IdealCare

SENDERO HEALTH PLANS

ICH-2019

# MEMBER HANDBOOK

01/2019

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**WELCOME**

Dear Subscriber,

Sendero Health Plans (Sendero) is pleased that you have chosen IdealCare. Sendero, a local non-profit health maintenance organization (HMO), is sponsored by the Travis County Healthcare District (d.b.a. Central Health). IdealCare products provide benefits to eligible members who live in the Travis Service Area. The Travis Service Area includes Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, and Williamson Counties. IdealCare has in-network providers and facilities within your health benefits plan network, within the Travis Service Area to provide you the health care treatment you need. You can also find our service area map at http://senderohealth.com/idealcareeng/providers.html along with more helpful information. If you move out of the service area you will no longer be eligible for health coverage with IdealCare. The information in this handbook will help answer any of your questions. This handbook provides a summary of:

- Your health care benefits
- How you and your family can receive health care services from in-network providers, within your health benefits plan network
- Your rights and responsibilities
- IdealCare procedures

To get the most from your IdealCare Plan, please read the entire IdealCare Handbook. For a complete explanation of your health care coverage please refer to your Evidence of Coverage (EOC), Summary of Benefits in Coverage (SBC), and Schedule of Benefits (SOC) which will answer many of your questions in detail. You can also find your EOC, SBC, and the SOC on our website at http://senderohealth.com/idealcareeng/benefits.html

IdealCare is committed to meeting the needs of our members and providing services to people of all cultures, races, ages, ethnicities, religious backgrounds and disabilities with the upmost respect, dignity, and accountability for you, our valued subscriber. Our values communicate not just who we are, but also our commitment to meeting the needs of our members and community.

IdealCare's values are:

- Commitment to quality and accessible health care at an affordable price.
- Loyalty to our members.
- Integrity in all business interactions.
- Accountability to our community.

***Welcome to IdealCare!***

**IMPORTANT INFORMATION**

| | |
|---|---|
| **Call Us:** | Member Services: Toll Free: 1-844-800-4693<br>For Hearing Impaired (TTY): 7-1-1 |
| **Write Us:** | IdealCare by Sendero Health Plans<br>2028 East Ben White Blvd.<br>Ste. 400<br>Austin, TX 78741 |
| **Regular Business Hours:** | Monday through Friday<br>8:00 AM – 5:00 PM CST |
| **Before 8:00 am or after 5:00pm:** | If you call before or after hours, leave a voice message. We will return your call the next business day. |
| **Behavioral Health Crisis Line:** | Call 1-855-765-9696 for information about behavioral and mental health services. If you have an emergency or crisis, call 9-1-1 or go to the closest emergency room. |
| **24 Hour Nurse Advise Line:**<br>(Carenet) | Call 1-855-880-7019 for medical advice or for information about medical conditions. Nurses are available 24 hours a day, 7 days a week. |
| **Vision and Eye Care Number:**<br>(Envolve Benefit Options) | Call 1-855-279-9680 for information about vision benefits and services. |
| **Pharmacy Line:**<br>(Navitus Health Solutions) | Call 1-866-333-2757 for information about medication and pharmacy benefits. |
| **Pediatric Dental Services Line:**<br>(LIBERTY Dental Plan) | Call 1-866-609-0426 for information about pediatric dental services. |

## NOTICE OF RIGHTS

Notice of Rights - Figure 28 TAC §11.1612(c):

-A health maintenance organization (HMO) plan provides no benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your evidence of coverage and below.

-You have the right to an adequate network of in-network physicians and providers (known as network physicians and providers).

-If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at:

www.tdi.texas.gove/consuner/compifrm.html

-If your HMO approves a referral for out-of-network services because no network physician or provider is available, or if you have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network physician's or provider's bill so that you only have to pay any applicable in-network copayment amounts.

-You may obtain a current directory of network physicians and providers at the following website: www.senderohealth.com or by calling 1-844-800-4693 for assistance in finding available network physicians and providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of-network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate

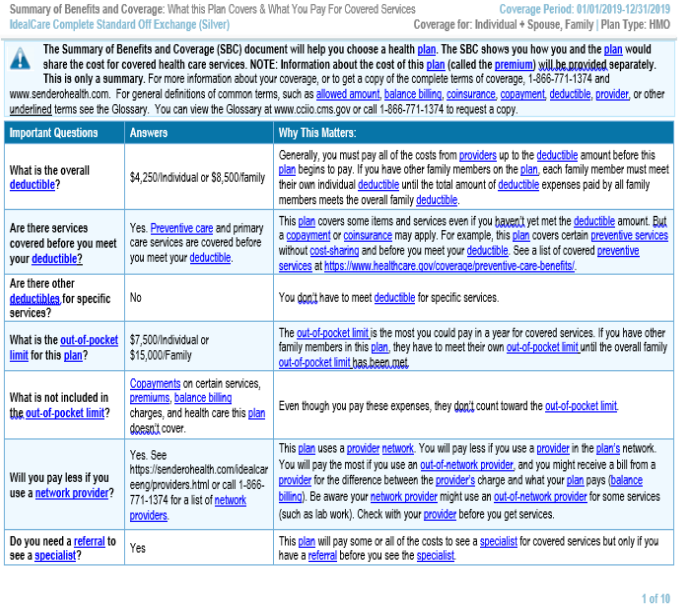
directory information to the HMO, dated not more than 30 days before you received the service.

**BENEFITS/ COVERED SERVICES**

To receive the benefits as indicated in your EOC and SBC you must choose an In-Network Provider, within your health benefits plan network, to provide your care (**other than emergency care and emergency transportation).**

IdealCare's network includes physicians, specialty providers, urgent care facilities and hospitals. Please consult your EOC and the SBC for a listing of benefits, covered services, limitations and exclusions. If you need help understanding your EOC, SBC or to inquire if a certain service is covered or requires preauthorization, call Customer Service toll-free at 1-844-800-4693 for assistance.

Below is an example of an SBC which provides details about covered services, co-pays, coinsurance, exclusions and deductible, if applicable:



Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services — Coverage Period: 01/01/2019-12/31/2019
IdealCare Complete Standard Off Exchange (Silver) — Coverage for: Individual + Spouse, Family | Plan Type: HMO

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, 1-866-771-1374 and www.senderohealth.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-866-771-1374 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | $4,250/Individual or $8,500/family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| Are there services covered before you meet your deductible? | Yes. Preventive care and primary care services are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| Are there other deductibles for specific services? | No | You don't have to meet deductible for specific services. |
| What is the out-of-pocket limit for this plan? | $7,500/Individual or $15,000/Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Copayments on certain services, premiums, balance billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| Will you pay less if you use a network provider? | Yes. See https://senderohealth.com/idealcareeng/providers.html or call 1-866-771-1374 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist? | Yes | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |

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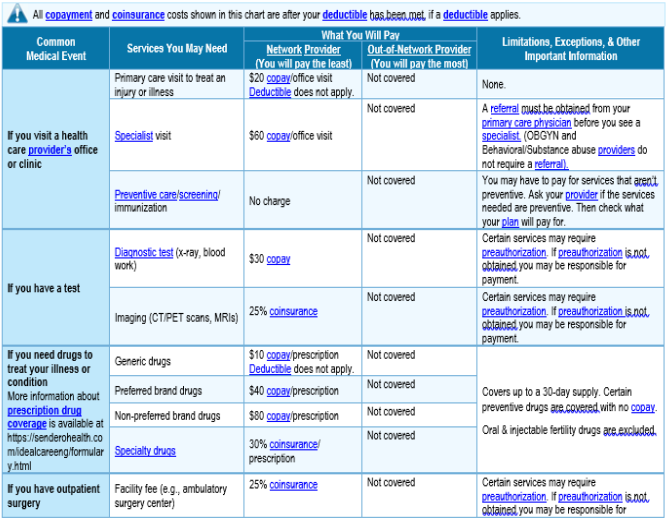

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event | Services You May Need | What You Will Pay: Network Provider (You will pay the least) | What You Will Pay: Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | $20 copay/office visit Deductible does not apply. | Not covered | None. |
| | Specialist visit | $60 copay/office visit | Not covered | A referral must be obtained from your primary care physician before you see a specialist. (OBGYN and Behavioral/Substance abuse providers do not require a referral). |
| | Preventive care/screening/ immunization | No charge | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | $30 copay | Not covered | Certain services may require preauthorization. If preauthorization is not obtained you may be responsible for payment. |
| | Imaging (CT/PET scans, MRIs) | 25% coinsurance | Not covered | Certain services may require preauthorization. If preauthorization is not obtained you may be responsible for payment. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://senderohealth.com/idealcareeng/formulary.html | Generic drugs | $10 copay/prescription Deductible does not apply. | Not covered | Covers up to a 30-day supply. Certain preventive drugs are covered with no copay. Oral & injectable fertility drugs are excluded. |
| | Preferred brand drugs | $40 copay/prescription | Not covered | |
| | Non-preferred brand drugs | $80 copay/prescription | Not covered | |
| | Specialty drugs | 30% coinsurance/ prescription | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 25% coinsurance | Not covered | Certain services may require preauthorization. If preauthorization is not obtained you may be responsible for |

* For more information about limitations and exceptions, see the plan or policy document at www.senderohealth.com.

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Your covered services include but are not limited to: preventive care visits, maternity care, behavioral health, vision care, prescription drugs, emergency care, durable medical equipment, dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases, amino–acid bases elemental formulas, acquired brain injury treatment, treatment for Autism Spectrum Disorder, diabetes equipment and supplies, benefits for routine patient costs for members in certain clinical trials.

Some of your covered services require that you pay either a coinsurance, deductible or a copay. Coinsurance is your share of the costs of a covered health care service, calculated as a percentage of the allowed amount for the service. You pay a coinsurance after you have met your deductible, if applicable. A copay is a fixed amount you pay for a covered health care service. **Your SBC states that "All copayment and coinsurance cost shown in this chart are after your deductible has been meet, if a deductible applies." Copayments that do not require that you meet your deductible will state on the SBC "Deductible does not apply."** The amount may vary by the type of covered health care service.

Certain covered services require preauthorization before receiving the service. If a service requires preauthorization, and it is not authorized by IdealCare, the service(s) provided will be denied.

Your IdealCare Plan is a network-based plan; the network provides you access to facilities, primary care, and specialty providers within your health benefits network within the IdealCare service area. To find out what network pertains to the plan you are enrolled in, please visit:

http://senderohealth.com/idealcareeng/providers.html or call Customer Service at 1-844-800-4693.

In-network providers, within your health benefits plan network, agree to IdealCare's standards, processes, and fee schedules. **Also, in-network providers,** within your health benefits plan network, **agree not to balance bill, our members, for any unpaid amounts for services rendered other than co-payment (s), coinsurance or applicable deductible amounts**.

