

2024 PEBTF Benefit Option Summary Comparison -- Active Members

BENEFIT	PPO CHOICE OPTION		PPO BASIC OPTION		HMO OPTION
	No Referrals Needed		No Referrals Needed		
	In Network	Out-of-Network	In Network	Out-of-Network	All care directed by Primary Care Physician
Deductible	\$400 single/\$800 family	\$800 single/\$1,600 family	\$1,500 single/\$3,000 family	\$3,000 single/\$6,000 family	\$0
Out-of-Pocket Maximums (includes Deductibles, coinsurance, Copayments and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This does not include balance billing amounts for Non-Network providers but it does include Out-of-Network cost sharing)	\$9,450 single/\$18,900 family	\$9,450 single/\$18,900 family	\$9,450 single/\$18,900 family	\$9,450 single/\$18,900 family	\$9,450 single/\$18,900 family
Physician Visits					
Primary Care Physician	\$20 Copayment	70%* after Deductible; Member pays 30% **	\$20 Copayment	70%* after Deductible; Member pays 30% **	\$5 Copayment
Specialist	\$45 Copayment	70%* after Deductible; Member pays 30% **	\$45 Copayment	70%* after Deductible; Member pays 30% **	\$10 Copayment
Preventative Care					
Adult (see list in SPD)	100%	70%* after Deductible; Member pays 30%	100%	70%* after Deductible; Member pays 30%	100%
Pediatric (see list in SPD)	100%	70%* after Deductible; Member pays 30%	100%	70%* after Deductible; Member pays 30%	100%
Urgent Care	\$50 Copayment	70%* after Deductible; Member pays 30%	\$50 Copayment	70%* after Deductible; Member pays 30%	\$50 Copayment
Emergency Room Services	\$200 Copayment, if considered a medical emergency as defined by the PPO (waived if admitted as an inpatient)	\$200 Copayment, if considered a medical emergency as defined by the PPO (waived if admitted as an inpatient)	\$200 Copayment, if considered a medical emergency as defined by the PPO (waived if admitted as an inpatient)	\$200 Copayment, if considered a medical emergency as defined by the PPO (waived if admitted as an inpatient)	\$150 Copayment if considered a medical emergency as defined by the HMO (waived if admitted as an inpatient)
Hospital Expenses (Inpatient & Outpatient)	100% after Deductible (up to 365 days per year) Semi-private room (private room if Medically Necessary)	70%* after Deductible (up to 70 days per calendar year); Member pays 30%	100% after Deductible (up to 365 days per year) Semi-private room (private room if Medically Necessary)	70%* after Deductible (up to 70 days per calendar year); Member pays 30%	100%; semi-private room (private room if Medically Necessary)
Medical/Surgical Expenses Including Physician Services (except office visits)	100% after Deductible	70%* after Deductible; Member pays 30%	100% after Deductible	70%* after Deductible; Member pays 30%	100%
Skilled Nursing Facility Care (medically necessary)	100% after Deductible (240 days per calendar year)	70%* (240 days) after Deductible; Member pays 30%	100% after Deductible (240 days per calendar year)	70%* (240 days) after Deductible; Member pays 30%	(180 days per calendar year at participating facility)
Home Health Care (medically necessary)	100% after Deductible	70%* after Deductible; Member pays 30%	100% after Deductible	70%* after Deductible; Member pays 30%	100%; up to 60 visits in 90 days; may be renewed at the option of the HMO
Diagnostic Tests (Labs)	100% at Quest Diagnostics or LabCorp; \$30 lab Copayment elsewhere	70%* after Deductible; Member pays 30%	100% at Quest Diagnostics or LabCorp; \$30 lab Copayment elsewhere	70%* after Deductible; Member pays 30%	100%
Imaging (X-ray, MRI, CT, etc.)	100% after Deductible	70%* after Deductible; Member pays 30%	100% after Deductible	70%* after Deductible; Member pays 30%	100%
Outpatient Therapies - Such as Outpatient Physical and Occupational Therapy, Speech Therapy, and Chiropractic Care (restorative, medically necessary; not for maintenance of a condition)	\$20 Copayment	70%* after Deductible; Member pays 30%	\$20 Copayment	70%* after Deductible; Member pays 30%	\$5 Copayment
Mental Health & Substance Abuse Treatment	Provided by Optum	Provided by Optum	Provided by Optum	Provided by Optum	Provided by Optum
Durable Medical Equipment/Prosthetic	Covered 100%	70% plan payment; Member pays 30%	Covered 100%	70% plan payment; Member pays 30%	Covered 100%
Out of the Area Care	Urgent and Emergency Care Only, or as defined by the PPO	70%* after Deductible; Member pays 30%	Urgent and Emergency Care Only, or as defined by the PPO	70%* after Deductible; Member pays 30% (Possible BlueCard)	Emergency Care Only, or as defined by the HMO
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

* Non-participating/non-network providers may balance bill for difference between plan allowance and actual charge.

** If not available In-Network, full cost shall be covered without any cost sharing

This Benefit Option Summary Comparison is for illustrative purposes only. It is not all inclusive nor definitive. The actual benefits are as set forth in the PEBTF Plan Document.