

IdealCare by Sendero Health Plans

Evidence of Coverage Marketplace

Exchange Health Benefit Plans:

[Total, Complete and Essential]

Consumer Choice Health Benefit Plans

THE CONTRACT UNDER WHICH THIS BENEFIT IS ISSUED IS NOT A CONTRACT OF WORKERS' COMPENSATION, YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

THIS EVIDENCE OF COVERAGE IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

This Consumer Choice of Benefits Health Maintenance Organization health care plan, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may not provide a more affordable health plan for you although, at the same time, it may not provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. Please consult your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage.

Notice of Rights - Figure 28 TAC §11.1612(c):

- A health maintenance organization (HMO) plan provides no benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your evidence of coverage and below.
- You have the right to an adequate network of in-network physicians and providers (known as network physicians and providers).
- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer/complfrm.html.
- If your HMO approves a referral for out-of-network services because no network physician or provider is available, or if you have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network physician's or provider's bill so that you only have to pay any applicable in-network copayment, coinsurance, and deductible amounts.
- You may obtain a current directory of network physicians and providers at the following website: www.senderohealth.com or by calling 844-800-4693 for assistance in finding available network physicians and providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of-network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service.

EVIDENCE OF COVERAGE

Sendero Health Plans, Inc.
(Herein called "Sendero Health Plans" or "Sendero")

Hereby certifies that it has issued an Individual Marketplace Exchange Managed Health Care and Pharmacy Benefits Contract (herein called the "Plan") for qualified Members. Subject to the provisions of the Plan, each Member to whom a Sendero Health Plans Identification Card is issued, shall have coverage under the Plan, beginning on the Effective Date shown on the Identification Card, if timely payment of the total premium due is paid. Issuance of this Evidence of Coverage by Sendero does not waive the eligibility and Effective Date provisions stated in the Plan.



Wesley Durkalski
President and CEO of Sendero Health Plans, Inc

SENDERO CONTACT INFORMATION

Sendero Health Plans
2028 East Ben White Blvd.,
Ste. 400
Austin, Texas 78741
Toll Free Phone Number: 844-800-4693

Resource	Contact Information	Accessible Hours
Member Services	1-844-800-4693	Monday-Friday 8:00 a.m. – 5:00 p.m.
Website	www.senderohealth.com/ Idealcarebenefits/	24 hours /7 days a week
Medical Preauthorizations	1-855-297-9191	Monday-Friday 7:30 a.m. – 6:00 p.m.
Mental Health/Chemical Dependency	1-855-765-9696	24 hours /7 days a week

The Schedule of Benefits and Coverage included with this Evidence of Coverage indicate benefits, copayment, amounts, maximums, and other benefits and payment issues that apply to the Plan.

Sendero Health Plans provides Managed Health Care Pharmacy Benefit Coverage.

This contract can be returned within 10 days of receiving it, and to have the premium paid refunded if, after examination of the contract if you, the contract holder, are not satisfied with it for any reason. If you return the contract to Sendero within 10 days it will be considered void from the beginning, and the relation would be as if no contract had been issued. If services are rendered or claims have been paid by the HMO during the 10 days, you will be responsible for repaying the Sendero or the rendering provider for such services or claims.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Sendero Health Plan’s toll-free telephone number for information or to make a complaint at:

1-844-800-4693

You may also write to Sendero Health Plan’s at:

2028 East Ben White Blvd., Ste. 400
Austin, Tx 78741-6931

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, Tx 78714-9104
Fax: (512) 490-1007
Web: www.tdi.texas.gov

E-Mail: CounsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning Sendero premium or about a claim, you should contact Sendero Health Plans first. If the dispute is not resolved, you may contact the Texas Department of insurance.

ATTACH THIS NOTICE TO SENDERO POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para presentar una queja:

Usted puede llamar al numero de telefono gratuito de Sendero Health Plan’s para obtener informacion o para presentar una queja al:

1-855-895-0475

Usted tambien puede escribir a Sendero Health Plans:

2028 East Ben White Blvd., Ste. 400
Austin, Tx 78741-6931

Usted puede comunicarse con el Departamento de Seguro de Texas para obtener informacion sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, Tx 78714-9104
Fax: (512) 490-1007
Web: www.tdi.texas.gov

E-Mail: CounsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS RECLAMACIONES: Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con Sendero Health Plans primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA: Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

EVIDENCE OF COVERAGE ENCLOSURE

IMPORTANT NOTICE ENCLOSURE

SCHEDULE OF BENEFITS AND COVERAGE ENCLOSURE

INTRODUCTION

Welcome to Sendero (Sendero) Health Plans IdealCare, a Health Maintenance Organization (HMO). The Patient Protection and Affordable Care Act (ACA) was signed into law in March 2010 and created the infrastructure for the creation of the Marketplace. Texas has a standardized set of benefits that are in compliance with the ACA requirements as well as a number of Texas-mandated benefits. The FFE and the Texas Department of Insurance certified Sendero as a Qualified Health Plan (QHP) which enables Sendero to provide an array of IdealCare Plans to the community.

The benefits provided are intended to assist you with many of your health care expenses for Medically Necessary services and supplies. There are provisions throughout this Evidence of Coverage (EOC)/ Contract that affect your health care coverage.

The terms “you” and “your” as used in the EOC refer to IdealCare Members. Use of the masculine pronoun “his,” “he,” or “him” will be considered to include the feminine unless the context clearly indicates otherwise.

SERVICE AREA

To receive benefits as indicated on Your Contract You must choose in-network providers for all care (other than for Emergency Care and Emergency Transportation). The Sendero's network consists of Physicians, Specialty Care Providers, Hospitals, and other health care Facilities and Providers to serve you throughout the IdealCare Plan Service Area. To find an in-network provider of your choice, refer to Your Provider directory, call Sendero's Member Services or visit the Sendero website at www.senderohealth.com/idealcarenetwork.com. The listing may change occasionally, so make sure the Providers You select are still in-network providers at the time of your appointment.

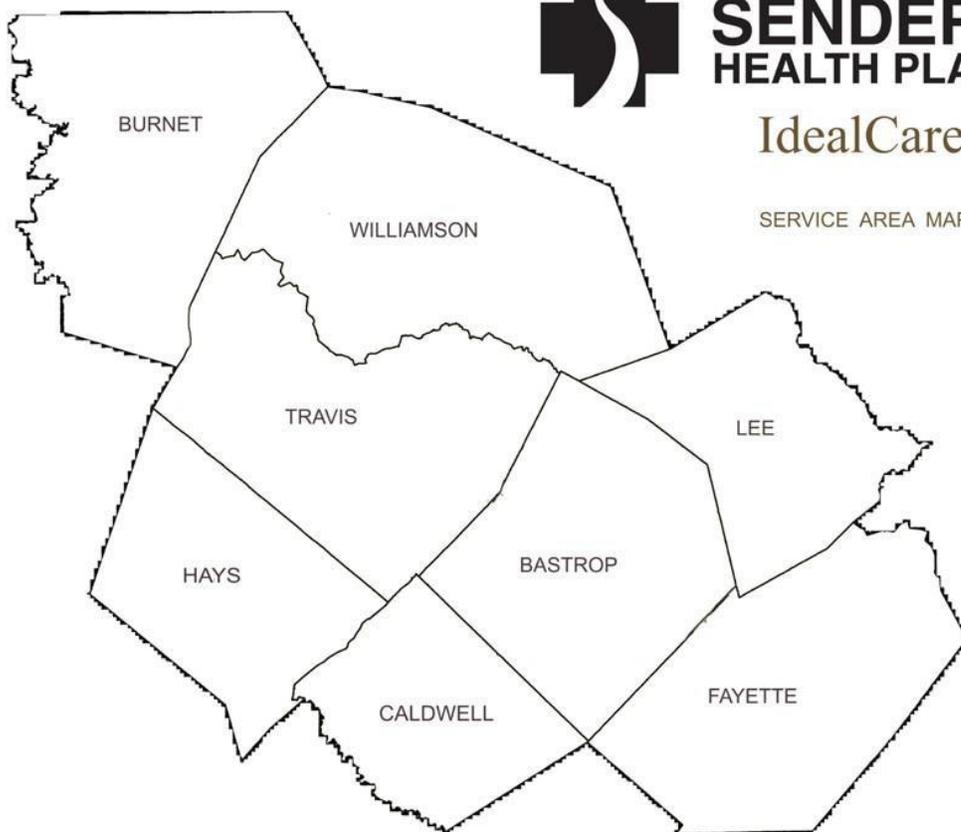
You are responsible for paying any copayment or deductible amounts (based on the Provider's contracted rate or fee). With few exceptions, you should not be balance billed. You may be required to pay for limited or excluded services.



**SENDERO
HEALTH PLANS**

IdealCare

SERVICE AREA MAP



Participating Providers

In most instances, there are Participating Providers available to provide Medically Necessary services. Participating Providers have agreed to accept discounted or negotiated fees. You are responsible for paying the Participating Provider for any applicable deductible and copayment for services received. We offer different managed care plans, and a provider who participates in one plan may not necessarily be a Participating Provider for this Contract.

When receiving services, you must make sure the Provider participates as a Participating Physician or Participating Provider to avoid additional out-of-pocket expenses billed.

Excluded Services Require Preauthorization

Unless preauthorized by Sendero or part of covered Emergency Care, Out-of-Network Benefits are considered Excluded Services and are not Covered Services by Sendero. You are responsible for the full cost of Excluded Services. Covered Services are Medically Necessary, appropriate, preauthorized by Sendero and/or included in your benefits. Excluded Services do not count toward your deductible and copayment Amounts.

If Medically Necessary, covered services are not available through an In-Network Provider, Your Primary Care Provider (PCP) may request a Preauthorization for You to see an Out-of-Network Provider. If You receive a Preauthorization to see an Out-of-Network Provider, Sendero will fully reimburse the Out-of- Network Provider at the usual and customary rate or at an agreed upon rate.

When an Out-Of-Network Provider receives a Preauthorization as described above, you are responsible for deductible and copayments as if the Provider were an In-Network Provider.

Sendero mails or otherwise transmits a Notice of Preauthorization no later than the third calendar day of receipt. If the preauthorization request is for a current hospitalization I or inpatient facility care, Sendero will transmit a notice of whether services are Preauthorization within 24 hours after the request is received by the physician or provider. If the preauthorization request is for post- stabilization treatment or a life- threatening condition, Sendero transmits a notice of whether services are Preauthorized as quickly as possible based on the appropriate delivery of services and the health condition of the member, but not later than one hour after the request is received. Sendero follows up within three working days with a letter to the member and provider of an adverse determination.

Selecting a Primary Care Physician or Provider (PCP)

You may select a Primary Care Physician or Provider (PCP) for yourself and for each covered Dependent. Selecting a PCP will provide you with a Medical Home, and selecting a PCP is important to your overall health. We provide you a number of choices to select for PCP services. The following Participating Provider types may serve as PCPs:

- Physicians from any of the following practice areas: General Practice, Family Practice, Internal Medicine, or Pediatrics, Obstetrical/Gynecology Physicians who notify the Health Plan that

they are willing to serve as PCP for selected Members, Other Specialty Care Physicians who notify the Health Plan that they are willing serve as PCP for selected Members with chronic, disabling, or Life Threatening Illness, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and similar community clinics, or Advanced Practice Nurses (APNs) and Physician Assistants (PAs) when practicing under the supervision of a Physician designated as a PCP.

In addition to choosing your Primary Care Physician, female enrollees can select an obstetrician or gynecologist to provide the health care services that are within the scope of the specialist.

If you have a chronic, disabling, or Life-Threatening Illness, You may apply to our Medical Director to use a Specialty Care Physician as your PCP. You may make this request by calling Our Member Services telephone number on Your Member Identification Card. If your request is denied, you have the right to seek review of the denial through the complaints process. Refer to the Appeals, Complaints and External Review Rights provision in this Contract for more information.

You may change your PCP online through the Member Portal or by calling Member Services. The effective date of the PCP change is on the first of the month; typically, if the request is received before the 15th of the month, the change is effective on the first day of the following month. If the request is received after the 15th of the month, the PCP change is effective on the first day of the month that is subsequent to the following month. In the meantime, your current PCP will continue to coordinate your care. You must arrange to have you/your Dependent's medical files transferred to the new PCP.

Role of the PCP

Your PCP is responsible for providing primary medical care and helping to guide and initiate referrals for any care you receive from other medical care providers, including Specialty Care Physicians.

When a PCP is Not Available

When your PCP is unavailable, you may need to obtain services from the back- up Participating Provider designated by your PCP. You must make sure the back-up Provider participates as a Participating Physician or Participating Provider to avoid additional out-of-pocket expenses. Please be sure to discuss these back-up arrangements with Your PCP.

Seeing a Specialist

All medical needs should be discussed with the PCP. A wide range of Specialty Care Physicians are included in the Sendero network. Some Specialty Care Physicians will require a referral from your PCP. If a Covered Person and his or her PCP determine that there is a need to see a Specialty Care Physician, the PCP should refer you to Sendero's Participating Providers only. Be sure to confirm with Sendero that the Provider you are referred to is In-Network.

We do require Prior Authorization for certain services. Visit our Web site at www.senderohealth.com or call the Member Services' telephone number on Your Member Identification Card for a list of services that require Prior Authorization.

Seeking Emergency Care Services

If you need Emergency Care:

Go to the nearest Participating Hospital emergency room; or

Find the nearest Hospital Emergency Room if your condition does not allow you to go to a Participating Hospital.

Sendero will pay for emergency care performed by non-network physicians at the usual and customary rate or at the agreed rate. In case of an emergency, Sendero will provide coverage for the following emergency care:

1. a medical screening examination or other evaluation required by state or federal law necessary to determine whether an emergency medical condition exists shall be provided to covered enrollees in a hospital emergency facility or comparable facility;
2. Necessary emergency care shall be provided to covered enrollees, including the treatment and stabilization of an emergency medical condition; and
3. Services originated in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility following treatment or stabilization of an emergency medical condition shall be provided to covered enrollees.

Sendero will approve or deny coverage of post stabilization care as requested by a treating physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but not to exceed one hour from the time of the request.

You, or someone on your behalf, must call Sendero within 48 hours after your admission to a Non-Participating Hospital for Emergency Care. If your condition does not allow you to call us within 48 hours after your admission, please contact us as soon as your condition allows. We may transfer you to a Participating Hospital in the Service Area when your condition is stable. You must see a Participating Provider for any follow-up care. If emergency services are provided at a Non-Participating Hospital, we will pay for those services at the usual and customary rate or an agreed rate.

Sendero will fully reimburse non-participating providers at the usual and customary rate or at the agreed 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.

If an enrollee is billed (balance-billed) in these instances, they should contact the plan. The enrollee's responsibility is limited to required copayments and other usual out-of-pocket amounts, such as deductibles and coinsurance.

Seeking Urgent Care Services

The steps for seeking Urgent Care services are as follows:

1. Contact Your PCP or his/her back-up.

If the Primary Care Physician is unavailable, you may go to an Urgent Care Center that is a Participating Provider. You can obtain the names of Participating Provider Urgent Care Centers by calling Sendero or accessing the Provider Directory at www.senderohealth.com. You must receive any services in follow-up to an Urgent Care Center visit from Your PCP or a Participating Provider. You must pay any deductible and copayment required for Urgent Care services.

Use of Non-Participating Providers

Except for emergencies, you must obtain Sendero's approval (a referral) for out-of-network services when (covered) medically necessary services are not available in-network because no network physician or provider is available. We must approve a referral to a non-network physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation.

Sendero will fully reimburse non-participating providers at the usual and customary rate or at the agreed 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.

If an enrollee is billed (balance-billed) in these instances, they should contact the plan. The enrollee's responsibility is limited to required copayments and other usual out-of-pocket amounts, such as deductibles and coinsurance.

Before denying a request for a referral to Non-Participating Provider, we will have the request reviewed by a specialist of the same or similar type of specialty as Non-Participating Provider to whom the referral is requested.

Not all Healthcare Practitioners who provide services at Participating Hospitals are Participating Providers. If services are provided by Non-Participating Providers including but not limited to pathologists, anesthesiologists, radiologists, and emergency room physicians (facility based physicians) at a Participating Hospital, we will pay for those services at the usual and customary rate or an agreed rate.

It is your responsibility to verify the network participation status of all Providers prior to receiving all Non-Emergency services. You should verify network participation status, only from Sendero by either calling the Member Services telephone number on the back of Your Member Identification Card or

accessing our Web site at www.senderohealth.com. We are not responsible for the accuracy or inaccuracy of network participation representations made by any PCP, Specialty Care Physician, Hospital, or other Provider whether contracted with us or not. In other words, if the In-Network Primary Care Physician, Specialty Care Physician, or other Provider recommends that services be received from another entity, it is your responsibility to verify the network participation status of that entity before receiving such services. If you do not, and the entity is not a Participating Provider (regardless of what the referring provider may have told you), you will be responsible for all costs incurred unless we have authorized the services provided.

Utilization Management

Prior Authorization

Prior Authorization means a determination by Sendero that services proposed to be provided to a Covered Person are Medically Necessary and appropriate. Prior Authorization does NOT guarantee coverage of or the payment for the service, or procedure or Prescription Drug reviewed if the Healthcare Practitioner, for those services, has materially misrepresented the proposed services or has substantially failed to perform the proposed services. If Sendero preauthorized the services, Sendero may not deny or reduce payment to the physician or provider for those services based upon medical necessity or appropriateness of care unless the physician or provider has materially misrepresented the proposed health care services or has substantially failed to perform the proposed health care services. For Prescription Drugs, Prior Authorization is a confirmation of the dosage, quantity, and duration as appropriate for the Covered Person's age, diagnosis and gender. For all other services or procedures, it is a confirmation of Medical Necessity and appropriateness only. Prior Authorization is not a representation that the healthcare services are covered or that the patient is a Covered Person.

All benefits payable under this Contract must be for services or Prescription Drugs that are Medically Necessary or for Preventive Services as stated in this Contract. Prior Authorization by Sendero is required for certain services and Prescription Drugs. Visit our Web site at www.senderohealth.com or call the Member Services telephone number on Your Member Identification Card to obtain a list of services that requires Prior Authorization or the Prescription Drug Formulary that indicates when Prior Authorization is required for Prescription Drugs. The list of services and Prescription Drugs that require Prior Authorization is subject to change. Coverage provided in the past for services or Prescription Drugs that did not receive or require Prior Authorization is not a guarantee of future coverage of the same service or Prescription Drug.

You are responsible for informing Your Physician or Provider of the Prior Authorization requirements. Your Physician or Provider must contact Sendero by telephone, electronically or in writing to request the appropriate authorization. The telephone number to call to request authorization is on Your Member Identification Card and on Sendero's Prior Authorization Form available to Your Provider for completion. No benefits are payable for services or Prescription Drugs that are not Covered Services.

Preauthorization is not required for In-Network Maternity Care and Treatment of Breast Cancer Unless Extension of Minimum Length of Stay Requested:

Your Plan is required to provide a minimum length of stay in a Hospital facility for the following:

Maternity Care

- 48 hours following an uncomplicated vaginal delivery
- 96 hours following an uncomplicated delivery by caesarean section

Treatment of Breast Cancer

- 48 hours following an uncomplicated vaginal delivery
- 96 hours following an uncomplicated delivery by caesarean section

Providers are required to Notify Sendero of:

- Medical Inpatient Hospital admissions
- Skilled Nursing Facility admissions
- Inpatient Hospice Services
- Inpatient Rehabilitation Long Term Acute Care Hospitals

Providers are required to obtain Preauthorization for the following services from Sendero:

All Out of Network or out of area services, including but not limited to, inpatient, outpatient hospital admissions, surgeries, procedures, referrals, evaluations, specialty services, prescriptions and/or treatments are excluded from coverage unless prior authorized.

