IdealCare Gold

Medical-Surgical and Behavioral Health/Substance Abuse Disorder Schedule of Coverage

The following information summarizes the benefits described in your Evidence of Coverage. It is important that you carefully read it so you are aware of plan requirements, provisions and limitations and exclusions.

Note: This Consumer Choice Health Benefit Plan does not include all state mandated health insurance benefits. Some benefits are provided at a reduced level from what is mandated. Reduced benefits are indicated in the chart below and in the separate Benefit Disclosure Form.

This Schedule of Coverage is not a Medicare Supplement. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

Overall Payment Provisions	**In-Network Benefits**	**Out-of-Network Benefits**
Calendar Year Deductibles (applies to all Eligible Expenses including Pharmacy)	$[0-350] Individual/$[0-700] Family (Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services)	
Out-of-Pocket Limits (applies to all Eligible Expenses including Pharmacy	$[0-5,500] Individual/$[0-11,000] Family (Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services)	
Maximum Lifetime Benefits-per participant	Unlimited (Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services)	
Physician office visit/consultation to treat an injury or illness	[0 to 30]% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services
Preventive Care/ Screening/Immunization	100% of Allowed Amount	No coverage for Out-of-Network Services
Specialist office visit/consultation	[0 to 40]% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services
Other practitioner office visits	[0 to 30]% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services
Urgent Care Center visit	[0 to 30]% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services
Outpatient Hospital emergency room/treatment room visit	[0 to 35]% of Allowable Amount after Calendar Year Deductible per Visit	[0 to 35]% of Allowable Amount after Calendar Year Deductible per Visit

Emergency Medical Transportation	[0 to 35]% of Allowable Amount after Calendar Year Deductible per Transport	[0 to 35]% of Allowable Amount after Calendar Year Deductible per Transport
Inpatient Hospital Expenses – All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	[0 to 35]% of Allowable Amount after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services
Inpatient Visits (Physician/surgeon)	[0 to 35]% of Allowable Amount after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services
Diagnostic testing (X-ray, blood work)	100% of Allowed Amount after a $[0-20] Copayment per Visit	No coverage for Out-of-Network Services
The administration of whole blood including cost of blood, blood plasma, and blood plasma expanders are covered services	[0 to 20] % of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services
Imaging (CT/PET scans, MRIs)	[0 to 50]% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services
Laboratory Outpatient and Professional Services	[0 to 20] % of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services
Home Infusion Therapy	[0 to 20]% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Outpatient Surgery Facility fee (ambulatory surgery center)	[0 to 30]% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Physician surgical services performed in an outpatient setting	[0 to 30]% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services

Skilled Nursing Facility Limited to 25 visits per year	[0 to 20]% of Allowable Amount after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services
Home Health Care Limited to 60 visits per year	[0 to 20]% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services
Hospice	[0 to 20]% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services
Mental Health Care Inpatient Hospital Services*	[0 to 35]% of Allowable Amount after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services
Mental Health Care Outpatient Hospital Services*	[0 to 30]% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services
Substance Use Disorder Inpatient Hospital Services*	[0 to 30]% of Allowable Amount after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services
Substance Use Disorder Outpatient Hospital Services*	[0 to 30]% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services
Annual Vision Exam – Children and Adults (1 per year)	[0 to 20]% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services
Annual Prescription Eyewear – Children (1 set of frames with lenses or contact lenses per year)	[0 to 20]% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services

Prenatal and Postnatal Care	[0 to 30]% of Allowable Amount after Calendar Year Deductible for the initial prenatal Visit.	No coverage for Out-of-Network Services
Delivery and all inpatient services	[0 to 35]% of Allowable Amount after Calendar Year Deductible per Delivery	No coverage for Out-of-Network Services
Annual Well Woman Exam – including cervical cancer and ovarian cancer screening (age 18 and over)	100% of Allowed Amount	No coverage for Out-of-Network Services
Annual screening by low-dose mammography for the presence of occult breast cancer for female participants age 35 and over – Outpatient facility or imaging center and Physician component	100% of Allowed Amount	No coverage for Out-of-Network Services
Bone Mass measurement for the detection of low bone mass to determine risk of osteoporosis and fractures associated with osteoporosis for qualified individuals	100% of Allowed Amount	No coverage for Out-of-Network Services
Routine annual prostate cancer detection exam, including a Prostate Specific Antigen test (PSA) for a male Covered Person age 40 or older.	100% of Allowed Amount	No coverage for Out-of-Network Services
Rehabilitation	100% of Allowed Amount after a $[0 - 35] Copayment per Visit	No coverage for Out-of-Network Services
Durable Medical Equipment	[0 to 20]% of Allowable Amount after Calendar Year Deductible per Equipment	No coverage for Out-of-Network Services
Hearing Aids for Adults (1 per ear every 3 years)	[0 to 20]% of Allowable Amount after Calendar Year Deductible per Hearing Aid	No coverage for Out-of-Network Services

Hearing Aid or Cochlear Implant, related services and supplies for a covered individual, if medically necessary.	[0 to 20]% of Allowable Amount after Calendar Year Deductible per Hearing Aid or Cochlear Implant	No coverage for Out-of-Network Services
Amino Acid-Based Formula	[0 to 20]% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Phenylketonuia (PKU) management products	[0 to 20]% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Children's dental check-up	[0 to 20]% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Basic Dental-Children	[0 to 20]% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Major Dental Care- Children	[0 to 20]% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Orthodontia-Children	[0 to 20]% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services

*IdealCare by Sendero Health Plans (IdealCare) will provide benefits and coverage for mental health conditions and substance use disorders under the same terms and conditions applicable to the plan's medical and surgical benefits and coverage. IdealCare may not impose quantitative or non-quantitative treatment limitations on benefits for a mental health condition or substance use disorder that are generally more restrictive than quantitative or non-quantitative treatment limitations imposed on coverage of benefits for medical or surgical expenses.