Sendero IdealCare Bronze / \$25 PCP / \$11 Gen Rx + Free Wellness & Preventive Screening + Free Dedicated Healthcare Team + Free 24/7 Virtual MD Visits + No Pre-existing Condition Restrictions

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	\$8,550.00 Individual (Out-of-Network Ser		\$0 Individual / \$0 Family
Expenses including	unless they are approv	ed by the Plan or are	1 arrilly
Pharmacy)	Emergency	•	
Out-of-Pocket Limits (applies to all Eligible Expenses including Pharmacy	\$8,600.00 Individual / \$17,200.00 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 unles by the Plan or are Emergency S		
Primary Care Visit to Treat an injury or illness	100% of Allowed Amount after a \$25.00 Copayment per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Specialist office visit/consultation	100% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Other Practitioner Office Visit (Nurse, Physician Assistant)	100% of Allowed Amount after a \$25.00 Copayment per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Outpatient Facility fee (e.g, Ambulatory Surgery Center)	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount

Outpatient Surgery Physician/Surgical services	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Hospice	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Urgent Care Centers or Facilities	100% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Home Health Care Services Limited to 60 visits per year.	100% of Allowable Amount	No coverage for Out-of-Network Services	100% of Allowed Amount
Emergency Room Services	100% of Allowable Amount after Calendar Year Deductible per Visit	100% of Allowable Amount after Calendar Year Deductible per Visit	100% of Allowed Amount
Emergency Medical Transportation/Ambulance	100% of Allowable Amount after Calendar Year Deductible per Transportation	100% of Allowable Amount after Calendar Year Deductible per Transportation	100% of Allowed Amount
Inpatient Hospital Services (Hospital Stay) – All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	100% of Allowable Amount after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services	100% of Allowed Amount
Inpatient Physician and Surgical Services	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Skilled Nursing Facility Limited to 25 visits per year.	100% of Allowable Amount after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services	100% of Allowed Amount
Prenatal and Postnatal Care	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Childbirth/Delivery Professional Services	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Delivery and All Inpatient Services for Maternity Care	100% of Allowable Amount after Calendar Year	No coverage for Out-of-Network Services	100% of Allowed Amount

Mental/Behavioral Health Care Outpatient Services* Mental/Behavioral Health Care Outpatient Services* Mental/Behavioral Health Care Inpatient Hospital Services* Substance Abuse Disorder Outpatient Services* Substance Abuse Disorder Inpatient Services* Outpatient Services* Outpatient Services* Outpatient Services* Outpatient Rehabilitation Substance Abuse Disorder Inpatient Services* Outpatient Rehabilitation Outpatient Rehabilitation Outpatient Rehabilitation Amount after Calendar Year Deductible per Stay Outpatient Rehabilitation Outpatient Rehabilitation Amount after Calendar Year Deductible per Stay Outpatient Rehabilitation Outpatient Rehabilitation Chiropractic Services Chiropractic Services Limited to 35 visits per year Durable Medical Equipment Durable Medical Equipment Hearing Aids for Adults (1 per ear every 3 years) Defluctible per Inpatient Plearing Aid or Cochlear Implant, related services and supplies, if medically 100% of Allowable Amount after Calendar Year Deductible per Hearing Aid Hearing Aid or Cochlear Implant, related Services and supplies, if medically 100% of Allowable Amount after Calendar Year Deductible per Hearing Aid 100% of Allowable Amount after Calendar Year Deductible per Hearing Aid 100% of Allowable Amount after Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible per Visit No coverage for Out-of-Network Services 100% of Allowable Amount after Calendar Year Deductible Per Hearing Aid or Cochlear A		Deductible		
Mental/Behavioral Health Care Outpatient Services*		Deductible per		
Mental/Behavioral Health Care Outpatient Services* Deductible				4000/ - £ All
