<b>Individual</b> PBT pays 50% of next \$20,000 eligible charges, then 100%  <b>Family</b> PBT pays 50% of next \$40,000 eligible charges, then 100%
<b>Your Out-of-Pocket Maximum per Calendar Year*</b>	Deductible + \$3,000 Per Person  Deductible + \$6,000 Per Family	Deductible + \$10,000 Per Person  Deductible + \$20,000 Per Family	Deductible + \$3,000 Per Person  Deductible + \$6,000 Per Family	Deductible + \$10,000 Per Person  Deductible + \$20,000 Per Family
<b>Physician Office Visit EXAM CHARGE ONLY (If not Preventive Care)</b>	\$30 co-payments per visit then 100%	50% of eligible charges after deductible	\$30 co-payments per visit then 100%	50% of eligible charges after deductible
<b>Preventive Care Benefit: **</b>	100% Deductible Waived	50% Deductible Waived	100% Deductible Waived	50% Deductible Waived

\* After the amount of patient's co-insurance shown is reached, 100% level of benefits applies for that person or family in that calendar year. Note that amounts applied toward the In-Network Deductible and Out-of-Pocket Maximum will be tracked separately from Out-of-Network Deductible and Out-of-Pocket Maximum. The following do not apply to and are not affected by the Out of Pocket Maximum: co-pays, cost containment penalties (see pre-certification requirements), patient's co-insurance for mental/nervous or substance abuse treatment, excluded charges, or charges in excess of any maximum or limit of the Plan.

\*\* Preventive Benefits include and are not limited to: Routine Mammograms and PSA Test, routine Sigmoidoscopy/Colonscopy Limited based on the American Cancer Guidelines; and, Immunizations for children between 0-19; deductible satisfaction not required. Preventive Benefits also includes a Wellness Benefit which covers your routine physical exams, labs, test, and immunizations

Pre-certification Requirements: Benefits subject to a penalty of \$200 per occurrence (in addition to deductible) when pre-certification procedures are not followed. To pre-certify call the toll free number on your identification card.

**This chart is a brief explanation of this plan and is not a contract. Individuals who become covered under the program will receive a Certificate of Insurance defining their coverage. In the event of any conflict or inconsistency between the benefits described in this chart and the provisions of the Certificate of Insurance, the terms and conditions of the Certificate of Insurance shall govern in all respects.**

**Please see the reverse side page for the Maternity and Prescription Drug coverage options and benefit descriptions.**

# PBT PPO Value Plans

Maternity Coverage***	Option 1	Option 2
No Coverage	In-Network Provider: Subject to a separate deductible equal to the Plan Deductible paid at 70%.	Out-of Network Provider: Subject to an a separate deductible equal to the Plan Deductible paid at 50%.

Prescription Drug Coverage Options****	First Option	Second Option	Third Option	Fourth Option
<b>Retail Prescription Drug Card Benefit</b> (up to 30-day supply through participating pharmacies).	\$15/generic, \$30/preferred brand; \$45/nonpreferred brand co-payment per prescription, then 100%	\$250 deductible then 100% after the following co-payments: \$15/generic deductible waived , \$30/ preferred brand; \$45/non-preferred brand co-payment per prescription	\$500 deductible then 100% after the following co-payments:\$15/generic deductible waived , \$30/ preferred brand; \$45/non-preferred brand co-pay per prescription	No Coverage
<b>Mail Order Drug Benefit</b> (up to 90-day supply per prescription through mail order pharmacy vendor).	\$30/generic, \$60/preferred brand; \$90/nonpreferred brand co-payment per prescription, then 100%	\$30/generic deductible waived , \$60/preferred brand; \$90/nonpreferred brand co-pay per prescription.	\$30/generic deductible waived, \$60/preferred brand; \$90/nonpreferred brand co-payment per prescription.	No Coverage

\*\*\* You can select from two options for Maternity benefits. If you do not want Maternity benefits as a part of your coverage select the First Option. Treatment for complications due to pregnancy is covered even if the optional maternity coverage is not chosen. The maternity coverage is available after meeting a 12-month waiting period and is payable the same as any other covered service.

\*\*\*\* You can select from four options for Prescription Drug coverage. . If you do not want Prescription Drug benefits as a part of your coverage select the Fourth Option.

**This chart is a brief explanation of this plan and is not a contract. Individuals who become covered under the program will receive a Certificate of Insurance defining their coverage. In the event of any conflict or inconsistency between the benefits described in this chart and the provisions of the Certificate of Insurance, the terms and conditions of the Certificate of Insurance shall govern in all respects.**