IdealCare HSA

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	\$[0 - 6,750] Individual/\$[0 - 13,500] Family	
all Eligible Expenses including	(Out-of-Network Services are Excluded unless they are approved by the Plan or are	
Pharmacy)		Emergency Services)
Out of Docket Limits (applies to all	\$[0-6,750]	Individual/\$[0 – 13,500] Family
Out-of-Pocket Limits (applies to all	(Out-of-Network Services are Excluded unless they are approved by the Plan or are	
Eligible Expenses including Pharmacy	Emergency Services)	
Maximum Lifatima Danafita non		Unlimited
Maximum Lifetime Benefits – per	(Out-of-Network Services are	e Excluded unless they are approved by the Plan or are
participant		Emergency Services)
	100% of Allowable	
	Amount after Calendar	
Physician office visit/consultation to	Year Deductible per	No comment for Out of Notes of Committee
treat an injury or illness	Visit *Zero Cost	No coverage for Out-of-Network Services
	Sharing Plan No	
	Charge	
Preventive	100% of Allowed	No covered for Out of Nativally Comices
Care/Screening/Immunization	Amount	No coverage for Out-of-Network Services
_	100% of Allowable	
	Amount after Calendar	
Consistint office wisit/s are sultation	Year Deductible per	No accompany for Out of Naturally Compines
Specialist office visit/consultation	Visit *Zero Cost	No coverage for Out-of-Network Services
	Sharing Plan No	
	Charge	
	100% of Allowable	
	Amount after Calendar	No coverage for Out-of-Network Services
Other prestitioner office visits	Year Deductible per	
Other practitioner office visits	Visit *Zero Cost	
	Sharing Plan No	
	Charge	
Urgent Care Center visit	100% of Allowable	
	Amount after Calendar	No coverage for Out-of-Network Services
	Year Deductible per	140 coverage for Out-of-Network Services
	Visit *Zero Cost	

	Sharing Plan No	
	Charge	
	100% of Allowable	
	Amount after Calendar	
Outpatient Hospital emergency	Year Deductible per	100% of Allowable Amount after Calendar
	Visit *Zero Cost	Year Deductible per Visit *Zero Cost
room/treatment room visit		Sharing Plan No Charge
	Sharing Plan No	
	Charge	
	100% of Allowable	
	Amount after Calendar	100% of Allowable Amount after Calendar
Emergency Medical Transportation	Year Deductible per	Year Deductible per Transport *Zero Cost
	Transport *Zero Cost	Sharing Plan No Charge
	Sharing Plan No	
	Charge	
	100% of Allowable	
Inpatient Hospital Expenses – All usual	Amount after Calendar	
Hospital services and supplies,	Year Deductible per	No coverage for Out-of-Network Services
including semiprivate room, intensive	Stay *Zero Cost	- 10 10 10 10 10 00 00 00 00 00 00 00 00
care, and coronary care units.	Sharing Plan No	
	Charge	
	100% of Allowable	
	Amount after Calendar	
Inpatient Visits (Physician/surgeon)	Year Deductible per	No coverage for Out-of-Network Services
inputient visits (i hysician/surgeon)	Stay *Zero Cost	140 coverage for out of factwork betwees
	Sharing Plan No	
	Charge	
	100% of Allowable	
	Amount after Calendar	
Diagnostic testing (X-ray, blood work)	Year Deductible per	No coverage for Out-of-Network Services
Diagnostic testing (A-ray, blood work)	Visit *Zero Cost	140 coverage for out-of-factwork services
	Sharing Plan No	
	Charge	
	100% of Allowable	
The administration of whole blood	Amount after Calendar	
including cost of blood, blood plasma,	Year Deductible per	No accompand for Out of Nativorily Compined
and blood plasma expanders are	Visit *Zero Cost	No coverage for Out-of-Network Services
covered services	Sharing Plan No	
	Charge	
Imaging (CT/PET scans, MRIs)	100% of Allowable	
	Amount after Calendar	
	Year Deductible per	No servers so for Ord of No. 1 C
	Visit *Zero Cost	No coverage for Out-of-Network Services
	Sharing Plan No	
	Charge	
Laboratory Outpatient and Professional	100% of Allowable	
	Amount after Calendar	
Services	Year Deductible per	No coverage for Out-of-Network Services
	Visit *Zero Cost	

