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, call us at 1-844-800-4693 or visit us at 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.https://www.healthcare.gov/sbc-glossary or call 1-844-800-4693 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0/Individual or $0/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?	$1,700/Individual or $3,400/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 limits 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/physician_search 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	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you

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Important Questions	Answers	Why This Matters:
see a specialist?		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	$5 copay/office visit	Not Covered	Covered expense during a Healthcare Practitioner's office visit does not include charges incurred for advanced imaging, pulmonary function studies, cardiac catheterization, electrocardiogram (EKG), electroencephalogram (EEG), laboratory test and / or diagnostic test. Copayment applies after deductible has been met, unless otherwise indicated. This category also applies to mental health and substance abuse office visits.
	Specialist visit	$10 copay/office 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, unless otherwise indicated.
	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 you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$30 copay/x-rays and diagnostic imaging $15 copay/ laboratory outpatient and	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, unless otherwise

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)	
		professional services.		indicated. Diagnostic tests are tests to figure out what your health problem is. Not all blood work falls under diagnostic test. Confirm if the services are for diagnostic testing with your provider.
	Imaging (CT/PET scans, MRIs)	10% 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 www.SenderoHealth.com/files/2025/Formulary.com	Generic drugs (Tier 2)	$5 copay/prescription	Not Covered	Covers up to a 30-day supply. Certain preventive drugs are covered with no copay. Oral and injectable fertility drugs are excluded. Copayment applies after deductible has been met, unless otherwise indicated. Certain prescription drugs may require preauthorization. If preauthorization is not obtained you may be responsible for payment.
	Preferred brand drugs (Tier 3)	$8 copay/prescription	Not Covered	
	Non-preferred brand drugs (Tier 4)	$50 copay/prescription	Not Covered	
	Specialty drugs (Tier 5)	30% coinsurance/ prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not Covered	Certain services may require preauthorization. If preauthorization is not obtained you may be responsible for payment.
	Physician/surgeon fees	10% coinsurance	Not Covered	
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, unless otherwise indicated.
	Emergency medical transportation	$350 copay/transport	$350 copay/transport	Copayment applies after deductible has been met, unless otherwise indicated.
	Urgent care	$30 copay/visit	Not Covered	Copayment applies after deductible has been met, unless otherwise indicated.
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay/stay	Not Covered	Preauthorization is required for services. If preauthorization is not obtained you may be responsible for payment. Copayment

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)	
				applies after deductible has been met, unless otherwise indicated.
	Physician/surgeon fees	10% coinsurance/stay	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	10% coinsurance/visit	Not Covered	Preauthorization is required for some outpatient mental health, behavioral health and / or substance abuse services. If preauthorization is not obtained you may be responsible for payment.
	Inpatient services	$300 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, unless otherwise indicated.
If you are pregnant	Office visits	$5 copay/office visit	Not Covered	Cost sharing does not apply to certain preventive services. No charge for subsequent prenatal visits with the same provider or provider group per pregnancy. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Copayment applies after deductible has been met, unless otherwise indicated.
	Childbirth/delivery professional services	10% coinsurance/stay	Not Covered	
	Childbirth/delivery facility services	$300 copay/delivery	Not Covered	
If you need help recovering or have other special health needs	Home health care	No charge/visit	Not Covered	Limited to 60 visits per year. Preauthorization is required for services. 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

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 has been met, unless otherwise indicated.
	Habilitation services	10% coinsurance	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/stay	Not Covered	Limited to 25 visits per year. Preauthorization is required for services. If preauthorization is not obtained you may be responsible for payment. Copayment applies after deductible has been met, unless otherwise indicated.
	Durable medical equipment	10% coinsurance/ equipment	Not Covered	Certain services may require preauthorization. If preauthorization is not obtained you may be responsible for payment.
	Hospice services	10% 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	$20 copay/visit	Not Covered	Limited to one (1) visit per year. Copayment applies after deductible has been met, unless otherwise indicated.
	Children's glasses	10% coinsurance	Not Covered	Limited to contact lenses or one (1) pair of glasses (frames and lenses) per 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	10% coinsurance	Not Covered	Limited to the last day of the month in which member turns 19.

For more information about limitations and exceptions, see the plan or policy documents at https://www.senderohealth.com/2025-plans-and-benefits.

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.)

- Abortions (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside of 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.)

- Chiropractic care, limited to 35 visits per year
- Hearing aids, 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.

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:

- 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/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa
- Healthcare.gov www.HealthCare.gov or call 1-800-318-2596

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 on how 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, 1601 Congress Avenue, Austin, TX 78701, (800) 578-4677, http://www.tdi.texas.gov/index.html

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable.
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 in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) copayment	$300
Other copayment	$300

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$700**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) copayment	$300
Other copayment	$300

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$400**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) copayment	$300
Other copayment	$300

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

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,100
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,120**

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