Mental/Behavioral Health Care Outpatient Services*	M4-1/D-1		No coverage for	
Deductible Services Deductible Amount after Calendar Year Deductible per Stay				Amount
Mental/Behavioral Health Care Inpatient Hospital Services* Substance Abuse Disorder Outpatient Services* Outpatient Rehabilitation Outpatient Rehabilitation Habilitation Services Chiropractic Services Deductible per Visit Down of Allowable Amount after Calendar Year Deductible per Visit Chiropractic Services Durable Medical Equipment Durable Medical Equipment Hearing Aids for Adults (1 per ear every 3 years) Deductible per Visit Durable Medical Services and Deductible per Visit Down of Allowable Amount after Calendar Year Deductible per Visit Down of Allowable Amount after Calendar Year Deductible per Visit Down of Allowable Amount after Calendar Year Deductible per Visit Down of Allowable Amount after Calendar Year Deductible per Visit Down of Allowable Amount after Calendar Year Deductible per Visit Durable Medical Equipment Durable Medical Equipme	Care Outpatient Services*			
Mental/Behavioral Healtin Care Inpatient Hospital Services* Services* Substance Abuse Disorder Outpatient Services* Substance Abuse Disorder Outpatient Services* Substance Abuse Disorder Inpatient Services* Outpatient Rehabilitation No coverage for Outpatient Rehabilitation Outpatient Rehabilitation Outpatient Rehabilitation Outpatient Rehabilitation No coverage for Outpatient Rehabilitation Outpatient Rehabilitation Outpatient Rehabilitation Outpatient Rehabilitation No coverage for Outpatient Rehabilitation Outpatient Rehabilitation No coverage for Outpatient Rehabilitation Outpatient Rehabilitation Outpatient Rehabilitation Outpatient Rehabilitation Outpa				
Care Inpatient Hospital Services* Amount after Calendar Year Deductible per Stay Substance Abuse Disorder Outpatient Services* Substance Abuse Disorder Inpatient Services* Substance Abuse Disorder Inpatient Services* Outpatient Services* Outpatient Services* Substance Abuse Disorder Inpatient Services* Outpatient Services* Outpatient Rehabilitation Outpatient Rehabilitation Outpatient Rehabilitation Amount after Calendar Year Deductible per Stay Outpatient Rehabilitation Outpatient Rehabilitation Amount after Calendar Year Deductible per Visit Outpatient Rehabilitation Habilitation Services Outpatient Rehabilitation Outpatient Rehabilitation Outpatient Rehabilitation Amount after Calendar Year Deductible per Visit Outpatient Rehabilitation Outpatient Rehabilitation Amount after Calendar Year Deductible per Visit Outpatient Rehabilitation Amount after Calendar Year Deductible per Visit Outpatient Rehabilitation Outpatient Rehabilitation Outpatient Rehabilitation Outpatient Rehabilitation Outpatient Rehabilitation No coverage for Outpatient Rehabilitation No coverage for Outpatient Rehabilitation Outpatient Rehabilitation No coverage for Outpatient Rehabilitation Outpatient Rehabilitation No coverage for Outpatient Rehabilitation Outpatient Rehabilitation No coverage for Outpatient Rehabilitation No coverage for Outpatient Rehabilitation Outpatient Rehabilitation No coverage for Outpatient Rehabilitation Outpatient Rehabilitation Outpatient Rehabilitation Outpatient Rehabilitation No coverage for Outpatient Rehabilitation Outpatient Rehabilitation No coverage for Outpatient Rehabilitation Outpatient Rehabilitat	Mental/Rehavioral Health		No coverage for	
Services* Calendar Year Deductible per Stay				Amount
Substance Abuse Disorder Outpatient Services* Substance Abuse Disorder Outpatient Services* Substance Abuse Disorder Inpatient Services* Outpatient Rehabilitation Habilitation Services Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible per Visit Outpatient Rehabilitation Chiropractic Services Limited to 35 visits per year Durable Medical Equipment Durable Medical Equipment Hearing Aids for Adults (1 per ear every 3 years) Deductible per Hearing Aid Hearing Aid or Cochlear Implant, related services and Outpatient Services Outpatient Services No coverage for Outpatient No coverage for Outpatien		Calendar Year		