	Sharing Plan No	
	Charge	
	100% of Allowable	
	Amount after Calendar	
Home Infusion Therapy	Year Deductible *Zero	No coverage for Out-of-Network Services
	Cost Sharing Plan No	
	Charge	
	100% of Allowable	
Outpatient Surgery Facility fee (ambulatory surgery center)	Amount after Calendar	
	Year Deductible *Zero	No coverage for Out-of-Network Services
	Cost Sharing Plan No	110 coverage for our of fiverwork pervices
	Charge	
	100% of Allowable	
	Amount after Calendar	
Physician surgical services performed	Year Deductible *Zero	No coverage for Out-of-Network Services
in an outpatient setting	Cost Sharing Plan No	110 coverage for out of freework pervices
	Charge	
	100% of Allowable	
	Amount after Calendar	
Skilled Nursing Facility	Year Deductible per	
Limited to 25 visits per year	Stay *Zero Cost	No coverage for Out-of-Network Services
Emitted to 25 visits per year	Sharing Plan No	
	Charge	
	100% of Allowable	
	Amount after Calendar	
Home Health Care	Year Deductible per	
Limited to 60 visits per year.	Visit *Zero Cost	No coverage for Out-of-Network Services
Eminted to 60 visits per year.	Sharing Plan No	
	Charge	
	100% of Allowable	
	Amount after Calendar	
	Year Deductible per	
Hospice	Visit *Zero Cost	No coverage for Out-of-Network Services
	Sharing Plan No	
	Charge	
	100% of Allowable	
	Amount after Calendar	
Mental Health Care Inpatient Hospital	Year Deductible per	No coverage for Out-of-Network Services
Services*	Stay*Zero Cost	
Scrvices	Sharing Plan No	
	Charge	
Mental Health Care Outpatient Hospital Services*	100% of Allowable	
	Amount after Calendar	
	Year Deductible per	
	Visit *Zero Cost	No coverage for Out-of-Network Services
	Sharing Plan No	
	Charge	
Substance Use Disorder Inpatient	100% of Allowable	
Hospital Services*	Amount after Calendar	No coverage for Out-of-Network Services
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	Year Deductible per Stay *Zero Cost Sharing Plan No	
Substance Use Disorder Outpatient Hospital Services*	Charge 100% of Allowable Amount after Calendar Year Deductible per Visit *Zero Cost Sharing Plan No Charge	No coverage for Out-of-Network Services
Annual Vision Exam – Children and Adults (1 per year)	100% of Allowable Amount after Calendar Year Deductible per Visit *Zero Cost Sharing Plan No Charge	No coverage for Out-of-Network Services
Annual Prescription Eyewear – Children (1 set of frames with lenses or contact lenses per year)	100% of Allowable Amount after Calendar Year Deductible *Zero Cost Sharing Plan No Charge	No coverage for Out-of-Network Services
Prenatal and Postnatal Care	100% of Allowable Amount after Calendar Year Deductible for the initial prenatal Visit *Zero Cost Sharing Plan No Charge	No coverage for Out-of-Network Services
Delivery and all inpatient services	100% of Allowable Amount after Calendar Year Deductible per Delivery *Zero Cost Sharing Plan No Charge	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 Allowable Amount after Calendar Year Deductible per Visit *Zero Cost Sharing Plan No Charge	No coverage for Out-of-Network Services
Durable Medical Equipment	100% of Allowable Amount after Calendar Year Deductible per Equipment *Zero Cost Sharing Plan No Charge	No coverage for Out-of-Network Services
Hearing Aids for Adults (1 per ear every 3 years)	100% of Allowable Amount after Calendar Year Deductible per Hearing Aid *Zero Cost Sharing Plan No Charge	No coverage for Out-of-Network Services
Hearing Aid or Cochlear Implant, related services and supplies for a covered individual, if medically necessary.	100% of Allowable Amount after Calendar Year Deductible per Hearing Aid or Cochlear Implant *Zero Cost Sharing Plan No Charge	No coverage for Out-of-Network Services
Amino Acid-Based Formula	100% of Allowable Amount after Calendar Year Deductible *Zero Cost Sharing Plan No Charge	No coverage for Out-of-Network Services
Phenylketonuria (PKU) management products	100% of Allowable Amount after Calendar Year Deductible *Zero Cost Sharing Plan No Charge	No coverage for Out-of-Network Services
Children's dental check-up	100% of Allowable Amount after Calendar Year Deductible *Zero Cost Sharing Plan No Charge	No coverage for Out-of-Network Services
Basic Dental-Children	100% of Allowable Amount after Calendar Year Deductible *Zero Cost Sharing Plan No Charge	No coverage for Out-of-Network Services

Major Dental Care- Children	100% of Allowable	
	Amount after Calendar	
	Year Deductible *Zero	No coverage for Out-of-Network Services
	Cost Sharing Plan No	
	Charge	
Orthodontia-Children	100% of Allowable	
	Amount after Calendar	
	Year Deductible *Zero	No coverage for Out-of-Network Services
	Cost Sharing Plan No	
	Charge	

^{*}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.