- Chiropractic care in excess of 8 visits
- All Organ and Tissue Transplants
- All Transplant Services
- Renal Dialysis
- All Hospice admissions
- All Diagnostic Genetic testing
- Tumor marker laboratory tests
- Investigational or Experimental Drugs or Procedures
- New and Emerging Technologies not Approved by the FDA

Durable Medical Equipment/Orthotics/Prosthetics:

- Durable Medical Equipment (rental or purchase) and Medical Supplies in excess of \$500 per item
- Wound VACs
- Orthotics or Prosthetics devices in excess of a \$250 purchase price of Hearing Aids
- Amino Acid-based Elemental formulas or formula for treatment of heritable diseases, or any canned nutritional
- CPAP/BiPAP Machines
- Breast Pumps over \$250
- Continuous Passive Movement (CPM) Machines

Surgeries/Procedures - Inpatient or Outpatient

- Circumcision if greater than 1 year of age
- Cochlear Implants

- Hyperbaric treatment for wound care
- Cosmetic, reconstructive or plastic surgery
- Accidental Dental Services
- Dental anesthesia, orthognathic and other oral surgery procedures related to accident or trauma
- Temporomandibular Joint (TMJ) surgery
- Robotic Radiosurgery (Cyber knife and others)
- Proton Beam therapies
- Implantable Pumps and Devices over \$500
- Treatment for Varicose Veins
- Vagal Nerve Stimulators
- Hysterectomy
- Nasal Septal Reconstructions or Revision
- Joint Replacement Surgery
- Spine Procedures (i.e. discectomy and decompression)
- Surgery for Obstructive Sleep Apnea
- Balloon Sinusplasty
- Umbilical Hernia Surgery if under age 5
- Osteochondral allograft or autologous chondrocyte implantation or Anesthesia for upper/lower OJ endoscopic procedures
- Anesthesia for upper/lower OJ endoscopic procedures

Outpatient Services/Treatment

- Injectable drugs in excess of \$500 average wholesale price per dose Synagis
- Sleep studies/sleep labs
- TMJ treatment
- Physical Therapy, Speech Therapy, or Occupational Therapy (including initial evaluation for Speech Therapy)
- Treatment for Acquired Brain Injury
- Treatment for Autism Spectrum Disorder
- Biofeedback
- GI tract imaging by Capsule Endoscopy
- Pain management procedures including, but not limited to, external or implanted infusion pumps or stimulator devices, epidural steroid injections, and trigger point injections
- Wound care services, including referral to wound care centers, use of wound vacuum devices and specialized wound dressings
- Allergy testing and injections

Radiological Services

- CT/CTA Scans, MRIs & MRAs not provided in an inpatient or Emergency
- Department setting
- PET Scans/SPECT scans
- Radiological procedures that require admission for observation
- OB ultrasound services in excess of two in a pregnancy unless done by a Maternal-Fetal Medicine (MFM) Specialist

- No authorization required for high-risk pregnancy ultrasound unless NOT done by a Material-Fetal Medicine (MFM) Specialist

Home Health Care

- Skilled Nursing Visits (excluding initial assessment evaluation)
- Physical Therapy, Speech Therapy, or Occupational Therapy (excluding initial evaluation)
- Infusion therapy
- Home Health Services (60 visits per year)

Non-emergent ground ambulance services, including facility to facility transport and all air transport services.

In-Network Benefits will be available if you use In-Network Providers. Services rendered by Out-of-Network Providers are considered Excluded Services, with limited exception. Exceptions include treatment for Emergency Care and services that are preauthorized. In-Network and Out-of-Network Providers are required to preauthorize services for your care.

Providers are required to obtain Preauthorization for the following behavioral health services from Beacon Health Options who provides behavioral care on behalf of Sendero:

- All inpatient treatment of Chemical Dependency and Mental Health Care
- Partial Hospital Programs- mental health and substance use disorder (PHP)
- Intensive Outpatient Program (IOP)
- Transfer from Medical to Acute Inpatient Psychiatric Services
- Autism Services/Applied Behavioral Analysis (up to age 10)
- Psychological and Neuropsychological Testing
- Electro-Convulsive Therapy (ECT)
- For medical anesthesia for ECT, obtain authorization from Sendero

In order to receive benefits, inpatient treatment for Chemical Dependency and Mental Health Care must be preauthorized by your treating practitioner.

The Mental Health/Chemical Dependency Preauthorization Helpline is available 24 hours a day, 7 days a week.

Covered Benefits

Refer to the General Exclusions and Prescription Drug Exclusions sections in this Contract. All terms and provisions of this Contract, including the Prior Authorization requirement specified in this Contract are applicable to Covered Services. Cost sharing and limitations depend on type and site of service.

Prescription Drugs

Any payments under this provision apply toward the Covered Person's Out-of-Pocket Maximum. Payments under this provision do not apply toward the Covered Person's Contract. Benefits may be subject to Dispensing Limits, Prior Authorization or Step Therapy requirements, if any.

Step Therapy, or exception process, will be provided to Covered Person(s) that is readily available to the patient and provider. Step therapy protocol including denials of step therapy exception requests are subject to adverse determination appeal rights as well as an independent review by an independent review organization (IRO).

If the dispensing Pharmacy's charge is less than the Prescription Drug Copayment, the Covered Person will be responsible for the lesser amount.

The amount paid by Sendero to the dispensing Pharmacy may not reflect the ultimate cost to Sendero for the drug. Prescription Drug Copayments are made on a Prescription or refill basis and will not be adjusted if we receive any retrospective volume discounts or Prescription Drug rebates.

We must be notified of any Cost Share that is applicable to a Covered Person's claim that is waived by the Pharmacy. Any amount thus waived and not paid by the Covered Person would not apply to any Prescription Drug Out-of-Pocket Maximum.

Members requesting higher tier drugs when a generic equivalent is available, and the physician did not specifically prescribe the requested drug, are responsible for the higher tier cost sharing amount plus any difference in cost. This cost difference does not apply to any Out-of-Pocket Maximum.

The Specialty Pharmacy program is part of your pharmacy benefit and is mandatory after your first fill at retail. Navitus SpecialtyRx works with a specialty pharmacy to offer services with the highest standard of care. Should you wish to use an alternative Specialty Pharmacy, see if Your Prescription Drug meets the Rx Specialty requirements please contact Navitus Customer Care at 1-866-333-2757.

Covered Prescription Drugs are:

1. Drugs prescribed to treat a chronic, disabling, or life-threatening illness that:
 - a. have been approved by the United States and Drug Administration for at least one indication; and
 - b. are recognized by the following for the treatment of the indication for which the drug is prescribed (1) a prescription drug reference compendium approved by the Department of Insurance, or (2) substantially accepted peer reviewed medical literature.
2. Drugs, medicines or medications that under Federal or State law may be dispensed only by Prescription from a Healthcare Practitioner;
3. Drugs, medicines or medications that are included on the Drug Formulary;
4. Insulin and Diabetic Supplies that are included on the Drug Formulary;
5. Hypodermic needles or syringes when prescribed by a Healthcare Practitioner for use with
 - a. insulin or Self-Administered Injectable Drugs that are included on the Drug Formulary
 - b. hypodermic needles and syringes used in conjunction with covered drugs may be available at no cost to the Covered Person;

6. Hypodermic needles, syringes or other method of delivery necessary for administration of a Specialty Drug, if included with the charge for the Specialty Drug. These may be available at no cost to the Covered Person;
7. Specialty drugs and Self-Administered Injectable Drugs that are included on the Drug Formulary approved by Sendero limited to a 30-day supply, unless otherwise determined by Sendero;
8. Drugs, medicines or medications required under the Affordable Care Act with a Prescription from a Healthcare Practitioner;
9. Enteral formulas and nutritional supplements necessary for the treatment of phenylketonuria (PKU) or other inherited metabolic diseases that are included on the Drug Formulary, or as otherwise determined by the orders of a physician;
10. Prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells;
11. Amino acid-based elemental formulas, regardless of delivery method, when prescribed or ordered by a Healthcare Practitioner as Medically Necessary for the treatment of:
 - a. Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
 - b. Severe food protein-induced enterocolitis syndrome;
 - c. Eosinophilic disorders, as evidenced by the results of a biopsy;
 - d. Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract; and spacers and/or peak flow meters for the treatment of asthma.

The most commonly prescribed drugs, medicines, and medications covered by Sendero are specified on our Drug Formulary. The Drug Formulary identifies categories of drugs, medicines or medications by levels. It also indicates Dispensing Limits and any applicable Prior Authorization or Step Therapy requirements. A Pharmacy and Therapeutics committee made up of Physicians and Pharmacists reviews this information on a regular basis. Placement on the Drug Formulary does not guarantee your Healthcare Practitioner will prescribe that Prescription Drug, medicine or medication for a particular medical or Mental Health condition.

You can obtain a copy of Sendero's Drug Formulary by visiting www.senderohealth.com or calling Navitus' Member Services telephone number on your Member Identification Card. If a specific drug, medicine or medication is not listed on the Drug Formulary, you may contact Sendero orally or in writing with a request to determine whether a specific drug is included on Our Drug Formulary. We will respond to your request no later than the third (3) business day after the receipt date of the request. If we do not approve coverage for a Prescription Drug because it is not on the Drug Formulary, you have the right to appeal that decision. Please refer to Appeals, Complaints and External Review Rights process in the General Provisions section.

Sendero will assist with synchronizing refills for maintenance medications and allows for pro-rated cost sharing amounts for partial supplies of certain medication. If you have any questions, please contact Sendero's Member Services. As a Covered Person, you are not required to make a payment for a prescription drug that is more than the lesser of your copayment, the allowable claim amount, or the amount you would pay if purchasing the prescription without health benefits or discounts.

Sendero may not impose a deductible, copayment, coinsurance, or other cost-sharing provision applicable to benefits for prescription contraceptive drugs, outpatient contraceptive services, or devices unless the amount of the required cost-sharing is the same as or less than the amount of the required cost-sharing applicable to benefits for other prescription drugs or devices under the plan.

Prescription Drug coverage is subject to change. Based on State law, advanced written notice to you is required for the following modification that affects Prescription Drug coverage:

1. Removal of a drug from the Drug Formulary;
2. Requirement that you receive prior authorization for a drug;
3. An imposed or altered quantity limit;
4. An imposed step-therapy restriction;
 - a. Moving a drug to a higher cost-sharing level unless a generic alternative to the drug is available.

Sendero will only make these types of changes to Prescription Drug coverage at renewal of the Contract. We will provide written notice no later than 60 days prior to the effective date of the change.

Emergency Services

Covered Services for Emergency Care in a hospital emergency facility, a freestanding emergency medical care facility or Comparable Emergency Facility. We will pay Non-Participating Physicians and Providers at the usual and customary rate or an agreed rate when you receive care due to a medical emergency.

Maternity Care and Newborn Services

Prenatal, delivery and inpatient services for Maternity Care and postnatal Care. Covered Services for a covered Dependent newborn child includes but is not limited to the following:

1. Bodily injury or Illness;
2. Care and treatment for premature birth; and
3. Medically diagnosed birth defects and abnormalities.

Maternity services include prenatal care, delivery, and postnatal treatment and pregnancy complications.

Prenatal and postnatal care are covered benefits. You may have a deductible and copayment for the initial prenatal visit. Laboratory, ultrasound, genetic testing and/or other medical service requested or provided by your doctor are subject to a copay, deductible and/or coinsurance.

Delivery benefits for vaginal deliveries include the first 48 hours for the mother and newborn. For cesarean section delivery, the first 96 hours for the mother and newborn are covered. Delivery and all inpatient services are covered benefits and are subject to a copay, deductible and/or a coinsurance.

Sendero provides coverage for post-delivery care;

- a. If a decision is made to discharge a woman who has given birth to a child or the newborn child from inpatient care before the expiration of the minimum hours of coverage, Sendero must provide to the woman and child coverage for timely post-delivery care.
- b. The timeliness of the post-delivery care shall be determined in accordance with recognized medical standards for that care.
- c. The post-delivery care may be provided by a physician, registered nurse, or other appropriate licensed health care provider.
- d. Subject to Subsection

The post-delivery care may be provided at:

1. the woman's home;
2. a health care provider's office;
3. a health care facility; or
4. another location determined to be appropriate under rules adopted by the commissioner.

Your plan provides the woman the option to have the care provided in her home.

Out of network prenatal, postnatal care, delivery and all inpatient services are not covered benefits without prior approval for services rendered outside of the network.

Preventive Care Services

Services for well child and adult care Preventive Services are recommended by the U.S. Department of Health and Human Services (HHS) or as mandated by State. This does not include Routine Nursery Care. For the recommended Preventive Services that apply to Your Contract, refer to the HHS at www.HHS.gov or call Sendero's Member Services telephone number on the back of Your Member Identification Card if you have questions on what and when Your Contract covers Preventive Services.

Copayment requirements do not apply to Preventive Services. Covered Services include, but are not limited to, the following:

1. Office visit to a Healthcare Practitioner for a routine or annual physical exam to detect or prevent illness;
2. Routine radiology, laboratory and/or, endoscopic services to detect or prevent illness related to routine or annual exam;
3. Routine mammogram every year for a female Covered Person age 35 years of age or older which includes forms of low-dose mammography including digital mammography or breast tomosynthesis for the presence of occult breast cancer;
4. An annual medically recognized diagnostic examination for a female Covered Person 18 years of age or older for the early detection of cervical cancer in accordance with guidelines adopted by the American College of Obstetricians and Gynecologists or another similar national organization of medical professionals recognized by the Commissioner.
 - a. Minimum requirements for the diagnostic examination to detect the human papillomavirus include a conventional Pap smear screening, alone or in combination with a test approved by the United States Food and Drug Administration;

- b. CA-125 tests and screenings are considered preventative and covered services.
- 5. An annual prostate cancer detection exam, including a Prostate Specific Antigen test (PSA) for a male Covered Person age 40 or older;
- 6. A medically recognized screening examination for the detection of colorectal cancer for a Covered Person 50 years of age or older and at normal risk for developing colon cancer which includes:
 - a. An annual fecal occult blood test;
 - b. An annual stool DNA test;
 - c. c. A flexible sigmoidoscopy every five years; or
 - d. d. A colonoscopy for a computed tomography (CT) colonography (virtual colonoscopy) every ten (10) years;
- 7. on-invasive screening tests for atherosclerosis and abnormal artery structure and function for a Covered Person who is:
 - a. A male over 45 and under 76 years of age; or
 - b. A female over 55 and under 76 years of age; and is a diabetic; or
 - c. Is at risk of developing heart disease based on a score derived from Framingham Health Study coronary prediction algorithm that is immediate or higher.
- 8. Routine immunizations (TB and allergy desensitization injections are not considered routine immunizations);
- 9. Immunizations against influenza and pneumonia;
- 10. Alcohol Misuse screening and counseling;
- 11. Blood Pressure screening for adults;
 - a. The administration of whole blood including cost of blood, blood plasma, and blood plasma expanders are covered services.
- 12. Type 2 Diabetes screening for adults with high blood pressure;
- 13. Diet counseling for adults at higher risk for chronic disease;
- 14. Depression screening for adults;
- 15. HIV screening for all adults at higher risk;
- 16. Obesity screening and counseling for all adults;
- 17. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk ;
- 18. Tobacco use screening for all adults and cessation interventions for tobacco users;
- 19. Syphilis screening for all adults at higher risk;
- 20. Anemia screening on a routine basis for pregnant women;
- 21. Bacteriuria urinary tract or other infection screening for pregnant women;
- 22. BRCA counseling about genetic testing for women at higher risk;
- 23. Breast Cancer Chemoprevention for women at higher risk;
 - Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women;
- 24. Cervical Cancer screening for sexually active women 18 years of age and older;
 - CA-125 tests and screenings are considered preventative and covered services.
- 25. Chlamydia Infection screening for younger women and other women at a higher risk;
- 26. Contraception Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs;
- 27. Domestic and interpersonal violence screening and counseling for all women;

28. Folic Acid supplements for women who may become pregnant;
29. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;
30. Gonorrhea screening for all women at higher risk;
31. Hepatitis B screening for pregnant women at their first prenatal visit;
32. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women;
33. Human Papillomavirus (HPV) DNA Test--high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older;
34. Osteoporosis screening for women over age 60 depending on risk factors;
35. Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk;
36. Tobacco Use screening and interventions for all women, and expanding counseling for pregnant tobacco users;
37. Sexually Transmitted Infections (STI) counseling for sexually active women;
38. Syphilis screening for all pregnant women or other women at increased risk;
39. Well-woman visits to obtain recommended preventive services;
40. Alcohol and Drug Use assessment for adolescents;
41. Autism screening for children at 18 and 24 months;
42. Behavioral assessments for children of all ages;
43. Blood Pressure screening for children;
44. Cervical Dysplasia screening for sexually active women 18 years of age and older;
45. Congenital Hypothyroidism screening for newborns;
46. Depression screening for adolescents;
47. Developmental screening for children under age three, and surveillance throughout childhood;
48. Dyslipidemia screening for children at higher risk of lipid disorders;
49. Fluoride Chemoprevention supplements for children without fluoride in their water source;
50. Gonorrhea preventive medication for the eyes of all newborns;
51. A hearing impairment screening for a Dependent child from birth through 30 days of age;
52. Height, Weight and Body Mass Index measurements for children;
53. Hematocrit and Hemoglobin screening for children;
54. Hemoglobinopathies or sickle cell screening for newborns;
55. HIV screening for adolescents at higher risk;
56. Immunization vaccines for children from birth to age 18 years old; immunization vaccines may vary based on provider recommendation and the age of the child;
57. Iron supplements for children ages 6 to 12 months for anemia;
58. Lead screening for children at risk of exposure;
59. Medical History for all children throughout development;
60. Obesity screening and counseling;
61. Oral Health risk assessment for young children;
62. Phenylketonuria (PKU) screening for this genetic disorder in newborns;
63. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk;
64. Tuberculin testing for children at higher risk of tuberculosis; and

65. Vision and hearing screening for children 17 and under; eye and ear examinations for children through age 17, to determine the need for vision and hearing correction complying with established medical guidelines.

Covered Services include one (1) of the following screenings every five (5) years:

- A computed tomography (CT) scanning measuring coronary artery calcification; or
- An ultrasonography measuring carotid intima-media thickness and plaque;

Your Contract Benefits Management

We will pay benefits for Covered Services as stated in this Contract section, and according to the General Exclusions and Prescription Drug Exclusions sections and any amendments, which are a part of your Contract that may modify your benefits.

If you obtain non-Covered Services, you are responsible for making the full payment to the Physician or Provider. The fact that a Physician or Provider has performed or prescribed a medically appropriate service or the fact that it may be the only available treatment for a Bodily Injury or Illness does not mean that the service is covered under this Contract.

You are required to pay any Copayments directly to the Physician or Provider. Once you have met Your Out-of-Pocket Maximum, you will no longer be responsible for Copayments for Participating Providers. There are no Deductibles or Copayments for Preventive Services.

If you have a Deductible under this Contract, you must pay your Deductible in full before we make any payments. You are required to pay any deductibles and copayments directly to the Physician or Provider. Once you have met your Out-of-Pocket Maximum, you will no longer be responsible for Copayments for Participating Providers. There are no Deductibles or Copayments for Preventive Services.

A Covered Person who has Special Circumstances may be eligible for continuation of services from a terminated provider through continuity of care. A terminated provider is a Participating Provider whose Contract is terminated or not renewed.

All terms and provisions of this Contract are applicable to Covered Services provided during the period of continued care by the terminated provider.

Continuity of care is not available:

1. If the provider was terminated due to reason of medical competence or professional behavior;
2. After the 90th day after the Effective Date of the provider 's termination; or
3. After the expiration of the nine month period after the effective date of the provider 's termination if the Covered Person was diagnosed as having a terminal Illness at the time of the termination .

If a Covered Person who has Special Circumstances is past the 24th week of pregnancy at the time of the provider's termination, continuity of care extends through delivery of the child and applies to the immediate postpartum care and follow-up checkup within the six-week period after delivery.

If a claim is denied as being Experimental, Investigational, you have the right to seek review of the denial by an Independent Review Organization .Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information.

BENEFITS

Refer to the General Exclusions and Prescription Drug Exclusions sections in this Contract. All terms and provisions of this Contract, including the Prior Authorization requirement specified in this Contract are applicable to Covered Services. Cost sharing and limitations depend on type and site of service.

Acquired Brain Injury

Rehabilitative and habilitative therapy and services that are Medically Necessary for the treatment of an Acquired Brain Injury, including Cognitive Rehabilitation Therapy, Cognitive Communication Therapy, Neurocognitive Therapy and Rehabilitation, Neurobehavioral, Neuropsychological, Neuropsychological and Psychophysiological Testing and Treatment, Neuro feedback Therapy, Remediation required for and related to treatment of an Acquired Brain Injury and Post-Acute Transition Services, Community Integration Services, including outpatient day treatment services or other Post-Acute Treatment Services, if such services are necessary because of and related to an Acquired Brain Injury. Reasonable expenses related to periodic reevaluation of the care of an individual who:

- a. has incurred an Acquired Brain Injury;
- b. has been unresponsive to treatment; and
- c. becomes responsive to treatment at a later date.

Rehabilitative and habilitative therapy and services for an Acquired Brain Injury may be provided at a hospital, an acute or post-acute rehabilitation hospital, an assisted living facility or any other facility at which appropriate services or therapies may be provided.

Treatment goals for therapy or services related to the treatment of an Acquired Brain Injury may include maintenance of functioning, the prevention of, or slowing of further deterioration.

In this section, therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brian Injury and service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury.

Dental Services

Treatment for a Dental Injury to a Sound Natural Tooth. Covered Person must seek treatment within 24 hours of the Dental injury or by the next business day if on a weekend or holiday. Treatment must begin within 90 days from the date of the Dental Injury and be completed within 12 months. Sendero will limit Covered Services to the least expensive service that we determine will produce professionally adequate results. Cost sharing and limitations depend on type and site of service.

Effective September 1, 2018, dental support of a child subject to child support in addition to medical support will be required per the Family Code and the Texas Insurance Code.

Diabetes Services

The following services are for a Covered Person with diabetes:

- Routine foot care;
- Outpatient self-management training and education, including medical nutritional therapy prescribed by a Healthcare Practitioner for the treatment of:
 - Insulin-Dependent diabetes;
 - Insulin-using diabetes;
 - Gestational diabetes;
 - Non-insulin using diabetes; and
 - Medical conditions associated with elevated blood glucose levels.

Equipment and supplies for diabetes are covered under Durable Medical Equipment and Medical Supplies. Prescription Drugs for the treatment of diabetes are covered under the Prescription Drug provision.

Durable Medical Equipment and Medical Supplies

Equipment or devices specifically designed and intended for the care and treatment of a Bodily Injury or illness for the following:

- Equipment and supplies for diabetes are covered under Durable Medical Equipment and Medical Supplies.
- Prescription Drugs for the treatment of diabetes are covered under the Prescription Drug provision.
- Durable Medical Equipment and Medical Supplies.

