PHP Schedule of Benefits for

Silver HSA OPT 5200 5200 25 - Options

Benefit Overview

Single Coverage

Deductible* .....$5,200 per Member

Coinsurance .....None

Total Out-of-Pocket Limit.....$5,200 per Member

Family Coverage

Deductible* .....$5,200 per Member or $10,400 per Family

Coinsurance .....None

Total Out-of-Pocket Limit.....$5,200 per Member or $10,400 per Family

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

***Because the Plan is intended to be a qualified high deductible health plan, deductible may automatically adjust when the IRS implements cost of living changes each year. A new schedule may not be provided.**

The Deductible and Total Out-of-Pocket Limit apply to all Covered Health Services unless otherwise stated. The Deductible counts toward the Total 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.

Expenses you incur on non-Covered Services do not count toward the Deductible or Total 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.	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.
Office Visit Charge for Par Doctor of specialty care.	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.
Other Services	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.

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Other Practitioner Visits Chiropractor services are limited to 12 visits per Calendar Year across outpatient and other professional visits.	No Coinsurance after Deductible. The Total 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.**	No Coinsurance after Deductible. The Total 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.**	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.
Inpatient **Prior Authorization required.**	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.
Emergency Health Services - Outpatient	For Emergency Health Services, No Coinsurance after Deductible. The Total 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.	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.
Ambulance	No Coinsurance after Deductible. The Total 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.
Home Health Care 100 visits per Calendar Year limit. Private duty nursing - 82 visits per Calendar Year, 164 visits per lifetime. **Prior Authorization required.**	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.
Hospice Care and Services 180 consecutive days per lifetime. **Prior Authorization required.**	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.
Inpatient Transitional Care Unit (Skilled Nursing) 90 day Calendar Year limit. **Prior Authorization required.**	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.
Durable Medical Equipment, Prosthetics, Orthotic Appliances and Ostomy Supplies **Prior Authorization required for specific DME, prosthetics and Orthotic Appliances.**	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.

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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.	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.
Outpatient Therapy Services - Rehabilitation Services Limit per Calendar Year: - Physical therapy: 40 visits - Occupational therapy: 40 visits - Speech therapy: 40 visits - Cardiac Rehabilitation: 36 visits - Pulmonary Rehabilitation: 20 visits	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.
Outpatient Therapy Services - Habilitation Services Limit per Calendar Year: - Physical therapy: 40 visits - Occupational therapy: 40 visits - Speech therapy: 40 visits	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.
Inpatient Therapy Services (Rehabilitation/Habilitation Services) 60 day Calendar Year limit. **Prior Authorization required.**	No Coinsurance after Deductible. The Total 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 **Prior Authorization required.**	No Coinsurance after Deductible. The Total 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	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.
Cancer Chemotherapy Treatment	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.
Accidental Dental $3000 per accidental injury.	No Coinsurance after Deductible. The Total 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. 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.

	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 Deductible, if the Brand Name Drug is ordered or requested and generic is available.)	No Coinsurance per Prescription Drug after Deductible. The Total 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 Deductible, 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 Coinsurance per Prescription Drug after Deductible. The Total Out-of-Pocket Limit applies.
Specialty Drugs (Up to a 30 Day Supply for Self-Administered Specialty Drugs) Except when manufacturer's packaging further limits the supply. **Prior Authorization required for specific Specialty Drugs**.	**Tier 1 – Preferred Specialty Drugs** - No Coinsurance per Self-Administered and Office Administered Specialty Drugs after Deductible. The Total Out-of-Pocket Limit applies. **Tier 2 – Specialty Drugs** - No Coinsurance per Self-Administered and Office Administered Specialty Drugs after Deductible. The Total 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 Deductible, if the Brand Name Drug is ordered or requested and generic is available.)	No Coinsurance per Prescription Drug after Deductible. The Total Out-of-Pocket Limit applies.
Mail Order Inhaler Aid Devices; Nail Fungus Drugs; Specialty Drugs	Not Covered

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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.	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.
Intensive Outpatient **Partial Hospitalization** **Prior Authorization required.**	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.
Inpatient **Prior Authorization required.**	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.

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

	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.**	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.

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

Dental Services must be provided by a Par Dentist in a Par Dentist's office.

	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.	No Coinsurance after Deductible. The Total 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.	No Coinsurance after Deductible. The Total 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 Par Dentist before receiving any such service, treatment or procedure and it meets our guidelines.	No Coinsurance after Deductible. The Total 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 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.