If you need to see a specialist or visit a facility, your primary care provider can assist you by requesting a referral or preauthorization so you can receive treatment and or care from an in-network provider, within your health benefits plan network. By seeing an in-network provider, within your health benefits plan network, you will keep your out-of-pocket expense to a minimum. To see a list of the IdealCare Plan in-network providers, within your health benefits plan network, visit http://senderohealth.com/idealcareeng/providers.html.

IdealCare providers will be in the Travis service area, which includes Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, and Williamson Counties.

Out-of-network providers are not contracted to provide services for IdealCare members. With the exception of assessment and stabilization for **Emergency Care.** The IdealCare Plan excludes coverage for services rendered by an out-of-network provider and you may be balance billed for these services.

Non-emergency services provided by an out-of-network provider, which are not preauthorized by IdealCare, are excluded from coverage. The total charges from an out-of-network provider for non-emergency services are the complete and full responsibility of the IdealCare member.

**MATERNITY SERVICES**

Maternity services include prenatal care, delivery, postnatal treatment, and pregnancy complications.

Prenatal and postnatal care are covered benefits. You may have a copayment for the initial prenatal visit. Any blood work, ultrasound, genetic testing and/ or any other medical service requested or provided by your doctor are subject to a copay, coinsurance or applicable deductible amount.

Vaginal Delivery includes the first 48 hours of care for the mother and newborn. Cesarean Section Delivery includes the first 96 hours of care for the mother and newborn. Delivery and the appropriate delivery services are covered benefits and are subject to a copayment per delivery.

Except for emergency care, out-of-network prenatal, postnatal care, delivery, and inpatient services are not covered benefits without IdealCare's prior approval for out-of-network services.

**BEHAVIORAL HEALTH**

If an IdealCare member, including dependents, need treatment for a mental or emotional disorder, or has a problem with of drugs or chemical dependency disorders call Customer Service toll-free at 1-844-800-4693. The IdealCare network includes mental health and substance abuse professionals who can help. Some substance abuse or mental health problems, such as severe depression, may require urgent care. You can schedule an appointment with an in-network behavioral health provider, within your health benefits plan network. You do not need a referral from your PCP for behavioral health treatment.

**If you are experiencing a crisis, please call the behavioral health crisis line 1-855-765-9696.**

**PREVENTATIVE HEALTH SERVICES**

IdealCare requires that certain screenings, exams, and immunizations be covered without cost sharing. Preventative services and routine exams must be provided by in-network providers, within your health benefits plan network, unless the required service is not available from a provider in IdealCare's network.

Preauthorization is required for preventive and routine services from an out-of-network provider. Some preventative and routine services have age and frequency restrictions.

Services for well child and adult care Preventive Services are recommended by the U.S. Department of Health and Human Services (HHS) or as mandated by State. This does not include Routine Nursery Care. For the recommended Preventive Services that apply to Your Contract, refer to the HHS at www.HHS.gov or call Sendero's Customer Service telephone number on the back of Your Member Identification Card if you have questions on what Preventive Services are covered by your Contract.

Copayment requirements do not apply to Preventive Services. Covered Services include, but are not limited to, the following:

1. Office visit to a Healthcare Practitioner for a routine or annual physical exam to detect or prevent Illness for adults;
2. Well-child care from birth
3. Routine radiology, laboratory and/or, endoscopic services to detect or prevent illness related to routine or annual exam;

4. Routine mammogram every year for a female Covered Person age 35 years of age or older which includes forms of low-dose mammography including digital mammography or breast tomosynthesis for the presence of occult breast cancer;
5. An annual medically recognized diagnostic examination for a female Covered Person 18 years of age or older for the early detection of cervical cancer and ovarian cancer in accordance with guidelines adopted by the American College of Obstetricians and Gynecologists or another similar national organization of medical processionals recognized by the Commissioner.
    a. Minimum requirements for the diagnostic examination to detect the human papillomavirus include a conventional Pap smear screening, alone or in combination with a test approved by the United States Food and Drug Administration;
    b. CA-125 tests and screenings are considered preventative and covered services.
6. An annual prostate cancer detection exam, including a Prostate Specific Antigen test (PSA) for a male Covered Person age 40 or older;
7. A medically recognized screening examination for the detection of colorectal cancer for a Covered Person 50 years of age or older and at normal risk for developing colon cancer which includes:
    a. An annual fecal occult blood test;
    b. Cologuard (stool DNA test) every 3 years. To qualify for Cologuard testing the following must be met:
        i. No Cologuard test within the last 3 years
        ii. No history of positive Cologuard test
        iii. No diagnosis of colon cancer or history of colon cancer
        iv. No history of abnormal colonoscopy
        v. No positive FIT test within the last 6 months
    c. A flexible sigmoidoscopy every five years; or
    d. A colonoscopy or a computed tomography (CT) colonography (virtual colonoscopy) every ten (10) years;
8. Non-invasive screening tests for atherosclerosis and abnormal artery structure and function for a Covered Person who is:
    a. A male over 45 and under 76 years of age; or
    b. A female over 55 and under 76 years of age; and
    c. Is a diabetic; or
    d. Is at risk of developing heart disease based on a score derived from Framingham Health Study coronary prediction algorithm that is immediate or higher.
9. Routine immunizations for adults under the United States Department of Health and Human Services Centers for Disease

Control Recommended Adult Immunization Schedule by Age Group and Medical Conditions, or its successor. (TB and allergy desensitization injections are not considered routine immunizations);

10. Immunizations against influenza and pneumonia;
11. Alcohol Misuse screening and counseling;
12. Blood Pressure screening for adults;
    a. The administration of whole blood including cost of blood, blood plasma, and blood plasma expanders that are not replaced by or for the enrollee are covered services.
13. Type 2 Diabetes screening for adults with high blood pressure;
14. Diet counseling for adults at higher risk for chronic disease;
15. Depression screening for adults;
16. HIV screening for all adults at higher risk;
17. Obesity screening and counseling for all adults;
18. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk;
19. Tobacco use screening for all adults and cessation interventions for tobacco users;
20. Syphilis screening for all adults at higher risk;
21. Anemia screening on a routine basis for pregnant women;
22. Bacteriuria urinary tract or other infection screening for pregnant women;
23. BRCA counseling about genetic testing for women at higher risk;
24. Breast Cancer Chemoprevention for women at higher risk;
25. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women;
26. Cervical Cancer and Ovarian Cancer screening for sexually active women 18 years of age and older;
    - CA-125 tests and screenings are considered preventative and covered services.
    - Minimum requirements for the diagnostic examination to detect the human papillomavirus include a conventional Pap smear screening, alone or in combination with a test approved by the United States Food and Drug Administration;
27. Chlamydia Infection screening for younger women and other women at a higher risk;
28. Contraception - Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs;
29. Sterilization procedures, and patient education and counseling, not including abortifacient drugs;
30. Domestic and interpersonal violence screening and counseling for all women;
31. Folic Acid supplements for women who may become pregnant;

32. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;
33. Gonorrhea screening for all women at higher risk;
34. Hepatitis B screening for pregnant women at their first prenatal visit;
35. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women;
36. Human Papillomavirus (HPV) DNA Test--high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older;
37. Osteoporosis screening for women over age 60 depending on risk factors;
38. Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk;
39. Tobacco Use screening and interventions for all women, and expanding counseling for pregnant tobacco users;
40. Sexually Transmitted Infections (STI) counseling for sexually active women;
41. Syphilis screening for all pregnant women or other women at increased risk;
42. Well-woman visits to obtain recommended preventive services;
43. Alcohol and Drug Use assessment for adolescents;
44. Autism screening for children at 18 and 24 months;
45. Behavioral assessments for children of all ages;
46. Blood Pressure screening for children;
47. Cervical Dysplasia screening for sexually active women 18 years of age and older;
48. Congenital Hypothyroidism screening for newborns;
49. Depression screening for adolescents;
50. Developmental screening for children under age three, and surveillance throughout childhood;
51. Dyslipidemia screening for children at higher risk of lipid disorders;
52. Fluoride Chemoprevention supplements for children without fluoride in their water source;
53. Gonorrhea preventive medication for the eyes of all newborns;
54. A hearing impairment screening for a Dependent child from birth through 30 days of age;
55. Height, Weight and Body Mass Index measurements for children;
56. Hematocrit and Hemoglobin screening for children;
57. Hemoglobinopathies or sickle cell screening for newborns;
58. HIV screening for adolescents at higher risk;
59. Immunization vaccines for children from birth to age 18 years old; immunization vaccines may vary based on provider recommendation and the age of the child;
60. Iron supplements for children ages 6 to 12 months for anemia;
61. Lead screening for children at risk of exposure;

62. Medical History for all children throughout development;
63. Obesity screening and counseling;
64. Oral Health risk assessment for young children;
65. Phenylketonuria (PKU) screening for this genetic disorder in newborns;
66. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk;
67. Tuberculin testing for children at higher risk of tuberculosis; and
68. Vision and hearing screening for children 21 and under; eye and ear examinations for children through age 21, to determine the need for vision and hearing correction complying with established medical guidelines and recommendations.
69. Covered Services include one (1) of the following screenings every five (5) years:
    (a) A computed tomography (CT) scanning measuring coronary artery calcification; or
    (b) An ultrasonography measuring carotid intima-media thickness and plaque;

**COVERED BENEFITS CHART**

| | | | |
|---|---|---|---|
| Primary Care Visit to Treat an Injury or Illness | Home Health Care Services* | Other Providers Visit (Nurse, Physician Assistant) | Outpatient Services (including facility provider and surgical fees) |
| Hospice Services | Infertility Treatment* (diagnosis of the cause of infertility only) | Routine Eye Exam* | Specialist Visit |
| Urgent Care Center / Facility Services | Emergency Services (including room and transportation) | Inpatient Hospital Services (including facility, provider, and surgical fees) | Skilled Nursing Services* |
| Prenatal and Postnatal Care | Delivery and all inpatient maternity care services | Behavioral Health* (inpatient and outpatient services) | Substance Abuse Disorder* (inpatient and outpatient services) |

| | | | |
|---|---|---|---|
| Prescription Drugs (see IdealCare formulary) | Outpatient Rehabilitation Services* (including physical, occupational, speech therapy, and Chiropractic care) | Durable Medical Equipment / Prosthetic Devices | *Hearing Aids/ Cochlear Implant*Hearing Aids are subject to a benefit limit of $1500.00 per hearing aid. |
| Imaging (including CT, PET scans, MRIs, laboratory services, x-rays, and diagnostic) | Transplants* | Dialysis | Diabetes Education/ Management |
| Reconstructive Surgery* | Infusion Therapy | Treatment for Temporomadibular Joint Disorders* | Nutritional Counseling |

***Review your EOC and the SBC for coverage specifications, limitations and exclusions at***
***http://senderohealth.com/idealcareeng/benefits.html***

**DENTAL SERVICES**

Sendero will limit Covered Services to the least expensive service that we determine will produce professionally adequate results. Cost sharing and limitations depend on type and site of service.