Equipment or devices specifically designed and intended for the care and treatment of a Bodily Injury or illness for the following:

1. Non-motorized wheelchair;
2. Hospital bed;
3. Ventilator
4. Hospital type equipment
5. Oxygen and rental of equipment for its administration;
 - a. Initial prosthetic and orthotic devices or supplies, including, but not limited to, limbs and eyes. The benefit is limited to the most appropriate model of prosthetic or orthotic device that adequately meets the medical needs of the Covered Person as determined by the Covered Person's treating physician, podiatrist and prosthetist or orthotist. Replacement or repair of prosthetic and orthotic devices is a Covered Expense unless the repair or replacement is necessitated by misuse or loss;
 - b. Services related to the fitting and use of prosthetic devices and orthotic devices.
 - c. Casts, splints (other than dental), trusses, braces (other than orthodontic), and crutches;
 - d. Standard wigs following cancer treatment (not to exceed one per lifetime);
6. The following special supplies up to a 30-day supply, when prescribed by the Healthcare Practitioner:

- Surgical Dressings;
- catheters;
- Colostomy bags, rings, and belts;
- Flotation pads; Flotation pads;

Diabetic equipment and supplies; and other Durable Medical Equipment. Visit www.senderohealth.com or call the Sendero's Member Services telephone line on your Member Identification Card.

Hearing Aids (limited to one set per three years)

Costs for these items will be limited to the lesser of the rental cost or the purchase price. If Sendero determines the lesser cost is the purchase option, any amount paid as rent for such Durable Medical Equipment shall be credited toward the purchase price.

If the equipment and device include comfort or convenience items or features that exceed what is Medically Necessary, Sendero will not pay more than is Medically Necessary. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair is all that is Medically Necessary. If the Covered Person chooses to upgrade the equipment or device; they will be responsible for the price difference between the cost of the standard item and the cost of the upgraded item.

Medically necessary hearing aid(s) or cochlear implants and related services and supplies are covered benefits for Covered Person(s) 18 years and younger. Coverage includes fittings and dispensing services, treatment for habilitation and rehabilitation, and for cochlear implants, and external speech processor and controller with necessary component and replacement every three years.

No benefits will be provided for, or on account of:

- Repair or maintenance of the Durable Medical Equipment, except for prosthetic and orthotic devices; or
- Duplicate or similar rentals of Durable Medical Equipment.

Emergency Services

Covered Services for Emergency Care in a hospital emergency facility, a freestanding emergency medical care facility; or Comparable Emergency Facility. We will pay Non- Participating Physicians and Providers at the Usual and Customary rate or an agreed rate.

Healthcare Treatment Facility Services

Daily room and board and general nursing care up to the semi-private room rate for each day of Confinement, including, but not limited to:

- a. not less than 48 hours following a mastectomy and 24 hours following a lymph node dissection for the treatment of breast cancer unless you and your attending physician determines a shorter period is appropriate;
- b. not less than 48 hours after an uncomplicated vaginal delivery and 96 hours after an uncomplicated delivery by cesarean section;
- c. Confinement in a critical care unit or intensive care unit and related services;

- d. Operating room and related facilities;
- e. Ancillary services;
- f. Administration of blood and blood products including blood extracts or derivatives;
 - The administration of whole blood including cost of blood, blood plasma, and blood plasma expanders are covered services.
- g. Other Healthcare Treatment Facility charges;
- h. Drugs, medicines and biologics that are provided or administered to the Covered Person while Confined in a Hospital or Skilled Nursing Facility;
- i. Regularly scheduled treatment such as dialysis, chemotherapy, inhalation therapy or radiation therapy in a Healthcare Treatment Facility as ordered by the Covered Person's Healthcare Practitioner;
- j. Outpatient services in a Hospital or Free Standing Surgical Facility;
- k. Short-term rehabilitation therapy services in an acute care Hospital setting;
- l. Laboratory and other diagnostic tests;
- m. Meals and special diets when Medically Necessary;
- n. Special duty nursing when Medically Necessary; and
- o. X-ray services.

Healthcare Practitioner Services

- Healthcare Practitioner visits;
- Diagnostic laboratory and radiology tests;
- Diagnostic follow-up care related to the hearing impairment for a Dependent child from birth through 24 months of age;
- Second surgical opinions;
- Surgery;
- Services of a surgical assistant and/or assistant;
- Services of a physician assistant (P.A.), registered Nurse (R.N.), or a certified operating room technician when Medically Necessary. Physician assistants, registered Nurses (R.N.), and certified operating room technicians;
- Anesthesia administered by a Healthcare Practitioner or certified registered anesthetist attendant to a Surgery;
- Services of a pathologist;
- Services of a radiologist;
- Services related to the administration of amino acid-based elemental formulas as provided under the Prescription Drugs provision;
- Allergy injections, therapy, testing, and serum. Therapy and testing for treatment of allergies must be approved by the America Academy of Allergy and Immunology or the Department of Health and Human Services or any of its offices or agencies;
- Injections other than allergy;
- Nutritional counseling;
- Telemedicine Medical Services or Telehealth Medical Services

A Healthcare Practitioner's office visit includes only the following services:

- Taking a history;

- Performing an examination;
- Making a diagnosis or medical decision and associated treatment;
- Administering allergy shots; and
- Diagnostic laboratory and radiology tests.

Covered expense during a Healthcare Practitioner's office visit does not include charges incurred for Advanced Imaging, pulmonary function studies, cardiac catheterization, electrocardiogram (EKG), or electroencephalogram (EEG).

Home Healthcare

Services provided by a Home Healthcare Agency at the Covered Person's home. Home Healthcare Services are subject to authorization guidelines. Home Health services are provided as ordered by the physician or provider.

Coverage determinations may be considered for or on account of:

- Charges for mileage or travel time to and from the Covered Person's home;
- Wage or shift differentials for any representative of a Home Healthcare Agency;
- Charges for supervision of home healthcare agencies;
- Custodial care; and
- Provision or administration of Self-Administered Injectable Drugs.

Hospice Care

Covered Services provided under a Hospice Care Program furnished in a Hospice Facility or in the Covered Person's home by a Hospice Care Agency. A Healthcare Practitioner must certify that the Covered Person is terminally ill and a life expectancy of six months or less. These services must be in lieu of a Confinement in a Hospital or Skilled Nursing Facility.

- Room and board in a Hospice Facility, when it is for management of acute pain or for an acute phase of chronic symptom;
- Part-time nursing care provided by or supervised by a Nurse for up to eight hours per day;
- Counseling for the Hospice Patient and his/her immediate Family Members by a licensed clinical social worker or pastoral counselor;
- Medical social services for the terminally ill Covered Person or his/her immediate Family Members including:
 - Assessment of social, emotional, and medical needs and the home and family situation; and
 - Identification of the community resources available;
 - Psychological and dietary counseling; and
 - Medical supplies, drugs and medicines prescribed by a Healthcare Practitioner for Palliative Care.

No benefits will be provided for, or on account of:

1. Private duty nursing when Confined in a Hospice Facility;
2. Services relating to a Confinement that is not for management of acute pain control or other treatment for an acute phase of chronic symptom management;

3. Funeral arrangements;
4. Financial or legal counseling, including estate planning or drafting of a will;
5. Homemaker or caretaker services, including :
 - Sitter or companion services;
 - Housecleaning;
 - Household maintenance; and
6. Services of a social worker other than a licensed clinical social worker;
7. Services by a licensed pastoral counselor to a member of his/her congregation. These are services in the course of the duties to which he/she is called as a pastor or minister; and
8. Respite care.

For this benefit only, immediate Family Member is considered to be the Covered Person's parent, spouse, and children, step-children or legally adopted children

Mental Health

Covered Services provided by a:

- Healthcare Practitioner;
- Hospital; or
- Healthcare Treatment Facility.

Covered Inpatient Mental Health Services for:

1. Inpatient services including room and board; and
2. Healthcare practitioner visits.

Covered outpatient Mental Health care and office services for Mental Health incurred for:

1. Office exams or consultations including laboratory tests and X-rays; and
2. Therapy.

Additional covered services for Mental Health:

1. A partial Hospitalization program;
2. A Residential Treatment Center.

No benefits will be provided for, or on account of a halfway house.

Maternity Care and Newborn Services

Prenatal, delivery and inpatient services for Maternity Care and postnatal Care. Covered Services for a covered Dependent newborn child includes but is not limited to the following:

- Bodily injury or illness;
- Care and treatment for premature birth ; and
- Medically diagnosed birth defects and abnormalities.

Outpatient Therapies

Rehabilitative and habilitative Outpatient Services ordered and performed by a Healthcare Practitioner for the following services for:

- Documented loss of physical function;
- Pain;
- Developmental defect;
- Developmental delay;
- Physical therapy services;
- Occupational therapy services;
- Chiropractic services such as spinal manipulations, adjustments and modalities;
- Speech therapy or speech pathology services;
- Cognitive Rehabilitation Services;
- Audiology therapy services;
- Radiation therapy services;
- Chemotherapy;
- Applied Behavioral Analysis for Autism Spectrum Disorders;
- Evaluation and Assessment for Autism Spectrum Disorder;
- Behavioral training and behavioral management for Autism Spectrum Disorder;
- Respiratory or pulmonary therapy services; and
- Cardiac Rehabilitation Services.

Covered Services include therapies that result in a practical improvement in the level of functioning within a reasonable period of time and the therapy is not considered Maintenance Care. When determined to be Medically Necessary by the Healthcare Practitioner, therapy services for a Covered Person who has a physical disability will not be considered Maintenance Care. These therapy services are provided without regard as to whether the purpose of the therapy is to maintain or improve functional capacity.

Therapy services for a dependent child with a developmental delay must be provided in accordance with an individual family service plan issued by the Interagency Council on Early Childhood Intervention under Chapter 73 of the Texas Human Resources Code.

Therapy services rendered during a Home Healthcare Visit are covered under the Home Healthcare provision.

Prescription Drugs

Any payments under this provision apply toward the Covered Person's Out-of-Pocket Maximum. Payments under this provision do not apply toward the Covered Person's Contract Deductible. Deductible requirements do not apply to Prescription Drugs. Benefits may be subject to Dispensing Limits, Prior Authorization or Step Therapy requirements, if any.

If the dispensing Pharmacy's charge is less than the Prescription Drug Copayment, the Covered Person will be responsible for the lesser amount.

The amount paid by Sendero to the dispensing Pharmacy may not reflect the ultimate cost to Sendero for the drug. Prescription Drug Copayments are made on a Prescription or refill basis and will not be adjusted if we receive any retrospective volume discounts or Prescription Drug rebates.

Tablet splitting is a voluntary program in which the PBM may designate certain Formulary drugs that the member can split the tablet of a higher strength dosage at home. Under this program, the member gets half the usual quantity for a 30-day supply, for example 15 tablets for a 30-day supply. Participants who use tablet splitting will pay half the normal Copayment amount.

We must be notified of any Cost Share that is applicable to a Covered Person's claim that is waived by the Pharmacy. Any amount thus waived and not paid by the Covered Person would not apply to any Prescription Drug Out-of-Pocket Maximum.

Members requesting higher tier drugs when a generic equivalent is available and the physician did not specifically prescribe the requested drug are responsible for the higher tier cost sharing amount plus any difference in cost. This cost difference does not apply to any out-of-pocket maximum.

The Specialty Pharmacy program is part of your pharmacy benefit and is mandatory after your first fill at retail. Additional information can be found by calling Navitus Customer Care at 866-333-2757. Navitus Specialty Rx works with a specialty pharmacy to offer services with the highest standard of care. Should you wish to use an alternative Specialty Pharmacy, please contact Navitus Customer Care at 866-333-2757. With Navitus Specialty Rx, delivery of your specialty medications is free, and right to your door or prescriber's office via FedEx. Local courier service is available for emergency, same-day medication needs. To start using Navitus Specialty Rx, please call toll-free 800-218-1488. We will work with your prescriber for current or new specialty prescriptions.

Covered Prescription Drugs are:

- Drugs prescribed to treat a chronic, disabling, or life-threatening illness that:
 - Have been approved by the United States and Drug Administration for at least one indication; and
 - Are recognized by the following for the treatment of the indication for which drug is prescribed
 1. a prescription drug reference compendium approved by the Department of Insurance, or
 2. Substantially accepted peer reviewed medical literature.
- Drugs, medicines or medications that under Federal or state law may be dispensed only by Prescription from a Healthcare Practitioner;
- Drugs, medicines or medications that are included on the Drug Formulary;
- Insulin and Diabetic Supplies that are included on the Drug Formulary;
- Hypodermic needles or syringes when prescribed by a Healthcare Practitioner for use with insulin or Self-Administered Injectable Drugs that are included on the Drug Formulary .Hypodermic needles and syringes used in conjunction with covered drugs may be available at no cost to the Covered Person ;

- Hypodermic needles, syringes or other method of delivery necessary for administration of a Specialty Drug, if included with the charge for the Specialty Drug. These may be available at no cost to the Covered Person;
- Specialty drugs and Self-Administered Injectable Drugs that are included on the Drug Formulary approved by Sendero limited to a 30-day supply, unless otherwise determined by Us;
- Drugs, medicines or medications required under the Affordable Care Act with a Prescription from a Healthcare Practitioner;
- Enteral formulas and nutritional supplements necessary for the treatment of phenylketonuria (PKU) or other inherited metabolic diseases that are included on the Drug Formulary, or as otherwise determined by the orders of a physician;
 - PKU or a heritable disease is provided to the same extent that coverage is provided for drugs that are available only on the order(s) of a physician.
- Prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells;
- Amino acid-based elemental formulas, regardless of delivery method, when prescribed or ordered by a Healthcare Practitioner as Medically Necessary for the treatment of:
 - Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
 - Severe food protein-induced enterocolitis syndrome;
 - Eosinophilic disorders, as evidenced by the results of a biopsy;
 - Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract; and
 - Spacers and/or peak flow meters for the treatment of asthma.

The most commonly prescribed drugs, medicines, and medications covered by Sendero are specified on our Drug Formulary. The Drug Formulary identifies categories of drugs, medicines or medications by levels. It also indicates Dispensing Limits and any applicable prior authorization or Step Therapy requirements. This information is reviewed on a regular basis by a Pharmacy and Therapeutics committee made up of physicians and Pharmacists. Placement on the Drug Formulary does not guarantee Your Healthcare Practitioner will prescribe that Prescription Drug, medicine or medication for a particular medical or Mental Health condition.

You can obtain a copy of Our Drug Formulary by visiting www.navitus.com or calling Navitus Member Services telephone number on Your Member Identification Card. If a specific drug, medicine or medication is not listed on the Drug Formulary, You may contact us orally or in writing with a request to determine whether a specific drug is included on Our Drug Formulary. We will respond to your request no later than the third business day after the receipt Date of the request. If we do not approve coverage for a Prescription Drug because it is not on the Drug Formulary, You have the right to appeal that decision. Please refer to Appeals, Complaints and External Review Rights process in the General Provisions section.

Prescription Drug coverage is subject to change. Based on state law, advanced written notice to you is required for the following modification that affects Prescription Drug coverage:

1. Removal of a drug from the Drug Formulary;

2. Requirement that you receive prior authorization for a drug;
3. An imposed or altered quantity limit;
4. An imposed step-therapy restriction;
5. Moving a drug to a higher cost-sharing level unless a generic alternative to the drug is available.

These types of changes to Prescription Drug coverage will only be made by Sendero at renewal of the Contract. We will provide written notice no later than 60 days prior to the Effective Date of the change.

Preventive Care Services

Services for well child and adult care Preventive Services recommended by the

U .S. Department of Health and Human Services (HHS) or as mandated by State. This does not include Routine Nursery Care.

For the recommended Preventive Services that apply to Your Contract, refer to the HHS Web site at www.HHS.gov or call the HMO Member Services telephone number on the back of your Member Identification Card.

Copayment requirements do not apply to Preventive Services. Covered Services include, but are not limited to, the following:

1. Office visit to a Healthcare Practitioner for a routine or annual physical exam to detect or prevent illness;
2. Routine radiology, laboratory and/or, endoscopic services to detect or prevent Illness related to routine or annual exam;
3. Routine mammogram every year for a female Covered Person age 35 years of age or older including low-dose mammography, digital mammography or breast tomosynthesis for the presence of occult breast cancer;
4. Annual medically recognized diagnostic examination for a female covered person 18 years of age or older for the early detection of cervical cancer in accordance with guidelines adopted by the American College of Obstetricians and Gynecologist or another similar national organization of medical professionals recognized by the Commissioner.
 - a) Minimum requirements for the diagnostic examination to detect the human papillomavirus include a conventional Pap smear screening, alone or in combination with a test approved by the United States Food and Drug Administration;
5. An annual prostate cancer detection exam, including a Prostate Specific Antigen test (PSA) for a male Covered Person age 40 or older;
6. A medically recognized screening examination for the detection of colorectal cancer for a Covered Person 50 years of age or older and at normal risk for developing colon cancer which includes:
 - An annual fecal occult blood test;
 - An annual stool DNA test ;
 - A flexible sigmoidoscopy every five years; or

- A colonoscopy for a computed tomography (CT) colonography (virtual colonoscopy) every 10 years;
7. Non-invasive screening tests for atherosclerosis and abnormal artery structure and function for a Covered Person who is:
- A male over 45 and under 76 years of age; or
 - A female over 55 and under 76 years of age; and
 - Is a diabetic; or
 - Is at risk of developing heart disease based on a score derived from Framingham Health Study coronary prediction algorithm that is immediate or higher.

Covered Services include one of the following screenings every five years:

- A computed tomography (CT) scanning measuring coronary artery calcification; or
- An ultrasonography measuring carotid intima-media thickness and plaque;
- Routine immunizations (TB tine and allergy desensitization injections are not considered routine immunizations);
- Immunizations against influenza and pneumonia;
- Alcohol Misuse screening and counseling;
- Blood Pressure screening for adults;
- Type 2 Diabetes screening for adults with high blood pressure;
- Diet counseling for adults at higher risk for chronic disease;
- Depression screening for adults;
- HIV screening for all adults at higher risk;
- Obesity screening and counseling for all adults;
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk;
- Tobacco use screening for all adults and cessation interventions for tobacco users;
- Syphilis screening for all adults at higher risk;
- Anemia screening on a routine basis for pregnant women;
- Bacteriuria urinary tract or other infection screening for pregnant women;
- BRCA counseling about genetic testing for women at higher risk;
- Breast Cancer Chemoprevention for women at higher risk;
- Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women;
- Cervical Cancer screening for sexually active women;
- CA-125 tests and screenings are considered preventative and covered services.
- Chlamydia Infection screening for younger women and other women at a higher risk;
- Contraception-Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs;
- Domestic and interpersonal violence screening and counseling for all women
- Folic Acid supplements for women who may become pregnant;
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;
- Gonorrhea screening for all women at higher risk;
- Hepatitis B screening for pregnant women at their first prenatal visit;

- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women;
- Human Papillomavirus (HPV) DNA Test-high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older;
- Osteoporosis screening for women over age 60 depending on risk factors;
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk;
- Tobacco Use screening and interventions for all women, and expanding counseling for pregnant tobacco users;
- Sexually Transmitted Infections (STI) counseling for sexually active women;
- Syphilis screening for all pregnant women or other women at increased risk;
- Well-woman visits to obtain recommended preventive services; Alcohol and Drug Use assessment for adolescents;
- Autism screening for children at 18 and 24 months; Behavioral assessments for children of all ages;
- Blood Pressure screening for children;
- Cervical Dysplasia screening for sexually active females;
- Congenital Hypothyroidism screening for newborns;
- Depression screening for adolescents;
- Developmental screening for children under age 3, and surveillance throughout childhood;
- Dyslipidemia screening for children at higher risk of lipid disorders;
- Fluoride Chemoprevention supplements for children without fluoride in their water source;
- Gonorrhea preventive medication for the eyes of all newborns; A hearing impairment screening for a Dependent child from birth through 30 days of age;
- Height, Weight and Body Mass Index measurements for children;
- Hematocrit and Hemoglobin screening for children;
- Hemoglobinopathies or sickle cell screening for newborns;
- HIV screening for adolescents at higher risk;
- Immunization vaccines for children from birth to age 18--doses, recommended ages, and recommended populations vary;
- Iron supplements for children ages 6 to 12 months for anemia;
- Lead screening for children at risk of exposure;
- Medical History for all children throughout development;
- Obesity screening and counseling;
- Oral Health risk assessment for young children;
- Phenylketonuria (PKU) screening for this genetic disorder in newborns;
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk;
- Tuberculin testing for children at higher risk of tuberculosis; and
- Vision and hearing screening for children 17 and under.

Reconstructive Surgery

We will provide benefits for Covered Services for Reconstructive Surgery incurred for the following:

- To restore function for conditions resulting from a Bodily Injury provided the Bodily Injury occurred while the Covered Person is covered under this Contract;
- That is incidental to or follows a covered Surgery resulting from Illness or a Bodily Injury of the involved part if the trauma, infection or other disease occurred or had its onset while the Covered Person is covered under this Contract;
- Following a Medically Necessary mastectomy. Reconstructive Surgery includes all stages and revisions of reconstruction of the breast on which the mastectomy has been performed, reconstruction of the other breast to establish symmetry , prostheses and physical complications in all stages of mastectomy, including lymphedemas; and
- Because of a congenital illness or anomaly of a Dependent child that resulted in a functional defect for a covered Dependent child to improve the function of or attempt to create a normal appearance of the abnormal body structure.

