Sendero Health Central Platinum

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.

As a Health Maintenance Organization (HMO), Sendero Health Plans (Sendero) may impose copayment charges to supplement payment for health care services. A reasonable copayment option may not exceed 50% of the total cost of services provided. In addition, an HMO may not impose copayment charges in excess of 200% of the total annual premium cost in that calendar year paid by or on behalf of that enrollee. This limitation applies only if the enrollee demonstrates that copayments in that amount have been paid in that year.

Overall Payment Provisions	**In-Network Benefits**	**Out-of-Network Benefits**
Calendar Year Deductibles (applies to all Eligible Expenses including Pharmacy)	$0 Individual / $0 Family (Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services)	
Out-of-Pocket Limits (applies to all Eligible Expenses including Pharmacy	$4,900.00 Individual / $9,800.00 Family (Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services)	
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	$10.00 Copayment per Visit	No coverage for Out-of-Network Services
Specialist office visit/consultation	$22.00 Copayment per Visit	No coverage for Out-of-Network Services
Other Practitioner Office Visit (Nurse, Physician Assistant)	$10.00 Copayment per Visit	No coverage for Out-of-Network Services
Outpatient Facility fee (e.g.., Ambulatory Surgery Center)	$45.00 Copayment	No coverage for Out-of-Network Services
Outpatient Surgery Physician/Surgical services	$80.00 Copayment	No coverage for Out-of-Network Services
Hospice	$10.00 Copayment	No coverage for Out-of-Network Services
Urgent Care Centers or Facilities	$10.00 Copayment per Visit	No coverage for Out-of-Network Services
Home Health Care Services Limited to 60 visits per year.	$10.00 Copayment per Visit	No coverage for Out-of-Network Services
Emergency Room Services	$200.00 Copayment per Visit	$200.00 Copayment per Visit

Emergency Medical Transportation/Ambulance	$10.00 Copayment per Transportation	$10.00 Copayment per Transportation
Inpatient Hospital Services (Hospital Stay) – All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	$250.00 Copayment per Stay	No coverage for Out-of-Network Services
Inpatient Physician and Surgical Services	$150.00 Copayment	No coverage for Out-of-Network Services
Skilled Nursing Facility Limited to 25 visits per year.	$250.00 Copayment per Stay	No coverage for Out-of-Network Services
Prenatal and Postnatal Care	$10.00 Copayment for the initial Prenatal Visit	No coverage for Out-of-Network Services
Childbirth/Delivery Professional Services	$150.00 Copayment	No coverage for Out-of-Network Services
Delivery and All Inpatient Services for Maternity Care	$150.00 Copayment per Delivery	No coverage for Out-of-Network Services
Mental/Behavioral Health Care Outpatient Services*	$10.00 Copayment	No coverage for Out-of-Network Services
Mental/Behavioral Health Care Inpatient Hospital Services*	$250.00 Copayment per Stay	No coverage for Out-of-Network Services
Substance Abuse Disorder Outpatient Services*	$10.00 Copayment	No coverage for Out-of-Network Services
Substance Abuse Disorder Inpatient Services*	$250.00 Copayment per Stay	No coverage for Out-of-Network Services
Outpatient Rehabilitation	$10.00 Copayment per Visit	No coverage for Out-of-Network Services
Habilitation Services	$10.00 Copayment per Visit	No coverage for Out-of-Network Services
Chiropractic Services Limited to 35 visits per year	$10.00 Copayment per Visit	No coverage for Out-of-Network Services
Durable Medical Equipment	$10.00 Copayment	No coverage for Out-of-Network Services
Hearing Aids for Adults (1 per ear every 3 years)	$10.00 Copayment per Hearing Aid	No coverage for Out-of-Network Services
Hearing Aid or Cochlear Implant, related services and supplies, if medically necessary for individuals who are 18 years of age or younger.	$10.00 Copayment per Hearing Aid or Cochlear Implant	No coverage for Out-of-Network Services
Imaging (CT/PET scans, MRIs)	$10.00 Copayment	No coverage for Out-of-Network Services
Preventative Care/Screening/Immunization	No charge	No coverage for Out-of-Network Services

