IdealCare Complete

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

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

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

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

| Overall Payment Provisions | In-Network Benefits | Out-of-Network Benefits | Indian Health Care Provider (IHCP) (You will pay the least) |
|-----------------------------------|---|---|---|
| Calendar Year Deductibles | \$[0 -4,250] Individua | 1/\$[0 – 8,500] Family | \$0 Individual/\$0 |
| (applies to all Eligible Expenses | (Out-of-Network Services as | re Excluded unless they are | Family |
| including Pharmacy) | approved by the Plan or are Emergency Services) | | • |
| Out-of-Pocket Limits (applies | \$[0 – 7,500] Individual | l/\$[0 - 15,000] Family | \$0 Individual/\$0 |
| to all Eligible Expenses | (Out-of-Network Services as | re Excluded unless they are | Family |
| including Pharmacy | approved by the Plan or a | re Emergency Services) | |
| Maximum Lifetime Benefits – | | Unlimited | |
| | (Out-of-Network Services are Excluded unless they are approved by the Plan or are | | |
| per participant | | | |
| Physician office | 100% of Allowed | No coverage for Out- | 100% of Allowed |
| visit/consultation to treat an | Amount after a \$[0-20] | of-Network Services | Amount |
| injury or illness | Copayment per Visit | | |
| Preventive | 100% of Allowed | No coverage for Out- | 100% of Allowed |
| Care/Screening/Immunization | Amount | of-Network Services | Amount |
| | 100% of Allowed | No coverage for Out- of-Network Services | 100% of Allowed |
| Specialist office | Amount after a \$[0-60] | | Amount |
| visit/consultation | Copayment per Visit | | |
| visit/consultation | after Calendar Year | | |
| | Deductible | | |
| | 100% of Allowed | No coverage for Out- of-Network Services | 100% of Allowed |
| Other practitioner office visits | Amount after a \$[0-20] | | Amount |
| | Copayment per Visit | of freework betvices | |
| | 100% of Allowed | No coverage for Out- of-Network Services | 100% of Allowed |
| Urgent Care Center visit | Amount after a \$[0-60] | | Amount |
| | Copayment per Visit | | |
| Outpatient Hospital emergency | 100% of Allowed | 100% of Allowed | 100% of Allowed |
| | Amount after a \$[0- | Amount after a \$[0- | Amount |
| room/treatment room visit | 350] Copayment per | 350] Copayment per | |
| Toom/treatment room visit | Visit after Calendar | Visit after Calendar | |
| | Year Deductible | Year Deductible | |

| | 1000/ 6 4 11 1 | 1000/ 6 411 1 | 1000/ 6 4 11 1 |
|---------------------------------|-----------------------------------|-----------------------|-----------------|
| | 100% of Allowed | 100% of Allowed | 100% of Allowed |
| | Amount after a \$[0- | Amount after a \$[0- | Amount |
| Emergency Medical | 350] Copayment per | 350] Copayment per | |
| Transportation | Transport after | Transport after | |
| | Calendar Year | Calendar Year | |
| | Deductible | Deductible | |
| Inpatient Hospital Expenses – | 100% of Allowed | | 100% of Allowed |
| All usual Hospital services and | Amount after a \$[0- | No coverage for Out- | Amount |
| supplies, including semiprivate | 500] Copayment per | of-Network Services | |
| room, intensive care, and | Stay after Calendar | or-network services | |
| coronary care units. | Year Deductible | | |
| _ | [0 to 30]% of | | 100% of Allowed |
| Inpatient Visits | Allowable Amount | No coverage for Out- | Amount |
| (Physician/surgeon) | after Calendar Year | of-Network Services | |
| | Deductible per Stay | | |
| | 100% of Allowed | | 100% of Allowed |
| | Amount after a \$[0-30] | | Amount |
| Diagnostic testing (X-ray, | Copayment per Visit | No coverage for Out- | |
| blood work) | after Calendar Year | of-Network Services | |
| | Deductible | | |
| The administration of whole | [0 to 25]% of | | 100% of Allowed |
| blood including cost of blood, | Allowable Amount | No coverage for Out- | Amount |
| blood plasma, and blood plasma | after Calendar Year | of-Network Services | Amount |
| | Deductible | or-Network Services | |
| expanders are covered services | | | 100% of Allowed |
| | [0 to 25]% of Allowable Amount | No servene se fon Out | |
| Imaging (CT/PET scans, MRIs) | | No coverage for Out- | Amount |
| | after Calendar Year | of-Network Services | |
| | Deductible | | 1000/ C A 11 1 |
| | [0 to 25]% of | N C O I | 100% of Allowed |
| Laboratory Outpatient and | Allowable Amount | No coverage for Out- | Amount |
| Professional Services | after Calendar Year | of-Network Services | |
| | Deductible | | 10001 0.11 |
| | [0 to 20]% of | | 100% of Allowed |
| Home Infusion Therapy | Allowable Amount | No coverage for Out- | Amount |
| | after Calendar Year | of-Network Services | |
| | Deductible | | |
| | [0 to 25]% of | | 100% of Allowed |
| Outpatient Surgery Facility fee | Allowable Amount | No coverage for Out- | Amount |
| (ambulatory surgery center) | after Calendar Year | of-Network Services | |
| | Deductible | | |
| Dhysioian surgical sarviors | [0 to 25]% of | | 100% of Allowed |
| Physician surgical services | Allowable Amount | No coverage for Out- | Amount |
| performed in an outpatient | after Calendar Year | of-Network Services | |
| setting | Deductible | | |
| Chilled Mancine Carillan | 100% of Allowed | | 100% of Allowed |
| | Amount after a \$[0- | No servere se fe : O | Amount |
| Skilled Nursing Facility | 300] Copayment per | No coverage for Out- | |
| Limited to 25 visits per year. | Stay after Calendar | of-Network Services | |
| | Year Deductible | | |
| | ** ** * * * * | l | |