No benefits are available for Surgery or treatment to change the texture or appearance of the skin or to change the size, shape or appearance of facial or body features (including but not limited to a Covered Person's nose, eyes, ears, cheeks, chin, chest or breasts).

Except as otherwise provided in this Contract, Cosmetic services and services for complications from cosmetic services are not covered regardless of whether the initial Surgery occurred while the Covered Person was covered under this Contract or under any prior coverage.

Routine Care during Clinical Trials

We will pay for Covered Services that are Routine Patient Care Costs furnished to a Covered Person participating in a Phase I. Phase II. Phase III, or Phase IV Clinical Trial if the service item or drug is otherwise covered under this Contract.

No benefits will be provided for services that are a part of the subject matter of the Clinical Trial and that are customarily paid for by the Research Institution conducting the Clinical Trial.

Skilled Nursing Facility and Rehabilitation Services

Covered Services include:

1. Daily room and board;
2. General nursing services for each day of Confinement; and
3. Rehabilitation services.

The Covered Person must enter the Sub-Acute Rehabilitation Facility or Skilled Nursing Facility within 14 days after discharge from the Hospital.

Coverage for Sub-Acute Rehabilitation Facility or Skilled Nursing Facility will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or has plateaued.

Rehabilitation services provided in a skilled nursing facility include but are not limited to:

1. Treatment of complications of the condition that required an inpatient Hospital stay;

2. Physical therapy, occupational therapy and speech therapy;
3. Pulmonary rehabilitation programs; and
4. The evaluation of the need for the services listed above.

Transplant Services

If a Covered Person requires an organ transplant or is a donor to a Covered Person, all related services including, but not limited to the following, must be preauthorized in advance by us;

- Hospital and Healthcare Practitioner services; and
- Organ acquisition and donor costs, including pre-transplant services, the acquisition procedure, and any complications resulting from the acquisition.

Donor costs will not exceed the Organ Transplant Treatment Period. After the benefits of a Covered Person who is a recipient have been paid, we will provide reimbursement of Covered Services of a live donor to the extent that the benefits remain and are available under this Contract. Any existing benefits available through the health coverage of the donor will be secondary to the benefits available under this Contract.

Prior Authorization from Us is required in advance of the organ transplant. The Covered Person's Healthcare Practitioner must notify us in advance of the need for an initial evaluation for the organ transplant in order for us to determine if the organ transplant will be covered. For approval of the organ transplant itself, we must be given a reasonable opportunity to review the clinical results of the evaluation before rendering a determination.

Once coverage for the organ transplant is approved, we will advise the Healthcare Practitioner. Benefits are payable only if the pre-transplant services, the organ transplant and post-discharge services are approved by us. Coverage for post-discharge services and treatment of complications after transplantation are limited to the Organ Transplant Treatment Period.

Covered Services for a Covered Organ Transplant includes pre-transplant services, transplant inclusive of any chemotherapy and associated services, post-discharge services and treatment of complications after transplantation of the following organs or procedures only:

- a. Heart
- b. Lung(s);
- c. Liver;
- d. Kidney;
- e. Bone marrow;
- f. Pancreas;
- g. Auto-islet cell;
- h. Intestine;
- i. Multivisceral;

Any combination of the above listed organs; and

Any organ not listed above, if required by state or federal law.

Corneal transplants and porcine heart valve implants, which are tissues rather than organs, are considered part of regular Contract benefits and are subject to other applicable provisions of this Contract.

No benefits will be provided for, or on account of:

- Transplants which are Experimental or Investigational;
- A transplant that does not meet Our pre-transplant criteria;
- Expenses that are eligible to be paid under any private or public research fund, government program except Medicaid, or another funding program, whether or not such funding was applied for or received;
- Expenses related to a transplant for which We do not approve coverage based on Our established criteria;
- Expenses related to the transplantation of any non-human organ or tissue except as expressly provided in this Contract;
- A denied transplant.
 - This includes the pre-transplant evaluation, pre-transplant services, the transplant procedure, post discharge services, immunosuppressive drugs and expenses related to complications of such transplant;
 - Expenses related to the storage of cord blood and stem cells unless it is an integral part of an organ transplant approved by Sendero; or
 - Expenses related to an organ transplant performed outside of the United States and any care resulting from that organ transplant.

Transplant Transportation and Lodging

Direct non-medical costs for:

The Covered Person receiving the organ transplant when the Hospital performing the Covered Organ Transplant is more than 100 miles away from the Covered Person's residence; and One designated caregiver or support person (two, if the Covered Person receiving the Covered Organ Transplant is under 18 years of age), if they live more than 100 miles from the Hospital performing the Covered Organ Transplant.

Direct non-medical costs include:

- Transportation Covered Services to and from the Hospital where the Covered Organ Transplant is performed limited to two round trips per Covered Organ Transplant; and
- Temporary lodging at a prearranged location when requested by the Hospital performing the Covered Organ Transplant and approved by Sendero.

All direct, non-medical costs for the Covered Person receiving the Covered Organ Transplant and the designated caregiver(s) or support person(s) are limited to a combined maximum per Covered Organ Transplant as shown on the Schedule of Benefits.

Transportation

Professional Air and Ground Ambulance service from the scene of a medical emergency to the nearest appropriate medical facility equipped to provide treatment for Emergency Care. We will pay Non-Participating providers at the Usual and Customary rate or an agreed rate.

Urgent Care Services

Covered services include Urgent Care Services in an Urgent Care Center participating in the Provider Network.

Vision Services

Covered services include one routine eye exam visit annually for children 17 and under. Eye exams are covered to determine the need for vision correction in accordance with established medical guidelines.

Covered services include one pair of select frames and standard lenses per year, and under or contact lenses per year for children 17 and under.

Sendero will accelerated refills of certain for certain prescription eye drops upon request. Sendero may not deny coverage for a refill of eye drops because the prescription is being refilled before the date established by the plan's general prescription refill guidelines if:

1. the original prescription states that additional quantities of the eye drops are needed; and
2. the refill does not exceed the total quantity of dosage units authorized by the prescribing provider on the original prescription, including refills.

Sendero will provide coverage for the refill of a prescription for eye drops that are dispensed on or before the last day of the prescribed dosage period and:

1. not earlier than the 21st day after the date a prescription for a 30-day supply of eye drops is dispensed;
2. not earlier than the 42nd day after the date a prescription for a 60-day supply of eye drops is dispensed; or
3. not earlier than the 63rd day after the date a prescription for a 90-day supply of eye drops is dispensed.

General Exclusions and Limitations

Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by us.

If a claim is denied as being Experimental or Investigational, you have the right to seek review of the denial by an Independent Review Organization. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information.

Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:

Services provided by a non-Participating Provider, except when:

- Authorized by Sendero; or
- The following services are Medically Necessary to render Emergency Care:
 - a. Professional ambulance service; or
 - b. Services in a Hospital emergency room, freestanding emergency medical care facility or Comparable Emergency Facility;
 - c. Services incurred before the Effective Date or after the termination date of this Contract;
 - d. Services not Medically Necessary to prevent, alleviate, cure or heal Bodily Injury or Illness, except for the specified routine Preventive Services;
 - e. Charges for prophylactic services including, but not limited to, prophylactic mastectomy or any other services performed to prevent a disease process from becoming evident in the organ tissue at a later date;
 - f. Services which are Experimental or Investigational, or related to such, whether incurred prior to, in connection with, or subsequent to the service which is Experimental or Investigational except as expressly provided in this Contract.

The fact that a service is the only available treatment for a condition may not make it eligible for coverage if Sendero deemed it to be Experimental or Investigational;

Complications directly related to a service that is not a Covered Service under this Contract because it was determined by us to be Experimental or Investigational or not Medically Necessary, except as expressly provided in this Contract.

Directly related means that the service occurred as a direct result of the Experimental or Investigational or not Medically Necessary;

- Service and would not have taken place in the absence of the Experimental or Investigational or not Medically Necessary service;
- Services exceeding the amount of benefits available for a particular services;
- Services for, or the treatment of complications of, non-covered procedures or services;

Services, except for Emergency Care, relating to an Illness or Bodily Injury incurred as a result of the Covered Person:

- Being intoxicated, as defined by applicable state law in the state in which the loss occurred; or
- Being under the influence of illegal narcotics or controlled substance unless administered or prescribed by a Healthcare Practitioner;
- Services relating to an Illness or Bodily Injury as a result of;

- Intentionally self-inflicted bodily harm or attempted suicide whether sane or insane, when not specifically the result of mental illness;
- War or an act of war, whether declared or not;
- Engaging in an illegal occupation; or
- Any act of armed conflict, or any conflict involving armed forces or any authority; Services:
- For charges which are not authorized, furnished or prescribed by a Participating Provider;
- For which no charge is made, or for which the Covered Person would not be required to pay if he/she did not have this coverage, unless charges are received from and reimbursable to the United States government, or any of its agencies as required by law;
- Furnished by or payable under any plan or law through a government or any political subdivision, except Medicaid, unless prohibited by law which You or the Covered Person is not legally obligated to pay;
- Furnished while a Covered Person is Confined in a Hospital or institution owned or operated by the United States government or any of its agencies for any service-connected Illness or Bodily Injury;
- Which are not rendered or not substantiated in the medical records;
- Provided by a Family Member or person who resides with the Covered Person;
- Performed in association with a non-covered service;
- Hospital Inpatient Services when the Covered Person is in Observation Status;
- Except as otherwise provided in this Contract, cosmetic services, or any complication there from Custodial care and Maintenance Care;
- Ambulance services for routine transportation to, from or between medical facilities and/or a Healthcare Practitioner's office;
- Elective medical or surgical abortion unless:
 - The pregnancy would endanger the life of the mother;
 - The pregnancy is a result of rape or incest;
 - Reversal of sterilization;
 - Infertility Treatment;
 - Sexual dysfunction;
 - Sex change services, regardless of any diagnosis of gender role or psychosexual orientation problems;
- Vision examinations or testing for the purposes of prescribing corrective lenses; radial keratotomy; refractive keratoplasty; or any other Surgery or procedure to correct myopia, hyperopia or stigmatic error; orthoptic treatment (eye exercises); or the purchase or fitting of eyeglasses or contact lenses, unless specified in this Contract;
- Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes including, but not limited to, excision of partially or completely un-erupted impacted teeth, any oral or periodontal Surgery and preoperative and postoperative care, implants and related procedures, orthodontic procedures, and any dental services related to a Bodily Injury or Illness except as expressly provided in this Contract;
- Pre-surgical / procedural testing duplicated during a Hospital Confinement;
- Any treatment for obesity, regardless of any potential benefits for co- morbid conditions, including but not limited to:
 - Surgical procedures for Morbid Obesity;

- Services or procedures for the purpose of treating an Illness or Bodily Injury caused by, complicated by, or exacerbated by the obesity; or
- Complications related to any services rendered for weight reduction;
- Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss Surgery;
- Foot care services, in the absence of diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency, including but not limited to:
 - Shock wave therapy of the feet;
 - Treatment of Weak, strained, flat, unstable or unbalanced feet;
 - Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
 - Tarsalgia, metatarsalgia or bunion treatment, except Surgery which involves exposure of bones, tendons or ligaments;
 - Cutting of toenails, except removal of nail matrix; and
 - Arch supports, heel wedges, lifts, shoe inserts, the fitting or provision of foot orthotics or orthopedic shoes, unless Medically Necessary because of diabetes or hammertoe;
 - Hair prosthesis, hair transplants or implants;
 - Hearing care that is routine, including but not limited to exams and tests, any artificial hearing device, auditory prostheses or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension, except as expressly provided in this Contract;
- Services rendered in a premenstrual syndrome clinic or holistic medicine clinic;
- Transplant services except as expressly provided in this Contract;
- Over the counter medical items or supplies that can maybe prescribed by a Healthcare Practitioner but are also available without a written order or Prescription, except for Preventive Services;
- Immunizations including those required for foreign travel for Covered Persons of any age except as expressly provided in this Contract;
- Treatment for any jaw joint problem, including but not limited to, temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and skull;
- Genetic testing, counseling or services;
- Expense for employment, school, sports or camp physical examinations or for the purpose of obtaining insurance, premarital tests/examinations;
- Services received in an emergency room unless Emergency Care;
- Any Expense Incurred for services received outside of the United States except for Emergency Care services;
- Services received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness;
- Services and supplies which are:
 - Rendered in connection with mental Illnesses not classified in the current Diagnostic and Statistical Manual of Mental Disorders;

- Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation; and
- Specifically excluded is marriage counseling;

No benefits will be provided for:

- Immunotherapy for recurrent abortion ;
- Chemonucleolysis;
- Biliary lithotripsy;
- Home uterine activity monitoring;
- Sleep therapy;
- Light treatment for Seasonal Affective Disorder (S.A.D.);
- Immunotherapy for food allergy;
- Prolotherapy;
- Cranial banding;
- Hyperhidrosis Surgery; and
- Sensory integration therapy;

Charges for alternative medicine, including medical diagnosis, treatment and therapy. Alternative medicine services includes, but is not limited to:

- Acupressure;
- Acupuncture ;
- Aromatherapy;
- Ayurveda;
- Biofeedback (except to the extent it includes Neurofeedback Therapy that is Medically Necessary for the treatment of an Acquired Brain Injury);
- Faith healing;
- Guided mental imagery;
- Herbal medicine;
- Holistic medicine;
- Homeopathy ;
- Hypnosis;
- Macrobiotic;
- Massage therapy;
- Naturopathy;
- Ozone therapy;
- Reflexology;
- Relaxation response;
- Rolfing;
- Shiatsu; and
- Yoga;
- Living expenses; travel; transportation, except as expressly provided in the Ambulance services provision or Transplants provision in the Your Contract Benefits section of this Contract; and

- Charges for services that are primarily and customarily used for a non- medical purpose or used for environmental control or enhancement (whether or not prescribed by a Healthcare Practitioner) including but not limited to:
 - Common household items such as air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows, or exercise equipment;
 - Scooters or motorized transportation equipment, escalators, elevators, ramps, modifications or additions to living/working quarters or transportation vehicles;
 - Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
 - Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools or spas or saunas;
 - Medical equipment including blood pressure monitoring devices, PUVA lights and stethoscopes;
 - Charges for any membership fees or program fees paid by a Covered Person, including but not limited to, health clubs, health spas, aerobic and strength conditioning, work-hardening programs and Weight loss or similar programs and any related material or products related to these programs;
 - Communication system, telephone, television or computer systems and related equipment or similar items or equipment; and
 - Communication devices except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.
 - Services for in vitro fertilization and promotion of fertility through extra- coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, Trans uterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.
 - Applied Behavioral Analysis for Autism Spectrum Disorders for a Covered Person 10 years or older is limited to \$36,000.00 per year.

Prescription Drug Exclusions

Except as expressly stated otherwise, no benefit will be provided for, or on account of, the following items:

- Drugs which are not included on the Drug Formulary;
- Dietary supplements except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or certain other inherited metabolic diseases and amino acid- based elemental formulas as expressly provided in this Contract;
- Nutritional products;
- Fluoride supplements except when prescribed to preschool children older than 6 months of age whose primary water source is deficient in fluoride;
- Minerals;
- Herbs and vitamins;
- Legend (prescription) drugs which are not deemed Medically Necessary by Sendero;

- Any drug prescribed for any Illness or Bodily Injury for which services are not covered under this Contract;
 - Any drug prescribed for intended use other than for Indications approved by the FDA ; or
 - Off-label indications recognized through peer-reviewed medical literature;
- Any drug, medicine or medication that is either:
 - Labeled "Caution-limited by Federal law to investigational use"; or
 - Experimental or investigational , even though a charge is made to the Covered Person;
- Allergen extracts;
- The administration of covered medication(s);
- Therapeutic devices or appliances, except as expressly provided in this Contract, including but not limited to:
 - Hypodermic needles and syringes except needles and syringes for use with insulin, and Self-Administered Injectable Drugs whose coverage is approved by Sendero;
 - Support garments;
 - Mechanical pumps for delivery of medication;
 - Other non-medical substances;
- Anorectic or any drug used for the purpose of Weight control;
- Abortifacients (drugs used to induce abortions);
- Any drug used for cosmetic purposes, including, but not limited to:
- Tretinoin, e.g. Retina, except if the Covered Person is under the age of 35 or is diagnosed as having adult acne;
- Dermatologicals or hair growth stimulants; or Pigmenting or de-pigmenting agents, Solaquin;

Contrary to any other provisions of this Contract, Sendero may decline coverage or, if applicable, exclude from the Drug Formulary any and all drugs, including new indications for an existing drug, until the conclusion of a review period not to exceed (six) 6 months following FDA approval for the use and release of the drug, including new indications for an existing drug into the market;

Any drug or medicine that is:

- Lawfully obtainable without a Prescription (over the counter drugs), except insulin; or drugs, medicines or medications required as part of Healthcare reform with a Prescription from a Healthcare Practitioner;
- Available in Prescription strength without a Prescription;
- Compounded estrogen, progesterone, and testosterone for the treatment of hormone replacement therapy ;
- Infertility Treatment including medications;
- Any drug prescribed for impotence and/or sexual dysfunction, e.g. Viagra
- Any drug, medicine or medication that is consumed or injected at the place where the Prescription is given or dispensed by the Healthcare Practitioner;
- Drug delivery implants;
- Prescriptions that are to be taken by or administered to the Covered Person, in whole or in part, while he/she is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
 - a. Hospital

- b. Skilled nursing facility; or
 - c. Hospice facility;
- Injectable drugs, including, but not limited to:
 - a. immunizing agents;
 - b. Biological sera; or
 - c. Self-administered injectable drugs or Specialty Drugs for which coverage is not approved by us.
- Prescription refills:
 - In excess of the number specified by the Healthcare Practitioner, or
 - Dispensed more than one year from the date of the original order;
 - Any portion of a Prescription or refill that exceeds a 90-day supply when received from either a mail-order Pharmacy or from a retail Pharmacy that participates in Our program which allows a Covered Person to receive a 90-day supply of a Prescription or refill;
 - Any portion of a Prescription or refill that exceeds a 30-day supply when received from a retail Pharmacy that does not participate in our program which allows a Covered Person to receive a 30-day supply of a Prescription or refill;
 - Any portion of a Specialty Drug or Self-Administered Injectable Drug that exceeds a 30-day supply;
 - Any portion of a drug for which Prior Authorization or Step Therapy is required and not obtained;
 - Any drug for which a charge is customarily not made;
- Any portion of a Prescription or refill that:
 - Exceeds our drug specific Dispensing Limit (i.e. IMITREX);
 - Is dispensed to a Covered Person whose age is outside the drug specific age limits defined by Sendero;
 - Is refilled early, as defined by Sendero; or
 - Exceeds the duration-specific Dispensing Limit;
- Any drug, medicine or medication received by the Covered Person:
 - Before becoming covered under this benefit; or
 - After the date the Covered Person 's coverage under this Contract has ended ;
 - Any costs related to the mailing, sending or delivery of Prescription Drugs;
 - Any intentional misuse of this benefit, including Prescriptions purchased for consumption by someone other than the Covered Person;
 - Any Prescription or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;
 - Any amount the Covered Person paid for a Prescription that has been filled, regardless of whether the Prescription is revoked or changed due to adverse reaction or change in dosage or Prescription;

If a claim is denied as being Experimental Investigation, You have the right to seek review of the denial by an Independent Review Organization. Refer to the Appeal Complaints and External Review provision in the General Provisions section in this Contract for more information.

Premium Payment

Your Duty to Pay Premium

You must pay the required premium to Sendero as it becomes due. If you do not pay your premium on time, subject to the grace period, we will terminate coverage.

The first premium is due on the date specified by Sendero. Subsequent premiums are due on the date we assign. Premium period means monthly, quarterly, semi- annually, or annually as selected by you. All premiums are payable to us at our address, at local area HEB locations, and PayPal or credit card at www.senderohealth.com

Advance Premium Tax Credit

You may qualify for an Advance Premium Tax Credit (APTC) to help reduce your premium. This is a monthly payment made on your behalf by the Federal Government to us to make this coverage more affordable. You are generally eligible for the APTC if You:

- Are enrolled in this Plan;
- Expect to have a household income below 400% of the Federal Poverty Level (FPL) during the Calendar Year;
- Are not eligible for Medicare Part A, Medicaid or other minimum essential coverage; and
- Attest that, for the Calendar Year:
 - You will file an income tax return or joint tax return (if You are married);
 - No other taxpayer will be able to claim You as a tax dependent; and
 - You will claim a (person) exemption deduction on your tax return for the members of your family, including you and your spouse.

Your APTC may change based on your household income, family size or changes in State or Federal law. If your APTC changes or is eliminated, we will be notified by the Federally Facilitated Health Insurance Marketplace, and you will continue to be responsible for payment of your premium.

If you have any questions regarding the APTC, please contact the Federally Facilitated Health Insurance Marketplace or consult with a tax professional.

Grace Period

You have 31 days from the premium due date to remit the required funds. If premium is not paid, we will terminate coverage effective the last day of the premium period for which premium was paid and you may be held liable for cost of services received during the grace period.

