

Sendero IdealCare Bronze / \$25 PCP / \$75 Specialist + 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.

| Overall Payment Provisions | In-Network Benefits | Out-of-Network Benefits | Indian Health Care Provider (IHCP) (You will pay the least) |
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| Calendar Year Deductibles (applies to all Eligible Expenses including Pharmacy) | \$8,550 Individual / \$17,100 Family (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) | \$8,600 Individual / \$17,200 Family (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 (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 after a \$25.00 Copayment per Visit | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Specialist office visit/consultation | 100% of Allowed Amount after a \$75.00 Copayment per Visit | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Other Practitioner Office Visit (Nurse, Physician Assistant) | 100% of Allowed Amount after a \$25.00 Copayment per Visit | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Outpatient Facility fee (e.g., Ambulatory Surgery Center) | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |

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| Outpatient Surgery Physician/Surgical services | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Hospice | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Urgent Care Centers or Facilities | 100% of Allowable Amount after Calendar Year Deductible per Visit | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Home Health Care Services Limited to 60 visits per year. | 100% of Allowable Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Emergency Room Services | 100% of Allowable Amount after Calendar Year Deductible per Visit | 100% of Allowable Amount after Calendar Year Deductible per Visit | 100% of Allowed Amount |
| Emergency Medical Transportation/Ambulance | 100% of Allowable Amount after Calendar Year Deductible per Transport | 100% of Allowable Amount after Calendar Year Deductible per Transport | 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 Allowable Amount after Calendar Year Deductible per Stay | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Inpatient Physician and Surgical Services | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Skilled Nursing Facility Limited to 25 visits per year. | 100% of Allowable Amount after Calendar Year Deductible per Stay | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Prenatal and Postnatal Care | 100% of Allowable Amount after Calendar Year Deductible per Visit | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Childbirth/Delivery Professional Services | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Delivery and All Inpatient Services for Maternity Care | 100% of Allowable Amount after Calendar | No coverage for Out-of-Network Services | 100% of Allowed Amount |

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| | Year Deductible per Delivery | | |
| Mental/Behavioral Health Care Outpatient Services* | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Mental/Behavioral Health Care Inpatient Hospital Services* | 100% of Allowable Amount after Calendar Year Deductible per Stay | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Substance Abuse Disorder Outpatient Services* | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Substance Abuse Disorder Inpatient Services* | 100% of Allowable Amount after Calendar Year Deductible per Stay | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Outpatient Rehabilitation | 100% of Allowable Amount after Calendar Year Deductible per Visit | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Habilitation Services | 100% of Allowable Amount after Calendar Year Deductible per Visit | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Chiropractic Services Limited to 35 visits per year | 100% of Allowable Amount after Calendar Year Deductible per Visit | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Durable Medical Equipment | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Hearing Aids for Adults (1 per ear every 3 years) | 100% of Allowable Amount after Calendar Year Deductible per Hearing Aid | 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 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. | 100% of Allowable Amount after Calendar Year Deductible per Hearing Aid or Cochlear Implant | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Imaging (CT/PET scans, MRIs) | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Preventative Care/Screening/Immunization | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |

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| 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 | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| 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 | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Bone Mass measurement for the detection of low bone mass to determine risk of osteoporosis and fractures associated with osteoporosis for qualified individuals | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Routine annual prostate cancer detection exam, including a Prostate Specific Antigen test (PSA) for a male Covered Person age 40 or older. | 100% of Allowed Amount | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Routine Foot Care | 100% of Allowable Amount after Calendar Year Deductible per Visit | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Routine Eye Exam for Children (1 per year) | 100% of Allowable Amount after Calendar Year Deductible per Visit | 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 Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Dental Check-Up for Children | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Rehabilitative Speech Therapy | 100% of Allowable Amount after Calendar Year Deductible per Visit | No coverage for Out-of-Network Services | 100% of Allowed Amount |

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| Rehabilitative Occupational and Rehabilitative Physical Therapy | 100% of Allowable Amount after Calendar Year Deductible per Visit | 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 Allowable Amount after Calendar Year Deductible | 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 Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| X-rays and Diagnostic Imaging | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Basic Dental-Children | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Orthodontia-Children | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Major Dental Care- Children | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Transplant | 20% of Allowable | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Accidental Dental | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Dialysis | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Allergy Testing | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Chemotherapy | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Radiation | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Diabetes Education | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |

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| Prosthetic Devices | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Infusion Therapy | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Treatment for Temporomandibular Joint Disorders | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Nutritional Counseling | 100% of Allowable Amount after \$5.00 Copayment for Visit | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Reconstructive Surgery | 20% of Allowable | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Mammography | 100% of Allowable Amount after \$250.00 Copayment after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Cardiovascular Disease | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Osteoporosis | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Diabetes Care Management | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Inherited Metabolic Disorder (PKU) | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Amino Acid-Based Formula | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Post-Mastectomy Care | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Brain Injury | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Transplant Donor Coverage | 100% of Allowable Amount after Calendar Year Deductible | No coverage for Out-of-Network Services | 100% of Allowed Amount |
| Autism Spectrum Disorders | 100% of Allowable Amount after Calendar Year Deductible | 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.