Sendero Health Original Silver

Pharmacy Benefits 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 the plan requirements, provisions, limitations, and exclusions.

Sendero prohibits step-therapy for prescription drugs used to treat stage-four advanced metastatic cancer or associated conditions. This prohibition only applies to an FDA-approved drug when its use is consistent with best practices for the treatment of stage-four advanced metastatic cancer or an associated condition and is supported by peer-reviewed, evidence-based literature.

Prescription Drug coverage is subject to change. Any prescription drug that was approved or covered under the plan for a medical condition or mental illness, regardless of whether the drug has been removed from the health benefit plan's drug formulary before the plan renewal date.

Based on State law, advanced written notice to you is required for the following modification that affects Prescription Drug coverage:

1. Removal of a drug from the Drug Formulary;
2. Requirement that you receive prior authorization for a drug;
3. An imposed or altered quantity limit;
4. An imposed step-therapy restriction;
5. Moving a drug to a higher cost-sharing level unless a generic alternative to the drug is available.

Sendero will only make these types of changes to Prescription Drug coverage at renewal of the Contract. We will provide written notice no later than 60 days prior to the effective date of the change.

This section does not prohibit a physician or other health professional who is authorized to prescribe a drug from prescribing a drug that is an alternative to a drug for which continuation of coverage is required under Subsection

(a) if the alternative drug is:

(1) covered under the health benefit plan; and

(2) medically appropriate for the enrollee.

Note: This Consumer Choice Health Benefit Plan does not include all state mandated health insurance benefits. The following benefit is provided at a reduced level from what is mandated:

Mandated Benefit Description	Benefit Reduced
An HMO may charge a deductible only for services performed out of the HMO’s service area or for services performed by a physician or provider who is not in the HMO’s delivery network.	A deductible will apply to Preferred (Tier 3), Non-preferred (Tier 4) and Specialty Drugs (Tier 5)

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
Calendar Year Deductibles (applies to all Eligible Expenses including Pharmacy)	$4,250.00 Individual / $8,500.00 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)	$12,000.00 Individual / $24,000.00 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)	
Generic (Tier 2)	$10.00 Copayment per 30 day supply	No coverage for Out-of-Network Services
Preferred (Tier 3)	$40.00 Copayment after Calendar Year Deductible per 30 day supply	No coverage for Out-of-Network Services
Non-preferred (Tier 4)	$80.00 Copayment after Calendar Year Deductible per 30 day supply	No coverage for Out-of-Network Services
Specialty Drugs (Tier 5)	30% Coinsurance per 30 day supply	No coverage for Out-of-Network Services
Preventive, includes Vaccinations obtained at the Pharmacy (Tier 1)	No Charge	No coverage for Out-of-Network Services

***Coinsurance applies after deductible, unless otherwise indicated.**