Effective September 1, 2018, dental support of a child subject to child support in addition to medical support will be required per the Family Code and the Texas Insurance Code.

**PRESCRIPTION DRUGS (FORMULARY DRUGS)**

IdealCare maintains a formulary list that tells you which medications are generic, preferred and non-preferred. A copy of the current list can be obtained by calling a Customer Service representative, who can answer questions about your copayments. The IdealCare Plan Formulary is also posted on the IdealCare Plan website at www.senderohealth.com/idealcareformulary. Please note that over-the-counter medications are not a covered benefit and some prescribed medications require prior authorization.

There is little difference between a brand name drug and the generic version. Generic drugs have the same active ingredients as brand name drugs and are less costly. They may be a different color and shape. Your pharmacy will fill your prescription with a generic drug if it is available. Food and Drug Administration (FDA) requires generic drugs to have the same high quality, strength, purity and stability as brand-name drugs. If your provider does not want a generic substitution, he or she must contact us and tell us the reason. If we do not approve the request, you and/or your provider will be informed of our decision. You have the right to request an appeal if the request is not approved. We will tell you how to do this when we give you or your provider our decision.

For some drugs, our approval is required, this is called prior authorization. If your provider decides that you should take a drug in this group, he or she will contact us to receive authorization before giving you a prescription for the drug.

Your provider must complete a prior authorization form and send it to us so that a decision about coverage can be reached. After the request is reviewed, you and/or your provider will be informed of our decision. If we approve the drug, you may obtain it from a participating pharmacy. If we do not approve the request, you and/or your provider will be informed of our decision. You have the right to request an appeal if the request is not approved. We will tell you how to do this when we give you our decision.

You have different coverage levels, depending on what 'tier' drug you are assigned to on the IdealCare Plan pharmacy formulary. With a five-level drug benefit, your prescription medications fall into one of the five categories or 'tiers'. Each tier has a different copay or coinsurance. Refer to your Summary of Benefits and Coverage and your Evidence of Coverage for additional details or contact Customer Service toll-free at 1-844-800-4693.

Some drugs require step therapy. This means that you must try a first step drug before the second step drug will be covered. Usually generic drugs are in the first step.

You may be asked to take a drug that is chemically different from the drug originally prescribed. This different drug will have the same therapeutic purpose and will be used for the same FDA approved conditions. This is called Therapeutic Interchange. The pharmacist or your prescriber may ask you to take this drug and will explain the reasons why he or she believes this is a better drug choice for you. You do not have to agree. If you do not agree, your original drug prescription will be filled.

- *Tier 1* – Most affordable drugs which include generics and select brand drugs; *lowest copay*.
- *Tier 2* – Preferred drugs have been proven to be effective and may be favorably priced compared to other drugs that treat the

same condition; *Middle-level copay*.

• *Tier 3* – Non-preferred drugs have not been found to be any more cost effective than available generics or preferred band; *Higher copay*.

• *Tier 4 – Specialty Drug (SP)* typically require special dispensing, and have limited availability and patient populations; *Highest coinsurance*.

• *Tier 5 –Medical Service drugs are drugs that may be covered under your medical benefit* (Physician visit or hospital visit). Medical Service Drugs require administration by a clinician or in a facility. They are not dispensed through the outpatient pharmacy; this is not covered under IdealCare

• *Tier 6- Preventative care drugs for qualified enrollees; Zero copay*

All medications are dispensed on a 30-day supply. *With the exception of Chronic Eye Disease eye drops, which you may receive a 30/60/90 supply. For more information, please contact the Customer Service Pharmacy Line at 1-866-333-2757. Mail order is not available for IdealCare members.

We encourage safe use of drugs by setting a maximum quantity per month for some drugs. These quantity limits are based on the FDA guidelines and the manufacturer's recommendations. There are circumstances that warrant exceptions to these limits. Your physician can request an exception by contacting us and telling us the reason for the exception. We will inform you about our decision. If we do not approve the request for an exception to the quantity limits we inform your physician how to appeal the decision.

For more information about our pharmacy procedures and to see if a drug is included in our formulary go to www.senderohealth.com/idealcareformulary. The formulary will tell you about:

- The drugs included in our formulary
- Quantity limits and copayments for drugs
- Restrictions that apply to drugs such as prior authorization requirements
- How to obtain prior authorization for a drug, if required
- How your physician may request an exception to our formulary, including the documentation that we require

to review this request

- How you or your physician may appeal our decision not to approve the request for an exception.
- The process for generic substitution of drugs
- Step therapy requirements
- Therapeutic interchange requirements
- Any other requirements, restrictions, limitations, or incentives that apply to the use of certain drugs

You can review our online formulary or by calling Customer Services to check on the coverage for a specific drug. As a member, if the drug you are taking is not listed in our formulary you may ask that we cover the drug. This is called an exception request. Your physician will need to tell us the reasons why he or she believes we should make an exception to our formulary.

If you need to request a Medication Exception, any of the following people can request a coverage determination:

- You the member,
- Your doctor may ask us for a coverage determination for you or
- Your representative (family member or friend, that has been identified as your representative).

Requests need to be submitted to Navitus. You can ask for two kinds of determination:

- Standard Request- Are requests that are not urgent. The turnaround time to receive a response to your request is 72 hours following receipt of the request.
- Expedited Requests- Urgent is defined as: There is an imminent and serious threat to your patient's health. The turnaround time to receive a response to your request is one 24 hours following receipt of the request.

Either of these requests can be made orally or in writing. If you want to submit your request in writing, use the Model Coverage Determination Request Form found on our website or in the Member Portal. You can fill the form out and fax it to 1-855-668-8551 or log in to the member portal and submit the form electronically. If you need help initiating the process for Medication Exception, please call 1-866-333-2757.

**USING YOUR FORMULARY BENEFITS**

You can get your prescription filled at any in-network pharmacy by presenting your IdealCare ID Card at any in-network pharmacy. IdealCare

also has a Prescription Drug Portal available on our website that will help you find a pharmacy close to you, confirm your copay for your prescription(s), and provide additional information about your medications.

When showing your IdealCare ID Card to the pharmacists, you are providing them with all the information they need to fill your prescription. The pharmacist will ask you for the copayment, coinsurance, or applicable deductible amounts for your prescription. You are not required to make a payment for a prescription drug that is more than the lesser of: your copayment, the allowable claim amount, or the amount you would pay if purchasing the prescription without health benefits or discounts. If you have any questions about your prescription, ask the pharmacist.

**EMERGENCY CARE**

Emergency Care includes those health care services you receive in a hospital emergency room or comparable facility to evaluate and stabilize certain medical conditions including behavioral health conditions. These conditions are of a recent onset and severity (such as severe pain) that would lead a person with average knowledge of medicine and health to believe that the person's condition, sickness or injury is such that failure to get immediate medical care could cause the following:

- Placing the patient's health in serious jeopardy
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement
- In the case of a pregnant woman, serious jeopardy to the health of the fetus

In addition, here is a limited list of situations that would also be considered medical emergencies. If you believe you have a medical emergency **go to the closest emergency room** or call 9-1-1. Emergencies include but are not limited to:

- Apparent heart attack
- Loss of consciousness
- Chest pain with symptoms of heart attack
- Stroke
- Poisoning
- Severe bleeding
- Convulsions
- Fractures
- Severe abdominal pain of sudden onset
- Severe injuries or trauma

- Shock from sudden illness or injury
- Difficulty in breathing, such as in a severe asthma attack

If you are within the IdealCare's service area and cannot reach your PCP, you may call Customer Service toll-free at 1-844-800-4693. Customer Service can assist you with finding an in-network urgent care center, within your health benefits plan network.

If you receive Emergency Services at an In-Network Facility and you receive a balance bill from a non-network facility based physician, or other health care practitioner for Emergency Services, please contact Member Services at 1-844-800-4693. Sendero will fully reimburse the non- network facility-based physician or provider at the usual and customary or agreed upon rate. You should not be balance billed for Emergency Services received at an In-Network Facility. You may be required to submit a copy of the itemized billing statement for investigation purposes. Sendero will work to hold you harmless for any amounts beyond the copayment, coinsurance or other out-of-pocket amounts that you would have paid had Sendero's network included network physicians or providers from whom you could obtain emergency services. Sendero will hold you harmless when services are rendered to you by a non-network facility based physician in a network facility.

**OUT OF THE AREA EMERGENCY CARE**

Emergency care services are covered in-network and out-of-network. Necessary Emergency Care Services will be provided to you including treatment, stabilization of a medical condition, medical screening examination, or other evaluation required by state or federal laws. The evaluation or services are necessary to determine if an emergency exists.

If after an evaluation emergency treatment is determined not necessary, you must contact your PCP to arrange any non-emergency care needed. If you choose to use the emergency room for non-emergency treatment you will be responsible for all billed charges. You must contact your PCP before receiving follow-up care. If you are referred to a specialty care provider from the emergency room, or advised to return to the emergency room by the treating provider you still have to follow-up with your PCP prior to scheduling those appointments. You or someone acting on your behalf should contact your PCP within 24-hours or as soon as reasonably possible to arrange for follow-up care after being discharged from the hospital.

If you need Emergency Services while outside of the IdealCare Service Area, go to a nearby hospital and call Customer Service at 1-844-800-4693. If you receive Emergency Services at an In-Network Facility and you receive a balance bill from a non-network facility based physician, or other health care practitioner for Emergency Services, please contact Member Services at 1-844-800-4693. Sendero will fully reimburse the non- network facility-based

physician or provider at the usual and customary or agreed upon rate. You should not be balance billed for Emergency Services received at an In-Network Facility. You may be required to submit a copy of the itemized billing statement for investigation purposes.

In circumstances where you receive **emergency care** in a non-network facility, IdealCare will fully reimburse the non-network physician or provider for emergency care services at the usual and customary or at an agreed rate until you can reasonably be expected to transfer to a network physician or provider. Sendero will work to hold you harmless for any amounts beyond the copayment, coinsurance or other out-of-pocket amounts that you would have paid had Sendero's network included network physicians or providers from whom you could obtain emergency services.

**HOW TO OBTAIN CARE AFTER NORMAL OFFICE HOURS**

If you or an IdealCare dependent is sick or has a severe injury that needs an assessment and/ or treatment at night or on the weekend, contact your PCP first. Your PCP will advise you of the steps needed to seek care, based on your symptoms. Your PCP may be available directly or will make arrangements with other providers to provide assistance 24 hour 7 days a week. IdealCare also provides you access to a 24 hours/7 days a week, Nurse Advice Line. The Nurse Advice Line phone number is 1-855-880-7019.

**URGENT CARE**

An urgent care situation is not as serious as an emergency. Urgent care includes services other than those for an emergency that result from an acute injury or illness that is severe or painful enough to lead a person to believe failure to get treatment within 24 hours would cause serious deterioration of his or her health.

