Sendero IdealCare Gold / 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)	$2,000.00 Individual / $4,0000.00 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	$8,700.00 Individual / $17,400.00 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 $30.00 Copayment per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Specialist office visit/consultation	100% of Allowed Amount after a $60.00 Copayment per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Other Practitioner Office Visit (Nurse, Physician Assistant)	Not Applicable	Not Applicable	Not Applicable
Outpatient Facility fee (e.g.., Ambulatory Surgery Center)	25% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount

Outpatient Surgery Physician/Surgical services	25% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Hospice	Not Applicable	Not Applicable	Not Applicable
Urgent Care Centers or Facilities	100% of Allowed Amount after a $45.00 Copayment per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Home Health Care Services	Not Applicable	Not Applicable	Not Applicable
Emergency Room Services	25% of Allowable Amount after Calendar Year Deductible per Visit	35% of Allowable Amount after Calendar Year Deductible per Visit	100% of Allowed Amount
Emergency Medical Transportation/Ambulance	Not Applicable	Not Applicable	Not Applicable
Inpatient Hospital Services (Hospital Stay) – All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	25% 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	Not Applicable	Not Applicable	Not Applicable
Skilled Nursing Facility Limited to 25 visits per year.	25% of Allowable Amount after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services	100% of Allowed Amount
Prenatal and Postnatal Care	Not Applicable	Not Applicable	Not Applicable
Childbirth/Delivery Professional Services	Not Applicable	Not Applicable	Not Applicable
Delivery and All Inpatient Services for Maternity Care	Not Applicable	Not Applicable	Not Applicable
Mental/Behavioral Health Care Outpatient Services*	100% of Allowed Amount after a $30.00 Copayment per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Mental/Behavioral Health Care Inpatient Hospital Services*	25% 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 Allowed Amount after a $30.00 Copayment per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount

Substance Abuse Disorder Inpatient Services*	25% of Allowable Amount after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services	100% of Allowed Amount
Outpatient Rehabilitation	Not Applicable	Not Applicable	Not Applicable
Habilitation Services	Not Applicable	Not Applicable	Not Applicable
Chiropractic Services	Not Applicable	Not Applicable	Not Applicable
Durable Medical Equipment	Not Applicable	Not Applicable	Not Applicable
Hearing Aids for Adults	Not Applicable	Not Applicable	Not Applicable
Hearing Aid or Cochlear Implant, related services, and supplies	Not Applicable	Not Applicable	Not Applicable
Imaging (CT/PET scans, MRIs)	25% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Preventative Care/Screening/Immunization	Not Applicable	Not Applicable	Not Applicable
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 Allowable Amount	Not Applicable	Not Applicable
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 Allowable Amount	Not Applicable	Not Applicable
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 Allowable Amount	Not Applicable	Not Applicable
Routine annual prostate cancer detection exam, including a Prostate Specific Antigen test (PSA) for a male	100% of Allowable Amount	Not Applicable	Not Applicable

Covered Person age 40 or older.			
Routine Foot Care	Not Applicable	Not Applicable	Not Applicable
Routine Eye Exam for Children	Not Applicable	Not Applicable	Not Applicable
Eye Glasses for Children	Not Applicable	Not Applicable	Not Applicable
Dental Check-Up for Children	Not Applicable	Not Applicable	Not Applicable
Rehabilitative Speech Therapy	100% of Allowed Amount after a $30.00 Copayment per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Rehabilitative Occupational and Rehabilitative Physical Therapy	100% of Allowed Amount after a $30.00 Copayment per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Well Baby Visits and Care	Not Applicable	Not Applicable	Not Applicable
Laboratory Outpatient and Professional Services	25% 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	25% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
X-rays and Diagnostic Imaging	25% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Basic Dental-Children	Not Applicable	Not Applicable	Not Applicable
Orthodontia-Children	Not Applicable	Not Applicable	Not Applicable
Major Dental Care- Children	Not Applicable	Not Applicable	Not Applicable
Transplant	Not Applicable	Not Applicable	Not Applicable
Accidental Dental	Not Applicable	Not Applicable	Not Applicable
Dialysis	Not Applicable	Not Applicable	Not Applicable
Allergy Testing	Not Applicable	Not Applicable	Not Applicable
Chemotherapy	Not Applicable	Not Applicable	Not Applicable
Radiation	Not Applicable	Not Applicable	Not Applicable
Diabetes Education	Not Applicable	Not Applicable	Not Applicable
Prosthetic Devices	Not Applicable	Not Applicable	Not Applicable
Infusion Therapy	Not Applicable	Not Applicable	Not Applicable
Treatment for Temporomandibular Joint Disorders	Not Applicable	Not Applicable	Not Applicable
Nutritional Counseling	Not Applicable	Not Applicable	Not Applicable
Reconstructive Surgery	Not Applicable	Not Applicable	Not Applicable
Mammography	Not Applicable	Not Applicable	Not Applicable
Cardiovascular Disease	Not Applicable	Not Applicable	Not Applicable

Osteoporosis	Not Applicable	Not Applicable	Not Applicable
Diabetes Care Management	Not Applicable	Not Applicable	Not Applicable
Inherited Metabolic Disorder (PKU)	Not Applicable	Not Applicable	Not Applicable
Post-Mastectomy Care	Not Applicable	Not Applicable	Not Applicable
Brain Injury	Not Applicable	Not Applicable	Not Applicable
Transplant Donor Coverage	Not Applicable	Not Applicable	Not Applicable
Autism Spectrum Disorders	Not Applicable	Not Applicable	Not Applicable

*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.