PHP Schedule of Benefits for

Legacy 2500 HMO 2 23

Benefit Overview

Per Member Deductible..$2,500

Per Family Deductible..$5,000

Per Member Out-of-Pocket Limit..$5,000

Per Family Out-of-Pocket Limit..$10,000

Deductibles and Out-of-Pocket Limits are based on a Calendar Year benefit period, unless otherwise indicated herein.

The Deductible and Out-of-Pocket Limit apply to all Covered Health Services unless otherwise stated. Copays do not count toward the Deductible. The Deductible, Copays and Coinsurance count toward the Out-of-Pocket Limit. If a Provider, a facility, or anyone else reduces or waives the required cost sharing (Deductible, Copays, Coinsurance) for a particular claim, we reserve the right to adjust the amount charged, the amount eligible under the terms of the policy, your Deductible and/or Out-of-Pocket Limit, to accurately reflect the amount actually charged for that claim.

This Plan is embedded: PHP will pay for a Member's Covered Health Services once the "per Member" Deductible is met by that Member. When the "per family" Deductible is met, PHP will pay for Covered Health Services for all Covered family Members.

Copays and Coinsurance for a Member's Covered Health Services are not required for the rest of the Calendar Year once the "per Member" Out-of-Pocket Limit is met by that Member. When the "per family" Out-of-Pocket Limit is met, Copays and Coinsurance for Covered Health Services are not required for the rest of the Calendar Year for all Covered family Members.

Expenses you incur on non-Covered Services do not count toward the Deductible or Out-of-Pocket Limit.

This schedule is a summary of the benefits available to you. It also may help you understand how much you may have to pay for a particular service. Before getting any Health Services, you should review your Certificate of Coverage and contact us to check your Coverage.

Medical Benefits

	You Pay
Doctor's Office Visit Illness, Injury or Sickness. Emergency services in a non-Par Doctor's office. **Prior Authorization required for specific surgeries and specific drugs. Additional Copays, Deductible or Coinsurance may apply when you receive other services during a Doctor's office visit.**	
Office Visit Charge for Par Doctor of primary care practice areas of family practice, pediatrics, internal medicine, obstetrics and gynecology.	$25 Copay The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies.
Office Visit Charge for Par Doctor of specialty care.	$50 Copay The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies.
Other Services	20% after Deductible. The Out-of-Pocket Limit applies.

Other Practitioner Visits Chiropractor services are limited to 12 visits per Calendar Year across outpatient and other professional visits.	20% after Deductible. The Out-of-Pocket Limit applies.
LabCorp Routine Labs Routine lab services, such as but not limited to: pregnancy test; blood test; or urine test performed at a freestanding LabCorp facility. **Urine drug screenings are limited to a total of 24 screenings per Calendar Year.**	No Charge Deductible waived
Diagnostic Routine radiology services, such as but not limited to: chest x-ray or MRI. Routine lab services, such as but not limited to: pregnancy test; blood test; or urine test performed at a facility other than LabCorp or in a Hospital (inpatient or outpatient) setting. **Urine drug screenings are limited to a total of 24 screenings per Calendar Year. Prior Authorization required for specific radiology services.**	20% after Deductible. The Out-of-Pocket Limit applies.
Preventive Care Services rated 'A' or 'B' by the U.S. Preventive Services Task Force. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Preventive care and screenings for women and children as recommended by the Health Resources and Services Administration. Visit www.phpni.com or call PHP Customer Service for a list of preventive services.	No Charge Deductible waived
Outpatient **Prior Authorization required for specific surgeries and specific drugs.**	20% after Deductible. The Out-of-Pocket Limit applies.
Inpatient **Prior Authorization required.**	20% after Deductible. The Out-of-Pocket Limit applies.
Emergency Health Services - Outpatient	For Emergency Health Services, $300 Copay per visit plus 20% of the remaining charges. (Copay waived if admitted) The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. Services received may not be covered unless diagnosis is emergent in nature.
Urgent Care Center Urgent Care services received within the Service Area must be received at a Par Provider to be Covered.	$50 Copay The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies.
Ambulance	20% after Deductible. The Out-of-Pocket Limit applies.
Home Health Care 100 visits per Calendar Year limit. **Prior Authorization required.**	20% after Deductible. The Out-of-Pocket Limit applies.
Hospice Care and Services 180 consecutive days per lifetime. **Prior Authorization required.**	20% after Deductible. The Out-of-Pocket Limit applies.
Inpatient Transitional Care Unit 30 day Calendar Year limit. **Prior Authorization required.**	20% after Deductible. The Out-of-Pocket Limit applies.
Durable Medical Equipment, Prosthetics, Orthotic Appliances and Ostomy Supplies **Prior Authorization required for specific DME, prosthetics and Orthotic Appliances.**	20% after Deductible. The Out-of-Pocket Limit applies.