If you are within the IdealCare Plan service area and cannot reach your PCP, you may call Customer Service toll-free at 1-844-800-4693. Customer Service can assist you with finding an in-network urgent care center, within your health benefits plan network.

**TRAVELING OR OUT OF THE SERVICE AREA**

If you get sick when you are out of town or traveling call IdealCare Customer Services toll-free at 1-844- 800-4693 for assistance.

If you need Emergency Services, while outside of the IdealCare Service Area, go to a nearby hospital and call Customer Service at 1-844-800-4693. If you receive Emergency Services at an In-Network Facility and you receive a balance bill from a non-network facility based physician, or other health care practitioner for Emergency Services, please contact Member Services at 1-844-800-4693. Sendero will fully reimburse the non- network facility-based physician or provider at the usual and customary or agreed upon rate. You

should not be balance billed for Emergency Services received at an In-Network Facility. You may be required to submit a copy of the itemized billing statement for investigation purposes.

When you or your dependent(s) will be out of the IdealCare Service area, contact your primary care physician (PCP) ahead of time to schedule appointments, or obtain prescriptions to last the duration of your time away.

Non-emergency services are not covered by IdealCare when you are out of the IdealCare service area. **If you receive non-emergency services out of the service area, you will be responsible to pay for the balance due to the facility or provider**

**HOSPITAL SERVICES**

When you require hospitalization, your PCP or specialist will refer you to an in-network hospital. Your PCP and IdealCare's Health Services staff will also assist you with coordinating your care throughout your hospital stay.

Please verify that the hospital you are being referred to is within your health benefits plan network.

**BALANCE BILLING**

If you receive care at an in-network hospital, within your health benefits plan network, there is a possibility that some of the hospital-based providers are not in-network with IdealCare. Some examples of hospital-based providers are anesthesiologist, radiologist, pathologist, an emergency department physician, a neonatologist, or an assistant surgeon. These providers can bill you for the difference between IdealCare's allowed amount and the providers billed charge. When a provider bills you for the difference this is called **balance billing. If you receive a balance bill, you should contact IdealCare at 1-844-800-4693.**

If you receive **Emergency Services** at an **In-Network Facility,** within **your health benefits plan network,** and you receive a balance bill from a non-network facility based physician, or other health care practitioner for **Emergency Services**, please contact Member Services at 1-844-800-4693. You should not be balance billed for **Emergency Services** received at an **In-Network Facility,** within **your health benefits plan**. You may be required to submit a copy of the itemized billing statement for investigation purposes.

**PAYMENT FOR SERVICES AND CLAIMS**

You are responsible for your copayment(s) and/or coinsurance, and deductible, if applicable, at the time services are rendered. Other than your copayments and/or coinsurance, and deductible, if applicable, you should not receive a bill from an IdealCare in-network provider, within your health benefits plan network, for covered services. If you believe, you have received a bill in error call Customer Service toll-free at 1-844-800-4693 for

assistance.

**MEDICAL LIMITATIONS AND EXCLUSIONS**

As described in the Evidence of Coverage (EOC), some benefits are not available for:

1. Services provided by a non-participating provider, except when:
   a. Authorized by Sendero or
   b. The following services are Medically Necessary to render Emergency Care:

      - Professional ambulance service; or
      - Services in a Hospital emergency room, freestanding emergency medical care facility or Comparable Emergency Facility;

2. Services incurred before the Effective Date or after the termination date of this EOC/Contract;
3. Services not Medically Necessary to prevent, alleviate, cure or heal Bodily Injury or Illness, except for the specified routine Preventive Services;
4. Charges for prophylactic services including, but not limited to, prophylactic mastectomy or any other services performed to prevent a disease process from becoming evident in the organ tissue at a later date;
5. Services which are Experimental or Investigational, or related to such, whether incurred prior to, in connection with, or subsequent to the service which is Experimental or Investigational except as expressly provided in this EOC/Contract. The fact that a service is the only available treatment for a condition may not make it eligible for coverage if We deem it to be Experimental or Investigational;
6. Complications directly related to a service that is not an EOC/Covered Service under this Contract because it was determined by us to be Experimental or Investigational or not Medically Necessary, except as expressly provided in this Contract. Directly related means that the service occurred as a direct result of the Experimental or Investigational or not Medically Necessary service and would not have taken place in the absence of the Experimental or Investigational or not Medically Necessary service;
7. Services exceeding the amount of benefits available for a particular service;
8. Services for, or the treatment of complications of, non-covered procedures or services;
9. Services, except for Emergency Care, relating to an Illness or Bodily Injury incurred as a result of the Covered Person. Services relating to an Illness or Bodily Injury as a result of:

   a. For which no charge is made, or for which the Covered Person would not be required to pay if he/she did not have

this coverage, unless charges are received from and reimbursable to the United States government, or any of its agencies as required by law;

b. Furnished by or payable under any plan or law through a government or any political subdivision, except Medicaid, unless prohibited by law which You or the Covered Person is not legally obligated to pay;
c. Furnished while a Covered Person is Confined in a Hospital or institution owned or operated by the United States government or any of its agencies for any service-connected Illness or Bodily Injury;
d. Which are not rendered or not substantiated in the medical records;
e. Provided by a Family Member or person who resides with the Covered Person;
f. Performed in association with a non-covered service.
g. Hospital Inpatient Services when the Covered Person is in Observation Status;
h. Except as otherwise provided in this Contract, cosmetic services, or any complication there from;
i. Custodial care and Maintenance Care;

10. Ambulance services for routine transportation to, from or between medical facilities and/or a Healthcare Practitioner's office;
11. Elective medical or surgical abortion unless:
    a. An abortion is performed due to a medical emergency. For purposes of this section, medical emergency means a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that, as certified by a physician, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed.
12. Reversal of sterilization;
13. Infertility Treatment;
14. Sexual dysfunction;
15. Sex change services, regardless of any diagnosis of gender role or psychosexual orientation problems;
16. Vision examinations or testing for the purposes of prescribing corrective lenses; radial keratotomy; refractive keratoplasty; or any other Surgery or procedure to correct myopia, hyperopia or stigmatic error; orthoptic treatment (eye exercises); or the purchase or fitting of eyeglasses or contact lenses, unless specified in this Contract;
17. Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes including, but not limited to, excision of partially or completely un-erupted impacted teeth, any oral or periodontal Surgery and preoperative and postoperative care, implants and related procedures, orthodontic procedures, and any dental services related to a Bodily Injury or Illness except as expressly provided in this

Contract;

18. Pre-surgical/procedural testing duplicated during a Hospital Confinement;
19. Any treatment for obesity, regardless of any potential benefits for co-morbid conditions, including but not limited to:

    a. Surgical procedures for Morbid Obesity;
    b. Services or procedures for the purpose of treating an Illness or Bodily Injury caused by, complicated by, or exacerbated by the obesity; or
    c. Complications related to any services rendered for weight reduction;
    d. Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss Surgery;

20. Foot care services, in the absence of diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency, including but not limited to:

    a. Shock wave therapy of the feet;
    b. Treatment of Weak, strained, flat, unstable or unbalanced feet;
    c. Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
    d. Tarsalgia, metatarsalgia or bunion treatment, except Surgery which involves exposure of bones, tendons or ligaments;
    e. Cutting of toenails, except removal of nail matrix; and
    f. Arch supports, heel wedges, lifts, shoe inserts, the fitting or provision of foot orthotics or orthopedic shoes, unless Medically Necessary because of diabetes or hammertoe;

21. Hair prosthesis, hair transplants or implants;
22. Hearing care that is routine, including but not limited to exams and tests, any artificial hearing device, auditory prostheses or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension, except as expressly provided in this Contract;
23. Services rendered in a premenstrual syndrome clinic or holistic medicine clinic;
24. Transplant services except as expressly provided in this Contract;
25. Over the counter medical items or supplies that can maybe prescribed by a Healthcare Practitioner but are also available without a written order or Prescription, except for Preventive Services;
26. Immunizations including those required for foreign travel for Covered Persons of any age except as expressly provided in this Contract;

27. Treatment for any jaw joint problem, including but not limited to, temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and skull;
28. Genetic testing, counseling or services;
29. Expense for employment, school, sports or camp physical examinations or for the purpose of obtaining insurance, premarital tests/examinations;
30. Services received in an emergency room unless Emergency Care;
31. Any Expense Incurred for services received outside of the United States except for Emergency Care services;
32. Services received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness;
33. Services and supplies which are:

    a. Rendered in connection with mental Illnesses not classified in the current Diagnostic and Statistical Manual of Mental Disorders;
    b. Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation; and
    c. Specifically excluded is marriage counseling;

34. No benefits will be provided for:

    a. Immunotherapy for recurrent abortion;
    b. Chemonucleolysis;
    c. Biliary lithotripsy;

35. Home uterine activity monitoring;
36. Sleep therapy;
37. Light treatment for Seasonal Affective Disorder (S.A.D.);
38. Immunotherapy for food allergy;
39. Prolotherapy;
40. Cranial banding;
41. Hyperhidrosis Surgery; and
42. Sensory integration therapy;
43. Charges for alternative medicine, including medical diagnosis, treatment and therapy.
44. Alternative medicine services include, but is not limited to:
45. Acupressure;
46. Acupuncture;
47. Aromatherapy;
48. Ayurveda;
49. Biofeedback (except to the extent it includes Neurofeedback Therapy that is Medically Necessary for the treatment of an Acquired Brain Injury);

50. Faith healing;
51. Guided mental imagery;
52. Herbal medicine;
53. Holistic medicine;
54. Homeopathy;
55. Hypnosis;
56. Macrobiotic;
57. Massage therapy;
58. Naturopathy;
59. Ozone therapy;
60. Reflexology;
61. Relaxation response;
62. Rolfing;
63. Shiatsu; and
64. Yoga;
65. Living expenses; travel; transportation, except as expressly provided in the Ambulance services provision or Transplants provision in the Your Contract Benefits section of this Contract; and
66. Charges for services that are primarily and customarily used for a non- medical purpose or used for environmental control or enhancement (whether or not prescribed by a Healthcare Practitioner) including but not limited to:
67. Common household items such as air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows, or exercise equipment;
68. Scooters or motorized transportation equipment escalators, elevators, ramps, modifications or additions to living/working quarters or transportation vehicles;
69. Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
70. Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools or spas or saunas;
71. Medical equipment including blood pressure monitoring devices, PUVA lights and stethoscopes;
72. Charges for any membership fees or program fees paid by a Covered Person, including but not limited to, health clubs, health spas, aerobic and strength conditioning, work-hardening programs and Weight loss or similar programs and any related material or products related to these programs;
73. Communication system, telephone, television or computer systems and related equipment or similar items or equipment; and
74. Communication devices except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.
75. Services for in vitro fertilization and promotion of fertility through extra- coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-

peritoneal insemination, trans- uterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.