| | [0 to 20]% of | | 100% of Allowed |
|--|--------------------------------|---|-----------------|
| Home Health Care | Allowable Amount | No coverage for Out- | Amount |
| Limited to 60 visits per year. | after Calendar Year | of-Network Services | 1 11110 WIIV |
| | Deductible per Visit | | |
| Hospice | [0 to 20]% of | | 100% of Allowed |
| | Allowable Amount | No coverage for Out- | Amount |
| | after Calendar Year | of-Network Services | |
| | Deductible per Visit | | |
| Mental Health Care Inpatient Hospital Services* | 100% of Allowed | | 100% of Allowed |
| | Amount after a \$[0- | No coverage for Out- of-Network Services | Amount |
| | 500] Copayment per | | |
| Hospital Services | Stay after Calendar | OI-INCLWOIR SCIVICES | |
| | Year Deductible | | |
| | [0 to 25]% of | | 100% of Allowed |
| Mental Health Care Outpatient | Allowable Amount | No coverage for Out- | Amount |
| Hospital Services* | after Calendar Year | of-Network Services | |
| | Deductible per Visit | | |
| | 100% of Allowed | | 100% of Allowed |
| Substance Use Disorder | Amount after a \$[0- | No coverage for Out- | Amount |
| Inpatient Hospital Services* | 500] Copayment per | of-Network Services | |
| | Stay after Calendar | | |
| | Year Deductible | | 1000/ 6 11 1 |
| | [0 to 25]% of | | 100% of Allowed |
| Substance Use Disorder | Allowable Amount | No coverage for Out- | Amount |
| Outpatient Hospital Services* | after Calendar Year | of-Network Services | |
| | Deductible per Visit | | 1000/ CAII 1 |
| Annual Vision Exam – Children | 100% of Allowed | No coverage for Out- | 100% of Allowed |
| and Adults (1 per year) | Amount after a \$[0-45] | of-Network Services | Amount |
| Approx Dragonintian Everyone | Copayment per Visit | | 100% of Allowed |
| Annual Prescription Eyewear – Children (1 set of frames with | [0 to 20]% of Allowable Amount | No coverage for Out- | Amount |
| lenses or contact lenses per | after Calendar Year | of-Network Services | Amount |
| year) | Deductible | OI-INCIWOIR SCIVICES | |
| year) | 100% of Allowed | | 100% of Allowed |
| | Amount after a \$[0-10] | No coverage for Out- | Amount |
| Prenatal and Postnatal Care | Copayment for the | of-Network Services | rimount |
| | initial Prenatal Visit | of freework pervices | |
| | 100% of Allowed | | 100% of Allowed |
| 5.1 | Amount after a \$[0- | | Amount |
| Delivery and all inpatient services | 500] Copayment per | No coverage for Out- of-Network Services | |
| | delivery after Calendar | | |
| | Year Deductible | | |
| Annual Well Woman Exam – | | | 100% of Allowed |
| including cervical cancer and | 100% of Allowed | No coverage for Out- | Amount |
| ovarian cancer screening (age | Amount | of-Network Services | |
| 18 and over) | | | |
| Annual screening by low-dose | 100% of Allowed | No coverage for Out- | 100% of Allowed |
| mammography for the presence | Amount | of-Network Services | Amount |
| of occult breast cancer for | 7 Hillouit | OI I TOUWOIK DOI VICES | |

