

PBT PREFERRED PROVIDER OPTIONS PLANS

Choice of Deductibles	ALL PLANS					
	\$150,	\$300,	\$500,	\$750,	\$1,000,	\$2,000,
	OPTION A		OPTION B		OPTION C	
	In-Network Provider	Out-of-Network Provider	In-Network Provider	Out-of-Network Provider	In-Network Provider	Out-of-Network Provider
Coinsurance Percentage	PBT pays 80% of next \$5,000 of eligible charges, then 100%	PBT pays 60% of next \$5,000 of eligible charges, then 100%	PBT pays 80% of next \$25,000 of eligible charges, then 100%	PBT pays 60% of next \$25,000 of eligible charges, then 100%	PBT pays 80% of next \$5,000 of eligible charges, then 100%	PBT pays 60% of next \$12,500 of eligible charges, then 100%
Your Annual Out-of-Pocket Maximum	Deductible + \$1,000	Deductible + \$2,000	Deductible + \$5,000	Deductible + \$10,000	Deductible + \$1,000	Deductible + \$5,000
Physician Office Visits (If not Preventive Care)*	\$20 co-payment then 100% Deductible Waived	60% of eligible charges Subject to deductible	\$20 co-payment then 100% Deductible Waived	60% of eligible charges Subject to deductible	\$20 co-payment then 100% Deductible Waived	60% of eligible charges Subject to deductible
Preventive Care Benefit	100% of eligible charges. Deductible Waived	60% of eligible charges. Subject to deductible	100% of eligible charges. Deductible Waived	60% of eligible charges. Subject to deductible	100% of eligible charges. Deductible Waived	60% of eligible charges. Subject to deductible
Newborn Routine Nursery Care	80% of eligible charges. Deductible Waived	60% of eligible charges. Subject to deductible	80% of eligible charges. Deductible Waived	60% of eligible charges. Subject to deductible	80% of eligible charges. Deductible Waived	60% of eligible charges. Subject to deductible
Emergency Room	For all plans: \$100 co-pay, then 100%. Deductible does not apply.					

* Preventive Benefits include and are not limited to: Routine Mammograms and PSA Test, routine Sigmoidoscopy/Colonoscopy 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 are subject to a penalty of \$200 per occurrence for in-patient hospital admissions, except for vaginal and caesarian deliveries, and certain out-patient procedures. There is a separate non-compliance penalty for organ transplants.

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.