**PRESCRIPTION DRUG EXCLUSIONS**

Except as expressly stated otherwise, no benefit will be provided for, or on account of, the following items:

1. Drugs which are not included on the Drug Formulary;
2. Dietary supplements except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or certain other inherited metabolic diseases and amino acid- based elemental formulas as expressly provided in this Contract;
3. Nutritional products;
4. Fluoride supplements except when prescribed to preschool children older than 6 months of age whose primary water source is deficient in fluoride;
5. Minerals;
6. Herbs and vitamins
7. Legend (prescription) drugs which are not deemed Medically Necessary by Us;
8. Any drug prescribed for any Illness or Bodily Injury for which services are not covered under this Contract;
9. Any drug prescribed for intended use other than for:

    a. Indications approved by the FDA; or o
    b. off-label indications recognized through peer-reviewed medical literature;

10. Any drug, medicine or medication that is either;

    a. Labeled “Caution-limited by Federal law investigational use”; or
    b. Experimental or investigation, even though a charge is made to the Covered Person;

11. Allergen extracts;
12. The administration of covered medication(s);
13. Therapeutic devices or appliances, except as expressly provided in this Contract, including, but not limited to:

    a. Hypodermic needles and syringes except needles and syringes for use with insulin, and Self-Administered Injectable Drugs whose coverage is approved by Us;
    b. Support garments;
    c. Mechanical pumps for delivery of medication; and
    d. Other non-medical substances;

14. Anorectic or any drug used for the purpose of Weight control;
15. Abortifacients (drugs used to induce abortions);

16. Any drug used for cosmetic purposes, including, but not limited to:

    a. Tretinoin, e.g. Retin A, except if the Covered Person is under the age of 35 or is diagnosed as having adult acne;
    b. Dermatologicals or hair growth stimulants; or
    c. Pigmenting or de-pigmenting agents, e.g. Solaquin;

17. Contrary to any other provisions of this Contract, We may decline coverage or, if applicable, exclude from the Drug Formulary any and all drugs, including new indications for an existing drug, until the conclusion of a review period not to exceed 6 months following FDA approval for the use and release of the drug, including new indications for an existing drug into the market;
18. Any drug or medicine that is:

    a. Lawfully obtainable without a Prescription (over the counter drugs), except insulin; or drugs, medicines or medications required as part of Healthcare reform with a Prescription from a Healthcare Practitioner;
    b. Available in Prescription strength without a Prescription;

19. Compounded estrogen, progesterone, and testosterone for the treatment of hormone replacement therapy;
20. Infertility Treatment including medications;
21. Any drug prescribed for impotence and/or sexual dysfunction, e.g. Viagra;
22. Any drug, medicine or medication that is consumed or injected at the place where the Prescription is given or dispensed by the Healthcare Practitioner;
23. Drug delivery implants;
24. Prescriptions that are to be taken by or administered to the Covered Person, in whole or in part, while he/she is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:

    a. Hospital;
    b. Skilled nursing facility; or
    c. Hospice facility;

25. Injectable drugs, including, but not limited to:

    a. Immunizing agents; or
    b. Self-administered injectable drugs or Specialty Drugs for which coverage is not approved by us

26. Prescription refills:

    a. In excess of the number specified by the Healthcare

Practitioner, or
b. Dispensed more than one year from the date of the original order;

27. Any portion of a Prescription or refill that exceeds a 90-day supply when received from either a mail-order Pharmacy or from a retail Pharmacy that participates in Sendero's program which allows a Covered Person to receive a 90-day supply of a Prescription or refill;
28. Any portion of a Prescription or refill that exceeds a 30-day supply when received from a retail Pharmacy that does not participate in Sendero's program which allows a Covered Person to receive a 30-day supply of a Prescription or refill;
29. Any portion of a Specialty Drug or Self-Administered Injectable Drug that exceeds a 30- day supply;
30. Any portion of a drug for which Prior Authorization or Step Therapy is required and not obtained;
31. Any drug for which a charge is customarily not made;
32. Any portion of a Prescription or refill that:
    a. Exceeds Sendero's drug specific Dispensing Limit (i.e. IMITREX);
    b. Is dispensed to a Covered Person whose age is outside the drug specific age limits defined by Us;
    c. Is refilled early, as defined by Us; or
    d. Exceeds the duration-specific Dispensing Limit;

33. Any drug, medicine or medication received by the Covered Person:

    a. Before becoming covered under this benefit; or
    b. After the date the Covered Person's coverage under this Contract has ended;

34. Any costs related to the mailing, sending or delivery of Prescription Drugs;
35. Any intentional misuse of this benefit, including Prescriptions purchased for consumption by someone other than the Covered Person;
36. Any Prescription or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;
37. Any amount the Covered Person paid for a Prescription that has been filled, regardless of whether the Prescription is revoked or changed due to adverse reaction or change in dosage or Prescription;

    If a claim is denied as being Experimental Investigation, You have the right to seek review of the denial by an Independent Federal External Review.

## PRIOR AUTHORIZATION REQUIREMENTS

Prior authorization lets IdealCare know in advance that a specific care plan or service is needed for you. Your PCP or in-network treating provider is responsible for obtaining the necessary preauthorization. Preauthorization does not guarantee payment of services if the physician or provider has materially misrepresented the proposed health care services or has substantially failed to perform the proposed health care services. Please confirm with your provider if the treatment or services are covered by IdealCare and if an authorization is needed. The availability of benefits is subject to other IdealCare requirements such as limitations and exclusions, payment of premium, and eligibility at the time of care and service.

IdealCare's preauthorization program uses written, medically acceptable screening criteria, and procedures that are established and updated with input from in-network providers.

IdealCare will notify your PCP or treating provider of the decision regarding the pre-authorization request no later than the third day after the date the request was received. If the preauthorization request is for **concurrent hospitalization care**, IdealCare will notify your PCP, or submitting provider within 24 hours after the request is received. If the preauthorization is for **post-stabilization treatment or life-threatening conditions**, IdealCare will provide notification to your PCP or submitting provider no later than one hour after the request was received. If IdealCare denies the service(s) we will provide written notification within three calendar days from the telephone or electronic transmission of the adverse determination. If the circumstance involves **post-stabilization treatment or life-threatening conditions,** IdealCare will provide a response for the proposed services requested within the appropriate timeframe relating to the delivery of the services, and the condition of the member, but in no case to exceed one hour from receipt of the request. If Sendero receives a prior authorization request for services after the services have been rendered, the requested services will be denied for no prior authorization within three (3) calendar days from receipt of request.

## CONTINUITY OF CARE

Continuity of care is important to your health. Continuity of care is concerned with quality of care over time. It is the process by which the patient and his/her physician-led care team are cooperatively involved in ongoing health care management toward the shared goal of high quality, cost-effective medical care. If you are receiving treatment for a medical condition at the time your PCP and/or specialist leaves the IdealCare network, you may be eligible to continue the treatment for a period of time with your treating provider regardless of the provider's network status.

Per Texas Insurance Code § 843.362. Continuity of Care; Obligation of Health Maintenance Organization

(a) In this section, “special circumstance” means a condition regarding which a treating physician or provider reasonably believes that discontinuing care by that physician or provider could cause harm to an enrollee who is a patient. Examples of an enrollee who has a special circumstance include an enrollee with a disability, acute condition, life-threatening illness, or who is past the 24th week of pregnancy.

(b) Each contract between a health maintenance organization and a physician and provider must provide that termination of the contract, except for reason of medical competence or professional behavior, does not release the health maintenance organization from the obligation of continuing to reimburse a physician or provider providing medically necessary treatment at the time of termination to an enrollee who has a special circumstance in accordance with the dictates of medical prudence. Subject to Subsections (d) and (e), the health maintenance organization must provide continued reimbursement at not less than the contract rate in exchange for the enrollee's continued receipt of ongoing treatment from the physician or provider.

(c) The treating physician or provider shall identify a special circumstance. The treating physician or provider must:

(1) request that an enrollee be permitted to continue treatment under the physician's or provider's care; and
(2) agree not to seek payment from the enrollee of any amount for which the enrollee would not be responsible if the physician or provider continued to be included in the health maintenance organization delivery network.

(d) Except as provided by Subsection

(e) This section does not extend the obligation of a health maintenance organization to reimburse a terminated physician or provider for ongoing treatment of an enrollee after:

(1) the 90th day after the effective date of the termination; or
(2) if the enrollee has been diagnosed with a terminal illness at the time of termination, the expiration of the nine-month period after the effective date of the termination.

(f) If an enrollee is past the 24th week of pregnancy at the time of termination, a health maintenance organization's obligation to reimburse a terminated physician or provider or, if applicable, an enrollee extends through delivery of the child and applies to immediate postpartum care and a follow-up checkup within the six-week period after delivery.

(g) A contract between a health maintenance organization and a

physician or provider must provide procedures for resolving disputes regarding the necessity for continued treatment by a physician or provider.

IdealCare will work with you to facilitate the transition to a new provider as appropriate. Contact Customer Service toll-free at 1-844-800-4693 for more information.

Providers are required by contract to provide IdealCare with a 90-day written notice of their intent to terminate their participation in the network. IdealCare will make every effort to provide a 30-day notice to impacted members when a provider's network relationship terminates. IdealCare will work with you to facilitate the transition to a new provider as appropriate.

**HOW TO FILE OR VOICE A COMPLAINT**

You have the right to file a complaint if you are unhappy about the services/ benefits or care you received from IdealCare or an IdealCare provider, call us at 1-844-800-4693. A full investigation will be conducted on your complaint. IdealCare will let you know the results of our investigation, and will follow-up with you in writing within 30 calendar days from receipt of your verbal or written complaint and/or Complaint Form.

You can also file a complaint by completing and returning the Complaint Form found on our website at http://senderohealth.com/idealcareeng/resources.html.

IdealCare will not discriminate or take punitive action against a member or a member's representative for making a complaint, an Appeal, or requesting an Expedited Appeal. IdealCare will not engage in retaliatory action including refusal to renew or cancel coverage because the member or a person acting on behalf of the member has filed a complaint against IdealCare or appealed a decision of IdealCare. Furthermore, IdealCare is prohibited from retaliating against a physician or providers because the physician or provider has filed a complaint or appealed a decision on behalf of the enrollee.

At any time, you may file a complaint with the Texas Department of Insurance (TDI) by writing or calling:

Texas Department of Insurance (TDI)
Consumer Protection, MC 111-1A
P.O. Box 149091
Austin, TX 78714-9091
Fax: (512) 490-1007
Web: http://www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

**APPEAL PROCESS**

You may appeal a decision that adversely affects your coverage, benefits or your relationship with IdealCare. If you are not happy with the decision, you may file an appeal by phone or mail. You may call us toll-free at 1-844-800-4693 if you need assistance with starting the appeal process. If you need language assistance, let us know and we will provide translation services. You may send a written appeal to:

IdealCare by Sendero Health Plans
Attn: Appeals
2028 E. Ben White Blvd., Suite 400
Austin, TX 78741

If your circumstance involves a life-threatening condition, prescription drugs or intravenous infusions for which the patient is receiving health benefits under the evidence of coverage you are entitled to an immediate appeal to an Independent Federal External Review.