| | T | | |
|--------------------------------|-------------------------|----------------------|-----------------|
| female participants age 35 and | | | |
| over – Outpatient facility or | | | |
| imaging center and Physician | | | |
| component | | | |
| Bone Mass measurement for the | | | 100% of Allowed |
| detection of low bone mass to | | | Amount |
| determine risk of osteoporosis | 100% of Allowed | No coverage for Out- | |
| and fractures associated with | Amount | of-Network Services | |
| osteoporosis for qualified | | | |
| individuals | | | |
| Routine annual prostate cancer | | | 100% of Allowed |
| detection exam, including a | 100% of Allowed | No coverage for Out- | Amount |
| Prostate Specific Antigen test | Amount | of-Network Services | |
| (PSA) for a male Covered | Amount | or-Network Services | |
| Person age 40 or older. | | | |
| | 1000/ -£ 411 1 | | 100% of Allowed |
| | 100% of Allowed | | Amount |
| Rehabilitation | Amount after a \$[0-65] | No coverage for Out- | |
| | Copayment per visit | of-Network Services | |
| | after Calendar Year | | |
| | Deductible | | |
| | [0 to 20]% of | | 100% of Allowed |
| | Allowable Amount | | Amount |
| Durable Medical Equipment | after Calendar Year | No coverage for Out- | |
| qq | Deductible per | of-Network Services | |
| | Equipment | | |
| | [0 to 20]% of | | 100% of Allowed |
| | Allowable Amount | N C O . | Amount |
| Hearing Aids for Adults (1 per | after Calendar Year | No coverage for Out- | |
| ear every 3 years) | Deductible per Hearing | of-Network Services | |
| | Aid | | |
| | [0 to 20]% of | | 100% of Allowed |
| Hearing Aid or Cochlear | Allowable Amount | | Amount |
| Implant, related services and | after Calendar Year | No coverage for Out- | |
| supplies for a covered | Deductible per Hearing | of-Network Services | |
| individual, if medically | Aid or Cochlear | | |
| necessary. | Implant | | |
| | [0 to 20]% of | | 100% of Allowed |
| A . A . 1 B . 1 B . 1 | Allowable Amount | No coverage for Out- | Amount |
| Amino Acid-Based Formula | after Calendar Year | of-Network Services | |
| | Deductible | | |
| | [0 to 20]% of | | 100% of Allowed |
| Phenylketonuria (PKU) | Allowable Amount | No coverage for Out- | Amount |
| management products | after Calendar Year | of-Network Services | |
| | Deductible | | |
| | [0 to 20]% of | | 100% of Allowed |
| Children's dental check-up | Allowable Amount | No coverage for Out- | Amount |
| | after Calendar Year | of-Network Services | |
| | Deductible | | |

| Basic Dental-Children | [0 to 20]% of | | 100% of Allowed |
|-----------------------------|---------------------|----------------------|-----------------|
| | Allowable Amount | No coverage for Out- | Amount |
| | after Calendar Year | of-Network Services | |
| | Deductible | | |
| Major Dental Care- Children | [0 to 20]% of | | 100% of Allowed |
| | Allowable Amount | No coverage for Out- | Amount |
| | after Calendar Year | of-Network Services | |
| | Deductible | | |
| Orthodontia-Children | [0 to 20]% of | | 100% of Allowed |
| | Allowable Amount | No coverage for Out- | Amount |
| | after Calendar Year | of-Network Services | |
| | Deductible | | |

^{*}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.