Sendero IdealCare Silver 94 / $5 PCP / $5 Gen Rx + Free Wellness & Preventive Screening + Free Dedicated Healthcare Team + Free 24/7 Virtual MD Visits + No Pre-existing Condition Restrictions

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

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

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

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

Overall Payment Provisions	**In-Network Benefits**	**Out-of-Network Benefits**
Calendar Year Deductibles (applies to all Eligible Expenses including Pharmacy)	$0 Individual / $0 Family (Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services)	
Out-of-Pocket Limits (applies to all Eligible Expenses including Pharmacy	$1,200.00 Individual / $2,400.00 Family (Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services)	
Maximum Lifetime Benefits – per participant	Unlimited (Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services)	
Primary Care Visit to Treat an injury or illness	100% of Allowed Amount after a $5.00 Copayment per Visit	No coverage for Out-of-Network Services
Specialist office visit/consultation	100% of Allowed Amount after a $10.00 Copayment per Visit	No coverage for Out-of-Network Services
Other Practitioner Office Visit (Nurse, Physician Assistant)	100% of Allowed Amount after a $5.00 Copayment per Visit	No coverage for Out-of-Network Services
Outpatient Facility fee (e.g.., Ambulatory Surgery Center)	10% of Allowable Amount	No coverage for Out-of-Network Services
Outpatient Surgery Physician/Surgical services	10% of Allowable Amount	No coverage for Out-of-Network Services
Hospice	10% of Allowable Amount	No coverage for Out-of-Network Services
Urgent Care Centers or Facilities	100% of Allowed Amount after a $30.00 Copayment per Visit	No coverage for Out-of-Network Services

Home Health Care Services Limited to 60 visits per year.	100% of Allowable Amount	No coverage for Out-of-Network Services
Emergency Room Services	100% of Allowed Amount after a $350.00 Copayment per Visit	100% of Allowed Amount after a $350.00 Copayment per Visit
Emergency Medical Transportation/Ambulance	100% of Allowed Amount after a $350.00 Copayment per Transportation	100% of Allowed Amount after a $350.00 Copayment per Transportation
Inpatient Hospital Services (Hospital Stay) – All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	100% of Allowed Amount after a $300.00 Copayment per Stay	No coverage for Out-of-Network Services
Inpatient Physician and Surgical Services	10% of Allowable Amount	No coverage for Out-of-Network Services
Skilled Nursing Facility Limited to 25 visits per year.	100% of Allowed Amount after a $300.00 Copayment per Stay	No coverage for Out-of-Network Services
Prenatal and Postnatal Care	100% of Allowed Amount after a $5.00 Copayment for the initial Prenatal Visit	No coverage for Out-of-Network Services
Childbirth/Delivery Professional Services	10% of Allowable Amount	No coverage for Out-of-Network Services
Delivery and All Inpatient Services for Maternity Care	100% of Allowed Amount after a $300.00 Copayment per Delivery	No coverage for Out-of-Network Services
Mental/Behavioral Health Care Outpatient Services*	10% of Allowable Amount	No coverage for Out-of-Network Services
Mental/Behavioral Health Care Inpatient Hospital Services*	100% of Allowed Amount after a $300.00 Copayment per Stay	No coverage for Out-of-Network Services
Substance Abuse Disorder Outpatient Services*	10% of Allowable Amount	No coverage for Out-of-Network Services
Substance Abuse Disorder Inpatient Services*	100% of Allowed Amount after a $300.00 Copayment per Stay	No coverage for Out-of-Network Services
Outpatient Rehabilitation	100% of Allowed Amount after a $65.00 Copayment per Visit	No coverage for Out-of-Network Services
Habilitation Services	10% of Allowable Amount per Visit	No coverage for Out-of-Network Services
Chiropractic Services Limited to 35 visits per year	100% of Allowed Amount after a $60.00 Copayment per Visit	No coverage for Out-of-Network Services
Durable Medical Equipment	10% of Allowable Amount	No coverage for Out-of-Network Services

Hearing Aids for Adults (1 per ear every 3 years)	10% of Allowable Amount per Hearing Aid	No coverage for Out-of-Network Services
Hearing Aid or Cochlear Implant, related services and supplies, if medically necessary for all covered individuals including individuals who are 18 years of age or younger. Please contact Sendero Customer Service Department at 1-844-800-4693 to obtain the cost of hearing aid or cochlear implant.	10% of Allowable Amount per Hearing Aid or Cochlear Implant	No coverage for Out-of-Network Services
Imaging (CT/PET scans, MRIs)	10% of Allowable Amount	No coverage for Out-of-Network Services
Preventative Care/Screening/Immunization	100% of Allowed Amount	No coverage for Out-of-Network Services
Annual Well Woman Exam – including detection of human papillomavirus, cervical cancer and ovarian cancer screening for woman age 18 and over. This includes any other test or screening approved by the United States Food and Drug Administration for the detection of human papillomavirus and ovarian cancer.	100% of Allowed Amount	No coverage for Out-of-Network Services
Annual screening by low-dose mammography for the presence of occult breast cancer for female participants age 35 and over – Outpatient facility or imaging center and Physician component	100% of Allowed Amount	No coverage for Out-of-Network Services
Bone Mass measurement for the detection of low bone mass to determine risk of osteoporosis and fractures associated with osteoporosis for qualified individuals	100% of Allowed Amount	No coverage for Out-of-Network Services

