PHP Schedule of Benefits for

Legacy 3000 HSA P1

Benefit Overview

Single Coverage	In-Network	Out-of-Network*
Deductible**	$3,000	$6,000
Coinsurance	None	30% up to $3,000
Total Out-of-Pocket Limit	$3,000	$9,000

Family Coverage	In-Network	Out-of-Network*
Deductible**	$6,000	$12,000
Coinsurance	None	30% up to $6,000
Total Out-of-Pocket Limit	$6,000	$18,000

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.**

In-Network: The In-Network Deductible and In-Network Total Out-of-Pocket Limit apply to all In-Network Covered Health Services unless otherwise stated. The In-Network Deductible counts toward the In-Network 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 non-embedded: if there are any Dependents enrolled during the Calendar Year:

- **the In-Network family Deductible can be met by one or more family Members, and then PHP will pay for In-Network Covered Health Services.**

Out-of-Network: The Out-of-Network Deductible and Out-of-Network Total 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 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 non-embedded: if there are any Dependents enrolled during the Calendar Year:

- **the Out-of-Network family Deductible can be met by one or more family Members, and then PHP will pay for Out-of-Network Covered Health Services.**
- **the Out-of-Network family Total Out-of-Pocket Limit can be met by one or more family Members, and then Coinsurance for Covered services is not required for the rest of that Calendar Year.**

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 Total Out-of-Pocket Limit.

PHP Schedule of Benefits for

Legacy 3000 HSA P1

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 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.	30% 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.	30% after Deductible. The Total Out-of-Pocket Limit applies.
Other Services	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.	30% after Deductible. The Total 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.	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.	30% 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	30% after Deductible. The Total 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.**	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.	30% 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	30% after Deductible. The Total Out-of-Pocket Limit applies.
Outpatient **Prior Authorization required for specific surgeries and specific drugs.**	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.	30% after Deductible. The Total Out-of-Pocket Limit applies.

PHP Schedule of Benefits for

Legacy 3000 HSA P1

Inpatient **Prior Authorization required.**	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.	30% 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.	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.	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.	30% 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.	Covered as an In-Network Benefit.
Home Health Care 100 visits combined In-Network and Out-of-Network Calendar Year limit. **Prior Authorization required**.	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.	30% 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.	Not Covered
Inpatient Transitional Care Unit 30 day combined In-Network and Out-of-Network Calendar Year limit. **Prior Authorization required**.	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.	30% 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.	30% after Deductible. The Total 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	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.	30% after Deductible. The Total 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	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.	30% after Deductible. The Total 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**.	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.	30% 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.	Not Covered
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder Services Limited to one treatment per side of head per lifetime. **Prior Authorization required.**	No Coinsurance after Deductible. The Total 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.	30% after Deductible. The Total Out-of-Pocket Limit applies.
Diabetes Services	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.	30% after Deductible. The Total Out-of-Pocket Limit applies.
Cancer Chemotherapy Treatment	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.	30% after Deductible. The Total Out-of-Pocket Limit applies.

PHP Schedule of Benefits for

Legacy 3000 HSA P1

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.

	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 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.	Not Covered
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.	Not Covered
Specialty Drugs (Up to a 30 Day Supply for Self-Administered Specialty Drugs) Except when manufacturer's packaging further limits the supply. Out-of-Network – Only Office Administered Specialty Drugs are Covered. **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.	30% per Office Administered Specialty Drug only 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.	Not Covered
Mail Order Inhaler Aid Devices; Nail Fungus Drugs; Specialty Drugs	Not Covered	Not Covered

PHP Schedule of Benefits for

Legacy 3000 HSA P1

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.	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.	30% 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.	30% after Deductible. The Total Out-of-Pocket Limit applies.
Inpatient **Prior Authorization required.**	No Coinsurance after Deductible. The Total Out-of-Pocket Limit applies.	30% after Deductible. The Total 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@**php**ni.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.