Special Provision for Covered Persons receiving Advance Premium Tax Credits:

If you previously paid at least one month's premium during the Calendar Year, Your Grace Period is 90 days for the Federal Government to remit the required premium. Community may pay all appropriate claims in the first month of the Grace Period, but may pend claims in the second and third months until the correct premium amount is paid. We will notify the Federal Government of the nonpayment, and we will notify providers of the possibility for denied claims when you are in the second and third month of the grace period. We will terminate coverage effective the last day of the premium period for which premium was paid after the grace period expires and you may be held liable for the cost of services received during the grace period.

Changes to Your Premium

Your Premium may change when:

1. Family members are added or deleted ;
2. Coverage is increased or decreased;

3. Premium payment method is changed;
4. A new rate table applies;
5. Any Covered Person's age increases;
6. Any Covered Person's rating classification changes;
7. The Covered Person moves to a different zip code or county; or
8. A misstatement on the application resulting in the proper amount due not being charged.

A 60-day notice will be provided prior to premium rate change for items 3, 4, 5, 6 and 8. Your continued payment of premium will constitute your agreement to the change.

Return of Premium

In no event, except for the following reasons will premium be returned:

- The Contract Holder returns the Contract as described in the Right to Return Contract provision;
- Rescission of coverage as described in the Incontestability provision in the General Provisions section; or
- The Contract Holder requests in writing for coverage to end and premium has been paid for any period of time after the later of the date requested by you or the date we receive your notice to cancel.

In the event that you cancel this Contract, the premium shall be computed at a pro rate.

Cancellation of this Contract will not affect claims incurred prior to the cancellation.

Changes to Contract

Your Rights to Make Changes to the Contract

You have several rights to make changes to Your Contract.

Changes in Benefits

You may call or write us to request additional, increased or decreased benefits.

If the change in benefits you request is available, as determined and approved by us, the benefit will become effective on the date we assign.

Change in Residence

We must be notified of any change in your resident address.

At least 14 days prior to your move, call or write us informing us of your new address and phone number. When we receive this information, we will inform you of any changes to your plan on such topics as new networks, benefits, and premium. If you move outside of this Contract's Service Area, We will terminate this Contract. If a Covered Person moves outside of this Contract's Service Area,

coverage for that Covered Person will terminate. See the Renewability and Termination section for the events that will cause this Contract and/or a Covered Person's coverage to end. Such change will be effective on the date we assign.

We have the right to change your resident address in our records upon our receipt of an address change from a third party and after confirmation from you that your address changed.

Changes to Covered Persons

You may request a change to the persons covered under Your Contract due to certain changes your family.

Removing Dependents

If you wish to remove a Covered Person from your Contract, simply call or write us at the address on your Member Identification Card.

Adding Dependents

If a child is born to a Contract Holder, or any Covered Person, a Contract Holder adopts a child, or a grand/child is placed with the Contract Holder for the purpose of adoption, or the Contract Holder is a party in a suit in which adoption of a grand/child is sought, We must be notified of the event verbally or in writing and receive any required premium on or before 60 days of the event. If we do not receive notice and premium for the first 60 days and forward, the child will not be a Covered Person under this Contract.

If a Dependent grand/child is the subject of a medical support order, coverage will be automatic for the first 60 days after receipt or date of the medical support order or notice of the medical support order and any required premium.

A Dependent not falling under the previous paragraph must apply to be added as a Covered Person and be accepted by us during the annual open enrollment period. A Dependent child is eligible to apply if they are under age 26. If accepted the Covered Person will be covered on the date we specify.

Effective Date of Dependent Changes

1. Coverage for a newborn or adopted child will be effective for the first 31 days following the date of the birth, placement, adoption, or date the court grants the petition for adoption. To continue coverage for the newborn or adopted child beyond the initial period You must provide notice to Us and remit the premium within 31 days of the child's date of birth or adoption;
2. Coverage of a Dependent child who is the subject of a medical support order will be effective for the first 31 days after receipt of the medical support order or notice of the medical support order;

3. If We receive the application or notification as applicable, and any required premium more than 31 days after the newborn's date of birth or the child's adoption, placement for adoption, or date the court grants the petition for adoption, such child will not be eligible;
4. Changes for other Dependents will be effective upon acceptance by us, and receipt of premium.

Our Rights to Make Changes to the Contract

We have the right to make certain changes to Your Contract. Changes to this Contract can be made by us at any time without prior consent when the changes are required by state or federal law.

Continuation of Coverage for Surviving Dependents

If this Contract has been in-force for at least 90 days and the Contract Holder dies while Dependent coverage is in-force, the surviving Dependents that are covered under this Contract on the date of death may be eligible to continue coverage under this Contract.

The surviving spouse or legal guardian of the covered Dependent child (ren) must notify us in writing within 31 days of the Contract Holder's death. Premium must continue to be paid in order for coverage to continue. The premium may change and will be based upon the classification of age of those continuing coverage.

The surviving Dependent spouse will become the Contract Holder if covered under this Contract on the date of death. In the case of child-only coverage, the surviving Dependent's parent or legal guardian will become the Contract Holder of the continued Contract.

All conditions, limitations, exclusions, and maximums of this Contract will continue to apply.

Continuation of Coverage Due to Marital Change

If a Covered Person is no longer eligible due to change in marital status, Sendero will offer coverage that most nearly approximates the coverage in effect prior to change in marital status including the expiration date.

Renewability and Termination

Reasons We Will Terminate Your Contract

This Contract is renewable at the option of the Contract Holder, except for the conditions stated below. We will terminate Your Contract at the end of the billing period in which the following events occur unless stated otherwise:

- The required premium was due to us and not received by us, including any grace period.
- Termination will be effective on the last day for which the premium was paid.
- The Contract Holder commits fraud or makes an intentional misrepresentation of a material fact, in which case, We will provide 30 days' notice of Our intent to Rescind this Contract. The Contract Holder will have the right to Appeal the rescission.

- You no longer reside, live or work within the Service Area .A map of the Service Area is located at www.senderohealth.com, in the Provider Directory, or you may call Our Member Services telephone number on Your Member Identification Card. Termination will be effective not less than 30 days after written notice. This provision does not apply to children who are subject of a medical support order.

The Contract Holder requests termination of the Contract in writing.

Termination will be effective on the later of the date requested by your or Sendero receives your notice to cancel, or we cease to offer a particular type of coverage or cease to do business in the individual basic health care market, as allowed by federal or state law.

If we decide to discontinue offering a type of Contract, the Contract Holder will be:

- Notified of such discontinuation at least 90 days prior to the date of discontinuation of such coverage; and
- Given the option to purchase any other individual Hospital, medical or surgical Contract providing medical benefits that are being offered by us at such time.

If we decide to cease doing business in the individual Hospital, medical or surgical market, the Contract Holders covered by such policies and the Commissioner of Insurance will be notified of such discontinuation at least 180 days prior to the date of discontinuation of such coverage.

Your Duty to Notify Us

You are responsible to notify us of any of the events stated above which would result in termination of this Contract or a Covered Person.

Reinstatement

If this Contract is terminated due to lack of premium payment, other than your initial premium payment, you may request reinstatement. We will reinstate Your Contract provided all of the following are met:

1. A new application is submitted by you;
2. Coverage has not been terminated for more than 90 days; and
3. We approve the reinstatement.

If your request for reinstatement is approved, coverage will be reinstated on the date we approve the reinstatement.

Fraud

You commit fraud against us, or make an intentional misrepresentation of a material fact by intentionally not telling us the correct facts or withholding information which is necessary for us to administer this Contract.

Fraud may be criminal offense that can be prosecuted .Any person(s) who willingly and knowingly engages in an activity intended to defraud us by filing a claim or form that contains a false or deceptive statement may be committing insurance fraud.

If you or the Covered Person commits fraud against us, as determined by a court of law, coverage will be terminated .We will provide 15 days' notice of our intent to terminate. Such termination may be made on a retroactive basis as of the date the fraud was committed or as of the date otherwise determined by us.

Reasons You May Terminate Your Contract

You may terminate your Contract after not less than 30 days written notice to us in the case of a material change by us to any provision of the Contract that is required to be disclosed to you or a Covered Person pursuant to state or federal law.

General Provisions Appeals, Complaints and External Review Rights

You have a right to Appeal any decision we make that denies payment on your claim or your request for coverage of a health care service or treatment. Included in Your rights are the right to appeal an Adverse Determination to Us and to External Review, to appeal a Contractual Denial, and to file a Complaint. We may not engage in any retaliatory action against you for filing a complaint against us or appealing an Adverse Determination.

Appeal from an Adverse Determination

If we determine that health care services provided or proposed to be provided are not Medically Necessary or appropriate, we will notify you or an individual acting on your behalf and your provider of record of our determination and of your right to Appeal the Adverse Determination and the process for requesting an Appeal. We will notify You, the individual acting on Your behalf and Your provider of record of the Adverse Determination within the time appropriate to the circumstances relating to the delivery of the services and Your condition, but in no case to exceed one hour from notification when denying post-stabilization care subsequent to emergency treatment as requested by a treating Healthcare Practitioner or if You are hospitalized, within one working day by telephone or Electronic transmission. If your case involves a life-threatening condition or if we do not meet internal timeframes, you will be entitled to an immediate appeal to an Independent Review Organization (IRO). You are not required to comply with procedures for an internal review.

Step Therapy protocol includes denials and exception requests are subject to adverse determination appeal rights as well as an IRO. If you need assistance, have questions about the exception request process, the IRO rights and appeal process contact Sendero's Member Services.

If your Adverse Determination is not related to you being in the hospital at the time of the review, Sendero will provide a written notice of Adverse Determination to the patient and the Provider of record within three business days.

If Sendero transmits an Adverse Determination for a retrospective utilization review, the notice of Adverse Determination will be transmitted to the Provider of record and the patient no later than 30 days after the date on which the claim is received. If an extension for a retrospective utilization review is required, Sendero has an extended 15 days to complete the review and provide a response.

The Utilization Review shall provide notice of an adverse determination for a concurrent review of the provision of prescription drugs or intravenous infusions for which the patient is receiving health benefits under the Evidence of Coverage no later than the 30th day before the date on which the provision of prescription drugs or intravenous infusions will be discontinued.

You or an individual acting on your behalf or Your provider of record may ask for an expedited (fast) Appeal for Emergency Care denials, denials of care for life-threatening conditions, intravenous infusion, prescription drugs, and denials of continued stays for a hospitalization is available. The expedited review will be a review by a Healthcare Practitioner who has not previously reviewed the case and who is of the same or a similar specialty as the health care provider that typically manages the medical condition, procedure, or treatment under review. Expedited Appeal requests will be decided based on the medical immediacy of your condition, procedure or treatment, but in no event will the decision exceed one working day from the date all information necessary to complete the appeal is received. A determination may be provided by telephone or electronic transmission, but will be followed with a letter within three (3) working days of the initial telephone or electronic notification.

When we receive an Appeal, We will, within five working days from the receipt of the Appeal, send to the appealing party a letter acknowledging the date of our receipt of the Appeal. This letter will include the Appeal procedures, a request for required documentation, and the time frames required for resolution. If an Appeal of an adverse determination is received orally, included in the acknowledgement letter will be a one-page Appeal form to the appealing party.

After review of the Appeal of an Adverse Determination, We will issue a response letter to You or the person acting on Your behalf and Your Healthcare Practitioner explaining the resolution of the appeal as soon as practical, but in no case later than the 30th calendar day after the date We receive the Appeal. If the Appeal is for Emergency Care, or denial of a continued stay for Hospitalized Covered Person, the time frame for resolution will be based on the medical or dental immediacy of the condition, procedure or treatment, but may not exceed one working day from the date the request is received. The resolution letter will contain the clinical basis for the Appeal determination, the specialty of the Healthcare Practitioner making the denial, and notice of the appealing party's right to seek review of the denial by an IRO.

If the Appeal of Adverse Determination is denied, Your provider within 10 working days, sets forth in writing good cause for having a particular type of specialty provider review the case, the Appeal denial shall be reviewed by a Participating Provider in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment under discussion for review in the Appeal, and such specialty review will be completed within 15 business days of receipt of the request from the provider.

Review by an Independent Review Organization (IRO)

In a circumstance involving a life-threatening condition or denial of prescription drugs or intravenous infusions for which the patient is receiving benefits under the Evidence of Coverage, you are entitled to an immediate appeal to an IRO and not required to comply with Sendero's procedures for an Appeal of the Adverse Determination. Any party whose Appeal of an Adverse Determination is denied by Sendero may seek review of the decision by an IRO. At the time the Appeal is denied, Sendero will provide you, your designated representative or Provider of record, information on how to Appeal the denial, including the approved form, which you, your designated representative, or your Provider of record must complete. In life- threatening or urgent care situations, you, your designated representative, or your Provider of record may contact Sendero by telephone to request the review and provide the required information. For all other situations, you or your designated representative must sign the form and return it to Sendero to begin the IRO process.

Sendero will submit medical records, names of Providers and pertinent documentation to the IRO within three business days from receipt of the request. Sendero will comply with the decision by the IRO. Sendero will pay for the IRO.

Upon request and free of charge, you or your designee may have reasonable access to, and copies of, all documents, records and other information relevant to the claim or appeal, including:

- Information relied upon to make the decision;
- Information submitted, considered or generated in the course of making the decision, whether or not it was relied upon to make the decision;
- Descriptions of the administrative process and safeguards used to make the decision;
- Records of any independent reviews conducted by Sendero;
- Medical judgments, including whether a particular service is
- Experimental /Investigational or not Medically Necessary or appropriate; and expert advice and consultation obtained by Sendero in connection with the denied claim, whether or not the advice was relied upon to make the decision.

The Appeal process does not prohibit you from pursuing other appropriate remedies, including: injunctive relief; a declaratory judgment or other relief available under law.

Appeal from Denial of Benefits

If we determine that a health care service provided or proposed to be provided is not covered for reasons other than an Adverse Determination, for example, it is not covered or it is expressly excluded, you have the right to appeal that determination by requesting an appeal orally or in writing. In which case, we will follow the procedure below for Complaints.

Request for Additional Information

You may request more explanation when you receive Denial of Benefits. Contact Sendero when you:

- Do not understand the reason for the denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was denied;

- Cannot find the applicable provision in Your Evidence of Coverage;
- Want a copy (free of charge) of the guideline, criteria or clinical rationale that We used to make Our decision; or
- Disagree with the denial or the amount not covered and you want to Appeal.

If your claim was denied due to missing or incomplete information, you or your health care provider may resubmit the claim to us with the necessary information to complete the claim.

The appeal process does not prohibit the Covered Person from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under Jaw, if the requirement of exhausting the process for appeal and review places the Covered Person's health in serious jeopardy.

For questions on appeal and external review rights, a Covered Person can call Our Member Services Department at the number on his/her Member Identification Card.

Complaint Process

If you notify us orally or in writing of a Complaint, We will not later than the fifth business day after the date of the receipt of the complaint, send to you a letter acknowledging the date we received the complaint. This letter will also include our complaint procedures and time frames for resolution. If the complaint was received orally, we will enclose a one-page complaint form clearly stating that the complaint form must be returned to us for prompt resolution of the complaint.

After receipt of the written Complaint or one-page Complaint Form the Covered Person, We will investigate and send a letter with our resolution to the Covered Person. We will notify You of Our determination within 30 calendar days after the date we received the complaint.

Appeals from a Complaint to the Plan

If the complaint is not resolved to the Covered Person's satisfaction, the Covered Person has the right either to appear in person before a complaint appeal panel where the Covered Person normally receives healthcare services, unless another site is agreed to by the Covered Person, or to address a written appeal to the complaint appeal panel. We shall complete the complaint appeal process not later than the 30th calendar day after the date of the receipt of the request for appeal.

- We shall send an acknowledgment letter to the Covered Person not later than the fifth business day after the date of receipt of the request for appeal.
- We shall appoint members to the complaint appeal panel, which shall advise us on the resolution of the dispute. The complaint appeal panel shall be composed of an equal number of our staff, Healthcare Practitioners, and other persons covered under a health plan provided by us. A member of the complaint appeal panel may not have been previously involved in the disputed decision.
- Not later than the fifth business day before the scheduled meeting of the panel, unless the Covered Person agrees otherwise, We shall provide to the Covered Person or Covered Person's designated representative:
 - Any documentation to be presented to the panel by Our staff;

- The specialization of any Healthcare Practitioner consulted during the investigation; and
- The name and affiliation of each of our representatives on the panel.
- The Covered Person or the Covered Person's designated representative if the Covered Person is a minor or disabled, are entitled to:
 - Appear in person before the complaint appeal panel;
 - Present alternative expert testimony; and
 - Request the presence of and question any person responsible for making prior determination that resulted in the appeal.

Where to Send Appeals, Complaints and Requests for IRO

All Appeals, Complaints and Requests for IRQ must be sent to:

Sendero Health Plans
Attn: Member Advocate
2636 S. Loop West Ste. 125
Houston, TX 77054

Filing Complaints with the Texas Department of Insurance

Any Covered Person, including persons who have attempted to resolve complaints through our complaint and appeal process and who are dissatisfied with the resolution, may report the information to:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Web: www.tdi.texas.gov

E-mail: ConsumerProtection@tdi.state.tx.us

The Commissioner will investigate a complaint against us to determine compliance within 60 days after the TDI's receipt of the complaint and all information necessary for the department to determine compliance. The Commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

- Additional information is needed;
- An on-site review is necessary;

- We, the Healthcare Practitioner, or the Covered Person does not provide all documentation necessary to complete the investigation; or
- Other circumstances beyond the control of the department occur.

Exhaustion of Remedies

You must complete levels of the Appeal, Complaints and External Review Rights process applicable to you and any regulatory/statutory review process available to you under state or federal law before you file a legal action. Completion of these administrative and/or regulatory processes assures that both you and we have a full and fair opportunity to resolve any disputes regarding the terms and conditions contained in this Contract.

Assignment of Benefits

Assignment of benefits may be made only with our consent. An assignment is not binding until we receive and acknowledge in writing the original or copy of the assignment before payment of the benefit. We do not guarantee the legal validity or effect of such assignment.

Conformity with State Statutes

If the Contract contains any provision not in conformity with Texas Insurance Code section 1271 or other applicable laws it shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the Insurance Code Chapter 1271 and other applicable laws.

Cost of Legal Representation

The costs of our legal representation in matters related to our rights under this Contract shall be borne solely by us. The costs of legal representation incurred by or on behalf of a Covered Person shall be borne solely by you or the Covered Person, unless we were given timely notice of the claim and an opportunity to protect Our Own interests and we failed or declined to do so.

Duplicating Provisions

If any charge is described as covered under two or more benefit provisions, we will pay only under the provision allowing the greater benefit. This may require us to make a recalculation based upon both the amounts already paid and the amounts due to be paid. We have no obligation to pay for benefits other than those this Contract provides.

Entire Contract

The application, endorsements, amendments, riders and Contract constitute the entire agreement between the parties.

No modification or amendment to this Contract will be valid unless approved by the President, Secretary or a Vice-President of Our company .The approval must be endorsed on or attached to this Contract. No agent has authority to modify this Contract, waive any of the Contract provisions, extend the time for premium payment, or bind us by making any promise or representation.

Incontestability

All statements made by you on your application are considered to be representations, not warranties. A statement may not be used to contest or void, cancel or non-renew this Contract unless it is in the written enrollment application Signed by you and a signed copy of the enrollment application was furnished to you or your personal representative. A Contract may only be contested because of fraud or intentional misrepresentation of material fact on an enrollment application.

Legal Action

The Covered Person must have exhausted his or her rights under the Appeal, Complaints and External Review Rights provisions before bringing legal action against us. No lawsuit with respect to benefits under this Contract may be brought after the expiration of three years after the later of:

- The date on which We first denied the service or claim, paid less than You believe appropriate, or failed to timely pay the claim; or
- 80 days after a final determination of a timely filed appeal.

Premium Adjustment

If it is determined that information about the age or smoking status of a Covered Person was omitted or misstated, we will make an equitable premium adjustment. This provision applies equally to the Covered Person and to us.

Notice of Claim

Generally, any services the Covered Person receives will be billed to us by the Physician or Provider.

If the Covered Person receives a service which will not be billed to us by the Physician or Provider, the Covered Person must send Us a letter with his/her name, the service received and the Contract number. The Covered Person should mail the letter to our address shown on the Member Identification Card. We must receive a letter from the Covered Person informing Us of the claim within 30 days from the date the service was received or as soon as reasonably possible but no later than 90 days after the date of service.

For Emergency Care received provided outside the United States, the information to be submitted by a Covered Person along with their complete claim includes but is not limited to:

- Proof of payment to the foreign provider for the services provided;
- Complete medical information and/or records;

- Proof of travel to the foreign country such as airline tickets or passport stamps; and
- The foreign provider's fee schedule if the provider uses a billing agency.

Not later than the 15th day after which we receive the claim, we will acknowledge receipt of the claim and investigate the claim. We may need to obtain additional information we reasonably believe will be required, including, but is not limited to:

1. Authorizations for the release of medical information including the names of all providers from whom the Covered Person received services;
2. Medical information and/or records from any provider;
3. Information about other insurance coverage; and
4. Any information we need to administer the terms of this Contract.

