Sendero IdealCare Extended Bronze / 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
Calendar Year Deductibles (applies to all Eligible Expenses including Pharmacy)	$7,500.00 Individual / $15,000.00 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	$9,000.00 Individual / $18,000.00 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)	
Primary Care Visit to Treat an injury or illness	100% of Allowed Amount after a $50.00 Copayment per Visit	No coverage for Out-of-Network Services
Specialist office visit/consultation	100% of Allowed Amount after a $100.00 Copayment per Visit	No coverage for Out-of-Network Services
Other Practitioner Office Visit (Nurse, Physician Assistant)	Not Applicable	Not Applicable
Outpatient Facility fee (e.g.., Ambulatory Surgery Center)	50% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Outpatient Surgery Physician/Surgical services	50% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Hospice	Not Applicable	Not Applicable
Urgent Care Centers or Facilities	100% of Allowed Amount after a $75.00 Copayment per Visit	No coverage for Out-of-Network Services
Home Health Care Services	Not Applicable	Not Applicable

Emergency Room Services	50% of Allowable Amount after Calendar Year Deductible per Visit	50% of Allowable Amount after Calendar Year Deductible per Visit
Emergency Medical Transportation/Ambulance	Not Applicable	Not Applicable
Inpatient Hospital Services (Hospital Stay) – All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	50% of Allowable Amount after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services
Inpatient Physician and Surgical Services	Not Applicable	Not Applicable
Skilled Nursing Facility Limited to 25 visits per year.	50% of Allowable Amount after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services
Prenatal and Postnatal Care	Not Applicable	Not Applicable
Childbirth/Delivery Professional Services	Not Applicable	Not Applicable
Delivery and All Inpatient Services for Maternity Care	Not Applicable	Not Applicable
Mental/Behavioral Health Care Outpatient Services*	100% of Allowed Amount after a $50.00 Copayment per Visit	No coverage for Out-of-Network Services
Mental/Behavioral Health Care Inpatient Hospital Services*	50% of Allowable Amount after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services
Substance Abuse Disorder Outpatient Services*	100% of Allowed Amount after a $50.00 Copayment per Visit	No coverage for Out-of-Network Services
Substance Abuse Disorder Inpatient Services*	50% of Allowable Amount after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services
Outpatient Rehabilitation	Not Applicable	Not Applicable
Habilitation Services	Not Applicable	Not Applicable
Chiropractic Services	Not Applicable	Not Applicable
Durable Medical Equipment	Not Applicable	Not Applicable
Hearing Aids for Adults	Not Applicable	Not Applicable
Hearing Aid or Cochlear Implant, related services, and supplies	Not Applicable	Not Applicable
Imaging (CT/PET scans, MRIs)	50% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Preventative Care/Screening/Immunization	100% of Allowable Amount	Not Applicable
Annual Well Woman Exam – including detection of human	100% of Allowable Amount	Not Applicable

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.		
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
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
Routine annual prostate cancer detection exam, including a Prostate Specific Antigen test (PSA) for a male Covered Person age 40 or older.	100% of Allowable Amount	Not Applicable
Routine Foot Care	Not Applicable	Not Applicable
Routine Eye Exam for Children	Not Applicable	Not Applicable
Eye Glasses for Children	Not Applicable	Not Applicable
Dental Check-Up for Children	Not Applicable	Not Applicable
Rehabilitative Speech Therapy	100% of Allowed Amount after a $50.00 Copayment per Visit	No coverage for Out-of-Network Services
Rehabilitative Occupational and Rehabilitative Physical Therapy	100% of Allowed Amount after a $50.00 Copayment per Visit	No coverage for Out-of-Network Services
Well Baby Visits and Care	Not Applicable	Not Applicable
Laboratory Outpatient and Professional Services	50% of Allowable Amount 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	50% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
X-rays and Diagnostic Imaging	50% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Basic Dental-Children	Not Applicable	Not Applicable

Orthodontia-Children	Not Applicable	Not Applicable
Major Dental Care- Children	Not Applicable	Not Applicable
Transplant	Not Applicable	Not Applicable
Accidental Dental	Not Applicable	Not Applicable
Dialysis	Not Applicable	Not Applicable
Allergy Testing	Not Applicable	Not Applicable
Chemotherapy	Not Applicable	Not Applicable
Radiation	Not Applicable	Not Applicable
Diabetes Education	Not Applicable	Not Applicable
Prosthetic Devices	Not Applicable	Not Applicable
Infusion Therapy	Not Applicable	Not Applicable
Treatment for Temporomandibular Joint Disorders	Not Applicable	Not Applicable
Nutritional Counseling	Not Applicable	Not Applicable
Reconstructive Surgery	Not Applicable	Not Applicable
Mammography	Not Applicable	Not Applicable
Cardiovascular Disease	Not Applicable	Not Applicable
Osteoporosis	Not Applicable	Not Applicable
Diabetes Care Management	Not Applicable	Not Applicable
Inherited Metabolic Disorder (PKU)	Not Applicable	Not Applicable
Post-Mastectomy Care	Not Applicable	Not Applicable
Brain Injury	Not Applicable	Not Applicable
Transplant Donor Coverage	Not Applicable	Not Applicable
Autism Spectrum Disorders	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.