Schedule of Benefits

Level Solutions 2000 POS 1 - Freedom

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 Summary Plan Description (SPD). Please refer to both of these documents for a full description on requirements and limitations of your Plan. To the extent that this Schedule of Benefits conflicts with those in your SPD, the terms of your SPD shall govern. ***Certain benefits require Prior Authorization; please contact Customer Service at 1-(260) 432-6690, extension 11 or toll free 1-(800) 982-6257, extension 11. Failure to prior authorize will result in denial of the claim.*** *For further information on this plan, see the Other Information section at the end of this document.*

Your Benefits at a Glance

	In-Network	Out-of-Network*
Per Individual Deductible	$2,000	$4,000
Per Family Deductible	$4,000	$8,000
Per Individual Out-of-Pocket Limit	$4,000	$8,000
Per Family Out-of-Pocket Limit	$8,000	$16,000

Benefits

	In-Network You Pay	Out-of-Network* You Pay
Doctor's Office Visit Illness, Injury or Sickness. Emergency services in a 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. See SPD.**		
Office Visit Charge for Par Doctor of primary care practice areas of family practice, pediatrics, internal medicine, obstetrics and gynecology.	$30 Copay The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.
Office Visit Charge for Par Doctor of specialty care.	$60 Copay The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.
Other Services	20% after Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.
Other Practitioner Visits Chiropractor services are limited to 25 visits combined In-Network and Out-of-Network per Calendar Year across outpatient and other professional visits.	20% after Deductible. The Out-of-Pocket Limit applies.	50% 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	50% after Deductible. The Out-of-Pocket Limit applies.

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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. See SPD.**	20% after Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.
Preventive Health Services 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	50% after Deductible. The Out-of-Pocket Limit applies.
Outpatient **Prior Authorization required for specific surgeries and specific drugs. See SPD.**	20% after Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.
Inpatient **Prior Authorization required. See SPD.**	20% after Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.
Emergency Health Services - Outpatient **Authorization required within 48 hours if admitted. See SPD.**	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.	Emergency Health Services are Covered as an In-Network Benefit. 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 as In-Network Benefits.	$60 Copay The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.
Ambulance	20% after Deductible. The Out-of-Pocket Limit applies. Ambulance is always paid at the in-network benefit however, non-contracted providers may bill you for charges that exceed our payment amount.	Covered as an In-Network Benefit.
Home Health Care 100 visits combined In-Network and Out-of-Network per Calendar Year limit. **Prior Authorization required. See SPD.**	20% after Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.
Hospice Care and Services 180 consecutive days per lifetime. **Prior Authorization required. See SPD.**	20% after Deductible. The Out-of-Pocket Limit applies.	Not Covered

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	In-Network You Pay	Out-of-Network* You Pay
Inpatient Transitional Care Unit (Skilled Nursing) 90 day combined In-Network and Out-of-Network Calendar Year limit. **Prior Authorization required. See SPD.**	20% after Deductible. The Out-of-Pocket Limit applies.	50% 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. See SPD.**	20% after Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.
Outpatient Therapy Services - Rehabilitation Services Combined In-Network and Out-of-Network limit per Calendar Year: - Physical therapy: 40 visits - Occupational therapy: 40 visits - Speech therapy: 40 visits - Cardiac Rehabilitation: 36 visits - Pulmonary Rehabilitation: 20 visits	20% after Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.
Outpatient Therapy Services - Habilitation Services Combined In-Network and Out-of-Network limit per Calendar Year: - Physical therapy: 40 visits - Occupational therapy: 40 visits - Speech therapy: 40 visits	20% after Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.
Inpatient Therapy Services (Rehabilitation/ Habilitation Services) 60 day combined In-Network and Out-of-Network Calendar Year limit. **Prior Authorization required. See SPD.**	20% after Deductible. The Out-of-Pocket Limit applies.	50% 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. See SPD.**	Benefits and cost share are based on the setting in which Covered Services are received as outlined on this Schedule of Benefits.	Not Covered
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder Services **Prior Authorization required. See SPD.**	20% after Deductible. The Out-of-Pocket Limit applies.	Covered as an In-Network Benefit.
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.	50% after Deductible. The Out-of-Pocket Limit applies.
Diabetes Services	Refer to the specific service.	Refer to the specific service.
Cancer Chemotherapy Treatment	$35 Copay The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.

