The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, 1-844-800-4693 and www.senderohealth.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-844-800-4693 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$4,250/Individual or $8,500/Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	$7,500/Individual or $15,000/Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://senderohealth.com/idealcareeng/_providers.html or call 1-844-800-4693 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/office visit Deductible does not apply.	Not covered	None.
	Specialist visit	$60 copay/visit	Not covered	A referral must be obtained from your primary care physician before you see a specialist. (OBGYN and Behavioral/Substance abuse providers do not require a referral). Copayment applies after deductible has been met.
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$30 copay	Not covered	Certain services may require preauthorization. If preauthorization is not obtained you may be responsible for payment. Copayment applies after deductible has been met.
	Imaging (CT/PET scans, MRIs)	25% coinsurance	Not covered	Certain services may require preauthorization. If preauthorization is not obtained you may be responsible for payment.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://senderohealth.com/idealcareeng/formulary.html	Generic drugs	$10 copay/prescription Deductible does not apply.	Not covered	Covers up to a 30-day supply. Certain preventive drugs are covered with no copay. Oral & injectable fertility drugs are excluded. Copayment applies after deductible has been met.
	Preferred brand drugs	$40 copay/prescription	Not covered	
	Non-preferred brand drugs	$80 copay/prescription	Not covered	
	Specialty drugs	30% coinsurance/prescription	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at www.senderohealth.com.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	Not covered	Certain services may require preauthorization. If preauthorization is not obtained you may be responsible for payment.
	Physician/surgeon fees	25% coinsurance	Not covered	Certain services may require preauthorization. If preauthorization is not obtained you may be responsible for payment.
If you need immediate medical attention	Emergency room care	$350 copay/visit	$350 copay/visit	Emergency room services copay is waived if admitted and inpatient benefits are applied. Copayment applies after deductible has been met.
	Emergency medical transportation	$350 copay/transport	$350 copay/transport	Copayment applies after deductible has been met.
	Urgent care	$60 copay/visit Deductible does not apply	Not covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/stay	Not covered	Preauthorization is required for services. If preauthorization is not obtained you may be responsible for payment. Copayment applies after deductible has been met.
	Physician/surgeon fees	30% coinsurance	Not covered	Preauthorization is required for services. If preauthorization is not obtained you may be responsible for payment.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance/visit	Not covered	Certain services may require preauthorization If preauthorization is not obtained you may be responsible for payment.
	Inpatient services	$500 copay/stay	Not covered	Preauthorization is required for services. If preauthorization is not obtained you may be responsible for payment. Copayment applies after deductible has been met.
If you are pregnant	Office visits	$10 copay/office visit	Not covered	Cost sharing does not apply for preventive

* For more information about limitations and exceptions, see the plan or policy document at www.senderohealth.com.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Deductible does not apply.		services. Copay per initial visit and delivery. No charge for subsequent prenatal visits with the same provider or provider group per pregnancy. Depending on the type of services, coinsurance, copay, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Copayment applies after deductible has been met.
	Childbirth/delivery professional services	30% coinsurance	Not covered	
	Childbirth/delivery facility services	$500 copay/per delivery	Not covered	
If you need help recovering or have other special health needs	Home health care	$0 copay Deductible does not apply.	Not covered	Limited to 60 visits per year. Preauthorization is required. If preauthorization is not obtained you may be responsible for payment.
	Rehabilitation services	$65 copay/visit	Not covered	Certain services may require preauthorization. If preauthorization is not obtained you may be responsible for payment. Copayment applies after deductible has been met.
	Habilitation services	25% coinsurance/visit	Not covered	Habilitation Services include: Autism services and the benchmark plan does not impose age or maximums on autism coverage. Certain services may require preauthorization. If preauthorization is not obtained you may be responsible for payment.
	Skilled nursing care	$300 copay/per stay	Not covered	Limited to 25 visits per year. Preauthorization is required. If preauthorization is not obtained you may be responsible for payment. Copayment applies after deductible has been met.
	Durable medical equipment	20% coinsurance/ equipment	Not covered	Certain services may require preauthorization. If preauthorization is not obtained you may be responsible for

* For more information about limitations and exceptions, see the plan or policy document at www.senderohealth.com.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				payment.
	Hospice services	20% coinsurance	Not covered	Preauthorization is required for services. If preauthorization is not obtained you may be responsible for payment.
If your child needs dental or eye care	Children's eye exam	$45 copay/visit Deductible does not apply.	Not covered	Limited to one (1) visit per year.
	Children's glasses	20% coinsurance	Not covered	Limited to contact lenses or 1 pair of glasses (frames and lenses) per calendar year for members 0-21 years of age. Limited to the end of the plan year in which age 21 is reached.
	Children's dental check-up	20% coinsurance	Not covered	Limited to the last day of the month in which member turns 19.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortions (endangerment of life of the mother, rape, or incest)
- Chiropractic care, limited to 35 visits per year.
- Hearing aids are limited to 1 per ear every 3 years.
- Infertility treatment is limited to diagnostic services only. Treatment to correct the infertility condition and services such as in vitro fertilization and artificial insemination are excluded from coverage.
- Private-duty nursing if medically necessary.
- Routine foot care is limited to foot care in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency.

