

PBT PREFERRED HEALTH SAVINGS ACCOUNT QUALIFIED PLANS

Calendar Year Deductibles	\$1,250 Deductible \$1,250 Individual \$2,500 Family*		\$1,800 Deductible \$1,800 Individual \$3,600 Family*		\$2,250 Deductible \$2,250 Individual \$4,500 Family*		\$2,700 Deductible \$2,250 Individual \$5,400 Family*		\$5,250 Deductible \$5,250 Individual \$10,500 Family*	
	In-Network Provider	Out-of-Network Provider	In-Network Provide	Out-of-Network Provider	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 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	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	Individual: Deductible Family: Deductible	Individual: Deductible + \$4,750 Family: Deductible+ \$9,500	Individual: Deductible Family: Deductible	Individual: Deductible + \$1,350 Family: Deductible+ \$2,700	Individual: Deductible Family: Deductible	Individual: Deductible + \$750 Family: Deductible+ \$1,500	Individual: Deductible Family: Deductible	Individual: Deductible + \$600 Family: Deductible+ \$1,200	Individual: Deductible Family: Deductible	Individual: Deductible + \$4,000 Family: Deductible+ \$8,000
Preventive** Care Benefit	100% of eligible charges. Deductible Waived	80% of eligible charges. Deductible Waived	100% of eligible charges. Deductible Waived	80% of eligible charges. Deductible Waived	100% of eligible charges. Deductible Waived	80% of eligible charges. Deductible Waived	100% of eligible charges. Deductible Waived	80% of eligible charges. Deductible Waived	100% of eligible charges. Deductible Waived	80% of eligible charges. Deductible Waived
Physician Office Visits	Payable as any other benefit.									
Prescription Drug Coverage	Payable at the In-Network co-insurance percentage after satisfaction of the in-network deductible.									

* The family deductible amount must be satisfied before benefits are payable for any family member. It may be satisfied through a combination of eligible expenses incurred by any covered family member.

** 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.

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.isdinsurance.com for the individual and family contribution limits.

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.