The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, a sample plan document is available at www.phpni.com or by calling 1-800-982-6257. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-982-6257 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$7500 single / $15,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$7500 single / $15,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.phpni.com or call 1-800-982-6257 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No coinsurance after deductible	Not covered	None
	Specialist visit	No coinsurance after deductible	Not covered	None
	Other practitioner visit	No coinsurance after deductible	Not covered	Chiropractor services: 12 visits/calendar year across outpatient & other professional visits.
	Preventive care/screening/ immunization	No charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Performed at a LabCorp facility: No charge; deductible does not apply Performed at a Non-LabCorp facility: No coinsurance after deductible	Not covered	For coverage of specific radiology services, preauthorization is required to prevent claim denial. Urine drug screenings are limited to a total of 24 screenings per Calendar Year.
	Imaging (CT/PET scans, MRIs)	No coinsurance after deductible	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.phpni.com**	Preferred generic drugs (Tier 1)	No coinsurance after deductible	Not covered	Covers up to 30 day supply (retail) or 90 day supply (mail order). Member pays price difference between brand name & generic, plus deductible, if the brand name drug is ordered & generic is available.
	Non-preferred generic drugs (Tier 2)	No coinsurance after deductible		
	Brand formulary drugs (Tier 3)	No coinsurance after deductible		
	Brand non-formulary drugs (Tier 4)	No coinsurance after deductible		
	Specialty drugs (Tier 1 - Preferred Specialty drugs) (Tier 2 - Specialty drugs)	Tier 1 – No coinsurance after deductible Tier 2 – No coinsurance after deductible	Not covered	Covers up to a 30 day supply, except when manufacturer's packaging further limits the supply. Preauthorization is required to prevent claim denial.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No coinsurance after deductible	Not covered	For coverage for specific outpatient services, preauthorization is required to prevent claim denial.
	Physician/surgeon fees	No coinsurance after deductible	Not covered	
If you need immediate medical attention	Emergency room care	No coinsurance after deductible	No coinsurance after deductible	ER diagnosis must be emergent in nature.
	Emergency medical transportation	No coinsurance after deductible	No coinsurance after deductible	Ambulance is always paid at the in-network benefit however, non-contracted providers may bill you for charges that exceed our payment amount.
	Urgent care	No coinsurance after deductible	Not covered	Services received within Service Area must be received at a network provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	No coinsurance after deductible	Not covered	Preauthorization is required to prevent claim denial.
	Physician/surgeon fees			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No coinsurance after deductible	Not covered	**Intensive Outpatient/Partial Hospitalization:** Preauthorization is required to prevent claim denial. **Inpatient Services:** Preauthorization is required to prevent claim denial.
	Inpatient services	No coinsurance after deductible	Not covered	
If you are pregnant	Office visits	No coinsurance after deductible	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Inpatient delivery does not require preauthorization unless exceeds normal delivery time of 48 hours or 96 hours for C-section.
	Childbirth/delivery professional services	No coinsurance after deductible	Not covered	
	Childbirth/delivery facility services	No coinsurance after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	No coinsurance after deductible	Not covered	100 visits/calendar year; 82 visits/calendar year and 164 visits/lifetime – Private duty nursing. Preauthorization is required to prevent claim denial.
	Rehabilitation services	No coinsurance after deductible	Not covered	**Inpatient**: 60 days/calendar year. Preauthorization is required to prevent claim denial. **Outpatient Rehab:** 40 visits/calendar year – PT, OT, ST. 36 visits/calendar year – Cardiac rehab. 20 visits/calendar year – Pulmonary rehab. **Outpatient Habilitation:** 40 visits/calendar year – PT, OT, ST.
	Habilitation services	No coinsurance after deductible	Not covered	
	Skilled nursing care	No coinsurance after deductible	Not covered	90 days/calendar year. Preauthorization is required to prevent claim denial.
	Durable medical equipment	No coinsurance after deductible	Not covered	For coverage of specific durable medical equipment, preauthorization is required to prevent claim denial.
	Hospice services	No coinsurance after deductible	Not covered	180 consecutive days/lifetime. Preauthorization is required to prevent claim denial.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No coinsurance after deductible	Not covered	Coverage limited to one exam/calendar year.
	Children's glasses	No coinsurance after deductible	Not covered	Coverage is limited to one standard frame every two years. In lieu of glasses, contact lenses (12 month supply based on contact type) per calendar year. Prior authorization is required for hardware expenses in excess of $130.
	Children's dental check-up	No coinsurance after deductible	Not covered	Diagnostic & preventive services limited to two exams/calendar year.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Indiana Department of Insurance at (800) 622-4461; (317) 232-2395 or www.in.gov/idoi; U.S. Department of Labor, Employee Benefits and Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: PHP at 1-800-982-6257; or the Indiana Department of Insurance Consumer Hotline at **1-800-622-4461** or you can contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform.

* For more information about limitations and exceptions, see the **plan** or policy document at www.phpni.com.

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

* For more information about limitations and exceptions, see the **plan** or policy document at www.phpni.com.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$7500
Specialist	0%
Hospital (facility)	0%
Other	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$7500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7560**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$7500
Specialist	0%
Hospital (facility)	0%
Other	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$5400**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$7500
Specialist	0%
Hospital (facility)	0%
Other	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2800**

Note: These numbers assume the patient is not participating in an employer-sponsored Health Reimbursement Arrangement (HRA). Your employer may or may not sponsor an HRA. If you participate in an HRA, your costs may be lower than the costs in these coverage examples. For information, including whether your employer sponsors an HRA, please contact your plan administrator.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.