IdealCare Silver 73% AV

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

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

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

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

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
Calendar Year Deductibles (applies to all Eligible Expenses including Pharmacy)	$4,000 Individual/$8,000 Family (Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services)	
Out-of-Pocket Limits (applies to all Eligible Expenses including Pharmacy	$6,500 Individual/$13,000 Family (Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services)	
Maximum Lifetime Benefits – per participant	Unlimited (Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services)	
Physician office visit/consultation to treat an injury or illness	100% of Allowed Amount after a $15 Copayment per Visit	No coverage for Out-of-Network Services
Preventive Care/Screening/Immunization	100% of Allowed Amount	No coverage for Out-of-Network Services
Specialist office visit/consultation	100% of Allowed Amount after a $50 Copayment per Visit after Calendar Year Deductible	No coverage for Out-of-Network Services
Other practitioner office visits	100% of Allowed Amount after a $15 Copayment per Visit	No coverage for Out-of-Network Services
Urgent Care Center visit	100% of Allowed Amount after a $50 Copayment per Visit	No coverage for Out-of-Network Services
Outpatient Hospital emergency room/treatment room visit	100% of Allowed Amount after a $350 Copayment per Visit after Calendar Year Deductible	100% of Allowed Amount after a $350 Copayment per Visit after Calendar Year Deductible
Emergency Medical Transportation	100% of Allowed Amount after a $350 Copayment per Transport	100% of Allowed Amount after a $350 Copayment per Transport after Calendar Year Deductible

	after Calendar Year Deductible	
Inpatient Hospital Expenses – All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	100% of Allowed Amount after a $350 Copayment per Stay after Calendar Year Deductible	No coverage for Out-of-Network Services
Inpatient Visits (Physician/surgeon)	30% of Allowable Amount after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services
Diagnostic testing (X-ray , blood work)	100% of Allowed Amount after a $30 Copayment per Visit after Calendar Year Deductible	No coverage for Out-of-Network Services
The administration of whole blood including cost of blood, blood plasma, and blood plasma expanders are covered services	25% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Imaging (CT/PET scans, MRIs)	25% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Laboratory Outpatient and Professional Services	25% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Home Infusion Therapy	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Outpatient Surgery Facility fee (ambulatory surgery center)	10% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Physician surgical services performed in an outpatient setting	10% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Skilled Nursing Facility Limited to 25 visits per year.	100% of Allowed Amount after a $300 Copayment per Stay after Calendar Year Deductible	No coverage for Out-of-Network Services
Home Health Care Limited to 60 visits per year.	100% of Allowed Amount	No coverage for Out-of-Network Services
Hospice	20% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services
Mental Health Care Inpatient Hospital Services*	100% of Allowed Amount after a $350 Copayment per Stay after	No coverage for Out-of-Network Services

	Calendar Year Deductible	
Mental Health Care Outpatient Hospital Services*	25% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Substance Use Disorder Inpatient Hospital Services*	100% of Allowed Amount after a $350 Copayment per Stay after Calendar Year Deductible	No coverage for Out-of-Network Services
Substance Use Disorder Outpatient Hospital Services*	25% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Annual Vision Exam for Members 21 years of age and under.	100% of Allowed Amount after a $40 Copayment per Visit	No coverage for Out-of-Network Services
Annual Prescription Eyewear for Members 21 years of age and under. (1 set of frames and lenses or contact lenses)	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Prenatal and Postnatal Care	100% of Allowed Amount after a $10 Copayment for the initial Prenatal Visit	No coverage for Out-of-Network Services
Delivery and all inpatient services.	100% of Allowed Amount after a $350 Copayment per delivery after Calendar Year Deductible	No coverage for Out-of-Network Services
The administration of a newborn screening test, including the cost of a test kit in the amount required by Health and Safety Code 33.019	100% of Allowed Amount	No coverage for Out-of-Network Services
Annual Well Woman Exam – including cervical cancer and ovarian cancer screening (age 18 and over)	100% of Allowed Amount	No coverage for Out-of-Network Services
Annual screening by low-dose mammography for the presence of occult breast cancer for female participants age 35 and over – Outpatient facility or imaging center and physician component. The 35 and over age restriction does not apply to diagnostic mammogram screenings. Diagnostic Mammogram means evaluation of new abnormalities or of patients with a past abnormality-requiring follow-up. Used to diagnose	100% of Allowed Amount	No coverage for Out-of-Network Services

unusual breast changes, such as a lump, pain, nipple discharge, change in breast size or shape and diagnose previous breast cancer.		
Bone Mass measurement for the detection of low bone mass to determine risk of osteoporosis and fractures associated with osteoporosis for qualified individuals	100% of Allowed Amount	No coverage for Out-of-Network Services
Routine annual prostate cancer detection exam, including a Prostate Specific Antigen test (PSA) for a male Covered Person age 40 or older.	100% of Allowed Amount	No coverage for Out-of-Network Services
Rehabilitation	100% of Allowed Amount after a $ 65 Copayment per visit after Calendar Year Deductible	No coverage for Out-of-Network Services
Durable Medical Equipment	20% of Allowable Amount after Calendar Year Deductible per Equipment	No coverage for Out-of-Network Services
Hearing Aids for Adults (1 per ear every 3 years)	20% of Allowable Amount after Calendar Year Deductible per Hearing Aid	No coverage for Out-of-Network Services
Hearing Aid or Cochlear Implant, related services and supplies for a covered individual, if medically necessary.	20% of Allowable Amount after Calendar Year Deductible per Hearing Aid or Cochlear Implant	No coverage for Out-of-Network Services
Amino Acid-Based Formula	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Phenylketonuria (PKU) management products	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Children’s dental check-up	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Basic Dental-Children	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Major Dental Care- Children	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services

Orthodontia-Children	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services

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