



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](http://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](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 <a href="#">deductible</a> ?	\$0/Individual or \$0/Family	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductible</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Not Applicable	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Not Applicable	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://senderohealth.com/physician_search">https://senderohealth.com/physician_search</a> or call 1-844-800-4693 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP 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	No charge	No charge	Not covered	None.
	<a href="#">Specialist</a> visit	No charge	No charge	Not covered	A <a href="#">referral</a> must be obtained from your <a href="#">Primary care physician</a> before you see a <a href="#">specialist</a> . (OB/GYN and Behavioral/Substance abuse <a href="#">providers</a> do not require a <a href="#">referral</a> ).
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	No charge	Not covered	Certain services may require <a href="#">preauthorization</a> . If <a href="#">preauthorization</a> is not obtained you may be responsible for payment. <a href="#">Diagnostic tests</a> are tests to figure out what your health problem is. Not all blood work falls under <a href="#">diagnostic testing</a> . Confirm if the services are for <a href="#">diagnostic testing</a> with your <a href="#">provider</a> .
	Imaging (CT/PET scans, MRIs)	No charge	No charge	Not covered	Certain services may require <a href="#">preauthorization</a> . If <a href="#">preauthorization</a> is not obtained you may be responsible for payment.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.SenderoHealth.com">www.SenderoHealth.com</a>	Generic drugs (Tier 2)	No charge	No charge	Not covered	Covers up to a 30-day supply. Certain preventive drugs are covered with no <a href="#">copay</a> . Oral and injectable fertility drugs are excluded. Certain <a href="#">prescription drugs</a> may require <a href="#">preauthorization</a> . If <a href="#">preauthorization</a> is not obtained you may be responsible for payment.
	Preferred brand drugs (Tier 3)	No charge	No charge	Not covered	
	Non-preferred brand drugs (Tier 4)	No charge	No charge	Not covered	
	<a href="#">Specialty drugs</a> (Tier 5)	No charge	No charge	Not covered	

For more information about limitations and exceptions, see the [plan](#) or policy documents at <https://www.senderohealth.com/2025-plans-and-benefits>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
/files/2025/Formulary.com					
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	Not covered	Certain services may require <a href="#">preauthorization</a> . If <a href="#">preauthorization</a> is not obtained you may be responsible for payment.
	Physician/surgeon fees	No charge	No charge	Not covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	No charge	No charge	Not covered	None.
	<a href="#">Emergency medical transportation</a>	No charge	No charge	Not covered	None.
	<a href="#">Urgent care</a>	No charge	No charge	Not covered	None.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge	No charge	Not covered	<a href="#">Preauthorization</a> is required for services. If <a href="#">preauthorization</a> is not obtained you may be responsible for payment.
	Physician/surgeon fees	No charge	No charge	Not covered	<a href="#">Preauthorization</a> is required for services. If <a href="#">preauthorization</a> is not obtained you may be responsible for payment.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No charge	No charge	Not covered	<a href="#">Preauthorization</a> is required for some outpatient mental health, behavioral health and / or substance abuse services. If <a href="#">preauthorization</a> is not obtained you may be responsible for payment.
	Inpatient services	No charge	No charge	Not covered	<a href="#">Preauthorization</a> is required for services. If <a href="#">preauthorization</a> is not obtained you may be responsible for payment.
<b>If you are pregnant</b>	Office visits	No charge	No charge	Not covered	Certain services may require <a href="#">preauthorization</a> . If <a href="#">preauthorization</a> is not obtained you may be responsible for payment. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	No charge	Not covered	
	Childbirth/delivery facility services	No charge	No charge	Not covered	

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	No charge	Not covered	Limited to 60 visits per year. <a href="#">Preauthorization</a> is required for services. If <a href="#">preauthorization</a> is not obtained you may be responsible for payment.
	<a href="#">Rehabilitation services</a>	No charge	No charge	Not covered	Certain services may require <a href="#">preauthorization</a> . If <a href="#">preauthorization</a> is not obtained you may be responsible for payment.
	<a href="#">Habilitation services</a>	No charge	No charge	Not covered	<a href="#">Habilitation services</a> include: Autism services and the benchmark <a href="#">plan</a> does not impose age or maximums on autism coverage. Certain services may require <a href="#">preauthorization</a> . If <a href="#">preauthorization</a> is not obtained you may be responsible for payment.
	<a href="#">Skilled nursing care</a>	No charge	No charge	Not covered	Limited to 25 visits per year. <a href="#">Preauthorization</a> is required for services. If <a href="#">preauthorization</a> is not obtained you may be responsible for payment
	<a href="#">Durable medical equipment</a>	No charge	No charge	Not covered	Certain services may require <a href="#">preauthorization</a> . If <a href="#">preauthorization</a> is not obtained you may be responsible for payment.
	<a href="#">Hospice services</a>	No charge	No charge	Not covered	<a href="#">Preauthorization</a> is required for services. If <a href="#">preauthorization</a> is not obtained you may be responsible for payment.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	No charge	Not covered	Limited to one (1) visit per year.
	Children's glasses	No charge	No charge	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

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
					end of the <a href="#">plan</a> year in which age 21 is reached.
	Children's dental check-up	No charge	No charge	Not covered	Limited to the last day of the month in which member turns 19.

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Abortions (except in cases of rape, incest, or when the life of the mother is endangered)</li> <li>• Acupuncture</li> <li>• Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside of the U.S.</li> <li>• Routine eye care (Adult)</li> <li>• Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Chiropractic care, limited to 35 visits per year</li> <li>• Hearing aids, limited to 1 per ear, every 3 years</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Private-duty nursing if <a href="#">medically necessary</a></li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> </ul>

**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](http://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](http://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

For more information about limitations and exceptions, see the [plan](#) or policy documents at <https://www.senderohealth.com/2025-plans-and-benefits>.

about the [Marketplace](#), visit [www.HealthCare.gov](http://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, kwijigo holne' 1-844-800-4693

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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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](#) \$0
- Hospital (facility) [copayment](#) \$0
- Other [copayment](#) \$0

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$0</b>

### 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](#) \$0
- Hospital (facility) [copayment](#) \$0
- Other [copayment](#) \$0

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$0</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$0
- Hospital (facility) [copayment](#) \$0
- Other [copayment](#) \$0

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$0</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.