* For more information about limitations and exceptions, see the plan or policy document at www.senderohealth.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- IdealCare by Sendero Health Plans 1-844-800-4693 or visit www.senderohealth.com
- Texas Department of Insurance: 1-800-578-4677 or visit http://www.tdi.texas.gov/index.html
- Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html.
- Healthcare.gov http://ww.HealthCare.gov or call 1-800-318-2596 OR state health insurance marketplace or SHOP.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Texas Department of Insurance 1-800-578-4677 or visit http://www.tdi.texas.gov/index.html

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-800-4693.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-800-4693.
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-800-4693.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-800-4693.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of network provider pre-natal care and a hospital delivery)

The plan's overall deductible	$4,250
Specialist copayment	$60
Hospital (facility) copayment	$500
Other copayment	$500

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$4,600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$7,500**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$4,250
Specialist copayment	$60
Hospital (facility) copayment	$500
Other copayment	$30

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,300
Copayments	$1,100
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$4,430**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$4,250
Specialist copayment	$60
Hospital (facility) copayment	$500
Other copayment	$350

This EXAMPLE event includes services like:
Emergency Room Care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$350
Copayments	$1,500
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,870**

The plan would be responsible for the other costs of these EXAMPLES covered services.

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.
IdealCare 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 need these services, contact IdealCare.

If you believe that IdealCare 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:

IdealCare by Sendero Health Plans, Attn: Member Advocate, 2028 E. Ben White Blvd. Ste. 400, Austin, TX 78741, Telephone: 1-844-800-4693, TTY: 711, Fax: 512-901-9724, Complaints@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.

1.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.
2. 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.
3. 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.
4. 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 위해서는1-844-800-4693 로 전화하십시오.
5. Arabic	لا ح لوص ف ي لا قح ف يدل ك ، Sendero Health Plans ب خ صوص أ س ئ ةل ت هدعاس صخش ل بد وأ ل يد ك ك نا نإ تا لص م مجرت عم ل ل ثدحت .ت ك ل ةف يا ة نود نم ب ل غ كت لا يرورض ة .لاو م ع تامول لا م ةدعاس ع بل ب 1-844-800-4693.
6. Urdu	ک و نود نو پا ت و م ني، ب ےرا ک ے Sendero Health Plans ہ ے ل اوس ک و نود نو پا روا ہ ني ہر ے ےد ددم ک و ک يس پا گا ر 1-844-800-4693 ل ےي، ک ے ک نر ے ب تا ےس ت نامجر ہ ۔ے قح ک ا ک نر ے اح لص م لاع تامو روا ددم م تف م ني بز نا پا ين ک ير ۔ں ف نو
7. 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.
8. 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.
9. 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 म□फ्त में सहायता और सूचना प्राप्त करने का अध□कार है। ककसी ध□ु□ भाषषए से बात करने के ध□ए , 1-844-800-4693पर कॉध□ु करें।

10. Persian	ر گا،امش ا ي س ی ک ه ک امش ه اب ه م ي ک ن دي ک ک م واب ه دروم رد لاوس ، Sendero Health Plans ، ت ه ش دي اد ش ا ب قح ن يا ر ا د راد ي ر ي ه ک م ک ک و اطا ع ل ا ت ا ه ب نا ب ز خ ب دوخ ه ار دوطب روط ناگ ار ي ت فا د ر ي دي مام ن 1-844-800-4693 ت سام ل ص ت ح ا دي مام ي
11. 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.
12. Gujarati	જો તમે અથવા તમે કોઇને મદદ કરી રહ્ો◌ા◌ો◌ં તેમ ◌ો◌ં◌થી કોઇને Sendero Health Plans ◌ વશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મે◌ુ નો અ◌વક ર છે. તે ખર્ય ◌વન તમ રી ભ ષ મ ◌ુ◌ુ પ્ર મ કરી શક ર્ છે. ૬ ભ વષર્◌ો ◌ુ ત ક◌ર મ ટે,આ 1-844-800-4693પર કોલ કરો.
13. 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.
14. 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。
15. Laotian	ຖ້າທ່ານ, ຫ ◌ົ◌ຄົນທ ◌ ່ທ່ານກ ໍາລ ັງຊ ່ວຍເຫ ◌ ົ◌ ືອ, ມ ◌ ໍາຖ າມກ ່ ຽວກ ັບ Sendero Health Plans ທ ່ ານມ ສ ິດທ ◌ ່ ຈ ະໄດ ້ ຮ ັ ບການຊ ່ ວຍເຫ ◌ ົ◌ ືອແ ◌ ລ ະ ຂ ໍ ້ ມ ູ ນຂ ່ າ ວ ສ ານທ ◌ ່ ເ ປ ັ ນ ພ າ ສ າ ຂ ອ ງ ທ ່ ານ ບ ໍ ່ ມ ຄ ່ າ ໃ ຊ ້ ຈ ່ າ ຍ. ການ ໂ ອ ້ ລ ົ ມ ກ ັ ບ ນ າ ຍ ພ າ ສ າ, ໃ ຫ ້ ໂ ທ ຫ າ 1-844-800-4693.