Routine annual prostate cancer detection exam, including a Prostate Specific Antigen test (PSA) for a male Covered Person age 40 or older.	100% of Allowed Amount	No coverage for Out-of-Network Services
Routine Foot Care	100% of Allowed Amount after a $20.00 Copayment per Visit	No coverage for Out-of-Network Services
Routine Eye Exam for Children (1 per year)	100% of Allowed Amount after a $20.00 Copayment per Visit	No coverage for Out-of-Network Services
Eye Glasses for Children (1 set of frames with lenses or contact lenses per year)	10% of Allowable Amount	No coverage for Out-of-Network Services
Dental Check-Up for Children	10% of Allowable Amount	No coverage for Out-of-Network Services
Rehabilitative Speech Therapy	100% of Allowed Amount after a $20.00 Copayment per Visit	No coverage for Out-of-Network Services
Rehabilitative Occupational and Rehabilitative Physical Therapy	100% of Allowed Amount after a $20.00 Copayment per Visit	No coverage for Out-of-Network Services
Well Baby Visits and Care	100% of Allowed Amount	No coverage for Out-of-Network Services
Laboratory Outpatient and Professional Services	10% of Allowable Amount	No coverage for Out-of-Network Services
The administration of whole blood including cost of blood, blood plasma, and blood plasma expanders are covered services	10% of Allowable Amount	No coverage for Out-of-Network Services
X-rays and Diagnostic Imaging	100% of Allowed Amount after a $30.00 Copayment	No coverage for Out-of-Network Services
Basic Dental-Children	10% of Allowable Amount	No coverage for Out-of-Network Services
Orthodontia-Children	10% of Allowable Amount	No coverage for Out-of-Network Services
Major Dental Care-Children	10% of Allowable Amount	No coverage for Out-of-Network Services
Transplant	10% of Allowable Amount	No coverage for Out-of-Network Services
Accidental Dental	10% of Allowable Amount	No coverage for Out-of-Network Services
Dialysis	10% of Allowable Amount	No coverage for Out-of-Network Services
Allergy Testing	10% of Allowable Amount	No coverage for Out-of-Network Services

Chemotherapy	10% of Allowable Amount	No coverage for Out-of-Network Services
Radiation	10% of Allowable Amount	No coverage for Out-of-Network Services
Diabetes Education	10% of Allowable Amount	No coverage for Out-of-Network Services
Prosthetic Devices	10% of Allowable Amount	No coverage for Out-of-Network Services
Infusion Therapy	10% of Allowable Amount	No coverage for Out-of-Network Services
Treatment for Temporomandibular Joint Disorders	10% of Allowable Amount	No coverage for Out-of-Network Services
Nutritional Counseling	100% of Allowed Amount after a $5.00 Copayment per Visit	No coverage for Out-of-Network Services
Reconstructive Surgery	10% of Allowable Amount	No coverage for Out-of-Network Services
Mammography	100% of Allowed Amount after a $250.00 Copayment	No coverage for Out-of-Network Services
Cardiovascular Disease	10% of Allowable Amount	No coverage for Out-of-Network Services
Osteoporosis	10% of Allowable Amount	No coverage for Out-of-Network Services
Diabetes Care Management	10% of Allowable Amount	No coverage for Out-of-Network Services
Inherited Metabolic Disorder (PKU)	10% of Allowable Amount	No coverage for Out-of-Network Services
Post-Mastectomy Care	10% of Allowable Amount	No coverage for Out-of-Network Services
Brain Injury	10% of Allowable Amount	No coverage for Out-of-Network Services
Transplant Donor Coverage	10% of Allowable Amount	No coverage for Out-of-Network Services
Autism Spectrum Disorders	10% of Allowable Amount	No coverage for Out-of-Network Services

*Sendero Health Plans (Sendero) will provide benefits and coverage for mental health conditions and substance use disorders under the same terms and conditions applicable to the plan's medical and surgical benefits and coverage. Sendero may not impose quantitative or non-quantitative treatment limitations on benefits for a mental health condition or substance use disorder that are generally more restrictive than quantitative or non-quantitative treatment limitations imposed on coverage of benefits for medical or surgical expenses.

Sendero will fully reimburse non-participating providers at the usual and customary rate or at the agreed-upon rate: when services are rendered to an enrollee by a non-network facility-based physician in a network facility, or in circumstances where an enrollee is not given the choice of a network physician or provider for emergency services performed in a non-network facility, and for prior authorized non-emergency services that are not available through an in-network provider. Sendero will not impose cost-sharing for such services that is greater than the cost-sharing

requirement that would apply if such services had been provided in-network; and shall count such cost sharing toward any in-network deductible and out-of-pocket maximum.