**Sendero Health Ideal Bronze LCS / $25 PCP / $11 Gen Rx**

**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) | $8,550.00 Individual / $17,100.00 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 | $9,450.00 Individual / $18,900.00 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 | $25.00 Copayment per Visit | No coverage for Out-of-Network Services | No charge |
| Specialist office visit/consultation | No charge after Calendar Year Deductible per Visit | No coverage for Out-of-Network Services | No charge |
| Other Practitioner Office Visit (Nurse, Physician Assistant) | $25.00 Copayment per Visit | No coverage for Out-of-Network Services | No charge |
| Outpatient Facility fee (e.g., Ambulatory Surgery Center) | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Outpatient Surgery Physician/Surgical services | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |

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| Hospice | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Urgent Care Centers or Facilities | No charge after Calendar Year Deductible per Visit | No coverage for Out-of-Network Services | No charge |
| Home Health Care Services Limited to 60 visits per year. | No charge | No coverage for Out-of-Network Services | No charge |
| Emergency Room Services | No charge after Calendar Year Deductible per Visit | No charge after Calendar Year Deductible per Visit | No charge |
| Emergency Medical Transportation/Ambulance | No charge after Calendar Year Deductible per Transportation | No charge after Calendar Year Deductible per Transportation | No charge |
| Inpatient Hospital Services (Hospital Stay) – All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units. | No charge after Calendar Year Deductible per Stay | No coverage for Out-of-Network Services | No charge |
| Inpatient Physician and Surgical Services | No charge after Calendar Year Deductible per Stay | No coverage for Out-of-Network Services | No charge |
| Skilled Nursing Facility Limited to 25 visits per year. | No charge after Calendar Year Deductible per Stay | No coverage for Out-of-Network Services | No charge |
| Prenatal and Postnatal Care | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Childbirth/Delivery Professional Services | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Delivery and All Inpatient Services for Maternity Care | No charge after Calendar Year Deductible per Delivery | No coverage for Out-of-Network Services | No charge |
| Mental/Behavioral Health Care Outpatient Services* | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Mental/Behavioral Health Care Inpatient Hospital Services* | No charge after Calendar Year Deductible per Stay | No coverage for Out-of-Network Services | No charge |
| Substance Abuse Disorder Outpatient Services* | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |

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

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| 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 | No charge | No coverage for Out-of-Network Services | No charge |
| Bone Mass measurement for the detection of low bone mass to determine risk of osteoporosis and fractures associated with osteoporosis for qualified individuals | No charge | No coverage for Out-of-Network Services | No charge |
| Routine annual prostate cancer detection exam, including a Prostate Specific Antigen test (PSA) for a male Covered Person age 40 or older. | No charge | No coverage for Out-of-Network Services | No charge |
| Routine Foot Care | No charge after Calendar Year Deductible per Visit | No coverage for Out-of-Network Services | No charge |
| Routine Eye Exam for Children (1 per year) Limited to children 21 years and under. | No charge after Calendar Year Deductible per Visit | No coverage for Out-of-Network Services | No charge |
| Eye Glasses for Children (1 set of frames with lenses or contact lenses per year) Limited to children 21 years and under. | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Dental Check-Up for Children Limited to the end of the month in which Member turns 19 years old. | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Rehabilitative Speech Therapy | No charge after Calendar Year Deductible per Visit | No coverage for Out-of-Network Services | No charge |
| Rehabilitative Occupational and Rehabilitative Physical Therapy | No charge after Calendar Year Deductible per Visit | No coverage for Out-of-Network Services | No charge |
| Well Baby Visits and Care | No charge | No coverage for Out-of-Network Services | No charge |
| Laboratory Outpatient and Professional Services | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| The administration of whole blood including cost of blood, blood plasma, and blood | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |

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| plasma expanders are covered services | | | |
| X-rays and Diagnostic Imaging | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Basic Dental-Children | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Orthodontia-Children | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Major Dental Care- Children | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Transplant | 20% Coinsurance, deductible does not apply | No coverage for Out-of-Network Services | No charge |
| Accidental Dental | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Dialysis | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Allergy Testing | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Chemotherapy | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Radiation | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Diabetes Education | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Prosthetic Devices | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Infusion Therapy | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Treatment for Temporomandibular Joint Disorders | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Nutritional Counseling | $5.00 Copayment per Visit | No coverage for Out-of-Network Services | No charge |
| Reconstructive Surgery | 20% Coinsurance, deductible does not apply | No coverage for Out-of-Network Services | No charge |

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| Mammography | $250.00 Copayment after Deductible | No coverage for Out-of-Network Services | No charge |
| Cardiovascular Disease | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Osteoporosis | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Diabetes Care Management | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Inherited Metabolic Disorder (PKU) | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Post-Mastectomy Care | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Brain Injury | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Transplant Donor Coverage | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |
| Autism Spectrum Disorders | No charge after Calendar Year Deductible | No coverage for Out-of-Network Services | No charge |

*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.

Coinsurance applies after deductible, unless otherwise indicated.

If a member receives Covered Services as teledentistry (pediatric only), telemedicine medical services or telehealth from an in-network Healthcare Practitioner, coverage for these services is the same as seeing a Healthcare Practitioner in an in-person setting. There is not a separate deductible,

annual maximum, or lifetime maximum for Covered Services delivered as teledentistry (pediatric only), telemedicine medical services or telehealth services.