

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 | Indian Health Care Provider (IHCP) | Ascension Network | Out-of-Network |
|---|------------------------------------|-------------------|----------------|
| *Individual Deductible | \$0 | \$0 | N/A |
| *Family Deductible | \$0 | \$0 | N/A |
| Coinsurance - plan pays | 100% | 60% | 60% |
| Coinsurance - you pay | 0% | 40% | 40% |
| **Individual total out-of-pocket max | N/A | \$9,450 | N/A |
| **Family total out-of-pocket max | N/A | \$18,900 | N/A |
| Lifetime maximum | Unlimited | Unlimited | Unlimited |
| Services | Indian Health Care Provider (IHCP) | In-Network | Out-of-Network |
| Abortion for Which Public Funding is Prohibited | Not covered | Not covered | Not covered |
| Acupuncture | Not covered | Not covered | Not covered |

| Services | Indian Health Care Provider (IHCP) | In-Network | Out-of-Network |
|---|------------------------------------|-------------|----------------|
| Allergy Testing | No charge | \$100.00 | Not covered |
| Bariatric Surgery | Not covered | Not covered | Not covered |
| Chemotherapy | No charge | 40% | Not covered |
| Chiropractic Care (12 visits per benefit period) | No charge | 40% | Not covered |
| Cosmetic Surgery | Not covered | Not covered | Not covered |
| Delivery and All Inpatient Services for Maternity Care | No charge | 40% | Not covered |
| Diabetes Education | No charge | 40% | Not covered |
| Dialysis | No charge | 40% | Not covered |
| Durable Medical Equipment | No charge | 40% | Not covered |
| Emergency Room Services | No charge | \$1,500.00 | \$1,500.00 |
| Emergency Transportation/Ambulance | No charge | \$1,500.00 | \$1,500.00 |
| Gender Affirming Care | Not Covered | Not covered | Not covered |
| Habilitation Services (Speech Therapy limited to 20 visits per benefit period, Occupational Therapy limited to 20 visits per benefit period, Physical Therapy limited to 20 visits per benefit period) | No charge | \$100.00 | Not covered |
| Hearing Aids | Not covered | Not covered | Not covered |
| Home Health Care Services (100 visits per benefit period) | No charge | 40% | Not covered |
| Hospice Services | No charge | 40% | Not covered |
| Imaging (CT/PET Scans, MRIs) | No charge | \$200.00 | Not covered |
| Infertility Treatment | Not covered | Not covered | Not covered |
| Infusion Therapy | No charge | 40% | Not covered |

| Services | Indian Health Care Provider (IHCP) | In-Network | Out-of-Network |
|--|------------------------------------|-------------|----------------|
| Inpatient Hospital Services (e.g., Hospital Stay) | No charge | 40% | Not covered |
| Inpatient Physician and Surgical Services | No charge | 40% | Not covered |
| Laboratory Outpatient and Professional Services | No charge | \$100.00 | Not covered |
| Long-Term/Custodial Nursing Home Care | Not covered | Not covered | Not covered |
| Mental Health/Substance Abuse Care Visits | No charge | \$30.00 | Not covered |
| Mental/Behavioral Health Inpatient Services | No charge | 40% | Not covered |
| Mental/Behavioral Health Outpatient Services | No charge | \$30.00 | Not covered |
| Nutritional Counseling | No charge | 40% | Not covered |
| Other Practitioner Office Visit (Nurse, Physician Assistant) | No charge | \$60.00 | Not covered |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center) | No charge | \$1,500.00 | Not covered |
| Outpatient Rehabilitation Services (Speech Therapy limited to 20 visits per benefit period, Occupational Therapy limited to 20 visits per benefit period, Physical Therapy limited to 20 visits per benefit period) | No charge | \$100.00 | Not covered |
| Outpatient Surgery Physician/Surgical Services | No charge | \$100.00 | Not covered |
| Prenatal and Postnatal Care | No charge | \$30.00 | Not covered |
| Preventive Care/Screening/Immunization | No charge | No charge | Not covered |
| Primary Care Visit to Treat an Injury or Illness | No charge | \$30.00 | Not covered |

| Services | Indian Health Care Provider (IHCP) | In-Network | Out-of-Network |
|---|------------------------------------|-------------|----------------|
| Private Duty Nursing (82 visits per year) | No charge | 40% | Not covered |
| Prosthetic Devices | No charge | 40% | Not covered |
| Radiation | No charge | 40% | Not covered |
| Reconstructive Surgery | No charge | 40% | Not covered |
| Rehabilitative Services (Speech Therapy limited to 20 visits per benefit period, Occupational Therapy limited to 20 visits per benefit period, Physical Therapy limited to 20 visits per benefit period) | No charge | \$100.00 | Not covered |
| Routine Foot Care | Not covered | Not covered | Not covered |
| Skilled Nursing Facility (90 days per benefit period) | No charge | 40% | Not covered |
| Specialist Visit | No charge | \$60.00 | Not covered |
| Substance Abuse Disorder Inpatient Services | No charge | 40% | Not covered |
| Substance Abuse Disorder Outpatient Services | No charge | \$30.00 | Not covered |
| Tobacco Cessation | No charge | No charge | Not covered |
| Transplant | No charge | 40% | Not covered |
| Treatment for Temporomandibular Joint Disorders | No charge | 40% | Not covered |
| Urgent Care Centers or Facilities | No charge | \$100.00 | Not covered |
| Virtual Care - Primary Care Visit | No charge | \$15.00 | Not covered |
| Virtual Care - Specialist Visit | No charge | \$30.00 | Not covered |
| Virtual Care - Urgent Care | No charge | \$45.00 | Not covered |
| Weight Loss Programs | Not covered | Not covered | Not covered |

| Services | Indian Health Care Provider (IHCP) | In-Network | Out-of-Network |
|---|------------------------------------|-------------|----------------|
| Well Baby Visits and Care | No charge | No charge | Not covered |
| X-rays and Diagnostic Imaging | No charge | \$200.00 | Not covered |
| Generic Drugs | No charge | \$30.00 | Not covered |
| Preferred Brand Drugs | No charge | \$100.00 | Not covered |
| Non-Preferred Brand Drugs | No charge | 50% | Not covered |
| Specialty Drugs | No charge | 50% | Not covered |
| Accidental Dental | No charge | 40% | Not covered |
| Dental Check-Up for Children | Not covered | Not covered | Not covered |
| Basic Dental Care - Child | Not covered | Not covered | Not covered |
| Major Dental Care - Child | Not covered | Not covered | Not covered |
| Orthodontia - Child | Not covered | Not covered | Not covered |
| Routine Dental Services (Adult) | Not covered | Not covered | Not covered |
| Basic Dental Care - Adult | Not covered | Not covered | Not covered |
| Major Dental Care - Adult | Not covered | Not covered | Not covered |
| Orthodontia - Adult | Not covered | Not covered | Not covered |
| Eyeglasses for Children (1 item per Plan year) | No charge | 40% | Not covered |
| Routine Eye Exam (Adult) | Not covered | Not covered | Not covered |
| Routine Eye Exam for Children (1 exam per Plan year) | No charge | \$30.00 | Not covered |