The Utilization Review shall provide notice of an adverse determination for a concurrent review of the provision of prescription drugs or intravenous infusions for which the patient is receiving health benefits under the evidence of coverage no later than the 30th day before the date on which the provision of prescription drugs or intravenous infusions will be discontinued.

When you appeal an adverse determination for a concurrent review of health care services IdealCare will provide:

(1) Coverage or benefits for the contested health care services, including prescription drugs and intravenous infusion, under the enrollee's evidence of coverage while the appeal is being considered; and
(2) Without regard to whether the adverse determination is upheld on appeal, IdealCare can still charge an enrollee for the applicable copayment, under the enrollee's evidence of coverage, including prescription drugs and intravenous infusion, received during the period the appeal was considered except for an applicable copayment, under the enrollee's evidence of coverage.
(3) Furthermore, IdealCare is prohibited from retaliating against a physician or providers because the physician or provider has filed a complaint or appealed a decision on behalf of the enrollee.

**EXPEDITED APPEALS**

An Expedited Appeal is when IdealCare is required to make a decision quickly based on your health status, and taking the time for a standard appeal could jeopardize your life or health, such as when you are in the

hospital continued treatment has been denied, prescription drugs or intravenous infusions. To request an Expedited Appeal, call our Health Services department toll-free at 1-855-297-9191. You may also request an Expedited Appeal in writing. We will make a determination as soon as possible and communicate the decision to you and your provider immediately based on your needs but not to exceed 72 hours from the date of your request.

Through the Expedited Appeals process, you have the right to continue any service you are presently receiving until the final decision of your appeal is issued. If the services being appealed are not medically necessary, you may be responsible for them. If IdealCare denies your request for an expedited appeal, we will notify you. Your request will be moved to the regular appeals process. We will mail you our decision within 30 days.

**INDEPENDENT FEDERAL EXTERNAL REVIEW**

Some appeals that are denied by IdealCare may be reviewable by an Independent Federal External Review. Any member whose Appeal of an Adverse Determination is denied by Sendero may seek review of that determination by submitting an appeal request through the Federal External Review Process. To find out about the process to request a Federal External Review, you may call Sendero's Health Services Department at 1-855-297-9191 for more information. You may also visit http://www.externalappeal.com/Forms.aspx to download and complete a HHS Federal External Review Request Form and return it to:

MAXIMUS Federal Services, Inc.,
3750 Monroe Avenue, Suite 705,
Pittsford, NY 14534,
Toll- Free phone: 888-866-6205
Fax: 888-866-6190

If you have any additional questions regarding this process, please call Sendero Health Services Department at 1-855-297-9191, Monday – Friday 8 AM to 5 PM.

**HOW TO OBTAIN INFORMATION ABOUT PROVIDERS**

Our Provider Directory contains information about the professional qualifications of our physicians. The Provider Online Search Tool at www.senderohealth.com/idealcarenetwork can supply information about our physicians' certification and indicate whether a particular provider is accepting new patients. It is a good idea to call the provider to make sure that they are in IdealCare's network prior to receiving services. Customer Service can also give you more information about a provider's qualifications such as medical school attended, residencies, board certification status, and can let you know if a provider is accepting new

patients. You can call Customer Service toll-free at 1-844-800-4693, if you would like more information about physicians.

**CHOOSING YOUR PHYSICIAN**

Now that you have chosen IdealCare, your next choice will be deciding who will provide the majority of your health care services. Your Primary Care Physician or Primary Care Provider (PCP) will be the one you call when you need medical advice, when you are sick, and when you need preventive care such as immunizations. Your PCP is also part of a 'network' or association of health professionals who work together to provide a full range of health care services. That means when you choose your PCP, you are also choosing a network and in most instances, you are not allowed to receive services from any physician or health care professional, including your obstetrician-gynecologist (OB-GYN) that is not also part of your PCP's network. You will not be able to select any physician or health care professional outside of your PCP's network, even though that physician or health care provider is listed with your health plan. The network to which your PCP belongs will provide or arrange for all of your care, so make sure that your PCP's network includes the specialists and hospitals that you prefer.

**SELECTING A PRIMARY CARE PROVIDER (PCP)**

After you make your first initial payment, you must select a Primary Care Physician (PCP) for yourself as well as anyone else listed on your plan. You have a choice to select a provider who will provide the majority of your health care services. You will select a PCP from the IdealCare Plan's network of family or general providers, internists and pediatricians, within your health benefits plan network. The selection of a PCP is crucial for immediate access to acute and preventive care. Your PCP will provide and/or coordinate all aspects of your medical care and oversee your course of treatment to ensure that proper care is maintained. For a list of IdealCare, providers visit our website at https://senderohealth.com/idealcareeng/providers.html

In-network providers, within your health benefits plan network, are located in the Travis Service Area, which includes: Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, and Williamson Counties. You can also call Customer Service toll-free at 1-844-800-4693 for assistance with finding a provider. IdealCare uses standardized processes to evaluate and approve providers for our network. The practices of in-network providers are reviewed on a regular basis to ensure they continue to meet IdealCare's standards.

Please assist your PCP by:

- Requesting that your prior medical records be transferred to your new PCP's office.

- Presenting your IdealCare ID card every time you receive medical services.
- Paying the provider copayment(s), coinsurance or applicable deductible amounts at the time of service.
- Contacting your PCP as soon as possible after a medical emergency so he or she can arrange for follow up care.
- Obtaining a referral from your PCP before seeking non-emergency specialty medical care, except when accessing care from an obstetrician/gynecologist (OB/GYN) within your health benefits plan network or behavioral health provider.

Your PCP is available, directly or through arrangements for coverage with other providers, 24 hours a day, 7 days a week. If you are admitted to an inpatient facility, a provider other than your PCP may direct and oversee your care. If you have a chronic, disabling or life-threatening condition, you may request to use a specialty care provider as your PCP. For a specialty care provider to be named as your PCP, he or she must meet all IdealCare PCP requirements, and be willing to accept the responsibility of coordinating all of your health care needs. If you want to request a specialty care provider as your PCP, call Customer Service to make the change request.

IdealCare provides no benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your evidence of coverage and below.

You have the right to an adequate network of in-network physicians and providers (known as network physicians and providers).

If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer/complfrm.html.

If IdealCare approves a referral for out-of-network services because no network physician or provider is available, or if you have received out-of-network emergency care, IdealCare must, in most cases, resolve the out-of-network physician's or provider's bill so that you only have to pay any applicable in-network copayment, coinsurance, and deductible amounts.

You may obtain a current directory of network physicians and providers at the following website: http://senderohealth.com/idealcareeng/providers.html or by calling 1-844-800-4693 for assistance in finding available network physicians and providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out of network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate directory information to IdealCare, dated not more than 30 days before you received the service.

## CHANGING YOUR PRIMARY CARE PROVIDER

We want our members to be satisfied with all aspects of their health care. If for any reason, you want to change your PCP call Customer Service toll-free at 1-844-800-4693. You may also request a PCP change through your secure member portal.

## SELECTING YOUR OBSTETRICIAN AND GYNECOLOGIST

ATTENTION FEMALE ENROLLEES: You have the right to select and visit an obstetrician-gynecologist (OB-GYN) without first obtaining a referral from your PCP that is within your health benefits plan network. You are not required to select an OB-GYN. You may elect to receive your OB-GYN services from your PCP.

You have the right to obtain the following services with an in-network provider within your health benefits plan network, without a referral or an authorization from IdealCare:

- One "well-woman" examination per year. This would include a pelvic, breast exam, and a Papanicolaou test (Pap test).
- Care for all gynecological conditions.
- Care for any disease or treatment within the scope of the provider's license, including diseases of the breast.

Check our website for a listing of in-network IdealCare OB/GYN providers within your health benefits plan network: http://senderohealth.com/idealcareeng/providers.html or contact Customer Service if you need additional information about how to access OB/GYN services.

## ACCESSING SPECIALTY SERVICES

IdealCare covers a full range of specialty services. If your PCP determines that your condition requires treatment by a specialist, he or she will refer you to the appropriate in-network specialist, within your health benefits plan network.

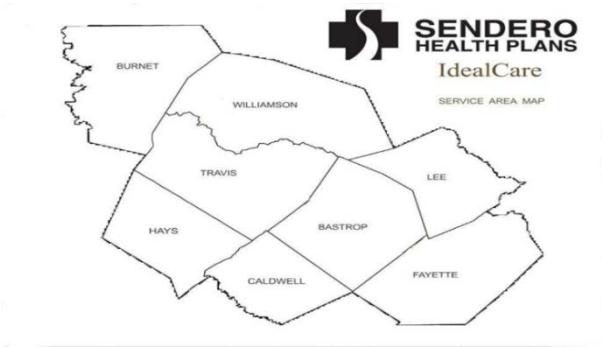
**NOTE: You are not required to obtain a referral from your PCP to access care from an OB/GYN or behavioral health provider within your health benefits plan network**.

For a list of specialty care providers in the IdealCare network within your health benefits plan network, visit our website http://senderohealth.com/idealcareeng/providers.html. IdealCare providers will be in the Travis service area, which includes Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, and Williamson Counties. The online search tool is updated every two weeks. You may also call Customer Service for the

most current network provider information toll-free at 1-844-800-4693.

**SERVICE AREA**

IdealCare products provide benefits to eligible members who live in the Travis Service Area. The Travis Service Area includes Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, and Williamson Counties. IdealCare has in-network providers and facilities within the Travis Service Area to provide you the health care treatment you need. You can also find our service area map at www.senderohealth.com/idealcarenetwork along with more helpful information. If you move out of the service area, you will no longer be eligible for health coverage with IdealCare.




**SCHEDULING APPOINTMENTS**

When scheduling an appointment to see a health care provider be specific about your medical needs. This information enables the provider's staff to schedule your appointment time appropriately. You should notify the provider's office as soon as possible if you cannot keep an appointment. Providers can charge you a fee if you do not cancel your appointment within 24-hours of the scheduled appointment time; this fee would be your responsibility. Ask your provider if he/she has a cancellation policy to ensure that you are not charged extra fees due to not canceling your appointment on time.

**COORDINATION OF BENEFITS**

Coordination of Benefits (COB) is when a plan is allowed to determine which insurance plan has the primary payment responsibility and the extent to which the other plans will contribute when an individual is covered by more than one plan.

If you are enrolled in a Marketplace plan, you must notify the Exchange if you gain or have access to other coverage such as a plan offered by an employer. You can contact the Marketplace Exchange at 1-800-318-2596.

If you are enrolled in an Off Exchange plan with IdealCare, you must notify IdealCare by calling 1-844-800-4693 if you gain or have access to other coverage such as a plan offered by an employer.