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
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
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
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
Routine Foot Care	$10.00 Copayment per Visit	No coverage for Out-of-Network Services
Routine Eye Exam for Children (1 per year)	$10.00 Copayment per Visit	No coverage for Out-of-Network Services
Eye Glasses for Children (1 set of frames with lenses or contact lenses per year)	$10.00 Copayment	No coverage for Out-of-Network Services
Dental Check-Up for Children	$10.00 Copayment	No coverage for Out-of-Network Services
Rehabilitative Speech Therapy	$10.00 Copayment per Visit	No coverage for Out-of-Network Services
Rehabilitative Occupational and Rehabilitative Physical Therapy	$10.00 Copayment per Visit	No coverage for Out-of-Network Services
Well Baby Visits and Care	No charge	No coverage for Out-of-Network Services

Laboratory Outpatient and Professional Services	$10.00 Copayment	No coverage for Out-of-Network Services
The administration of whole blood including cost of blood, blood plasma, and blood plasma expanders are covered services	$10.00 Copayment	No coverage for Out-of-Network Services
X-rays and Diagnostic Imaging	$10.00 Copayment	No coverage for Out-of-Network Services
Basic Dental Care-Children	$10.00 Copayment	No coverage for Out-of-Network Services
Orthodontia-Children	$10.00 Copayment	No coverage for Out-of-Network Services
Major Dental Care- Children	$10.00 Copayment	No coverage for Out-of-Network Services
Transplant	$10.00 Copayment	No coverage for Out-of-Network Services
Accidental Dental	$10.00 Copayment	No coverage for Out-of-Network Services
Dialysis	$10.00 Copayment	No coverage for Out-of-Network Services
Allergy Testing	$10.00 Copayment	No coverage for Out-of-Network Services
Chemotherapy	$10.00 Copayment	No coverage for Out-of-Network Services
Radiation	$10.00 Copayment	No coverage for Out-of-Network Services
Diabetes Education	$10.00 Copayment	No coverage for Out-of-Network Services
Prosthetic Devices	$10.00 Copayment	No coverage for Out-of-Network Services
Infusion Therapy	$10.00 Copayment	No coverage for Out-of-Network Services
Treatment for Temporomandibular Joint Disorders	$10.00 Copayment	No coverage for Out-of-Network Services
Nutritional Counseling	$5.00 Copayment per Visit	No coverage for Out-of-Network Services
Reconstructive Surgery	25% of coinsurance	No coverage for Out-of-Network Services
Mammography	$10.00 Copayment	No coverage for Out-of-Network Services
Cardiovascular Disease	$10.00 Copayment	No coverage for Out-of-Network Services
Osteoporosis	$10.00 Copayment	No coverage for Out-of-Network Services
Diabetes Care Management	$10.00 Copayment	No coverage for Out-of-Network Services

Inherited Metabolic Disorder (PKU)	$10.00 Copayment	No coverage for Out-of-Network Services
Post-Mastectomy Care	$10.00 Copayment	No coverage for Out-of-Network Services
Brain Injury	$10.00 Copayment	No coverage for Out-of-Network Services
Transplant Donor Coverage	$10.00 Copayment	No coverage for Out-of-Network Services
Autism Spectrum Disorders	$10.00 Copayment	No coverage for Out-of-Network Services

*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.

“Allowed amount” means the maximum amount a plan will pay for a covered health care service. The allowed amount may also be called “eligible expense”, “payment allowance” or “negotiated rate”. If a provider charges more than the plan’s allowed amount and bills you for the difference, it is called balance billing. In-network providers may not balance bill you for covered services. If you are balance billed, please contact Sendero at 1-844-800-4693.

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.