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	$0	N/A
*Family deductible	$0	N/A
Coinsurance - plan pays	60%	60%
Coinsurance - you pay	40%	40%
**Individual total out-of-pocket max	$550	N/A
**Family total out-of-pocket max	$1,100	N/A
Lifetime maximum	Unlimited	Unlimited
Services	**You Pay In-Network**	**You Pay Out-of-Network**
Abortion for Which Public Funding is Prohibited	Not covered	Not covered
Acupuncture	Not covered	Not covered
Allergy Testing	$100.00	Not covered
Bariatric Surgery	Not covered	Not covered

Services	You Pay In-Network	You Pay Out-of-Network
Chemotherapy	40%	Not covered
Chiropractic Care	40%	Not covered
Cosmetic Surgery	Not covered	Not covered
Delivery and All Inpatient Services for Maternity Care	40%	Not covered
Diabetes Education	40%	Not covered
Dialysis	40%	Not covered
Durable Medical Equipment	40%	Not covered
Emergency Room Services	$550.00	$550.00
Emergency Transportation/Ambulance	$550.00	$550.00
Gender Affirming Care	$25.00	Not covered
Habilitation Services	$100.00	Not covered
Hearing Aids	Not covered	Not covered
Home Health Care Services **(3 visits per year on educational visits)**	40%	Not covered
Hospice Services	40%	Not covered
Imaging (CT/PET Scans, MRIs)	$200.00	Not covered
Infertility Treatment	40%	Not covered
Infusion Therapy	40%	Not covered
Inpatient Hospital Services (e.g., Hospital Stay)	40%	Not covered
Inpatient Physician and Surgical Services	40%	Not covered
Laboratory Outpatient and Professional Services	$100.00	Not covered
Long-Term/Custodial Nursing Home Care	Not covered	Not covered
Mental Health/Substance Abuse Care Visits	$25.00	Not covered
Mental/Behavioral Health Inpatient Services	40%	Not covered
Mental/Behavioral Health Outpatient Services	$25.00	Not covered

Ascension Personalized Care benefits are underwritten by US Health and Life Insurance Company.

Services	You Pay In-Network	You Pay Out-of-Network
Nutritional Counseling	Not covered	Not covered
Other Practitioner Office Visit (Nurse, Physician Assistant)	$50.00	Not covered
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$550.00	Not covered
Outpatient Rehabilitation Services **(Speech Therapy is limited to one service per day, up to 90 days)**	$100.00	Not covered
Outpatient Surgery Physician/Surgical Services	$100.00	Not covered
Prenatal and Postnatal Care	$25.00	Not covered
Preventive Care/Screening/Immunization	No charge	Not covered
Primary Care Visit to Treat an Injury or Illness	$25.00	Not covered
Private Duty Nursing	40%	Not covered
Prosthetic Devices	40%	Not covered
Radiation	40%	Not covered
Reconstructive Surgery	40%	Not covered
Rehabilitative Occupational and Rehabilitative Physical Therapy	$100.00	Not covered
Rehabilitative Speech Therapy **(Limited to one service per day up to a maximum benefit of 90 daily services per insured per benefit period)**	$100.00	Not covered
Routine Foot Care	No charge	Not covered
Skilled Nursing Facility **(Covered Skilled Nursing Facility Expenses include: Semi-private room and board, other services and supplies ordered by a Physician and furnished by the Skilled Nursing Facility for Inpatient medical care, or services provided in the course of Treatment of the Insured by an anesthesiologist, pathologist, physical therapist, occupational therapist, speech therapist, or radiologist. Refer to Policy for coverage details)**	Not covered	Not covered
Specialist Visit	$50.00	Not covered

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Services	You Pay In-Network	You Pay Out-of-Network
Substance Abuse Disorder Inpatient Services	40%	Not covered
Substance Abuse Disorder Outpatient Services	$25.00	Not covered
Tobacco Cessation	No charge	Not covered
Transplant	40%	Not covered
Treatment for Temporomandibular Joint Disorders	40%	Not covered
Urgent Care Centers or Facilities	$100.00	Not covered
Virtual Care - Primary Care Visit	$10.00	Not covered
Virtual Care - Specialist Visit	$25.00	Not covered
Virtual Care - Urgent Care	$50.00	Not covered
Weight Loss Programs	Not covered	Not covered
Well Baby Visits and Care	No charge	Not covered
X-rays and Diagnostic Imaging	$200.00	Not covered
Generic Drugs	$25.00	Not covered
Preferred Brand Drugs	$50.00	Not covered
Non-Preferred Brand Drugs	40%	Not covered
Specialty Drugs	40%	Not covered
Accidental Dental	40%	Not covered
Dental Check-Up for Children	Not covered	Not covered
Basic Dental Care - Child	Not covered	Not covered
Major Dental Care - Child	Not covered	Not covered
Orthodontia - Child	Not covered	Not covered
Routine Dental Services (Adult)	Not covered	Not covered
Basic Dental Care - Adult	Not covered	Not covered
Major Dental Care - Adult	Not covered	Not covered

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Services	You Pay In-Network	You Pay Out-of-Network
Orthodontia - Adult	Not covered	Not covered
Eyeglasses for Children (**3 frames and 3 lenses per year)**	No charge	Not covered
Routine Eye Exam (Adult)	Not covered	Not covered
Routine Eye Exam for Children	No charge	Not covered

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