SelectCare Expanded Bronze Simple
Free 24/7 Doctor by Phone / $25 PCP / $10 Generic Rx

Pharmacy Benefits 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 plan has a Narrow Network, see https://senderohealth.com/idealcareeng/providers.html or call 1-844-800-4693 for a list of network providers.

Sendero prohibits step-therapy for prescription drugs used to treat stage-four advanced metastatic cancer or associated conditions. This prohibition only applies to a FDA-approved drug when its use is consistent with best practices for the treatment of stage-four advanced metastatic cancer or an associated condition and is supported by peer-reviewed, evidence-based literature.

Note: This Consumer Choice Health Benefit Plan does not include all state mandated health insurance benefits. The following benefit is provided at a reduced level from what is mandated:

Mandated Benefit Description	Benefit Reduced
An HMO may charge a deductible only for services performed out of the HMO's service area or for services performed by a physician or provider who is not in the HMO's delivery network.	A deductible will apply to Preferred (Tier 2), Non-preferred (Tier 3), and Specialty Drugs (Tier 4).

Overall Payment Provisions	**In-Network Benefits**	**Out-of-Network Benefits**
Calendar Year Deductibles (applies to all Eligible Expenses including Pharmacy)	$[0-8,150] Individual/$[0–16,300] 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)	$[0-8,150] Individual/$[0–16,300] 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)	
Generic (Tier 1)	100% of Allowed Amount after a $[0-10] Copayment per 30 day supply **Zero Cost Sharing Plan No Charge*	No coverage for Out-of-Network Services
Preferred (Tier 2)	100% of Allowable Amount after Calendar Year Deductible **Zero Cost Sharing Plan No Charge* per 30 day supply	No coverage for Out-of-Network Services
Non-preferred (Tier 3)	100% of Allowable Amount after Calendar Year Deductible **Zero Cost Sharing Plan No Charge* per 30 day supply	No coverage for Out-of-Network Services

Specialty Drugs (Tier 4)	100% of Allowable Amount after Calendar Year Deductible **Zero Cost Sharing Plan No Charge* per 30 day supply	No coverage for Out-of-Network Services
Preventive, includes Vaccinations obtained at the Pharmacy (Tier 6)	100% of Allowed Amount	No coverage for Out-of-Network Services