We will notify you in writing of the acceptance or rejection of the claim no later than 15 business days after the date we receive all information required to make a determination. If we reject the claim, we will state the reason(s). If we are unable to accept or reject the claim by the end of the 15th business day, we will notify you of the reasons why we need additional time. We will accept or reject the claim no later than the 45th day after the date of our notice.

If we notify You We will pay the claim or part of the claim, we will pay not later than the 5th business day after our notice. If payment is conditioned on an act to be performed by You, We will pay the claim no later than the 5th business day after you perform.

If you fail to cooperate or provide the necessary information, we may recover payments made by us and deny any pending or subsequent claims for which the information is requested, unless the services were preauthorized by us and determined to be Medically Necessary or appropriate. We also have the right to terminate this Contract.

However, your claims will not be reduced or denied nor will this Contract be terminated if it was not reasonably possible to give such proof.

Our Relationship with Providers

Participating Providers are not our agents, employees or partners. Participating Providers are independent contractors. We do not endorse or control the clinical judgment or treatment recommendation made by Participating Physician or Participating Providers.

Nothing contained in this Contract or any agreement or reimbursement document shall, nor is it intended to, interfere with communication between You and Your Healthcare Practitioner regarding Your medical condition or treatment options. When requesting authorizations and ordering services, Participating Physicians or Participating Providers are acting on your behalf. All decisions related to patient care are the responsibility of the patient and the treating Participating Physicians or Participating Providers regardless of any coverage Determination we have made or will make. We are not responsible for any misstatements made by any provider with regard to the scope of Covered Services and/or non-Covered Services under Your Contract. If you have any questions concerning your coverage, please call the Member Services Department at the telephone number on Your Member Identification Card.

Rights That Affect Our Obligation to Pay

Your obligation to assist in the recovery process.

The Covered Person is obligated to cooperate and assist us and our agents in order to protect our recovery rights by:

- Promptly notifying Us that You may have a claim;
- Obtaining our consent before releasing any party from liability for payment of medical expenses;
- Providing Us with a copy of any legal notices arising from the Covered Person's injury and its treatment;
- Taking all action to assist our enforcement of recovery rights and doing nothing after the Illness, Bodily Injury or accident to prejudice our recovery rights; and
- Refraining from designating all (or any disproportionate part) of any recovery as exclusively for pain and suffering.

If you fail to cooperate with Us, We shall be entitled to recover from you any payments made by Us.

Right to Request Information

The Covered Person must cooperate with us and when asked, assist us by:

- Authorizing the release of medical information including the names of all providers from whom medical attention was received ;
- Obtaining medical information/or records from any Physician or Provider as requested by Us;
- Providing information regarding the circumstances of the Illness, Bodily Injury or accident;
- Providing information about other coverage benefits, including information related to any Bodily Injury or Illness for which another party may be liable to pay compensation or benefits; and
- Providing information we request to administer the Contract.

If you fail to cooperate or provide the necessary information, we may recover payments made by us and deny any pending or subsequent claims for which the information is requested, unless the services were approved by us in advance.

Non-duplication of Medicare benefits

We will not duplicate benefits for expenses that are paid by Medicare if it is the primary payer.

In all cases, coordination of benefits with Medicare and the provisions of Title XVIII of the Social Security Act as amended will conform to Federal Statutes and Regulations.

For purposes of this section, Medicare means Title XVIII, Part B, of the Social Security Act, as enacted or amended.

Coordination of Benefits

This Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. You should not have other health plan coverage per the ACA regulations. The Plan is defined below.

Following are definitions applicable to this COB provision, Section 9.3, Coordination of Benefits "Plan" is any of the following that provides benefits or services for medical or dental care or treatment.

Plan includes: group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in-force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and governmental benefits, as permitted by law.

Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance contract agreement that is designed to fully integrate with other policies through a variable deductible.

Each contract for coverage is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

"This Plan" is the part of the contract providing the health care benefits to which the COB provision applies.

The order of benefit determination rules determine whether this Plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this Plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this Plan is secondary, it determines its benefits after those of another plan and

may reduce the benefits it pays so that all plan benefits equal 100 percent of the total allowable expense.

"Allowable expense" is a health care expense, including deductibles and copayments that is covered at least in part by any plan covering the Member. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a health care provider or physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

Order of Benefit Determination Rules

When a Member is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

- The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.
- Except as provided in Section 8(2) (h), a plan that does not contain a COB provision that is consistent with this contract agreement is always primary unless the provisions of both plans state that the complying plan is primary.
- Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out of network benefits.
- A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.
- If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a noncontract health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary plan.
- When multiple contracts providing coordinated coverage are treated as a single plan under this subchapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this subchapter.
- If a person is covered by more than one secondary plan, the order of benefit determination rules of this subchapter decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.

- Each plan determines its order of benefits using the first of the following rules that apply.
- Nondependent or Dependent. The plan that covers the Member other than as a dependent, for example as an employee, member, contract agreement holder, subscriber, or retiree, is the primary plan, and the plan that covers the Member as a dependent is the secondary plan . However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the Member as a dependent and primary to the plan covering the Member as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering the Member as an employee, member, contract agreement holder, subscriber, or retiree is the secondary plan and the other plan is the primary plan.
- Dependent Child Covered Under More Than One Plan. Unless there is a court order stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply.
- For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - the plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or if both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
- For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
 - if a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.
 - If a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Section 8.ii. (a) must determine the order of benefits.
 - if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Section 8.ii. (a) must determine the order of benefits.
 - if there is no court order allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the childcare as follows:
 - the plan covering the custodial parent;
 - the plan covering the spouse of the custodial parent;
 - the plan covering the noncustodial parent; then
 - the plan covering the spouse of the noncustodial parent.
- For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of Section 8.ii.(a) or 8.ii.(b) must determine the order of benefits as if those individuals were the parents of the child.
- For a dependent child who has coverage under either or both parents' plans and has his or her own coverage as a dependent under a spouse's plan, Section 8.v. applies.
- In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits must be determined by applying the birthday rule in Section 8.ii.(a) to the dependent child's parent(s) and the dependent's spouse.

- Active, Retired, or Laid-off Employee. The plan that covers a Member as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan that covers that same Member as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the plan that covers the same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if can determine the order of benefits.
- COBRA or State Continuation Coverage. If a Member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree or covering the Member as a dependent of an employee, member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if the order of benefits cannot be determined.
- Longer or Shorter Length of Coverage. If none of the above rules determine the order of benefits, the plan that has covered the Member as an employee, member, contract agreement holder, subscriber, or retiree longer is the primary plan, and the plan that has covered the person the shorter period is the secondary plan.
- If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of This Plan

This section applies when this Plan is secondary in accordance with the order of benefits determination outlined above. In this event, the benefits of this Plan may be reduced so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100 percent of the total allowable expense for that claim. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, Sendero may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. Sendero will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Release of Information

For purposes of this Evidence of Coverage, Sendero may, subject to applicable confidentiality requirements set forth in this Evidence of Coverage, release to or obtain from any insurance company or other organization necessary information to implement these Coordination of Benefit provisions. Any Member claiming benefits under this Evidence of Coverage must furnish to Sendero all information deemed necessary by it to implement these Coordination of Benefits provisions.

Right of Reimbursement

If we pay benefits and you recover or are entitled to recover benefits from other coverage or from any legally responsible party, we have the right to recover from you the amount we paid.

You must notify us, in writing, within 31 days of any benefit payment, settlement, compromise or judgment. If you waive or impair our right to reimbursement, we will suspend payment of past or future services until all outstanding lien(s) are resolved.

If you recover payment from and release any legally responsible party for future medical expenses relating to an Illness or Bodily Injury, We shall have a continuing right to seek reimbursement from you. This right, however, shall apply only to the extent allowed by law.

This reimbursement obligation exists in full regardless of whether the settlement, compromise, or judgment designates the recovery as including or excluding medical expenses.

Our Right of Subrogation

To the extent allowed by Texas Law, we have the right to recover payments acquired by you against any third party for negligence or any willful act resulting in Illness or Bodily Injury to the extent we have paid for services. As a condition of receiving benefits from Us, You agree to assign to us any rights you may have to make a claim, take legal action or recover any expenses paid for benefits covered under this Contract.

If we are precluded from exercising our right of subrogation, we may exercise our right of reimbursement.

Assignment of Recovery Rights

If your claim against the insurer is denied or partially paid, we will process such claim according to the terms and conditions of this Contract. If payment is made by us on behalf of a You, You agree that any right you have against the other insurer for medical expenses we pay will be assigned to us.

Right to Request Overpayments

We reserve the right to recover any payments made by us that were:

- Made in error;
- Made to You and/or any party on Your behalf, where We determine that such payment made is greater than the amount payable under this Contract;
- Made to You and/or any party on Your behalf, based on fraudulent or intentional misrepresentation of a material fact; or
- Made to You and/or any party on your behalf for charges that were discounted, waived or rebated.

We reserve the right to adjust any amount applied in error to any Deductible or Out-of-Pocket Maximum.

Right to Require Medical Examinations

We have the right to have the Covered Person examined or autopsied during the pendency of a claim, unless prohibited by law. These procedures will be conducted as often as we deem reasonably necessary to determine Contract benefits, at our expense.

State Public Medical Assistance

If a Covered Person received medical assistance from a program under the Texas Health and Human Services Commission while insured under this Contract, We will reimburse the program for the actual cost of medical expenses the program pays through medical assistance, if such assistance was paid for a Covered Expense for which benefits are payable under this Contract, and if We received timely notice from the Commission, or its designated health plan, of payment of such assistance. Any reimbursement to the Commission or its designated health plan made by us will discharge us to the extent of the reimbursement. This provision applies only to the extent we have not already made payment of the claim to you or to the provider.

If the Texas Health and Human Services Commission is paying financial and medical assistance for a child and You are a parent who purchased this Contract or a parent covered by this Contract and have possession or access to the child, or are not entitled to access or possession of the child but are required by the court to pay child support, all benefits paid on behalf of the child or children under this Contract must be paid to the Texas Health and Human Services Commission.

We must receive written notice affixed to the claim when first submitted that benefits must be paid directly to the Texas Health and Human Services Commission.

Time of Payment of Claims

Payments due under this Contract to Participating Physicians and Participating Providers will be paid in accordance with applicable Texas Prompt Payment of Claims laws.

Unpaid Premium

If any premium is due or unpaid and a payment of a claim is made under this Contract, the due or unpaid premium may be deducted from the payment due on the claim.

Workers' Compensation

This Contract is not in lieu of any Workers' Compensation or Occupational Disease insurance.

Definitions

The following are definitions of terms as they are used in this Contract.

Acquired Brain Injury means a neurological insult to the brain, which is not hereditary, congenital or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Advanced Imaging for the purpose of this definition, includes Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET), Single Photon Emission Computed Tomography (SPECT), Computed Tomography (CT) imaging, and nuclear medicine.

Advanced Premium Tax Credit means payments made monthly on your behalf by the Federal Government directly to Community, decreasing your monthly premium payment. **Adverse Determination** means a determination by Us or a designee that the healthcare services furnished or proposed to be furnished to a Covered Person are not Medically Necessary or are Experimental or investigational. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review. In the case of a prescription drug, it is an Adverse Determination if we refuse to provide benefits if the drug is not included in the Drug Formulary and Your Physician has determined that the drug is Medically Necessary.

Affordable Care Act means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152).

Appeal means our formal process by which a Covered Person, an individual acting on behalf of a Covered Person or a Covered Person's provider of record may request reconsideration of an Adverse Determination or Denial of Benefits.

Basic Health Care Services means health care services that the commissioner determines an enrolled population might reasonably need to be maintained in good health.

Bodily Injury means bodily damage other than Illness, including all related conditions and recurrent symptoms, resulting from sudden physical trauma which could not be avoided or predicted in advance. The Bodily Injury must be the direct cause of the loss, independent of disease, bodily infinity or any other cause. Bodily damage resulting from infection or muscle strain due to athletic or physical activity is considered an Illness and not a Bodily Injury.

Bone Marrow Transplant means the transplant of human blood precursor cells which are administered to a patient following high-dose, ablative or myelosuppressive chemotherapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant from a matched related or unrelated donor or cord blood. If chemotherapy is an integral part of the treatment involving a Covered Organ Transplant of bone marrow, the term bone marrow includes the harvesting, the transplantation, and the chemotherapy components.

Brand-Name Drug means a drug, medicine or medication that is manufactured and distributed by only one pharmaceutical manufacturer, or any drug product that has been designed as brand-name by an industry recognized source used by us.

Calendar Year means the period of time beginning on any January 1st and ending on the following December 31st. The first Calendar Year begins for a Covered Person on the date benefits under this Contract first become effective for that Covered Person and ends on the following December 31st.

Cognitive Communication Therapy means services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

Cognitive Rehabilitative Therapy means services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficit.

Community Reintegration Therapy means services that facilitate the continuum of care as an affected individual transitions into the community.

Chemical Dependency means the abuse of, or psychological or physical dependence on, or addiction to alcohol or a controlled substance.

Clinical Trial means a clinical research study or clinical investigation that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease and is approved by:

- The Centers for Disease Control (CDC) and Prevention of the U.S. Department of Health and Human Services; The National Institutes of Health (NIH); The U.S. Food and Drug Administration (FDA); 4.The U.S. Department of Defense (DOD); The U.S. Department of Veterans Affairs (VA); or An Institutional review board of an institution in this state that has an agreement with the Office for Human Research Protection (OHRP) of the U.S. Department of Health and Human Services (HHS); The Agency for Health Care Research and Quality; The Centers for Medicare and Medicaid Services; The Department of Energy.

Comparable Emergency Facility means (i) any stationary or mobile facility, including, but not limited to, Level V Trauma Facilities and Rural Health Clinics which have licensed and/or certified personnel and equipment to provide Advanced Cardiac Life Support (ACLS) consistent with American Heart Association (AHA) and American Trauma Society (ATS) standards of care: for purposes of emergency care related to mental illness, mental health facility that can provide 24-hour residential and psychiatric services and that is: (I) a facility operated by the Texas Department of State Health Services; (II) a private mental hospital licensed by the Texas Department of State Health Services; (III) a community center as defined by the Texas Health and Safety Code section 534.00 I; (IV) a facility operated by a community center or other entity the Texas Department of State Health Services

designates to provide mental healthcare ; an identifiable part of a general hospital in which diagnosis, treatment, and care for persons with mental illness is provided and that is licensed by the Texas Department of State Health Services; or (VI) a hospital operated by a federal agency.

Complaint means any dissatisfaction expressed orally or in writing by a complainant to a health maintenance organization regarding any aspect of the health maintenance organization's operation. The term includes dissatisfaction relating to plan administration, procedures related to review or appeal of an adverse determination, the denial, reduction, or termination of a service for reasons not related to medical necessity, the manner in which a service is provided, and a disenrollment decision. A Complaint does not include: a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the enrollee; or a Provider's or Covered Person's oral or written expression of dissatisfaction or disagreement with an adverse determination.

Complainant means a Covered Person, or a Physician, Provider, or other person designated to act on behalf of a Covered Person, who files a complaint.

Confined/Confinement means the status of being a resident patient in a Hospital or Healthcare Treatment Facility receiving Inpatient Services. Confinement does not mean detainment in Observation Status.

Successive Confinements are considered to be one Confinement if they are:

- Due to the same Bodily Injury or illness; and
- Separated by fewer than 30 consecutive days when the Covered Person is not confined.

Consumer Choice Health Benefit Plan means group or individual accident or sickness insurance contract agreement, or evidence of coverage that , in whole or in part, does not offer or provide state-mandated health benefits, but provides creditable coverage as defined by the Texas Insurance Code § 1205.004(a) or 1501.102(a).

Contract means this document, together with any amendments, riders, and endorsements which describe the agreement between you and us.

Contract Holder means the person to whom this Contract is issued.

Contractual Denial means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of the Contract Holder or Your eligibility to participate in a plan and rescission of this Contract.

Copayment/Copay means a specified dollar amount or amount expressed as a percentage shown on the Schedule of Benefits You are obligated to pay to a Physician or Provider toward covered expenses of certain benefits specified in this Contract each time a covered service is received, regardless of any amounts that may be paid by us. Any Copayments do not apply toward the Deductible.

Cosmetic Surgery means Surgery, procedure, injection, medication, or treatment primarily designed to improve appearance, self-esteem or body image and/or to relieve or prevent social, emotional or psychological distress.

Cost Share means the Deductible and/or Copayment that must be paid by the Covered Person for Prescription Drugs.

Covered Service means a service or supply that is covered under this Contract and is Medically Necessary and appropriate. To be a Covered Service, the Service must not be Experimental or Investigational or otherwise excluded or limited by this Contract or by any amendment.

Covered Organ Transplant means only the services, care and treatment received for or in connection with the pre-approved transplant of the organs identified in the Your Contract Benefits section, which are Medically Necessary services and which are not Experimental or Investigational. Transplantation of multiple organs, when performed simultaneously, is considered one organ transplant.

Covered Person means anyone eligible to receive Contract benefits as a Covered Person.

Custodial Care means services given to a Covered Person if:

- The Covered Person needs services that include, but are not limited to, assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication which is ordinarily self-administered, getting in and out of bed and maintaining continence; or
- The services are required to primarily maintain and not likely to improve the Covered Person's condition.

Services may still be considered Custodial Care by Us even if:

- The Covered Person is under the care of a Healthcare Practitioner;
- The services are prescribed by a Healthcare Practitioner to support or maintain the Covered Person's condition;
- Services are being provided by a Nurse; or
- The services involve the use of skills which can be taught to a layperson and do not require the technical skills of a Nurse.

Deductible means the amount of covered expense that an individual and/or family must incur in a Plan Year and is responsible to pay before any Copayment, is applied. This amount will be applied on a Plan Year basis and does not apply to certain Services. The Deductible is shown on the Schedule of Benefits.

One or more of the following Deductibles may apply to Covered Services:

- **Medical Deductible.** The amount of Covered Expense an individual and/or a family must incur in the plan year before benefits become payable and before any Copayment is applied. Medical Deductible does not apply to Preventive Services, Prescription Drugs, or the first 3 Primary Care office visits.
- **Family Deductible.** Each Calendar Year, once the number of individual Deductibles, as shown on the Schedule of Benefits is fulfilled, no further individual Deductibles will have to be paid for the rest of that same Calendar Year.

- Prescription Drug Deductible. The amount of Prescription Drug expenses that each Covered Person must incur each Plan Year before any Copayment is applied. These expenses do not apply toward any other Deductible stated in this Contract.

Denial of Benefits means any of the following: a denial, reduction, or termination of, or a failure to provide a benefit.

Dental Injury means an injury to a Sound Natural Tooth caused by a sudden and external force that could not be predicted in advance and could not be avoided. It does not include biting or chewing injuries.

Dependent means Contract Holder's legally recognized spouse, natural born child, step-child , legally adopted child, a child placed for adoption or a child for whom the Contract Holder is a party in a suit in which adoption of the child is sought by the Contract Holder, whose age is less than the limiting age, a child whose age is less than the limiting age and for whom You have received a court or administrative order to provide coverage until such court or administrative order is no longer in effect, the child is enrolled for comparable health insurance or will be enrolled in comparable coverage that will take effect no later than the Effective Date of the cancellation or non-renewal, an unmarried grandchild, if the grandchild is a dependent for Federal Income Tax purposes at the time of application, whose age is less than the limiting age or the Contract Holder's adult child who meets the following conditions :

- Is beyond the limiting age of a child ;
- Is unmarried ;
- Is permanently mentally or physically handicapped ;and
- Incapable of self-sustaining employment.

In order for the covered adult Dependent child to remain eligible as specified above, we must receive notification within 31 days of the covered Dependent child's attainment of the limiting age of these conditions.

Each child, other than the child who qualifies because of a court or administrative order, must meet all of the qualifications of a Dependent as determined by us.

You must furnish satisfactory proof to us upon our request that the condition as defined in the items above, continuously exists on and after the date the limiting age is reached. After two years from the date the first proof was furnished, we may not request such proof more often than annually. If satisfactory proof is not submitted to us, the child's coverage will not continue beyond the last date of eligibility.

The limiting age for each child to be considered a Dependent under this Contract is the child's 26th birthday.

Diabetes Equipment means:

1. Blood glucose monitors, including noninvasive glucose monitors and glucose monitors designed to be used by blind individuals;
2. Insulin pumps and associated appurtenances;
3. Insulin infusion devices; and

4. Podiatric appliances for the prevention of complications associated with diabetes.

Diabetic Supplies means:

1. Test strips for blood glucose monitors;
2. Visual reading and urine test strips;
3. Lancets and lancet devices;
4. insulin and insulin analogs;
5. injection aids;
6. Syringes;
7. Prescriptive and non-prescription oral agents for controlling blood sugar levels;
8. Glucagon emergency kits; and
9. Alcohol swabs.

Dispensing Limit means the monthly drug dosage limit and/or the number of months the drug usage is usually needed to treat a particular condition.

Drug Formulary means a list of Prescription Drugs, medicines, medications, and supplies specified by us and indicates applicable Dispensing Limits and/or any Prior Authorization or Step Therapy requirements. Visit Our Web site at www.senderohealth.com or call Our Member Services Department at the telephone number on Your Member Identification Card to obtain the Drug Formulary .The Drug Formulary is subject to change without notice.

