




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	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	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. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
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> ?	\$7,350/Individual or \$14,700/Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
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 plan's <a href="#">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	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

Important Questions	Answers	Why This Matters:
see a <a href="#">specialist</a> ?		have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$40 <a href="#">copay</a> /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 <a href="#">diagnostic test</a> . This category also applies to mental health and substance abuse office visits.
	<a href="#">Specialist</a> visit	\$75 <a href="#">copay</a> /visit	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	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)	\$125 <a href="#">copay</a> /x-rays and diagnostic imaging  \$20 <a href="#">copay</a> / laboratory outpatient and professional service	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,	\$350 <a href="#">copay</a> / scan	Not Covered	Certain services may require

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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	MRIs)			<a href="#">preauthorization</a> . If <a href="#">preauthorization</a> is not obtained you may be responsible for payment.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.SenderoHealth.com/files/2025/Formulary.com">www.SenderoHealth.com/files/2025/Formulary.com</a>	Generic drugs (Tier 2)	\$15 <a href="#">copay</a> /prescription	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)	\$75 <a href="#">copay</a> /prescription	Not Covered	
	Non-preferred brand drugs (Tier 4)	\$150 <a href="#">copay</a> /prescription	Not Covered	
	<a href="#">Specialty drugs</a> (Tier 5)	\$300 <a href="#">copay</a> /prescription	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$400 <a href="#">copay</a> /visit	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	\$400 <a href="#">copay</a> /visit	Not Covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$900 <a href="#">copay</a> /visit	\$900 <a href="#">copay</a> /visit	<a href="#">Emergency room services copay</a> is waived if admitted and inpatient benefits are applied.
	<a href="#">Emergency medical transportation</a>	\$900 <a href="#">copay</a> /transport	\$900 <a href="#">copay</a> /transport	None.
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit	Not Covered	None.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$3,100 <a href="#">copay</a> /stay	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	20% <a href="#">coinsurance</a> /stay	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	\$141.25 <a href="#">copay</a> /visit	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.

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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Inpatient services	\$3,100 <a href="#">copay</a> /stay	Not Covered	<a href="#">Preauthorization</a> is required for services. If <a href="#">preauthorization</a> is not obtained you may be responsible for payment. <a href="#">Copayment</a> applies after <a href="#">deductible</a> has been met, unless otherwise indicated.
If you are pregnant	Office visits	\$10 <a href="#">copay</a> /office visit	Not Covered	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . No charge for subsequent prenatal visits with the same <a href="#">provider</a> or <a href="#">provider</a> group per pregnancy. Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a> /stay	Not Covered	
	Childbirth/delivery facility services	\$3,100 <a href="#">copay</a> /delivery	Not Covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge/visit	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>	\$70 <a href="#">copay</a> /visit	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>	\$70 <a href="#">copay</a> /visit	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>	\$300 <a href="#">copay</a> /stay	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>	20% <a href="#">coinsurance</a> /	Not Covered	Certain services may require

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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		equipment		<a href="#">preauthorization</a> . If <a href="#">preauthorization</a> is not obtained you may be responsible for payment.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required for services. If <a href="#">preauthorization</a> is not obtained you may be responsible for payment.
If your child needs dental or eye care	Children's eye exam	\$45 <a href="#">copay</a> /visit	Not Covered	Limited to one (1) visit per year.
	Children's glasses	20% <a href="#">coinsurance</a>	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 <a href="#">plan</a> year in which age 21 is reached.
	Children's dental check-up	20% <a href="#">coinsurance</a>	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>

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

**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 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$75
■ Hospital (facility) <a href="#">copayment</a>	\$3,100
■ Other <a href="#">coinsurance</a>	20%

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>	\$3,700
<a href="#">Coinsurance</a>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$4,000</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$75
■ Hospital (facility) <a href="#">copayment</a>	\$3,100
■ Other <a href="#">copayment</a>	\$125

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>	\$1,700
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,700</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$75
■ Hospital (facility) <a href="#">copayment</a>	\$3,100
■ Other <a href="#">copayment</a>	\$900

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>	\$2,000
<a href="#">Coinsurance</a>	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,050</b>

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