Outpatient Therapy Services – Rehabilitation Services Limit per Calendar Year: - Physical therapy: 20 visits - Occupational therapy: 20 visits - Speech therapy: 20 visits - Cardiac Rehabilitation: 36 visits - Pulmonary Rehabilitation: 20 visits	20% after Deductible. The Out-of-Pocket Limit applies.
Outpatient Therapy Services - Habilitation Services Limit per Calendar Year: - Physical therapy: 20 visits - Occupational therapy: 20 visits - Speech therapy: 20 visits	20% after Deductible. The Out-of-Pocket Limit applies.
Inpatient Therapy Services (Rehabilitation/Habilitation Services) 60 day Calendar Year limit. **Prior Authorization required.**	20% after Deductible. The Out-of-Pocket Limit applies.
Transplant Procedure Services Transplant services must be performed at a Designated Transplant Center of Excellence. **Prior Authorization required**.	Benefits and cost share are based on the setting in which Covered Services are received as outlined on this Schedule of Benefits.
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder Services Limited to one treatment per side of head per lifetime. **Prior Authorization required.**	20% after Deductible. The Out-of-Pocket Limit applies.
Maternity Services Inpatient Delivery does not require Prior Authorization unless it exceeds normal delivery times of 48 hours or 96 hours for C-section.	Benefits and cost share are based on the setting in which Covered Services are received as outlined on this Schedule of Benefits.
Diabetes Services	Refer to the specific service.
Cancer Chemotherapy Treatment	$30 Copay The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies.

Outpatient Prescription Drug Benefits

To the extent a Provider, drug manufacturer, Pharmacy, or third-party (other than family) waives, discounts, reduces or pays (directly or indirectly) the required cost sharing (Deductible, Copay, or Coinsurance) for a particular claim, the applicable cost sharing met by the Member on the claim will be reduced to reflect the amount of such waiver, discount, reduction or third-party payment. Prescription Drug Copays/Coinsurance do not apply toward the medical Deductible. Prescription Drug Copays/Coinsurance count toward the medical Out-of-Pocket Limit. Certain Prescription Drugs require the use of an alternate Prescription Drug before they are Covered. The alternate Prescription Drug must have been used within a specified number of days. This process is called Step Therapy. **Prior Authorization required for specific Specialty Prescription Drugs**.

	You Pay
Retail Prescription Drugs (Up to a 30 Day Supply) Per Prescription or refill (except when manufacturer's packaging further limits the supply). Includes diabetic supplies and a one unit limit for inhaler aid devices such as but not limited to: Aerochambers, Inspirease and Breathancer. (Member is required to pay the price difference between Brand Name and Generic Drug, in addition to the Copay/Coinsurance, if the Brand Name Drug is ordered or requested and generic is available.) **Prior Authorization required for specific Specialty Prescription Drugs.**	**Tier 1 Prescription Drug** - $4 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. **Tier 2 Prescription Drug** - $10 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. **Tier 3 Prescription Drug** - $30 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. **Tier 4 Prescription Drug** - $60 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. **Specialty Prescription Drugs** – 25% per Prescription Drug The Out-of-Pocket Limit applies.
Retail Prescription Drugs (Up to a 90 Day Supply) Per Prescription or refill (except when manufacturer's packaging further limits the supply). Includes diabetic supplies. (Member is required to pay the price difference between Brand Name and Generic Drug, in addition to the Copay, if the Brand Name Drug is ordered or requested and generic is available.) **Not all retail prescription drugs are available with a 90 day supply. No Specialty Prescription Drugs are available with a 90 day supply.**	**Tier 1 Prescription Drug** - $12 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. **Tier 2 Prescription Drug** - $30 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. **Tier 3 Prescription Drug** - $90 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. **Tier 4 Prescription Drug** - $180 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies.

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Mail Order Prescription Drugs (Up to a 90 Day Supply) Per Prescription or refill (except when manufacturer's packaging further limits the supply). Includes diabetic supplies. (Member is required to pay the price difference between Brand Name and Generic Drug, in addition to the Copay, if the Brand Name Drug is ordered or requested and generic is available.) **No Specialty Prescription Drugs are available for Mail Order Prescription Drugs.**	**Tier 1 Prescription Drug** - $8 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. **Tier 2 Prescription Drug** - $20 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. **Tier 3 Prescription Drug** - $75 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. **Tier 4 Prescription Drug** - $180 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies.
Mail Order Inhaler Aid Devices; Nail Fungus Drugs; Specialty Drugs	Not Covered

Behavioral Health and Mental Health and Substance Use Disorder Benefits

	You Pay
Outpatient Services Individual or interactive diagnostic interview exams or testing; crisis intervention; therapeutic services; individual and/or group outpatient evaluations.	$50 Copay The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies.
Intensive Outpatient **Partial Hospitalization** **Prior Authorization required**.	20% after Deductible. The Out-of-Pocket Limit applies.
Inpatient **Prior Authorization required.**	20% after Deductible. The Out-of-Pocket Limit applies.

The information contained in this Schedule of Benefits is not intended to provide a full description of eligible benefits, requirements and limitations. The full description, requirements and limitations are reflected in the Certificate of Coverage. A copy of the Certificate of Coverage will be provided to you upon enrollment or upon request. If you have questions, please refer to your Certificate of Coverage or contact our Customer Service Department at (260) 432-6690, extension 11; 1-800-982-6257, extension 11; (260) 459-2600 for the hearing impaired; or custsvc@phpni.com (e-mail). To the extent that this Schedule of Benefits, description of eligible benefits, requirements, and limitations conflict with those in your Certificate of Coverage as amended from time to time, the terms of your Certificate of Coverage shall govern.