USHL
US Health and Life
US HEALTH AND LIFE INSURANCE COMPANY

Ascension
Personalized Care
Standard Silver

Schedule of Benefits

In-Network benefits are based on the Exclusive Provider Organization's approved amount. This Policy does not pay benefits for Covered Medical Expenses from an Out-of-Network provider, except for Emergency Services. Benefits are determined after any applicable Deductible and Coinsurance and are subject to General Exclusions and other applicable limitations.

***Deductible**
-Individual
-Family, embedded

"Embedded" = If the policy is covering a family, the amount of Covered Expenses can be satisfied by any combination of family members, but any one individual cannot contribute more than the Individual Deductible amount. An individual family member may be entitled to benefits before the Family Deductible is satisfied if that family member satisfies the Individual Deductible.

****Cost Sharing Maximum**
-Individual
-Family, embedded

Deductible, Coinsurance, and Copays apply to the Cost Sharing Maximum.

"Embedded" = If the policy is covering a family, the amount of Covered Expenses can be satisfied by any combination of family members, but any one individual cannot contribute more than the Individual Deductible amount. An individual family member may be entitled to benefits before the Family Deductible.

Benefits	In-Network	Out-of-Network
*Individual Deductible	$5,800	N/A
*Family Deductible	$11,600	N/A
Coinsurance - plan pays	60% after deductible	60% after deductible
Coinsurance - you pay	40% after deductible	40% after deductible
**Individual total out-of-pocket max	$8,900	N/A
**Family total out-of-pocket max	$17,800	N/A
Lifetime maximum	Unlimited	Unlimited
Services	**You Pay In-Network**	**You Pay Out-of-Network**
Primary care visit to treat an injury or illness	$40 copay	Not covered
Specialist visit	$80 copay	Not covered
Other practitioner office visit	$80 copay	Not covered
Outpatient facility fee (e.g., Ambulatory Surgery Center)	40% coinsurance after Deductible	Not covered

Services	You Pay In-Network	You Pay Out-of-Network
Outpatient surgery physician/surgical services	40% coinsurance after Deductible	Not covered
Hospice services	40% coinsurance after Deductible	Not covered
Routine dental services (adult)	Not covered	Not covered
Infertility treatment	Not covered	Not covered
Long-term/custodial nursing home care	Not covered	Not covered
Private-duty nursing	Not covered	Not covered
Routine eye exam (adult)	Not covered	Not covered
Urgent care centers or facilities	$60 copay	Not covered
Home health care services - 60 visits per Plan Year (Excludes durable medical equipment)	40% coinsurance after Deductible	Not covered
Emergency room services	40% coinsurance after Deductible	40% coinsurance after Deductible
Emergency transportation/ambulance - Non-emergent ambulance is not covered OON	40% coinsurance after Deductible	40% coinsurance after Deductible
Inpatient hospital services (e.g., hospital stay)	40% coinsurance after Deductible	Not covered
Inpatient physician and surgical services	40% coinsurance after Deductible	Not covered
Bariatric surgery	Not covered	Not covered
Cosmetic surgery	Not covered	Not covered
Skilled nursing facility - 25 days per Plan Year	40% coinsurance after Deductible	Not covered
Prenatal and postnatal care	$40 copay	Not covered
Delivery and all inpatient services for maternity care	40% coinsurance after Deductible	Not covered
Mental/behavioral health outpatient services	$40 copay	Not covered
Mental/behavioral health inpatient services	40% coinsurance after Deductible	Not covered
Substance abuse disorder outpatient services	$40 copay	Not covered
Substance abuse disorder inpatient services	40% coinsurance after deductible	Not covered

Services	You Pay In-Network	You Pay Out-of-Network
Generic drugs	$20 copay	Not covered
Preferred brand drugs	$40 copay	Not covered
Non-preferred brand drugs	$80 copay after deductible	Not covered
Specialty drugs - subject to prior auth	$350 copay after deductible	Not covered
Outpatient rehabilitation services - 35 visits per year (PT/OT/chiro combined)	$40 copay	Not covered
Habilitation services - 35 visits per year (PT/OT/chiro combined)	$40 copay	Not covered
Chiropractic care - Limited to 35 visits in combination with physical therapy and occupational therapy.	40% coinsurance after deductible	Not covered
Durable medical equipment	40% coinsurance after deductible	Not covered
Hearing aids	40% coinsurance after deductible	Not covered
Imaging (CT/PET scans, MRIs)	40% coinsurance after deductible	Not covered
Preventive care/screening/immunization	No charge	Not covered
Routine foot care	Not covered	Not covered
Acupuncture	Not covered	Not covered
Routine eye exam for children	$40 copay	Not covered
Eyeglasses for children	40% coinsurance after deductible	Not covered
Dental check-up for children	Not covered	Not covered
Rehabilitative speech therapy - 20 visits per benefit period	$40 copay	Not covered
Rehabilitative occupational and rehabilitative physical therapy - 40 visits per benefit period	40% coinsurance after deductible	Not covered
Laboratory outpatient and professional services	40% coinsurance after deductible	Not covered
X-rays and diagnostic imaging	40% coinsurance after deductible	Not covered
Basic dental care – child	Not covered	Not covered

Services	You Pay In-Network	You Pay Out-of-Network
Well baby visits and care (Includes annual routine visitation and hearing exams as part of a physical to determine vision or hearing loss. For newborns, screening test for hearing impairment and necessary diagnostic follow-up care through age two (2).)	No charge	Not covered
Orthodontia – child	Not covered	Not covered
Major dental care – child	Not covered	Not covered
Basic dental care – adult	Not covered	Not covered
Orthodontia – adult	Not covered	Not covered
Major dental care – adult	Not covered	Not covered
Abortion for which public funding is prohibited	Not covered	Not covered
Transplant	40% coinsurance after deductible	Not covered
Accidental dental	40% coinsurance after deductible	Not covered
Dialysis	40% coinsurance after deductible	Not covered
Allergy testing that is Medically Necessary on an Outpatient basis only. (Excludes allergy serums and testing materials or Inpatient allergy testing and treatment)	40% coinsurance after deductible	Not covered
Chemotherapy	40% coinsurance after deductible	Not covered
Radiation	40% coinsurance after deductible	Not covered
Diabetes Care and Education (Including Medically Necessary foot orthotics which are not subject to a Plan Year maximum. Also including Nutritional and Diet counseling through a diabetes management plan and for adults at higher risk of chronic disease)	40% coinsurance after deductible	Not covered
Prosthetic devices	40% coinsurance after deductible	Not covered
Infusion therapy	40% coinsurance after deductible	Not covered
Treatment for temporomandibular joint disorders	40% coinsurance after deductible	Not covered

Services	You Pay In-Network	You Pay Out-of-Network
Nutritional counseling	Not covered	Not covered
Reconstructive surgery	40% coinsurance after deductible	Not covered
Virtual care - primary care visit	$20 copay	Not covered
Virtual care - specialist visit	$40 copay	Not covered
Virtual care - urgent care	$60 copay	Not covered
Tobacco cessation	No charge	Not covered
Mental health/substance abuse office visits	$40 copay	Not covered