

PBT Value Health Savings Account Qualified Plans

Individual Plan Deductibles	\$1,500 Deductible		\$3,000 Deductible		\$4,000 Deductible		\$5,000 Deductible	
	In-Network	Out-of Network	In-Network	Out-of Network	In-Network	Out-of Network	In-Network	Out-of Network
Deductible	\$1,500	\$3,000	\$3,000	\$6,000	\$4,000	\$8,000	\$5,000	\$10,000
Co-Insurance	PBT pays 80% of eligible charges	PBT pays 60% of eligible charges	PBT pays 100% of eligible charges	PBT pays 80% of eligible charges	PBT pays 100% of eligible charges	PBT pays 80% of eligible charges	PBT pays 100% of eligible charges	PBT pays 80% of eligible charges
Your Annual Out-of-Pocket Maximum	Deductible	Deductible + \$6,000	Deductible	Deductible + \$6,000	Deductible	Deductible + \$6,000	Deductible	Deductible + \$6,000
Preventive Care*	100% of eligible charges	60% of eligible charges	100% of eligible charges	80% of eligible charges	100% of eligible charges	80% of eligible charges	100% of eligible charges	80% of eligible charges
Prescription Drug Coverage	Payable at the In-Network co-insurance percentage after satisfaction of the In-Network deductible.							
Maternity	Option 1: No coverage. Treatment for complications due to pregnancy is covered even if the optional maternity coverage is not chosen.				Option 2: Subject to a separate deductible equal to plan deductible then covered at the in and out of network coinsurance level. 12 month waiting period.			

* Preventive Care - Deductible waived. 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.

Your Contribution to your Health Savings Account: The maximum allowable contribution goes up every year with the rise of the Consumer Price Index. Please visit www.pbtinsurance.com or www.isdsinsurance.com for information on this year's individual and/or family contribution limit.

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.

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	In-Network	Out-of Network	In-Network	Out-of Network	In-Network	Out-of Network
Family Plan Deductible	\$3,000 Each Person \$6,000 Per Family	\$6,000 Each Person \$12,000 Per Family	\$4,000 Each Person \$7,000 Per Family	\$8,000 Each Person \$14,000 Per Family	\$5,000 Each Person \$8,000 Per Family	\$10,000 Each Person \$16,000 Per Family
Co-Insurance	100% of eligible charges	80% of eligible charges	100% of eligible charges	80% of eligible charges	100% of eligible charges	80% of eligible charges
Your Annual Out-of-Pocket Maximum	Deductible	Deductible + \$12,000	Deductible	Deductible + \$12,000	Deductible	Deductible + \$12,000
Preventive Care*	100% of eligible charges	80% of eligible charges	100% of eligible charges	80% of eligible charges	100% of eligible charges	80% of eligible charges
Prescription Drug Coverage	Payable at the In-Network co-insurance percentage after satisfaction of the In-Network deductible.					
Maternity	Option 1: No coverage. Treatment for complications due to pregnancy is covered even if the optional maternity coverage is not chosen.			Option 2: Subject to a separate deductible equal to the in and out of network plan deductible then covered at the in and out of network coinsurance level. 12 month waiting period.		

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