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Behavioral Health and Mental Health and Substance Use Disorder **Outpatient Services -** Individual or interactive diagnostic interview exams or testing; crisis intervention; therapeutic services; individual and/or group outpatient evaluations.	$60 Copay The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.
Intensive Outpatient **Partial Hospitalization** **Prior Authorization required. See SPD.**	20% after Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.
Inpatient - Prior Authorization required. See SPD.	20% after Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.
Outpatient Prescription Drugs **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. (Individual 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 and any Prescription Drug or Refill over $1500. See SPD.**	**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** – $15 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. **Tier 3 Prescription Drug** – $35 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. **Tier 4 Prescription Drug** – $75 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. **Specialty Prescription Drugs (Self-Administered)** **Tier 1 – Preferred Specialty Drugs** – 15% per Prescription Drug The Out-of-Pocket Limit applies. **Tier 2 – Specialty Drugs** – 25% per Prescription Drug The Out-of-Pocket Limit applies.	Not Covered

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	In-Network You Pay	Out-of-Network* You Pay
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. (Individual 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.) **Prior Authorization required for any Prescription Drug or Refill over $1500. See SPD.** **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** – $45 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. **Tier 3 Prescription Drug** – $105 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. **Tier 4 Prescription Drug** – $225 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies.	Not Covered
Specialty Drugs - Office Administered Specialty Drugs only. **Prior Authorization required for specific Specialty Drugs and any Prescription Drug or Refill over $1500. See SPD.**	**Tier 1 – Preferred Specialty Drugs** – 15% per Office Administered Specialty Drug only The Out-of-Pocket Limit applies. **Tier 2 – Specialty Drugs** – 25% per Office Administered Specialty Drug only The Out-of-Pocket Limit applies.	50% per Office Administered Specialty Drug only after Deductible. The Out-of-Pocket Limit applies.
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. (Individual 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.) **Prior Authorization required for any Prescription Drug or Refill over $4500. See SPD.** **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** – $30 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. **Tier 3 Prescription Drug** – $87.50 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. **Tier 4 Prescription Drug** – $225 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies.	Not Covered
Mail Order - Inhaler Aid Devices; Nail Fungus Drugs; Specialty Drugs	Not Covered	Not Covered

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**** All services listed under Out-of-Network are subject to Reasonable and Customary Charges, except for Out-of-Network Emergency benefits.***

Other Information:

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

There may be more than one Deductible and Out-of-Pocket Limit set forth in this document.

In-Network: The In-Network Deductible and In-Network Out-of-Pocket Limit apply to all In-Network Covered Health Services unless otherwise stated. In-Network Copays do not count toward the In-Network Deductible. The In-Network Deductible, Copays and Coinsurance count toward the In-Network 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, the Plan reserves 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 benefit plan is embedded: the Plan will pay for an individual's In-Network Covered Health Services once the In-Network "per individual" Deductible is met by that individual. When the In-Network "per family" Deductible is met, the Plan will pay for In-Network Covered Health Services for all Covered family members.

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

Out-of-Network: The Out-of-Network Deductible and Out-of-Network Out-of-Pocket Limit apply to all Out-of-Network Covered Health Services unless otherwise stated. The Out-of-Network Deductible and Coinsurance count toward the Out-of-Network 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, the Plan reserves 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 benefit plan is embedded: the Plan will pay for an individual's Out-of-Network Covered Health Services once the Out-of-Network "per individual" Deductible is met by that individual. When the Out-of-Network "per family" Deductible is met, the Plan will pay for Out-of-Network Covered Health Services for all Covered family members.

Coinsurance for an individual's Out-of-Network Covered Health Services is not required for the rest of the Calendar Year once the Out-of-Network "per individual" Out-of-Pocket Limit is met by that individual. When the Out-of-Network "per family" Out-of-Pocket Limit is met, Coinsurance for Out-of-Network Covered Health Services is 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 applicable In-Network or Out-of-Network Deductible or toward the applicable In-Network or Out-of-Network Out-of-Pocket Limit.

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 Covered Person on the claim will be reduced to reflect the amount of such waiver, discount, reduction or third-party payment. 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 and any Prescription Drug or Refill over $1500 for Retail Prescription Drugs and $4500 for Mail Order Prescription Drugs.

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 Summary Plan Description and contact Customer Service at the number provided below to check your Coverage.

If you have questions about this plan, please contact Customer Service at 1-(260) 432-6690, extension 11; toll free 1-(800) 982-6257, extension 11; or custsvc@phpni.com (e-mail).