Durable Medical Equipment means equipment, defined by Medicare Part B, which meets the following criteria:

- It can withstand repeated use;
- It is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience;
- It is usually not useful to a person except to treat a Bodily Injury or Illness;
- It is Medically Necessary and necessitated by the Covered Person's Bodily Injury or Illness;
- It is not typically furnished by a Hospital or Skilled Nursing Facility; and
- It is prescribed by a Healthcare Practitioner as appropriate for use in the home.

Effective Date means the first date all the terms and provisions of this Contract apply. It is the date that appears on Your Member Identification Card.

Electronic/Electronically means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic or similar capabilities.

Emergency Care means any service provided for a Bodily Injury or Illness manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of that individual in serious jeopardy;
- Serious impairment of bodily functions;
- Serious disfigurement ; or

- Serious dysfunction of any bodily organ or part; or
- For pregnant women, result in serious jeopardy to the health of the fetus

Emergency Care does not mean any service for the convenience of the Covered Person or the provider of treatment or services.

Experimental or Investigational means any procedure, treatment, supply, device, equipment, facility or drug (all services) determined by Our Medical Director or his/her designee to:

1. Not be a benefit for diagnosis or treatment of an Illness or a Bodily Injury;
2. Not be as beneficial as any established alternative; or
3. Not show improvement outside the investigational setting.

A drug, biological product, device, treatment or procedure that meets any one of the following criteria will be considered Experimental or Investigational:

- Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) for the particular Illness or Bodily Injury and which lacks such final FDA approval for the use or proposed use, unless:
 - Found to be accepted for that use in the most recently published edition of the United States Pharmacopoeia-Drug Information for Healthcare Professional (USP-DI) or in the most recently published edition of the American Hospital Formulary Service (AHFS) Drug Information;
 - Identified as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service; or
 - Is mandated by state law;
- Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA, but has not received a PMA or 510K approval ;
- Is not identified as safe, widely used , and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;
- Is the subject of a National Cancer Institute (NCI) Phase I, II or III trial, or any trial not recognized by NCI regardless of the Phase except as expressly provided in this Contract;
- Is identified as not covered by the Centers for Medicare and Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Contract agreement Letter or a CMS National Coverage Decision except as required by state or federal law;

The FDA has not determined the device to be contraindicated for the particular Illness or Bodily Injury for which the device has been prescribed; or the treatment. Services or supplies are:

- Not as effective in improving health outcomes and not as cost effective as established technology; or;
- Not usable in appropriate clinical contexts in which established technology is not employable.

Any service which is not covered due to being Experimental or Investigational is eligible for review of that determination by an Independent Review Organization (IRO). See the Appeals Process to Independent Review Organization provision in the General Provisions section of this Contract.

Family Member means you or your spouse, or you or your spouse's child, brother, sister or parent. Family Out-of-Pocket Maximum means each Plan Year once a family has fulfilled the Family

Out-of-Pocket Maximum amount, as shown on the Schedule of Benefits, no Covered Person in that Family will have any additional out-of-pocket responsibility for Covered Services for the rest of that same Plan Year. The maximum amount any one Covered Person in a family can contribute toward the Family Out-of-Pocket Maximum in a Calendar Year is the amount applied toward the individual Out-of-Pocket Maximum.

Federally Facilitated Health Insurance Marketplace means a structured marketplace created by the Affordable Care Act where qualified individuals and small business can shop for private health insurance coverage.

Free-Standing Surgical Facility means any licensed public or private establishment which has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient Surgery. It does not provide services or accommodations for patients to stay overnight.

Generic Drug means a drug, medicine or medication that is manufactured, distributed, and available from a pharmaceutical manufacturer and identified by a chemical name, or any drug product that has been designated as generic by an industry-recognized source used by us.

Healthcare Practitioner means an individual practitioner, professionally licensed by the appropriate state agency, to diagnose or treat a Bodily Injury or Illness, and who provides services within the scope of that license. A Healthcare Practitioner's services are not covered if the practitioner resides in the Covered Person's home or is a Family Member.

Healthcare Treatment Facility means only a facility, institution or clinic duly licensed by the appropriate state agency, and is primarily established and operating within the scope of its license. Healthcare treatment facility does not include a Residential Treatment Center or halfway house.

Home Healthcare Agency means a Home Healthcare Agency or Hospital which meets all of the following requirements:

1. It must primarily provide skilled nursing services and other therapeutic services under the supervision of Healthcare Practitioners or Nurses;
2. It must be operated according to established processes and procedures by a group of professional medical people, including Healthcare Practitioners and Nurses;
3. It must maintain clinical records on all patients; and
4. It must be licensed by the jurisdiction where it is located, if licensure is required. It must be operated according to the laws of that jurisdiction which pertains to agencies providing home healthcare.

Home Healthcare Plan means a plan of healthcare established with a home healthcare provider. The home healthcare plan must consist of:

- Care by or under the supervision of a Nurse or another Healthcare Practitioner and not for Custodial Care;
- Physical, speech, occupational and respiratory therapy;
- Medical social work and nutrition services; or
- Medical appliances, equipment and laboratory services, if expenses incurred for such supplies would have been Covered Services during a Confinement.

A Healthcare Practitioner must:

- Review and approve the Home Healthcare Plan;
- Certify and verify that the Home Healthcare Plan is required in lieu of Confinement or a continued Confinement; and
- Not be related to the Home Healthcare Agency by ownership or Contract.

Home Healthcare Visit means home healthcare services provided by any one Healthcare Practitioner for four consecutive hours or any portion thereof.

Hospice Care Agency means an agency which:

1. Has the primary purpose of providing hospice services to Hospice Patients; Is licensed and operated according to the laws of the state in which it is located; and Meets the following requirements:
 - Has obtained any required certificate of need;
 - Provides 24-hour-a-day, seven-day-a- Week service, supervised by a Healthcare Practitioner;
 - Has a full-time administrator;
 - Keeps written records of services provided to each patient; and
 - Has a coordinator who:
 - Is a Nurse; and
 - Has four years of full-time clinical experience, of which at least two were involved in caring for terminally ill patients; and
 - Has a licensed social service coordinator.

Hospice Care Program means a coordinated, interdisciplinary program provided by a hospice designed to meet the special physical, psychological, spiritual, and social needs of a terminally ill Covered Person and his/her immediate Family Members, by providing Palliative Care and supportive medical, nursing, and other services through at- home or inpatient care. A hospice must:

- Be licensed by the laws of the jurisdiction where it is located and run as a hospice as defined by those laws; and
- Provide a program of treatment for a least two unrelated individuals who have been medically diagnosed as having no reasonable prospect for cure for their illness; and as estimated by their Healthcare Practitioners, are expected to live less than six months as a result of that illness.

For purposes of the Hospice Care benefit only, immediate Family Member is considered to be the Covered Person's parent, spouse, and children or step-children.

- Hospice Facility means a licensed facility or part of a facility which: Principally provides hospice care;
- Keeps medical records of each patient;
- Has an ongoing quality assurance program ;
- Has a Healthcare Practitioner on call at all times;
- Provides 24-hour-a-day skilled nursing services under the direction of a Nurse; and has a full-time administrator.

Hospice Patient means a terminally ill person who has six months or less to live, as certified by a Healthcare Practitioner.

Hospital means an institution that meets all of the following requirements:

1. It must provide, for a fee, medical care and treatment of sick or injured patients on an inpatient basis;
2. It must provide or operate, either on its premises or in facilities available to the Hospital on a pre-arranged basis, medical, diagnostic, and surgical facilities;
3. Care and treatment must be given by and supervised by Healthcare Practitioners .Nursing services must be provided on a 24-hour basis and must be given by or supervised by Nurses;
4. It must be licensed by the laws of the jurisdiction where it is located; and
5. It must be operated as a Hospital as defined by those laws; and
6. It must not be primarily a convalescent , rest or nursing home; or
7. Facility providing custodial, educational or rehabilitative care. The Hospital must be accredited by one of the following:
 - The Joint Commission on the Accreditation of Hospitals;
 - The American Osteopathic Hospital Association;
 - The Commission on the Accreditation of Rehabilitative Facilities; or
 - DNV (Det Norske Veritas).

Identification or ID Cards means cards each Covered Person receives which contain our address and telephone number.

Illness means disturbance in function or structure of the Covered Person's body which causes physical signs or symptoms which if left untreated, will result in a deterioration of the health state of the structure or system(s) of the Covered Person's body Congenital defects will be treated the same as any other Illness. Complications of pregnancy will be treated the same as any other Illness.

Infertility Treatment means any treatment, supply, medication or service given to achieve pregnancy or to achieve or maintain ovulation. This includes, but is not limited to:

1. Artificial insemination;
2. In vitro fertilization;
3. GIFT;
4. Tubal ovum transfer;
5. Embryo freezing or transfer;
6. Sperm storage or banking;

7. Ovum storage or banking;
8. Embryo or zygote banking;
9. Diagnostic and/or therapeutic laparoscopy;
10. Hysterosalpingography;
11. Ultrasonography;
12. Endometrial biopsy; and
13. Any other assisted reproductive techniques or cloning methods.

Inpatient Services are services rendered to a Covered Person during their Confinement.

Legend Drug means any medicinal substance the label of which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend: Caution: Federal Law prohibits dispensing without Prescription.

Life-Threatening Disease means a disease or condition from which the likelihood of death is probable unless the course of the disease is interrupted.

Limiting Age means the Dependent's 26th birthday. Maintenance Care means services furnished mainly to:

- Maintain, rather than improve, a level of physical or mental function ; or
- Provide a protected environment free from exposure that can worsen the Covered Person's physical or mental condition.

Medical Home is a team health care delivery modelled by a physician, P.A., or N.P. that provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes.

Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Healthcare Practitioner would provide to his/her patient for the purpose of diagnosing, palliating, or treating an Illness or Bodily Injury or its symptoms. The fact that a Healthcare Practitioner may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered under this Illness. Such healthcare service, treatment or procedure must be:

- In accordance with nationally recognized standards of medical practice and identified as safe, widely used , and generally accepted as effective for the proposed use;
- Clinically appropriate in terms of type, frequency, intensity, toxicity, extent , setting, and duration;
- Not primarily for the convenience of the patient or Healthcare Practitioner ;
- Clearly substantiated and supported by the medical records and documentation concerning the patient's condition ;
- Performed in the most cost effective setting required by the patient's condition;
- Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and
- Not Experimental or Investigational.

Mental Health means Mental Illness and Chemical Dependency.

Mental Illness means the diagnostic testing and treatment of a neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind. This is true regardless of the original cause of the disorder.

Morbid Obesity (clinically severe obesity) means a body mass index (BMI) as determined by a Healthcare Practitioner as of the date of service of:

- 40 kilograms or greater per meter squared (kg/m²); or
- 35 kilograms or greater per meter squared (kg/m²) with an associated co- morbid condition such as hypertension, type II diabetes, life-threatening cardiopulmonary conditions or joint disease that is treatable, if not for the obesity.

Neurobehavioral Testing means an evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.

Neurobehavioral Treatment means interventions that focus on behavior and the variables that control behavior.

Neurocognitive Rehabilitation means services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurocognitive Therapy means services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

Neurofeedback Therapy means services that utilize operant conditioning learning procedures based on electroencephalography (EEG) parameters, and are designed to result in improved mental performance and behavior, and stabilized mood.

Neurophysiological Testing means an evaluation of the functions of the nervous system. Neurophysiological Treatment means interventions that focus on the functions of the nervous system.

Neuropsychological Testing means the administering of a comprehensive battery of tests to evaluate neurocognitive , behavioral , and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Neuropsychological Treatment means interventions designed to improve or minimize deficits in behavioral and cognitive processes.

Non-Participating Pharmacy means a Pharmacy that has not signed a direct agreement with Us or has not signed a direct agreement with Us as an independent contractor or been contracted by Us to provide covered Pharmacy services, covered Specialty Pharmacy services defined by Us, to Covered Persons including covered Prescription or refills.

Non-Participating Physician means a Physician who has not signed a direct agreement with us as an independent Contractor or been Contracted by us as a Participating Provider.

Non-Participating Provider means a Hospital , Healthcare Treatment Facility, Healthcare Practitioner, or other provider who has not signed a direct agreement with Us as an independent Contractor or been Contracted by Us as a Participating Provider.

Nuclear Medicine means radiology in which radioisotopes (compounds containing radioactive forms of atoms) are introduced into the body for the purpose of imaging, evaluating organ function or localizing disease or tumors.

Nurse means a registered Nurse (R.N.), a licensed practical Nurse (L.P.N.), or a licensed vocational Nurse (L.V.N.).

Observation Status means a stay in a Hospital or Healthcare Treatment Facility for less than 24 hours if the Covered Person:

- Has not been admitted as a resident inpatient;
- Is physically detained in an emergency room, treatment room, observation room or other such area; or
- Is being observed to determine whether a Confinement will be required.

Off Label Drug means an approved drug legally prescribed for a purpose for which it has not been specifically approved by the United States Food and Drug Administration.

Organ Transplant Treatment Period means 365 days from the date of discharge from the Hospital following a Covered Organ Transplant received while covered by us.

Out-of-Pocket Maximum means the maximum amount an individual and/or family pays each Plan Year for services covered under this Contract. This amount includes Copayments, Prescription

Drug Deductibles and Medical Deductibles but does not include:

- Utilization management or Prescription Drug penalties;
- Non-covered services; or
- Other Contract limits.

There are separate individual and family Participating Provider Out-of-Pocket Maximums. See the Schedule of Benefits for the specific amounts.

Outpatient Day Treatment Services means structured services provided to address deficits in physiological, behavioral, and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or nonresidential treatment settings.

Outpatient Services means services that are rendered to a Covered Person while they are not confined as a registered inpatient. Outpatient services include, but are not limited to, services provided in:

- A Healthcare Practitioner's office;
- A Hospital outpatient setting;
- A free-standing surgical facility;
- A licensed birthing center; or
- An independent laboratory or clinic.

Palliative Care means care given to a Covered Person to relieve, ease or alleviate, but not to cure, a Bodily Injury or Illness.

Partial Hospitalization means services provided in an outpatient program by a Hospital or Healthcare Treatment Facility in which patients do not reside for a full 24-hour period.

- For a comprehensive and intensive interdisciplinary psychiatric treatment for a minimum of five hours a day, five days per week;
- That provides for social, psychological, and rehabilitative training programs with a focus on reintegration back into the community and admits children and adolescents who must have a treatment program designed to meet the special needs of that age range; and
- That has Healthcare Practitioners readily available for the emergent and urgent needs of the patients.

The partial Hospitalization program must be accredited by the Joint Commission of the Accreditation of Hospitals or in compliance with an equivalent standard.

Licensed drug abuse rehabilitation programs and alcohol rehabilitation programs accredited by the Joint Commission on the Accreditation of Health Care Organizations or approved by the appropriate state agency are also considered partial Hospitalization services.

Partial Hospitalization does not include services that are for:

- Custodial care; or
- Day care.

Participating Pharmacy means a Pharmacy that has signed a direct agreement with us or has been contracted by us to provide covered Pharmacy services, covered Specialty Pharmacy services as defined by us, to Covered Persons including covered Prescription or refills.

Participating Physician means a Physician that is designated as such and has signed a direct agreement with us as an independent contractor, or who has been contracted by us to provide services to Covered Persons.

Participating Provider means a Hospital, Healthcare Treatment Facility, Healthcare Practitioner or other provider who is designated as such and has signed a direct agreement with us as an independent contractor, or who has been contracted by us to provide services to Covered Persons.

Pharmacist means a person who is licensed to prepare, compound, and dispense medication and who is practicing within the scope of his/her license.

Pharmacy means a licensed establishment where Prescription medications are dispensed by a Pharmacist.

Physician means:

- a. an individual licensed to practice medicine in this state;
- b. a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes);

- c. an approved nonprofit health corporation certified under Chapter 162, Occupations Code;
- d. a medical school or medical and dental unit, as defined or described by Section 61.003, 61.501, or 74.60 I, Education Code, that employs or contracts with physicians to teach or provide medical services or employs physicians and contracts with physicians in a practice plan ; or
- e. another person wholly owned by physicians.

Plan Year means the period of time beginning on the date benefits under this Contract become effective for that Covered Person and end December 31 of that year.

Post-Acute Care Treatment Services means services provided after acute-care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral , or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or reestablishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms .

Post-Acute Transition Services means services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

Prescription means a direct order for the preparation and use of a drug, medicine, or medication, or biological. The drug, medicine, or medication, or biological must be obtainable only by Prescription.

The Prescription must be given by a Healthcare Practitioner to a Pharmacist for the benefit of and use by a Covered Person for the treatment of a Bodily Injury or Illness which is covered under this Contract. The Prescription may be given to the Pharmacist verbally, electronically, or in writing by the Healthcare Practitioner.

The Prescription must include at least:

- The name of the Covered Person ;
- The type and quantity of the drug, medicine, medication, or biological prescribed and the directions for its use;
- The date the Prescription was prescribed ; and
- The name and address of the prescribing Healthcare Practitioner.

Pre-Surgical/Procedural Testing means:

Laboratory tests or radiological examinations done on an outpatient basis in a Hospital or other facility accepted by the Hospital before Hospital Confinement or outpatient Surgery or procedures; and the tests must be for the same Bodily Injury or Illness causing the Covered Person to be Hospital Confined or to have the outpatient Surgery or procedure.

Preventive Services means services in the following recommendations appropriate for a Covered Person:

1. The recommendations by the USPSTF for breast cancer screenings, mammography and preventions issued prior to November 2009 will be considered current ;

2. Immunizations recommended by the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention (CDC);
3. Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
4. Preventive care for women provided in the comprehensive guidelines supported by HRSA.

For the recommended Preventive Services that apply to your contract agreement, refer to the U. S. Department of Health and Human Services (HHS) Web site at www.HHS.gov or call the Member Services telephone number on the back of Your ID card.

Primary Care Physician or Primary Care Provider (PCP) (PCP) means a Physician or

Provider who has agreed with Sendero to provide a medical home to you and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care. Provider types that can be PCPs are from any of the following practice areas : General Practice , Family Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology (OB/GYN), Advanced Practice Nurses (APNs) and Physician Assistants (when APNs and PAs are practicing under the supervision of a physician specializing in Family Practice, Internal Medicine , Pediatrics or Obstetrics/Gynecology who also qualifies as a PCP under this contract), Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and similar community clinics; and specialist physicians who are willing to provide a Medical Home to selected Members with special needs and conditions .

Prior Authorization means a determination by us, or our designee, that a Service or Prescription Drug is Medically Necessary prior to it being provided.

Provider means:

1. A person, other than a physician, who is licensed or otherwise authorized to provide a health care service in this state, including:
 - a chiropractor, registered nurse , pharmacist , optometrist, registered optician, or acupuncturist; or
 - a pharmacy, hospital , or other institution or organization;
2. A person who is wholly owned or controlled by a provider or by a group of providers who are licensed or otherwise authorized to provide the same health care service; or
3. A person who is wholly owned or controlled by one or more hospitals and physicians, including a physician-hospital organization.

Psychophysiological Testing means an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

Psychophysiological Treatment means interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

Qualified Health Plan means a health benefit plan that is certified by the Federally Facilitated Health Insurance Marketplace to be offered in Texas.

Reconstructive Surgery means Surgery performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumor or disease in order to improve function.

Rehabilitation Services means specialized treatment for Illness or a Bodily Injury which meets all of the following requirements:

1. Is a program of services provided by one or more members of a multi-disciplinary team;
2. Is designed to improve the patient's function and independence;
3. Is under the direction of a qualified Healthcare Practitioner,
4. Includes a formal written treatment plan with specific attainable and measurable goals and objections; and may be provided in either an inpatient or outpatient setting.

Remediation means the process or processes of restoring or improving a specific function. Rescission means the cancellation or discontinuance of coverage that has retroactive effect. It is a cancellation that treats a contract agreement as void from the time of the Contract Holder or Your enrollment.

Research Institution means the institution or other person or entity conducting a phase I, phase II, phase III or phase IV Clinical Trial.

Residential Treatment Center means an institution which:

- Is licensed as a 24-hour residential, intensive, inpatient facility, although NOT licensed as a Hospital;
- Provides a multidisciplinary treatment plan in a controlled environment, with periodic supervision of a licensed Healthcare Practitioner or Ph.D. psychologist; and
- Provides programs such as social, psychological, and rehabilitative training, age appropriate for the special needs of the age group of patients, with a focus on reintegration back into the community.

Residential treatment is utilized to provide structure, support, and reinforcement of the treatment required to reverse the course of behavioral deterioration.

Routine Nursery Care means the charges made by a Hospital or licensed birthing center for the use of the Nursery. It includes normal services and supplies given to well newborn children following birth. Healthcare practitioner visits are not considered Routine Nursery Care. Treatment of Bodily Injury, Illness, birth abnormality or congenital defect following birth and care resulting from prematurity are not considered routine Nursery care.

Routine Patient Care Costs mean the costs of any Medically Necessary healthcare service for which coverage is provided under this Contract, without regard to whether the Covered Person is participating in a Clinical Trial.

Routine patient care costs do not include:

- The cost of an investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration (FDA), including a drug or device that is the subject of the Clinical Trial;

- The cost of a service that is not a healthcare service, regardless of whether the service is required in connection with participation in a Clinical Trial;
- The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- The cost associated with managing a Clinical Trial; or
- The cost of a healthcare service that is specifically excluded from coverage under this Contract.

