PHP Schedule of Benefits for

Silver POS 5500 10000 26 - Freedom

Benefit Overview

	In-Network	Out-of-Network*
Per Member Deductible	$5,500	$11,000
Per Family Deductible	$11,000	$22,000
Per Member Out-of-Pocket Limit	$10,000	$20,000
Per Family Out-of-Pocket Limit	$20,000	$40,000

There may be more than one Deductible and Out-of-Pocket Limit set forth in the Contract. Deductibles and Out-of-Pocket Limits are based on a Calendar Year benefit period, unless otherwise indicated herein.

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, 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 In-Network Covered Health Services once the In-Network "per Member" Deductible is met by that Member. When the In-Network "per family" Deductible is met, PHP will pay for In-Network Covered Health Services for all Covered family Members.

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

Coinsurance for a Member's Out-of-Network Covered Health Services is not required for the rest of the Calendar Year once the Out-of-Network "per Member" Total Out-of-Pocket Limit is met by that Member. When the Out-of-Network "per family" Total 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.

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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

	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.**		
Office Visit Charge for first visit for which a copay would normally apply for Par Doctor of primary care practice areas of family practice, pediatrics, internal medicine, obstetrics and gynecology.	No Charge Deductible waived	50% after Deductible. The Out-of-Pocket Limit applies.
Additional Visits	$40 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.	$80 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	30% 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 12 visits combined In-Network and Out-of-Network per Calendar Year across outpatient and other professional visits.	30% 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.
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.**	30% after Deductible. The Out-of-Pocket Limit applies.	50% 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	50% after Deductible. The Out-of-Pocket Limit applies.

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Outpatient **Prior Authorization required for specific surgeries and specific drugs.**	30% after Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.
Inpatient **Prior Authorization required.**	30% after Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.
Emergency Health Services - Outpatient	For Emergency Health Services, $400 Copay per visit plus 30% 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 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.	$80 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	30% 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. Private duty nursing - 82 visits combined In-Network and Out-of-Network per Calendar Year, 164 visits per lifetime. **Prior Authorization required.**	30% 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.**	30% after Deductible. The Out-of-Pocket Limit applies.	Not Covered
Inpatient Transitional Care Unit (Skilled Nursing) 90 day combined In-Network and Out-of-Network Calendar Year limit. **Prior Authorization required.**	30% 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.**	30% after Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.
Wigs Limited to one wig per Calendar Year following cancer chemotherapy treatment. Prior Authorization is not required unless the wig exceeds $250. A Wig exceeding $250 is not Covered unless it meets our guidelines and is Prior Authorized.	30% 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	30% 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	30% 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.**	30% 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.**	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.**	30% 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	$45 Copay The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.
Accidental Dental $3000 per accidental injury.	30% after Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.

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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 Drugs and Prescription Drug Copays do not count toward the medical Deductible. Prescription Drugs and Prescription Drug Copays count toward the In-Network or Out-of-Network 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**.

	In-Network You Pay	**Out-of-Network* 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** - $20 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. **Tier 3 Prescription Drug** - $45 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. **Tier 4 Prescription Drug** - $95 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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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** - $60 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. **Tier 3 Prescription Drug** - $135 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. **Tier 4 Prescription Drug** - $285 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.**	**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. (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** - $40 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. **Tier 3 Prescription Drug** - $112.50 Copay per Prescription Drug The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. **Tier 4 Prescription Drug** - $285 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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Behavioral Health and Mental Health and Substance Use Disorder Benefits

	In-Network You Pay	Out-of-Network* You Pay
Outpatient Services Individual or interactive diagnostic interview exams or testing; crisis intervention; therapeutic services; individual and/or group outpatient evaluations.	$80 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.**	30% after Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.
Inpatient **Prior Authorization required.**	30% after Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.

Vision Benefits for Children (up to, but not including, age 19)

	In-Network You Pay	Out-of-Network* You Pay
Vision **Routine Eye Exams** (including dilation, if professionally indicated) One exam per Calendar Year. **Standard Eyeglass Lenses** (contact lenses may be obtained in lieu of glasses). One pair of lenses per Calendar Year. **Frames** – One standard frame every two years. **Contact Lens** – (in lieu of glasses) 12 month supply based on contact type. **Prior Authorization required for hardware expenses in excess of $130.**	$80 Copay The Copay does not apply to the Deductible. The Out-of-Pocket Limit applies. 30% after Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.

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Dental Benefits for Children (up to, but not including, age 19)

	In-Network You Pay	Out-of-Network* You Pay
Basic Pediatric Preventive Dental Care: • Diagnostic & Preventive Services - exams (limited to two per Calendar Year), cleanings, fluoride, and space maintainers. • Two sets of bitewing X-rays per Calendar Year.	30% after Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.
Other Pediatric Dental Care: • Oral Surgery Services – extractions and dental surgery. • Endodontic Services – root canals. • Periodontic Services – to treat gum disease. • Relines and Repairs – to bridges and dentures. • Restorative Services – fillings and crown repair. • Pediatric Prosthodontic Services – bridges, implants, and dentures. • Other Services, including: - Brush Biopsy – to detect oral cancer. - Emergency Palliative Treatment – to temporarily relieve pain. - Sealants.	30% after Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.
Medically Necessary Pediatric Orthodontia Services: • Services, treatments and procedures to correct malposed teeth. Medically Necessary orthodontia may be Covered if you submit a treatment plan from a Dentist before receiving any such service, treatment or procedure and it meets our guidelines.	30% after Deductible. The Out-of-Pocket Limit applies.	50% after Deductible. The Out-of-Pocket Limit applies.

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

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 and any Amendments 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; 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.