Sendero Health Capital Silver Limited Cost Share

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)**
Calendar Year Deductibles (applies to all Eligible Expenses including Pharmacy)	$6,000.00 Individual / $12,000.00 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	$8,900.00 Individual / $17,800.00 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	$40.00 Copayment per Visit	No coverage for Out-of-Network Services	No Charge
Specialist office visit/consultation	$80.00 Copayment per Visit	No coverage for Out-of-Network Services	No Charge
Other Practitioner Office Visit (Nurse, Physician Assistant)	$20.00 Copayment per Visit	No coverage for Out-of-Network Services	No Charge
Outpatient Facility fee (e.g.., Ambulatory Surgery Center)	40% Coinsurance	No coverage for Out-of-Network Services	No Charge
Outpatient Surgery Physician/Surgical services	40% Coinsurance	No coverage for Out-of-Network Services	No Charge
Hospice	30% Coinsurance	No coverage for Out-of-Network Services	No Charge
Urgent Care Centers or Facilities	$60.00 Copayment 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	40% Coinsurance per Visit	40% Coinsurance per Visit	No Charge
Emergency Medical Transportation/Ambulance	40% Coinsurance per Transportation	40% Coinsurance per Transportation	No Charge
Inpatient Hospital Services (Hospital Stay) – All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	40% Coinsurance per Stay	No coverage for Out-of-Network Services	No Charge
Inpatient Physician and Surgical Services	30% Coinsurance	No coverage for Out-of-Network Services	No Charge
Skilled Nursing Facility Limited to 25 visits per year.	40% Coinsurance per Stay	No coverage for Out-of-Network Services	No Charge
Prenatal and Postnatal Care	$10.00 Copayment for the initial Prenatal Visit	No coverage for Out-of-Network Services	No Charge
Childbirth/Delivery Professional Services	30% Coinsurance	No coverage for Out-of-Network Services	No Charge
Delivery and All Inpatient Services for Maternity Care	$500.00 Copayment after Calendar Year Deductible per Delivery	No coverage for Out-of-Network Services	No Charge
Mental/Behavioral Health Care Outpatient Services*	$40.00 Copayment per Visit	No coverage for Out-of-Network Services	No Charge
Mental/Behavioral Health Care Inpatient Hospital Services*	40% Coinsurance per Stay	No coverage for Out-of-Network Services	No Charge
Substance Abuse Disorder Outpatient Services*	$40.00 Copayment per Visit	No coverage for Out-of-Network Services	No Charge
Substance Abuse Disorder Inpatient Services*	40% Coinsurance per Stay	No coverage for Out-of-Network Services	No Charge
Outpatient Rehabilitation	20% Coinsurance per Visit	No coverage for Out-of-Network Services	No Charge
Habilitation Services	$40 copayment per Visit	No coverage for Out-of-Network Services	No Charge
Chiropractic Services Limited to 35 visits per year	$60.00 Copayment after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services	No Charge
Durable Medical Equipment	20% Coinsurance	No coverage for Out-of-Network Services	No Charge
Hearing Aids for Adults (1 per ear every 3 years)	20% Coinsurance 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 individuals who are 18 years of age or younger.	20% Coinsurance per Hearing Aid or Cochlear Implant	No coverage for Out-of-Network Services	No Charge
Imaging (CT/PET scans, MRIs)	40% Coinsurance	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
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	Not covered	Not covered	Not covered
Routine Eye Exam for Children (1 per year)	$45.00 Copayment per Visit	No coverage for Out-of-Network Services	No Charge

Limited to children 21 years and under.			
Eye Glasses for Children (1 set of frames with lenses or contract lenses per year) Limited to children 21 years and under.	20% Coinsurance	No coverage for Out-of-Network Services	No Charge
Dental Check-Up for Children Limited to the end of the month which Member turns 19 years old.	20% Coinsurance	No coverage for Out-of-Network Services	No Charge
Rehabilitative Speech Therapy	$40.00 Copayment per Visit	No coverage for Out-of-Network Services	No Charge
Rehabilitative Occupational and Rehabilitative Physical Therapy	$40.00 Copayment 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	40% Coinsurance	No coverage for Out-of-Network Services	No Charge
The administration of whole blood including cost of blood, blood plasma, and blood plasma expanders are covered services	40% Coinsurance	No coverage for Out-of-Network Services	No Charge
X-rays and Diagnostic Imaging	40% Coinsurance	No coverage for Out-of-Network Services	No Charge
Basic Dental-Children	20% Coinsurance	No coverage for Out-of-Network Services	No Charge
Orthodontia-Children	20% Coinsurance	No coverage for Out-of-Network Services	No Charge
Major Dental Care-Child	20% Coinsurance	No coverage for Out-of-Network Services	No Charge
Transplant	20% Coinsurance	No coverage for Out-of-Network Services	No Charge
Accidental Dental	20% Coinsurance	No coverage for Out-of-Network Services	No Charge
Dialysis	20% Coinsurance	No coverage for Out-of-Network Services	No Charge
Allergy Testing	20% Coinsurance	No coverage for Out-of-Network Services	No Charge
Chemotherapy	20% Coinsurance	No coverage for Out-of-Network Services	No Charge
Radiation	20% Coinsurance	No coverage for Out-of-Network Services	No Charge
Diabetes Education	20% Coinsurance	No coverage for Out-of-Network Services	No Charge

Prosthetic Devices	20% Coinsurance	No coverage for Out-of-Network Services	No Charge
Infusion Therapy	20% Coinsurance	No coverage for Out-of-Network Services	No Charge
Treatment for Temporomandibular Joint Disorders	20% Coinsurance	No coverage for Out-of-Network Services	No Charge
Nutritional Counseling	Not covered	Not covered	Not covered
Reconstructive Surgery	30% Coinsurance, deductible does not apply	No coverage for Out-of-Network Services	No Charge
Mammography	$250.00 Copayment after Calendar Year Deductible	No coverage for Out-of-Network Services	No Charge
Cardiovascular Disease	20% Coinsurance	No coverage for Out-of-Network Services	No Charge
Osteoporosis	20% Coinsurance	No coverage for Out-of-Network Services	No Charge
Diabetes Care Management	20% Coinsurance	No coverage for Out-of-Network Services	No Charge
Inherited Metabolic Disorder (PKU)	20% Coinsurance	No coverage for Out-of-Network Services	No Charge
Post-Mastectomy Care	20% Coinsurance	No coverage for Out-of-Network Services	No Charge
Brain Injury	20% Coinsurance	No coverage for Out-of-Network Services	No Charge
Transplant Donor Coverage	20% Coinsurance	No coverage for Out-of-Network Services	No Charge
Autism Spectrum Disorders	25% Coinsurance	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.