Self-Administered Injectable Drug means an FDA approved medication which a person may administer to himself/herself by means of intramuscular, intravenous or subcutaneous injection excluding insulin, and prescribed for use by the Covered Person.

Sendero means Sendero Health Plans, Inc., a licensed health maintenance organization.

Service Area means the geographic area designated by us and approved by the Department of Insurance of the state in which this Contract is issued, if such approval is required. The Service Area is the geographic area within which direct service benefits are available and accessible to Covered Persons who live, reside or work within the geographic area. The Service Area is listed at www.senderohealth.com, in the HMO Provider Directory, and you may call the HMO Member Services Department at the telephone number on Your Member Identification Card.

Services means procedures, surgeries, consultations, advice, diagnosis, referrals, treatment, supplies, drugs, devices or technologies.

Skilled Nursing Facility means a facility that provides continuous skilled nursing services on an inpatient basis for persons recovering from an Illness or a Bodily Injury. The facility must meet all of the following requirements:

- Be licensed by the state to provide skilled nursing services;
- Be staffed by an on call Healthcare Practitioner 24 hours per day;
- Provide skilled nursing services supervised by an on duty Nurse 24 hours per day; 4. Maintain full and complete daily medical records for each patient; and
- Not primarily be a place for rest, for the aged or for Custodial Care or provide care for Mental Health although these services may be provided in a distinct section of the same physical facility. The facility may also provide extended care or Custodial Care which would not be covered under this Contract.

Sound Natural Tooth means a tooth that:

- Is organic and formed by the natural development of the body (not manufactured, capped, crowned or bonded);
- Has not been extensively restored;
- Has not become extensively decayed or involved in periodontal disease; and
- Is not more susceptible to injury than a whole natural tooth (for example a tooth that has been previously broken, chipped, filled, cracked or fractured).

Special Circumstances means a condition for which the treating Healthcare Practitioner or healthcare provider reasonably believes that discontinuing care by the treating Healthcare Practitioner or provider could cause harm to the Covered Person. Examples of Special Circumstances include:

1. A Covered Person with a disability;
2. A Covered Person with an acute condition;
3. A Covered Person with a Life-Threatening Disease; or
4. A Covered Person who is past the 24th week of pregnancy.

Specialty Care Physician means a network Healthcare Practitioner who has received training in a specific medical field other than the specialties listed for a PCP.

Specialty Drug means a drug, medicine, or medication, or biological used as a specialized therapy developed for chronic, complex illnesses or bodily injuries. Specialty drugs may:

- Require nursing services or special programs to support patient compliance;
- Require disease-specific treatment programs;
- Have limited distribution requirements; or
- Have special handling, storage or shipping requirements.

Specialty Pharmacy means a Pharmacy that provides covered specialty Pharmacy services, as defined by us, to Covered Persons.

Step Therapy means a type of Prior Authorization. We may require a Covered Person to follow certain steps prior to our coverage of some high-cost drugs, medicines, or medications, or biologicals. We may require a Covered Person to try a similar drug, medicine or medication that has been determined to be safe, effective, and less costly for most people that have the same condition as the Covered Person. Alternatives may include over-the-counter drugs, Generic Medications, and brand-name medications.

Sub-Acute Medical Care means a short-term comprehensive inpatient program of care for a Covered Person who has an Illness or a Bodily Injury that:

- Does not require the Covered Person to have a prior admission as an inpatient in a Healthcare Treatment Facility;
- Does not require intensive diagnostic and/or invasive procedures ;and
- Requires Healthcare Practitioner direction, intensive nursing care, significant use of ancillaries, and an outcome-focused, interdisciplinary approach using a professional medical team to deliver complex clinical interventions.

Sub-Acute Rehabilitation Facility means a facility that provides Sub-Acute Medical Care for Rehabilitation Services for illness or a Bodily Injury on an inpatient basis. This type of facility must meet all of the following requirements:

- Be licensed by the state in which the services are rendered to provide Sub-Acute Medical Care for Rehabilitation Services;
- Be staffed by an on call Healthcare Practitioner 24 hours per day;
- Provide nursing services supervised by an on duty Nurse 24 hours per day;

- Maintain full and complete daily medical records for each patient ; and
- Not primarily provide care for Mental Health although these services may be provided in a distinct section of the same physical facility. The facility may also provide extended care or Custodial Care which would not be covered under this Contract.

Surgery means categorized as Surgery in the Current Procedural Terminology (CPT) Manuals published by the American Medical Association .The term Surgery includes, but is not limited to:

1. Excision or incision of the skin or mucosal tissues or insertion for exploratory purposes into a natural body opening;
2. Insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes; and Treatment of fractures.

Telehealth service means a health service, other than a telemedicine medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional’s license, certification, or entitlement to a patient at a different physical location that the health professional using telecommunications or information technology.

Telemedicine Medical Services means a health care service delivered by a physician licensed in this state, or a health profession acting under the delegation and supervision of a physician licensed in this state, and acting within the scope of the physician’s or health professional’s license to a patient at a different physical location than the physician or health professional using telecommunications or information technology.

Urgent Care means health services or Mental Health services provided in other than an emergency which are typically provided in a setting such as a Physician or provider's office or Urgent Care Center, as a result of acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, illness or injury is of such nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of his or her health.

Urgent Care Center means any licensed public or private non-Hospital free standing facility which has permanent facilities equipped to provide urgent care services on an outpatient basis.

Usual and Customary means the customary fee in the geographic area in which Services are provided, which is reasonably based on the circumstances.

We, Us or Our means or otherwise refers to the insurer as shown on the cover page of this Contract.

Your means the Covered Person.

Where to Mail Completed Claim Forms

Medical Claims

Sendero Health Plans
Attention: Claims
P.O. Box 301425
Houston, TX 77230

Prescription Drug Claims

Navitus Health Solutions
Operations Division -Claims
P.O. Box 1039
Appleton, WI 54912-1039

Behavioral Health Claims

Beacon Health Options
500 Unicorn Park Drive, Suite 401
Woburn, MA 01801

REVIEW OF CLAIM DETERMINATIONS

Claim Determinations

Following the receipt of a properly submitted claim (clean claim), Sendero will provide reimbursement for covered benefits in accordance with the Plan provisions. Sendero will acknowledge the receipt, acceptance, or rejection of your claims no later than the 15th business day after the date Sendero receives all items, statements, and forms required to process your claim. Sendero will pay or deny a claim within 30 days of receipt of the claim. If Sendero requires further information in order to process the claim, Sendero will request it within that 30-day period. If Sendero agrees to pay a claim or part of a claim, Sendero will pay the claim no later than the 5th business day after the date of notice to pay is made.

You have the right to seek and obtain a full and fair review by Sendero of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by Sendero of your benefits under the Plan.

If A Claim Is Denied Or Not Paid In Full

On occasion, Sendero may deny all or part of your claim. There are a number of reasons why this may happen, including claims denied for services which are excluded by this Evidence of Coverage document. It may also include denial of claims for services rendered before or after termination of your coverage with Sendero. We suggest that you first read the *Explanation of Benefits* summary prepared by Sendero; then review this EOC to see whether you understand the reason for determination. If you have additional information that you believe could change the decision, send it to Sendero and request a review of the decision. Include your full name and Member number with the request.

Sendero Health Plans
Claim Review
Attn: IdealCare
Claims

SND_2018_EOC_Consumer_Choice

P.O. Box 301425
Houston, TX 77230

NOTICES

NOTICE

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN , OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER PROVIDERS WHO ARE NOT MEMBERS OF THAT NETWORK . YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN.

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided in your health plan insured by Sendero. This notice is required by legislation to be provided to you. If you have questions regarding this notice, call Sendero Health Plans at 1-844-800-4693.

Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

- 48 hours following a mastectomy; and
- 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

Coverage and/or Benefits for Reconstructive Surgery after Mastectomy

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

All stages of the reconstruction of the breast on which mastectomy has been performed;
Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician.

Copayment Amounts as shown on your Schedule of Benefits will be the same as those applied to other similarly covered Inpatient Hospital or Medical-Surgical, or Preventive Services.

Prohibitions: We may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

NOTICE OF CERTAIN MANDATORY BENEFITS

Examinations for Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

- A physical examination for the detection of prostate cancer; and
- A prostate-specific antigen test for each covered male who is:
 - At least 50 years of age; or
 - At least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

Inpatient Stay Following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery; and
- 96 hours following an uncomplicated delivery by Cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to:

Give birth in a hospital or other health care facility; or
Remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriately licensed health care provider, and the Mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Prohibitions: We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) order the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (e) penalize a physician for recommending inpatient care for the mother or the newborn child.

Coverage of Tests for Detection of Human Papillomavirus and Cervical and Ovarian Cancer

NOTICE OF CERTAIN MANDATORY BENEFITS

Coverage is provided, for each woman enrolled in the plan who is 18 years of age or older, for expenses incurred for an annual medically recognized diagnostic examination for the early detection of cervical and ovarian cancer. Coverage required under this section includes at a minimum:

1. A CA 125 blood test and screenings
2. A conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug

A screening test required under this section must be performed in accordance with the guidelines adopted by:

1. The American College of Obstetricians and Gynecologists; or
2. Another similar national organization of medical professionals recognized by the commissioner.

Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of:

- a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years,
- or a colonoscopy performed every 10 years.

If any person covered by this plan has questions concerning the above, please call Sendero Health Plans at 1-844-800-4693 or write us at 2028 East Ben White Blvd., Ste. 400 Austin, Texas 78741-6931.

Sendero Health Plans

HIPAA NOTICE OF PRIVACY PRACTICES

This Notice is effective October 1, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY SENDERO AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have questions about this Notice or need more information about Sendero privacy rights, you may contact Sendero at 1-844-800-4693.

PURPOSE:

Sendero Health Plans (Sendero) takes Sendero legal responsibility under state and federal law to protect the privacy and security of Enrollee Protected Health Information (PHI). PHI is individually identifiable health information, including Sendero name, date of birth, Social Security Number, medical, genetic and demographic information, collected from You or created or received by Sendero that relates to Sendero past, present or future physical or mental health condition; the health care that receive; or the past, present, or future payment for the provision of health care services to you.

This Notice describes how Sendero uses and discloses Enrollee PHI in administering benefits, and the legal rights of Enrollees with respect to their PHI.

In this Notice, Sendero Health Plans is referred to as "Sendero," "Us," "Sendero" or "We."

HOW SENDERO MAY USE AND DISCLOSE ENROLLEE PHI:

- **Treatment:** In order to provide you with coverage for the health care services that you receive, Sendero needs PHI about You. We obtain that PHI from You, Your doctor, and the Federally Facilitated Exchange. We may disclose Sendero PHI to Sendero doctor, specialist, pharmacy, or a hospital where you received health care services. For example, Sendero doctor may request Sendero hospital or pharmacy records from us to make treatment decisions about you.
- **Payment:** Sendero may use or disclose Enrollee PHI to pay, or collect payment for, You or Sendero child's covered health care services; for conducting utilization and Medical Necessity reviews, and for determining eligibility for services or medications; and for calculating Sendero copayment amounts. For example, we may use Sendero medical history to decide whether a particular treatment or service is Medically Necessary and what the payment for that treatment should be.
- **Health Care Operations.** Sendero may use or disclose Enrollee PHI to operate Sendero HMO. That includes performing certain health care operations such as:
 - activities to assess and improve the quality of You or Your child's health care services;
 - reviewing the competence, qualifications, and performance of health providers who contract

- with Us to provide health care services;
- conducting performance measurement and outcomes assessments;
- disease management program for Enrollees with specific conditions such as diabetes and asthma; and
- business management or general administrative activities, including data and information management systems, communications with Sendero accountants, lawyers, consultants and other business associates to determine Sendero compliance with state and federal laws. We will first enter into a business associate agreement to ensure that such consultants or business associates agree to be bound by Sendero Privacy and Security Policies and Procedures and the requirements of state and federal law with respect to use and disclosure of Sendero PHI.

As required by Law. We will disclose PHI about you when required to do so by federal or Texas laws or regulations.

To Avert a Serious Threat to Health or Safety. We may use and disclose PHI about You to medical or law enforcement personnel when necessary to prevent a serious threat to Sendero health and safety or the health and safety of another person.

Research. Under certain circumstances, we may use and disclose Sendero PHI for research purposes.

- For example, a research project may involve comparing the outcome of Enrollees who were provided one type of medication with the outcome of Enrollees who were given another type of medication. All research projects, however, are subject to a special approval process. Prior to using or disclosing any PHI, the project must be approved through a research approval process. We will ask for Sendero specific authorization if the researcher will have access to Sendero name, address, or other information that reveals who you are.

SPECIAL SITUATIONS:

Qualified Personnel. We may disclose PHI for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation, or otherwise disclose Sendero identity in any manner.

Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following activities:

- To prevent or control disease, injury, or disability;
- To report reactions to medications or problems with products ;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
- To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence.

All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.

Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal Laws.

Lawsuits and Disputes. If you are involved in certain lawsuits or administrative disputes, we may disclose PHI about you in response to a court or administrative order.

Law Enforcement. We may release medical information if asked to do so by a Law enforcement official in response to a court order or subpoena; or

Coroners. Medical Examiners and Funeral Directors. We may release PHI to a coroner or medical examiner when authorized by law (e.g., to identify a deceased person or determine the cause of death).

Inmates. If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.

Electronic Disclosure. Texas law requires that we provide you with notice that your PHI is subject to electronic disclosure. Please note that we may use and disclose Your PHI electronically. For example, your PHI is maintained on an electronic health record. If another provider providing your treatment requests a copy of your medical record, we may forward such record electronically.

Personal Representative. We may disclose Your PHI to the personal representative of your estate.

Marketing. Marketing generally includes a communication made to describe a health- related product or service that may encourage you to purchase or use the product or service. For example, marketing includes communications to you about new state-of-the-art equipment. We will not use Your PHI for marketing purposes without your authorization. Marketing does not include communications from us to You to describe a health-related product or service that is included in, available through, added or replaced in Sendero's plan of benefits, or is about the entities participating in Sendero's health care provide network.

Sale of your Medical Information. Sendero will not disclose your PHI to any person in exchange for direct or indirect remuneration without your authorization, except to another covered entity unless the disclosure is to another covered entity for the purpose of payment, health care operations or performing an HMO function.

Any other sale of Protected Health Information requires your written authorization.

Government Programs. Sendero may disclose an Enrollee's PHI to another government agency offering public benefits if:

- the information relates to whether an Enrollee qualifies for or are enrolled in CHIP or STAR and the law requires or specifically allows the disclosure; or
- the other government agency has the same privacy protections as Sendero, has programs that serve similar types of people, and the disclosure is needed to coordinate or improve how the programs are run; and
- to alert a law enforcement official of a death that occurred from criminal conduct.

For Judicial or Administrative Proceedings. Sendero may disclose an Enrollee's PHI for judicial and administrative purposes, including an order from a regular or administrative court.

Secretary of Health and Human Services. Sendero has to disclose Enrollee PHI to the Secretary of Health and Human Services when the Secretary requests the information to enforce privacy protections.

Other Uses and Disclosures. Sendero may use or disclose Enrollee PHI:

- to create health information that does not identify any specific individual;
- to the U.S. military or a foreign military for military purposes, if an Enrollee is a member of the group asking for the information;
- for purposes of lawful national security;
- to federal officials to protect the President and others;
- to a prison or jail, if You are an inmate of that prison or jail, or to law enforcement personnel if the Enrollee is in custody; and
- to comply with workers' compensation laws or similar laws.

ANY OTHER USES OR DISCLOSURE OF PHI WILL BE MADE ONLY UPON YOUR INDIVIDUAL WRITTEN AUTHORIZATION. YOU MAY REVOKE AN AUTHORIZATION AT ANY TIME PROVIDED THAT IT IS WRITING AND WE HAVE NOT ALREADY RELIED ON THE AUTHORIZATION.

YOUR RIGHTS:

You have the following rights regarding the PHI we maintain:

1. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. We are not required to agree to or abide by your request. If we do agree, we will comply with your request unless the PHI is required to provide you with emergency treatment or the agreement has been terminated in accordance HIPAA guidelines. Requests must be received in writing. If you pay for treatment or service, in full and in cash and ask your provider not to disclose to Sendero that you have received the treatment or service, your provider must agree to your request.
2. **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by telephone at work or that we only contact you by mail at home. Your request must specify how, where, or when you wish to be contacted .We will attempt to accommodate all reasonable requests.
3. **Right to Accept and Receive a Copy.** Enrollees have the right to request access to inspect, receive a physical or electronic copy, or be provided a summary of the Enrollee's PHI or accounting information. We must provide you your records or the summary within 15 days of your request.
4. **Right to Amend.** If you believe that the PHI we have about you is incorrect or incomplete, you may request an amendment. You have the right to request an amendment for as long as the PHI is kept by or for Sendero. You must include a reason that supports your request. All requests for amendment should be made in writing. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny Your request if You ask us to amend PHI that:
 - was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment ;
 - is not part of the PHI kept by or for Sendero;
 - is not part of the PHI that You would be permitted to inspect and copy; or
 - is accurate and complete. Sendero will notify you if we deny the request and will include instructions as to how you may appeal the request or file a complaint.
 - **Right to be notified.** You have a right to be notified regarding an unlawful breach of unsecured PHI and a breach of Sendero's security system as defined by Texas law.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures regarding your health information. Under federal law, you may request an accounting for a period of three years prior to the date the accounting is requested.

Information Maintained of Paper Records. You may request a record of disclosures that have been made to persons or entities other than for treatment, payment, or health care operations that have taken place in the past six (6) years.

Right to a Copy of this Notice. You have the right to a paper copy of this Notice at any time. You may also obtain an electronic copy of this notice at our web site, www.senderohealth.com/idealcarebenefits.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES:

Sendero reserves the right to change our practices and to make the new provisions effective for all PHI we maintain. If Sendero's information practices change, Sendero will post an amended Notice of Privacy Practices in Sendero's office and on Sendero's website. You may request that a copy be provided to you by contacting the Privacy Officer. The new practices will apply to all the health information about you or your child, regardless of when Sendero received or created the information.

If you would like additional copies of this Notice or require a translation of this Notice in another language, please contact us at 1-844-800-4693.

NONDISCRIMINATION AND ACCESSIBILITY

IdealCare by Sendero Health Plans, Inc. (IdealCare) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. IdealCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ideal Care:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages
- If you believe that Ideal Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
 - Ideal Care by Sendero Health Plans, Attn: Connie McFadden Chief Operations Officer, 2028 E. Ben White Blvd. Ste. 400, Austin, TX 78741, Telephone: 1-844-800-4693, TTY: 711, Fax: 512-901-9724, Complaints.Sendero@senderohealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, IdealCare Customer Service is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at;

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>,

or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

TAGLINES:

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Sendero Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-800-4693.

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Sendero Health Plans quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-800-4693.

Chinese: 如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Sendero Health Plans, 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-800-4693.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Sendero Health Plans, 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-800-4693 로 전화하십시오.

Arabic: يف قحلا كيدلف ، Sendero Health Plans صوصخب ؤلئسا هءعاست صخش بدل وأ كيدل ناك نأ 1-844-800-4693 ب لصتا مجرتم عم ئدحتلل .ءفلكت ؤيا نود نم كتغلب ؤيرورضلا .تامولعملاو ؤءعاسملا بلع لوصحلا 4693.

Urdu: وٲ نيم، ےراب ےك Sendero Health Plans ےه لاوس وك نونود پا روا نيه ےهر ےد دم وك يسك پارگا :1-844-800-4693 ےيل، ےك ےنرك تاب ےس نامجرت .ےه قح اك ےنرك لصاح تامولاعم روا دم تقم نيم نابز ينپا وك نونود پا نيرك نوف 800-4693

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Sendero Health Plans may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-800-4693.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Sendero Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-800-4693.

Hindi: यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Sendero Health Plans के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मफ्त में सहायता और सचचना प्राप्त

करने का अधिकार है।

ककसी धुुभाषण से बात करने के धिए , 1-844-800-4693पर कॉधु करेेे।

Persian: قح ديشاب هتشاد ، Sendero Health Plans دروم رد ل اوس ، دين کييم کمک و ا هب امش هک يسک اي امش، رگا ديبامن لصاح سامت 1-844-800-4693 ديبامن تفايرد ناگي ار روط هب ار دوخ نايز هب تااعلاطا و کمک هک ديراد ار نيا

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Sendero Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-800-4693 an

Gujarati: જો તમને અથવા તમને કોઇને મદદ કરી રહ્યા છો તો તમને Sendero Health Plans વડે પ્રશ્નો ઊર્તો તમને મદદ અને મહત્તી મેવિવુનો અવવક ર છે. તો ખયય વવન તમ રી ભ ષ મ ડુ ડુ પ્ર મ કરી શક ર છે. દ ભ વષરુ ં વુત કરર મ ટે, આ 1-844-800-4693 પર કોલ કરો.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Sendero Health Plans то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-844-800-4693.

Japanese: ご本人様、またはお客様の身の回りの方でも、Sendero Health Plans についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-800-4693 までお電話ください。

Laotian: ຖ້າທ່ານ, ຫຼື ຄົນທີ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ, ມີ ຄໍາຖາມກ່ຽວກັບ Sendero Health Plans ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອ ທີ່ເໝາະສົມຂອງທ່ານ ບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ການໂອ້ນລັກບັນຍາຍພາສາ, ໃຫ້ໂທຫາ 1-844-800-4693.