

**Sendero IdealCare Gold / 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.

| <b>Overall Payment Provisions</b>   | <b>In-Network Benefits</b>   | <b>Out-of-Network Benefits</b>          | <b>Indian Health Care Provider (IHCP) (You will pay the least)</b> |
|---|--|---|--|
| Calendar Year Deductibles (applies to all Eligible Expenses including Pharmacy) | \$0 Individual / \$0 Family<br>(Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services) |   | \$0 Individual / \$0 Family  |
| Out-of-Pocket Limits (applies to all Eligible Expenses including Pharmacy)      | \$0 Individual / \$0 Family<br>(Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services) |   | \$0 Individual / \$0 Family  |
| Maximum Lifetime Benefits – per participant                                     | Unlimited<br>(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   | No coverage for Out-of-Network Services | 100% of Allowed Amount   |
| Specialist office visit/consultation  | 100% of Allowed Amount   | No coverage for Out-of-Network Services | 100% of Allowed Amount   |
| Other Practitioner Office Visit (Nurse, Physician Assistant)                    | 100% of Allowed Amount   | No coverage for Out-of-Network Services | 100% of Allowed Amount   |
| Outpatient Facility fee (e.g., Ambulatory Surgery Center)                       | 100% of Allowed Amount   | No coverage for Out-of-Network Services | 100% of Allowed Amount   |
| Outpatient Surgery Physician/Surgical services                                  | 100% of Allowed Amount   | No coverage for Out-of-Network Services | 100% of Allowed Amount   |
| Hospice   | 100% of Allowed Amount   | No coverage for Out-of-Network Services | 100% of Allowed Amount   |

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| Urgent Care Centers or Facilities  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Home Health Care Services Limited to 60 visits per year.   | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Emergency Room Services  | 100% of Allowed Amount | 100% of Allowed Amount                  | 100% of Allowed Amount |
| Emergency Medical Transportation/Ambulance   | 100% of Allowed Amount | 100% of Allowed Amount                  | 100% of Allowed Amount |
| Inpatient Hospital Services (Hospital Stay) – All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units. | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Inpatient Physician and Surgical Services  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Skilled Nursing Facility Limited to 25 visits per year.  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Prenatal and Postnatal Care  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Childbirth/Delivery Professional Services  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Delivery and All Inpatient Services for Maternity Care   | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Mental/Behavioral Health Care Outpatient Services*   | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Mental/Behavioral Health Care Inpatient Hospital Services*   | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Substance Abuse Disorder Outpatient Services*  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Substance Abuse Disorder Inpatient Services*   | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Outpatient Rehabilitation  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Habilitation Services  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Chiropractic Services Limited to 35 visits per year  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Durable Medical Equipment  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Hearing Aids for Adults (1 per ear every 3 years)  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Hearing Aid or Cochlear Implant, related services, and supplies, if medically necessary for all covered  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |

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| <p>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.</p>  |                               |  |                               |
| <p>Imaging (CT/PET scans, MRIs)</p>   | <p>100% of Allowed Amount</p> | <p>No coverage for Out-of-Network Services</p> | <p>100% of Allowed Amount</p> |
| <p>Preventative Care/Screening/Immunization</p>   | <p>100% of Allowed Amount</p> | <p>No coverage for Out-of-Network Services</p> | <p>100% of Allowed Amount</p> |
| <p>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.</p> | <p>100% of Allowed Amount</p> | <p>No coverage for Out-of-Network Services</p> | <p>100% of Allowed Amount</p> |
| <p>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</p>  | <p>100% of Allowed Amount</p> | <p>No coverage for Out-of-Network Services</p> | <p>100% of Allowed Amount</p> |
| <p>Bone Mass measurement for the detection of low bone mass to determine risk of osteoporosis and fractures associated with osteoporosis for qualified individuals</p>  | <p>100% of Allowed Amount</p> | <p>No coverage for Out-of-Network Services</p> | <p>100% of Allowed Amount</p> |
| <p>Routine annual prostate cancer detection exam, including a Prostate Specific Antigen test (PSA) for a male Covered Person age 40 or older.</p>   | <p>100% of Allowed Amount</p> | <p>No coverage for Out-of-Network Services</p> | <p>100% of Allowed Amount</p> |

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| Routine Foot Care  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Routine Eye Exam for Children (1 per year)   | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Eye Glasses for Children (1 set of frames with lenses or contact lenses per year)  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Dental Check-Up for Children   | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Rehabilitative Speech Therapy  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Rehabilitative Occupational and Rehabilitative Physical Therapy  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Well Baby Visits and Care  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Laboratory Outpatient and Professional Services  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| The administration of whole blood including cost of blood, blood plasma, and blood plasma expanders are covered services | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| X-rays and Diagnostic Imaging  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Basic Dental-Children  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Orthodontia-Children   | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Major Dental Care-Child  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Transplant   | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Accidental Dental  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Dialysis   | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Allergy Testing  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Chemotherapy   | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Radiation  | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Diabetes Education   | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Prosthetic Devices   | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |

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|---|------------------------|---|------------------------|
| Infusion Therapy                                | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Treatment for Temporomandibular Joint Disorders | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Nutritional Counseling                          | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Reconstructive Surgery                          | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Mammography                                     | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Cardiovascular Disease                          | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Osteoporosis                                    | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Diabetes Care Management                        | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Inherited Metabolic Disorder (PKU)              | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Post-Mastectomy Care                            | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Brain Injury                                    | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Transplant Donor Coverage                       | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Autism Spectrum Disorders                       | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |

\*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.