If you have any questions about coordination of benefits, contact Customer Service toll-free at 1-844-800-4693.

## HOW TO SUBMIT A CLAIM FOR COVERED SERVICES

Most providers will file claims for you. A claim is a detailed invoice that your health care provider (such as your doctor, clinic, or hospital) sends to the health insurer. This invoice shows exactly what services you received. If the provider does not file a claim for services you received, you can submit the information yourself by using the claim form found online at http://senderohealth.com/idealcareeng/resources.html. It is your responsibility to make sure your claim is submitted to Sendero within 95 days from the date services were received. To help assist your provider with submitting claims timely to Sendero, please provide your insurance information as soon as possible and respond to any correspondence sent to you by the provider. You may be responsible for billed charges if your claim is not submitted to Sendero within 95 days from the date of service. IdealCare will review the claim, and if the services received were provided by an in-network provider or facility within your health benefits plan network, we will pay the claim based on our contracted rate with the provider or facility. If you receive emergency services from an out-of-network physician or provider, IdealCare will fully reimburse the provider at the usual and customary rate or at an agreed rate.

If you receive emergency services from an out-of-network physician or provider, Sendero will fully reimburse the provider at the usual and customary rate or at an agreed rate. Sendero will work to hold you harmless for any amounts beyond the copayment, coinsurance or other out-of-pocket amounts that you would have paid had Sendero's network included network physicians or providers from whom you could obtain emergency services in a network facility.

Sendero will work to hold you harmless for any amounts beyond the copayment, coinsurance or other out-of-pocket amounts that you would have paid had Sendero's network included network physicians or providers from whom you could obtain emergency services in a non-network facility.

You will be held harmless for any amounts beyond the copayment, coinsurance or other out-of-pocket amounts in circumstances when non-emergency care is not available through a network physician or provider or on request of a network physician or provider, prior authorization is required and must be approved. Otherwise, non-emergency services received from an out-of-network provider or facility will not be covered.

Send your claim to:

IdealCare by Sendero Health Plans
Attn: Claims
P.O. Box 16493
Austin, TX 78761

**If you choose to receive non-emergency medical treatment from an out-of-network provider, at an out-of-network facility, in an emergency room, urgent care centers, or other facilities without authorization from IdealCare, you will be responsible for the bill(s).**

If you receive **Emergency Services** at an **In-Network Facility, within your health benefits plan network,** and you receive a balance bill from a non-network facility based physician, or other health care practitioner for **Emergency Services**, please contact Member Services at 1-844-800-4693. You should not be balance billed for **Emergency Services** received at an **In-Network Facility, within your health benefits plan network**. You may be required to submit a copy of the itemized billing statement for investigation purposes. To help assist the provider with submitting claims timely to IdealCare, please provide your insurance information as soon as possible and respond to any correspondence sent to you by the provider. You may be responsible for billed charges if your claim is not submitted to Sendero within 95 days from the date of service.

If you receive a bill for laboratory work or another service, which should have been sent to IdealCare, contact Customer Service and we will assist you. Customer Service can also assist you if you paid for services which you believe should be reimbursed.

## MEDICAL NECESSITY

Your provider will make decisions about your care based on "medical necessity" for both medical and behavioral health services. Medically necessary means health care services or supplies needed to prevent, diagnose, or treat an illness, injury, disease, or its symptoms. Medical necessity is:

- Reasonable and necessary to prevent illness or medical conditions or provide early screening, interventions and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a member, or endanger life;
- Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's medical conditions;
- Consistent with health care practice guidelines and standards that are issued by professionally recognized health care organizations or

government agencies;

- Consistent with the diagnosis of the conditions; and
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness and efficiency;
- Furnished in the most appropriate and least restrictive setting in which services can be safely provided;
- Provided at the most appropriate level or supply of services which can safely be provided; and
- Care or services that could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care required.

**ADVANCE DIRECTIVES**

It is your right to accept or refuse medical care. Advance directives can protect you if you ever become mentally or physically unable to choose or communicate about your care due to injury or illness.

**UTILIZATION MANAGEMENT (UM) DECISION MAKING STANDARDS**

UM decisions made by IdealCare employees, delegates and contractors must be based solely on appropriateness of care and service and existence of coverage. IdealCare does not specifically reward providers or other individuals for issuing denials of coverage. Financial incentives for UM decision makers does not encourage decisions that result in underutilization.

**DENIALS OR LIMITATIONS OF PROVIDER'S REQUEST FOR COVERED SERVICES**

IdealCare may deny coverage for health care services that are not covered by your benefit plan. If IdealCare denies healthcare services a letter will be mailed to you with the explanation for the denial including instructions on how to file an appeal, if applicable.

If you are not happy with the decision, you may file an appeal by phone or by mail. You may also request an appeal if IdealCare denied payment of services in whole or in part for covered benefits from an in-network provider, within your health benefits plan network. You can mail your completed appeal form to us or call us toll-free at 1-844-800-4693. You can also download an appeal form at: http://senderohealth.com/idealcareeng/resources.html. If you appeal by phone you or your representative will need to send us a written signed appeal. You do not need to do this if, an Expedited Appeal is requested.

Mail in appeal form to:

IdealCare by Sendero Health Plans Attn: Appeals
2028 E. Ben White, Blvd
Suite 400
Austin, TX 78741

A letter will be mailed to you within five business days informing you that your appeal has been received. We will mail you our decision within 30 calendar days. If IdealCare needs more information to process your appeal, we will notify you of what is needed within the appeal acknowledgement letter. For life threatening care concerns or hospital admissions, you may request an Expedited Appeal.

**CUSTOMER SERVICE**

The IdealCare Customer Service Department has specially trained representatives who are available to assist you with questions regarding your benefits.

They can:

- Assist you in choosing a PCP.
- Explain covered benefits and services.
- Help coordinate around any barriers to accessing health care.
- Send you a new ID card, EOC or any other lost member material.

Our Customer Service Representatives are available Monday through Friday 8:00 am to 5:00 pm toll-free at 1-844-800-4693. If you are hearing impaired, call TTY toll-free at 7-1-1 for assistance.

**LANGUAGE ASSISTANCE**

If you need to speak to a Customer Service Representative in regards to your benefits, access to care, or have any other questions or concerns, please call us. We have bilingual representatives that can assist you in English and Spanish. If you speak a language other than English or Spanish, we can provide an interpreter over the phone to assist with translation. There is no charge for this service.

If you need face-to-face interpretation assistance for a medical appointment, call us toll-free at 1-844-800-4693. At minimum, we will need a 48-hour notice prior to your appointment date to schedule a face-to-face interpreter for your appointment.

**IDENTIFICATION CARD**

Every IdealCare Plan Member will receive a Member ID card which must be presented each time you visit a provider or obtain services. The ID card lists the Member name, Member ID number, Effective Date, Co-payment

and coinsurance amounts and your selected PCP. Important telephone numbers are also listed on your ID card. If you lose your ID card, call Customer Service toll-free at 1-844-800-4693 for a replacement card as soon as possible. IdealCare does not allow for anyone, other than the Member listed on the ID card, to receive IdealCare benefits. Keep your ID card to yourself. IdealCare can terminate your coverage for fraudulent or intentional misrepresentation.


IdealCare SENDERO HEALTH PLANS

TDI/QHP

Member Name:
Member ID#:
Effective Date:

Plan Name:

Co-payment Amounts: OV: ER: IP: SP:
RX Brand: RX Generic:
RX Non-Preferred: RX Specialty:
**After Deductible has been met (if applicable)*

PCP: (Name of Provider)
PCP Phone #:
**Customer Service Phone Number:**
1-844-800-4693

NAVITUS

**IMPORTANT INFORMATION/INFORMACIÓN IMPORTANTE**

| | |
|---|---|
| **CUSTOMER SERVICE/** SERVICIO AL CLIENTE | **1-844-800-4693** |
| **TTY/** LÍNEA DE AYUDA TTY | **7-1-1** |
| **BEHAVIORAL HEALTH/** SALUD DEL COMPORTAMIENTO | **1-855-765-9696** |
| **NURSE LINE/** LÍNEA DE ENFERMEROS | **1-855-880-7019** |
| **VISION SERVICES/** SERVICIOS PARA LA VISTA | **1-855-279-9680** |
| **PHARMACY/** FARMACIA | **1-866-333-2757** |

**NOTICE TO PROVIDER:** The member whose name appears on the face of this card is covered by Sendero Health Plans for IdealCare services. For provider billing questions call 1-844-800-4693. For UM questions call 1-855-297-9191. The UM fax number is 512-901-9724.

In case of emergency call 9-1-1 or go to the closest emergency room. After treatment, call your PCP within 24 hours.

En caso de emergencia, llame al 9-1-1 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame a su PCP dentro de las 24 horas.

**Submit Professional Claims to:** IdealCare, P.O.Box 16493, Austin, TX 78761

REV 10/18

**CONFIDENTIALITY**

We are committed to ensuring that your personal health information is secure and confidential. Our providers are held to the same standard. Except as required in administering your individual health care needs and fulfilling state and federal requirements, your personal information will not be disclosed without your written consent.

If you would like someone other than yourself to access your account, or if you are the Head of Household (HOH) or Legal Guardian of a minor covered by IdealCare, you must submit a Protected Health Information (PHI) Form in order to obtain account information. The PHI form can be downloaded from the IdealCare website. You can also contact Member

Services at 1-844-800-4693 to request that a form be mailed to the address listed in the Member's account.

**NOTIFICATION OF CHANGES**

If you are enrolled in a plan through the Federally Facilitated Exchange (Exchange), it is your responsibility to notify the Exchange within 30 days, or as soon as possible, of a qualifying event, such as a change in marital status, the addition of dependents, a court-ordered change in coverage or other changes that may affect eligibility. The Exchange is responsible for all eligibility decisions. You will also need to contact the Exchange directly to terminate your coverage. Please notify the Exchange and IdealCare about a change in your address or contact information as soon as possible.

If you are enrolled in an off-exchange plan directly with IdealCare, it is your responsibility to notify IdealCare within 30 days, or as soon as possible, of a qualifying event, such as a change in marital status, the addition of dependents, a court-ordered change in coverage or other changes that may affect eligibility. IdealCare is responsible for all eligibility decisions. You will also need to contact IdealCare directly to terminate your coverage. Please notify IdealCare about a change in your address or contact information as soon as possible.

**GRACE PERIOD**

Grace Period is a time period in which an overdue premium can be paid after the due date and the member is able retain ongoing coverage.

IdealCare provides members with a grace period of 90 days if the member is receiving an Advance Premium Tax Credit (APTC) and has paid at least one full month's premium during the benefit year. Members that are not receiving an APTC or are enrolled in an off-exchange plan have a one-month grace period.

