

PBT PPO Value Plans

	Plan 1		Plan 2	
	In-Network Provider	Out-of-Network Provider	In-Network Provider	Out-of-Network Provider
Calendar year Deductibles*	\$1,000 Per Person \$2,000 Per Family	\$2,000 Per Person \$4,000 Per Family	\$2,000 Per Person \$4,000 Per Family	\$3,000 Per Person \$6,000 Per Family
Coinsurance Percentage	Individual After deductible, PBT pays 70% of the next \$10,000 eligible charges, then 100% Family After deductible, PBT pays 70% of the next \$20,000 eligible charges, then 100%	Individual After deductible, PBT pays 50% of the next \$20,000 eligible charges, then 100% Family After deductible, PBT pays 50% of the next \$40,000 eligible charges, then 100%	Individual After deductible, PBT pays 70% of the next \$10,000 eligible charges, then 100% Family After deductible, PBT pays 70% of the next \$20,000 eligible charges, then 100%	Individual After deductible, PBT pays 50% of the next \$20,000 eligible charges, then 100% Family After deductible, PBT pays 50% of the next \$40,000 eligible charges, then 100%
Your Out-of-Pocket Maximum per Calendar Year** (After Deductible)	\$3,000 Per Person \$6,000 Per Family	\$10,000 Per Person \$20,000 Per Family	\$3,000 Per Person \$6,000 Per Family	\$10,000 Per Person \$20,000 Per Family
Physician Office Visit EXAM CHARGE ONLY	\$30 co-payment per visit, then 100%	50%	\$30 co-payment per visit, then 100%	50%
Preventive Care Benefit: ***	100%, Deductible Waived	50%, Deductible Waived	100%, Deductible Waived	50%, Deductible Waived

* Taken before benefits are payable unless waived or where co-payments apply.

** 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: Routine Mammograms and PSA Test limited to one per year (not included in the \$500 maximum); Routine Sigmoidoscopy/Colonscopy Limited based on the American Cancer Guidelines - (not included in the \$500 maximum); and, Immunizations for children between 0-19 covered at 100% in and out of network; deductible satisfaction not required. Preventive Benefits also includes a Wellness Benefit which covers your routine physical exams, labs, test, and immunizations – limited to \$500 per person per calendar year.

Pre-certification - 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.

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Maternity Coverage Options****	First Option		Second Option	
	In-Network Provider	Out-of-Network Provider	In-Network Provider	Out-of-Network Provider
	No Coverage		Subject to a separate deductible equal to the Plan Deductible paid at 70%.	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
Retail Prescription Drug Card Benefit (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
Mail Order Drug Benefit (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.

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