Sendero IdealCare Bronze / $25 PCP / $11 Gen Rx + Free Wellness & Preventive Screening + Free Dedicated Healthcare Team + Free 24/7 Virtual MD Visits + No Pre-existing Condition Restrictions

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, 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**	**Indian Health Care Provider (IHCP) (You will pay the least)**
Calendar Year Deductibles (applies to all Eligible Expenses including Pharmacy)	$8,550.00 Individual / $17,100.00 Family (Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services)		$0 Individual / $0 Family
Out-of-Pocket Limits (applies to all Eligible Expenses including Pharmacy	$8,600.00 Individual / $17,200.00 Family (Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services)		$0 Individual / $0 Family
Maximum Lifetime Benefits – per participant	Unlimited (Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services)		
Primary Care Visit to Treat an injury or illness	100% of Allowed Amount after a $25.00 Copayment per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Specialist office visit/consultation	100% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Other Practitioner Office Visit (Nurse, Physician Assistant)	100% of Allowed Amount after a $25.00 Copayment per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Outpatient Facility fee (e.g.., Ambulatory Surgery Center)	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount

Outpatient Surgery Physician/Surgical services	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Hospice	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Urgent Care Centers or Facilities	100% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Home Health Care Services Limited to 60 visits per year.	100% of Allowable Amount	No coverage for Out-of-Network Services	100% of Allowed Amount
Emergency Room Services	100% of Allowable Amount after Calendar Year Deductible per Visit	100% of Allowable Amount after Calendar Year Deductible per Visit	100% of Allowed Amount
Emergency Medical Transportation/Ambulance	100% of Allowable Amount after Calendar Year Deductible per Transportation	100% of Allowable Amount after Calendar Year Deductible per Transportation	100% of Allowed Amount
Inpatient Hospital Services (Hospital Stay) – All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	100% of Allowable Amount after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services	100% of Allowed Amount
Inpatient Physician and Surgical Services	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Skilled Nursing Facility Limited to 25 visits per year.	100% of Allowable Amount after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services	100% of Allowed Amount
Prenatal and Postnatal Care	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Childbirth/Delivery Professional Services	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Delivery and All Inpatient Services for Maternity Care	100% of Allowable Amount after Calendar Year	No coverage for Out-of-Network Services	100% of Allowed Amount

	Deductible per Delivery		
Mental/Behavioral Health Care Outpatient Services*	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Mental/Behavioral Health Care Inpatient Hospital Services*	100% of Allowable Amount after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services	100% of Allowed Amount
Substance Abuse Disorder Outpatient Services*	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Substance Abuse Disorder Inpatient Services*	100% of Allowable Amount after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services	100% of Allowed Amount
Outpatient Rehabilitation	100% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Habilitation Services	100% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Chiropractic Services Limited to 35 visits per year	100% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Durable Medical Equipment	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Hearing Aids for Adults (1 per ear every 3 years)	100% of Allowable Amount after Calendar Year Deductible per Hearing Aid	No coverage for Out-of-Network Services	100% of Allowed Amount
Hearing Aid or Cochlear Implant, related services and supplies, if medically necessary for all covered individuals including individuals who are 18 years of age or younger. Please contact Sendero Customer Service Department at 1-844-800-4693 to obtain the cost	100% of Allowable Amount after Calendar Year Deductible per Hearing Aid or Cochlear Implant	No coverage for Out-of-Network Services	100% of Allowed Amount

of hearing aid or cochlear implant.			
Imaging (CT/PET scans, MRIs)	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Preventative Care/Screening/Immunization	100% of Allowed Amount	No coverage for Out-of-Network Services	100% of Allowed Amount
Annual Well Woman Exam – including detection of human papillomavirus, cervical cancer and ovarian cancer screening for woman age 18 and over. This includes any other test or screening approved by the United States Food and Drug Administration for the detection of human papillomavirus and ovarian cancer.	100% of Allowed Amount	No coverage for Out-of-Network Services	100% of Allowed Amount
Annual screening by low-dose mammography for the presence of occult breast cancer for female participants age 35 and over – Outpatient facility or imaging center and Physician component	100% of Allowed Amount	No coverage for Out-of-Network Services	100% of Allowed Amount
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	100% of Allowed Amount
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	100% of Allowed Amount
Routine Foot Care	100% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Routine Eye Exam for Children (1 per year)	100% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount

Eye Glasses for Children (1 set of frames with lenses or contact lenses per year)	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Dental Check-Up for Children	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Rehabilitative Speech Therapy	100% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Rehabilitative Occupational and Rehabilitative Physical Therapy	100% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Well Baby Visits and Care	100% of Allowable Amount	No coverage for Out-of-Network Services	100% of Allowed Amount
Laboratory Outpatient and Professional Services	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
The administration of whole blood including cost of blood, blood plasma, and blood plasma expanders are covered services	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
X-rays and Diagnostic Imaging	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Basic Dental-Children	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Orthodontia-Children	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Major Dental Care- Children	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Transplant	20% of Allowable Amount	No coverage for Out-of-Network Services	100% of Allowed Amount
Accidental Dental	100% of Allowable Amount after	No coverage for Out-of-Network Services	100% of Allowed Amount

	Calendar Year Deductible		
Dialysis	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Allergy Testing	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Chemotherapy	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Radiation	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Diabetes Education	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Prosthetic Devices	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Infusion Therapy	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Treatment for Temporomandibular Joint Disorders	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Nutritional Counseling	100% of Allowed Amount after a $5.00 Copayment per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Reconstructive Surgery	20% of Allowable Amount	No coverage for Out-of-Network Services	100% of Allowed Amount
Mammography	100% of Allowed Amount after a $250.00 Copayment after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Cardiovascular Disease	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount

Osteoporosis	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Diabetes Care Management	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Inherited Metabolic Disorder (PKU)	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Post-Mastectomy Care	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Brain Injury	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Transplant Donor Coverage	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Autism Spectrum Disorders	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount

*Sendero Health Plans (Sendero) 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. Sendero 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.

Sendero will fully reimburse non-participating providers at the usual and customary rate or at the agreed-upon rate: when services are rendered to an enrollee by a non-network facility-based physician in a network facility, or in circumstances where an enrollee is not given the choice of a network physician or provider for emergency services performed in a non-network facility, and for prior authorized non-emergency services that are not available through an in-network provider. Sendero will not impose cost-sharing for such services that is greater than the cost-sharing requirement that would apply if such services had been provided in-network; and shall count such cost sharing toward any in-network deductible and out-of-pocket maximum.