The 90-day health insurance grace period starts the first month you fail to pay, even if you make payments for following months. For example:

- You don't make your premium payment for May.
- You submit premium payments on time for June and July, but still haven't paid for May.
- Your grace period ends July 31 (90 days from May 1).
- If you haven't paid your May premium by July 31 you lose coverage retroactive to the last day of May

The one-month grace period starts the first day of the month that you fail to make a payment. For Example:

- You don't make your June payment by June 1st.
- You are now considered in Grace Period.
- Your Grace Period ends June 30th.

- If you do not pay your entire premium amount due, no later than June 30th, you will lose coverage.
- Your last day of coverage will be May 31st.

Failure to pay outstanding insurance premiums during a grace period may result in your coverage terminating.

**PREMIUM REFUNDS**

Members may call in to request a refund of overpaid premiums. The refunds can be processed by two methods, electronically or by a manual check. The type of refund that is issued depends on the method of payment. Payments made with a debit/credit card on our member portal/website, IVR, auto pay, may be reversed to your debit/credit card. Payments made by check/money order to our lockbox or auto pay with a checking or savings account are refunded manually via a live check. Please contact Customer Service at 1-844-800-4693 to request your refund.

**FRAUD, WASTE AND ABUSE**

If you suspect a person who receives benefits or a provider (e.g., provider, dentist, counselor, etc.) has committed waste, abuse or fraud, you have the responsibility and a right to report it.

**REPORTING PROVIDER / CLIENT FRAUD, WASTE AND ABUSE**

To report Fraud, Waste or Abuse gather as much information as possible. You must report members or providers directly to: Lighthouse Services, and you must include Sendero's name in your report by using the:

- Confidential hotline at 833-290-0001
- Confidential fax at 215-689-3885
- Confidential email at reports@lighthouse-services.com
- Confidential website at www.lighthouse-services.com/senderohealth
- Call Customer Service at 1-844-800-4693; or
- You can report directly to:

  Sendero IdealCare
  2028 East Ben White, Suite 400
  Austin, TX 78741

When reporting a provider (e.g., dentist, counselor, etc.) provide the following:

- Name, address and phone number of provider;
- Name and addresses of the facility (hospital, nursing home, home health agency, etc.);
- Type of provider (provider, physical therapist, pharmacist, etc.);

- Names and the number of other witnesses who can aid in the investigation;
- Dates of events; and
- Summary of what happened

When reporting a person who receives benefits provide the following:

- The person's name;
- The person's date of birth or social security number (if available);
- The city where the person resides; and
- Specific details about the waste, abuse and/or fraud.
- Dates of events

**INTERNAL PROTECTION OF PERSONAL HEALTH INFORMATION**

The steps IdealCare has taken to safeguard members' medical information include but are not limited to:

- Disseminated a Notice of Privacy Practices to covered members and posted it on the IdealCare website at www.senderohealth.com/IdealCare
- Disseminated a Notice of Privacy Practices and other information to providers and facilities about IdealCare's privacy practices
- In daily interaction with members and providers, IdealCare providers and Customer Service representatives inform providers and members of our procedures to verify identity and authority of callers to discuss protected health information

**TECHNOLOGY ASSESSMENT**

IdealCare systematically evaluates the inclusion of new technologies and the new applications of existing technologies as covered services in a timely manner. Your insurance benefit provides coverage only for therapies that have been shown in the scientific medical literature to be safe and effective. The IdealCare technology assessment process assures that coverage will be available when evidence of safety and effectiveness exists. A review of current technology as well as care-specific reviews will be conducted by the IdealCare medical technology assessment team using up-to-date information from sources including but not limited to evidence based medical literature, board certified consultants, physician work groups, professional societies, and government agencies. Drugs that are new to the medical community are reviewed and discussed by the IdealCare pharmacy and therapeutics committee.

**SUBROGATION**

If the plan pays or provides medical benefits for an illness or injury that was caused by an act or omission of any party or entity, the plan will subrogate all rights of recovery of an IdealCare member. The extent of subrogation will be to the level of benefits provided, the reasonable value of services, or benefits provided by the plan.

In addition, the IdealCare member having accepted benefits by the plan agrees to assign their claim against the person or entity responsible for their illness or injury to the plan to the extent of the benefits provided. IdealCare member agrees to cooperate in any way with the plan or the plan's contractor in furtherance of the subrogation/assignment claim; agree to sign any authorization requested by the plan or its contractor; and authorizes the use of their medical records and billing records in furtherance of their subrogation/assignment claim.

Please see the EOC located at http://www.senderohealth.com/idealcareeng/benefits.html for a full description of your rights and obligations.

**MEMBERS RIGHTS AND RESPONSIBILITIES**

As an IdealCare member, you have certain rights and responsibilities, as outlined below.

**You have the right to:**

- Receive coverage for the medical benefits and treatment that is available when you need it and is handled in a way that respects your privacy and dignity.
- Receive information about your health benefit plan, services, and providers, member rights and responsibilities, including information about services that are covered and not covered and any costs that you will be responsible for paying.
- Have a discussion and participate with your health care professional in health decisions and have your health care professional give you information about your medical condition and your treatment options, regardless of coverage or cost. You have the right to receive this information in terms and language you understand.
- Learn about any care you receive. You should be advised of who is available to assist you with any special IdealCare programs or services you receive and who can assist you with any requests to change programs or services.
- Voice complaints and appeals about IdealCare or any provider. Our process is designed to hear and act on your complaint or concern about IdealCare and/or the quality of care you receive from health care professionals and the various places you receive care in our network; provide a courteous, prompt

response and guide you through our grievance process if you do not agree with our decision.

- Make recommendations regarding our policies that affect your rights and responsibilities. If you have recommendations or concerns, please call Customer Service at the toll-free number on your ID card.

**You have the responsibility to:**

- Review and understand the information you receive about your health benefit plan. Please call Customer Service when you have questions or concerns.
- Understand how to obtain services and what supplies are covered under your plan.
- Show your ID card before you receive care.
- Understand your health condition and work with your provider to develop treatment goals that you both agree upon.
- Follow the plans and instructions for care that have been agreed upon by you and your provider.
- Supply information to IdealCare and its providers in order to provide care to you.
- Pay all copays, coinsurance or applicable deductible amounts for which you are responsible at the time service is rendered or when they are due.
- Keep scheduled appointments and notify the health care professional's office ahead of time if you are going to be late or miss an appointment.
- Voice your opinions, concerns or complaints to IdealCare Customer Service and/or your health care professional.
- Notify your plan administrator and treating health care professional as soon as possible about any changes in family size, address, phone number or status with your health benefit plan if you decide to dis-enroll from IdealCare's programs and services.

**NONDISCRIMINATION AND ACCESSIBILITY**

IdealCare by Sendero Health Plans, Inc. (IdealCare) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. IdealCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

IdealCare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio,

accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact IdealCare.

If you believe that IdealCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

IdealCare by Sendero Health Plans
Attn: Member Advocate
2028 E. Ben White Blvd. Ste. 400
Austin, TX 78741
Telephone: 1-844-800-4693
TTY: 711
Fax: 512-901-9724
Complaints.Sendero@senderohealth.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, IdealCare Customer Service is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TTY)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

**TAGLINES:**

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| 1.Spanish | Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Sendero Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-800-4693. |
| 2. Vietnamese | Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Sendero Health Plans quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-800-4693. |
| 3. Chinese | 如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Sendero Health Plans, 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-800-4693. |
| 4. Korean | 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Sendero Health Plans, 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는1-844-800-4693 로 전화하십시오. |
| 5. Arabic | نإ نا ك ك يد ل وأ بد ل صخش هدعاس ت ۡل ئ س أ صوص Sendero Health Plans ، ك يدل ف قح لا ي ف لوص ح لا بل ع قدعاس م لا تامول ع م لاو. ة يرورض لا كت غ ل ب نم نود ة يا قف ل ك ت. 1-844-800-4693. ثدحت ل ل عم مجرت م لص تا ب |
| 6. Urdu | ل اوس ک و نود نو پا رواہ ني بر ے ےد ددم ک و ک پس پا گا ر نود نو پا ت و م ني، ب ےرا ک ے Sendero Health Plans ہ ے ا ک نر ے اح لص م لاع تامو روا ددم م تف م ني بز نا پا ين ک و 1-844- ل ےي، ک ے ک نر ے ب تا ےس ت نامجر ہ .ے قح ک ک ير ں ف نو 800-4693 |
| 7. Tagalog | Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Sendero Health Plans may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-800-4693. |

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| 8. French | Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Sendero Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-800-4693. |
| 9. Hindi | यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Sendero Health Plans के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में म□फ्त में सहायता और सूचना प्राप्त करने का अधकार है। ककसी धु□ भाषषए से बात करने के धए , 1-844-800-4693पर कॉधु करें। |
| 10. Persian | لاوس ،م ي ک ن دي ک ک م وا ب ه امش ک ه ک ی س ي ا امش، گ ا ر دروم رد Sendero Health Plans ، د ار يا ن قح ب ا ش دي ادـ ش ت ت يار ناگ روطـ ب ه ار دوخ بز نا ب ه تـاعـل اطـا و ک ک م ک ه ي راد ن يام دي اح لص ت سام 1-844-800-4693 ن يام دي يرد فا |
| 11. German | Falls Sie oder jemand, dem Sie helfen, Fragen zum Sendero Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-800-4693 an. |
| 12. Gujarati | જો તમે અથવા તમે કોઇને મદદ કરી રહ્ય◌ા તેમ કોઇને Sendero Health Plans ◌વશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મે નો અવક ર છે. તે ખર્ય વન તમ રી ભ ષ મ પ્ર મ કરી શક ર્ છે. ૬ ભ વષર્◌ુો ◌ુ ત કર મ ટે,આ 1-844-800-4693 પર કોલ કરો. |
| 13. Russian | Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Sendero Health Plans то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-844-800-4693. |
| 14. Japanese | ご本人様、またはお客様の身の回りの方でも Sendero Health Plans についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合, 1-844-800-4693 までお電話ください。 |

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| 15. Laotian | ຖ້າທ່ານ, ຫ ູ ືຄົນທ ່ທ່ານກ ໍາລ ັງຊ ່ວຍເຫ ູ ືອ, ມ ໍ ່ າຖ າມກ ່ ງ ວກ ັ ບ Sendero Health Plans ທ ່ ານ ມ ສ ິ ດທ ່ ຈ ະ ໄ ດ ້ ຮ ັ ບ ການ ຊ ່ ວ ຍ ເ ຫ ູ ື ອ ແ ລ ະ ຂ ໍ ້ ມ ູ ນ ຂ ່ າ ວ ສ ານ ທ ່ ເ ປ ັ ນ ພ າ ສ າ ຂ ອ ງ ທ ່ ານ ບ ໍ ່ ມ ຄ ່ າ ໃ ຊ ້ ຈ ່ າ ຍ. ການ ໂ ອ ້ ລ ົ ມ ກ ັ ບ ນ າ ຍ ພ າ ສ າ, 1-844-800-4693. |