**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?** | $3,350/Individual or $6,700/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 see a specialist?** | No. | You can see the specialist you choose without a referral. |

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 | 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. This category also applies to mental health and substance abuse office visits. This plan includes two $0 Primary Care visits. |
| | Specialist visit | $40 copay/visit | Not Covered | You can see the specialist you choose without a referral. |
| | 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) | $100 copay/x-rays and diagnostic imaging<br><br>$10 copay/ laboratory outpatient and professional service | Not Covered | Certain services may require preauthorization. If preauthorization is not obtained you may be responsible for payment. Diagnostic tests are tests to figure out what your health problem is. Not all blood work falls under diagnostic testing. Confirm if the services are for diagnostic testing with your provider. |
| | Imaging (CT/PET scans, MRIs) | $250 copay/ scan | 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/2027/Formulary.com | Generic drugs (Tier 2) | $15 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. Certain prescription drugs may require preauthorization. If preauthorization is not obtained you may be responsible for payment. |
| | Preferred brand drugs (Tier 3) | $30 copay/prescription | Not Covered | |
| | Non-preferred brand drugs (Tier 4) | $40 copay/prescription | Not Covered | |
| | Specialty drugs (Tier 5) | $60 copay/prescription | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $300 copay/visit | Not Covered | Certain services may require preauthorization. If preauthorization is not obtained you may be responsible for payment. |
| | Physician/surgeon fees | $300 copay/visit | Not Covered | |
| **If you need immediate medical attention** | Emergency room care | $700 copay/visit | $700 copay/visit | Emergency room services copay is waived if admitted and inpatient benefits are applied. |
| | Emergency medical transportation | $700 copay/transport | $700 copay/transport | None. |
| | Urgent care | $25 copay/visit | Not Covered | None. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $1,700 copay/stay | Not Covered | Preauthorization is required for services. If preauthorization is not obtained you may be responsible for payment. |
| | Physician/surgeon fees | 20% 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 | $20 copay/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 | $1,700 copay/stay | Not Covered | Preauthorization is required for services. If preauthorization is not obtained you may be responsible for payment. |

| | | | | |
|---|---|---|---|---|
| **If you are pregnant** | Office visits | $10 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). |
| | Childbirth/delivery professional services | 20% coinsurance/stay | Not Covered | |
| | Childbirth/delivery facility services | $2,500 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 | $50 copay/visit | Not Covered | Certain services may require preauthorization. If preauthorization is not obtained you may be responsible for payment. |
| | Habilitation services | $50 copay/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 | $250 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. |
| | Durable medical equipment | 20% coinsurance/ equipment | Not Covered | Certain services may require preauthorization. If preauthorization is not obtained you may be responsible for 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 | $30 copay/visit | Not Covered | Limited to one (1) visit per year. |
| | Children's glasses | 20% 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 | 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.)**

- Abortions (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic Surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing
- 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
- 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.
- Hearing aids limited to 1 per ear every 3 years

**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.

For more information about limitations and exceptions, see the plan or policy documents at https://www.senderohealth.com/2027-plans-and-benefits.

**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.*

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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 | $40 |
| Hospital (facility) copayment | $1,700 |
| Other coinsurance | 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)*

| **Total Example Cost** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $2,100 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$2,400** |

### 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 | $40 |
| Hospital (facility) copayment | $1,700 |
| Other copayment | $100 |

**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 | $800 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$800** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $40 |
| Hospital (facility) copayment | $1,700 |
| Other copayment | $700 |

**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 | $1,700 |
| Coinsurance | $50 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,750** |

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