Sendero Health Original Silver

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
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)	
Primary Care Visit to Treat an injury or illness	$20.00 Copayment per Visit	No coverage for Out-of-Network Services
Specialist office visit/consultation	$60.00 Copayment after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services
Other Practitioner Office Visit (Nurse, Physician Assistant)	$20.00 Copayment per Visit	No coverage for Out-of-Network Services
Outpatient Facility fee (e.g., Ambulatory Surgery Center)	40% Coinsurance	No coverage for Out-of-Network Services
Outpatient Surgery Physician/Surgical services	40% Coinsurance	No coverage for Out-of-Network Services
Hospice	20% Coinsurance	No coverage for Out-of-Network Services
Urgent Care Centers or Facilities	$60.00 Copayment per Visit	No coverage for Out-of-Network Services

Home Health Care Services Limited to 60 visits per year.	No Charge	No coverage for Out-of-Network Services
Emergency Room Services	$350.00 Copayment after Calendar Year Deductible per Visit	$350.00 Copayment after Calendar Year Deductible per Visit
Emergency Medical Transportation/Ambulance	$350.00 Copayment after Calendar Year Deductible per Transportation	$350.00 Copayment after Calendar Year Deductible per Transportation
Inpatient Hospital Services (Hospital Stay) – All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	$500.00 Copayment after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services
Inpatient Physician and Surgical Services	30% Coinsurance	No coverage for Out-of-Network Services
Skilled Nursing Facility Limited to 25 visits per year.	$300.00 Copayment after Calendar Year Deductible 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	30% Coinsurance	No coverage for Out-of-Network Services
Delivery and All Inpatient Services for Maternity Care	$500.00 Copayment after Calendar Year Deductible per Delivery	No coverage for Out-of-Network Services
Mental/Behavioral Health Care Outpatient Services*	20% Coinsurance	No coverage for Out-of-Network Services
Mental/Behavioral Health Care Inpatient Hospital Services*	$500.00 Copayment after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services
Substance Abuse Disorder Outpatient Services*	20% Coinsurance	No coverage for Out-of-Network Services
Substance Abuse Disorder Inpatient Services*	$500.00 Copayment after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services
Outpatient Rehabilitation	$65.00 Copayment after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services
Habilitation Services	20% Coinsurance	No coverage for Out-of-Network Services
Chiropractic Services Limited to 35 visits per year	$60.00 Copayment after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services
Durable Medical Equipment	20% Coinsurance	No coverage for Out-of-Network Services
Hearing Aids for Adults (1 per ear every 3 years)	20% Coinsurance 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.	20% Coinsurance per Hearing Aid or Cochlear Implant	No coverage for Out-of-Network Services
Imaging (CT/PET scans, MRIs)	25% Coinsurance	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	$45.00 Copayment per Visit	No coverage for Out-of-Network Services
Routine Eye Exam for Children (1 per year). Limited to children 21 years and under.	$45.00 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). Limited to children 21 years and under.	20% Coinsurance	No coverage for Out-of-Network Services
Dental Check-Up for Children. Limited to the end of the month in which Member turns 19 years old.	20% Coinsurance	No coverage for Out-of-Network Services
Rehabilitative Speech Therapy	$60.00 Copayment after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services
Rehabilitative Occupational and Rehabilitative Physical Therapy	$60.00 Copayment after Calendar Year Deductible 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	$30.00 Copayment after Calendar Year Deductible per Visit	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	$30.00 Copayment after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services
X-rays and Diagnostic Imaging	$30.00 Copayment after Calendar Year Deductible	No coverage for Out-of-Network Services
Basic Dental-Children	20% Coinsurance	No coverage for Out-of-Network Services
Orthodontia-Children	20% Coinsurance	No coverage for Out-of-Network Services
Major Dental Care-Child	20% Coinsurance	No coverage for Out-of-Network Services
Transplant	20% Coinsurance	No coverage for Out-of-Network Services
Accidental Dental	20% Coinsurance	No coverage for Out-of-Network Services
Dialysis	20% Coinsurance	No coverage for Out-of-Network Services
Allergy Testing	20% Coinsurance	No coverage for Out-of-Network Services
Chemotherapy	20% Coinsurance	No coverage for Out-of-Network Services

Radiation	20% Coinsurance	No coverage for Out-of-Network Services
Diabetes Education	20% Coinsurance	No coverage for Out-of-Network Services
Prosthetic Devices	20% Coinsurance	No coverage for Out-of-Network Services
Infusion Therapy	20% Coinsurance	No coverage for Out-of-Network Services
Treatment for Temporomandibular Joint Disorders	20% Coinsurance	No coverage for Out-of-Network Services
Nutritional Counseling	$5.00 Copayment	No coverage for Out-of-Network Services
Reconstructive Surgery	30% Coinsurance, deductible does not apply	No coverage for Out-of-Network Services
Mammography	$250.00 Copayment after Calendar Year Deductible	No coverage for Out-of-Network Services
Cardiovascular Disease	20% Coinsurance	No coverage for Out-of-Network Services
Osteoporosis	20% Coinsurance	No coverage for Out-of-Network Services
Diabetes Care Management	20% Coinsurance	No coverage for Out-of-Network Services
Inherited Metabolic Disorder (PKU)	20% Coinsurance	No coverage for Out-of-Network Services
Post-Mastectomy Care	20% Coinsurance	No coverage for Out-of-Network Services
Brain Injury	20% Coinsurance	No coverage for Out-of-Network Services
Transplant Donor Coverage	20% Coinsurance	No coverage for Out-of-Network Services
Autism Spectrum Disorders	20% Coinsurance	No coverage for Out-of-Network Services

*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.