Substance Abuse Disorder Outpatient Services* Substance Abuse Disorder Inpatient Services* Substance Abuse Disorder Inpatient Services* Substance Abuse Disorder Inpatient Services* Outpatient Rehabilitation Outpatient Rehabilitation Outpatient Rehabilitation Habilitation Services Chiropractic Services Chiropractic Services Durable Medical Equipment Durable Medical Equipment Hearing Aids for Adults (1 per ear every 3 years) Outpatient Services and Amount after Calendar Year Deductible per Hearing Aid or Cochlear Inpatient Services Amount after Calendar Year Deductible per Hearing Aid or Cochlear Implant, related services and Inpatient Services Amount after Calendar Year Deductible per Manual Amount after Calendar Year Deductible per Hearing Aids Amount after Calendar Year Deductible per Hearing Aid or Cochlear Implant, related services and Inpatient Services Amount after Calendar Year Deductible per Hearing Aid or Cochlear Implant, related services and Inpatient Services Amount after Calendar Year Deductible per Hearing Aid Inpatient Services Amount after Calendar Year Deductible per Hearing Aid Inpatient Services No coverage for Out-of-Network Services Inpatient Ser	Services	Deductible per Stay	Oct vices	
Outpatient Services* Outpatient Services* Calendar Year Deductible Substance Abuse Disorder Inpatient Services* Outpatient Services* Outpatient Services* Outpatient Services* Outpatient Rehabilitation Outpatient Services Indow of Allowable Amount after Calendar Year Deductible per Visit Outpatient Rehabilitation Outpatient Rehabilitation Outpatient Rehabilitation No coverage for Out-of-Network Services Outpatient Rehabilitation No coverage for Outpatient Rehabilitation Outpatient Rehabilitation No coverage for Outpatient Rehabilitation Outpatient Rehabilitation No coverage for Outpatient Rehabilitation Outpatient Rehabilitation Outpatient Rehabilitation Outpatient Rehabilitation Outpatient Rehabilitation Outpat		100% of Allowable	No severene for	100% of Allowed
Calendar Year Deductible Per Stay Substance Abuse Disorder Inpatient Services* Outpatient Rehabilitation Outpatient Rehabilitation Outpatient Rehabilitation Habilitation Services Calendar Year Deductible per Visit Calendar Year Deductible per Visit Outpatient Rehabilitation Habilitation Services Calendar Year Deductible per Visit Calendar Year Deductible per Visit Out-of-Network Services I 100% of Allowable Amount after Calendar Year Deductible per Visit Chiropractic Services Limited to 35 visits per year Deductible per Visit Durable Medical Equipment Hearing Aids for Adults (1 per ear every 3 years) Hearing Aid or Cochlear Implant, related services and Town of Allowable Amount after Calendar Year Deductible per Hearing Aid No coverage for Out-of-Network Services 100% of Allowable No coverage for Out-of-Network Services No coverage for Out-of-Network Services 100% of Allowable No coverage for Out-of-Network Services 100% of Allowable Amount after Calendar Year Deductible Per Hearing Aid No coverage for Out-of-Network Services 100% of Allowable No coverage for Out-of-Network Services 100% of Allowable No coverage for Out-of-Network Services 100% of Allowable Amount after Calendar Year Deductible Per Hearing Aid No coverage for Out-of-Network Services 100% of Allowable Amount after Calendar Year Deductible Per Hearing Aid No coverage for Out-of-Network Services 100% of Allowable Amount 100% of Allowable Amount No coverage for Out-of-Network Services 100% of Allowable Amount 100% of Allowable Amount 100% of Allowable Amount 100% of Allowable Amount	Substance Abuse Disorder	Amount after		Amount
Substance Abuse Disorder Inpatient Services* Outpatient Rehabilitation Outpatient Rehabilitation Habilitation Services Calendar Year Deductible per Stay Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible per Visit Calendar Year Deductible per Visit Outpatient Rehabilitation Habilitation Services Calendar Year Deductible per Visit Chiropractic Services Limited to 35 visits per year Deductible per Visit Durable Medical Equipment Durable Medical Equipment Hearing Aids for Adults (1 per ear every 3 years) Hearing Aid or Cochlear Implant, related services and Deductible Manunt after Calendar Year Deductible per Hearing Aid Hearing Aid or Cochlear Implant, related services and No coverage for Out-of-Network Services 100% of Allowable No coverage for Out-of-Network Services No coverage for Out-of-Network Services 100% of Allowable No coverage for Out-of-Network Services 100% of Allowable Amount after Calendar Year Deductible per Hearing Aid No coverage for Out-of-Network Services 100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount	Outpatient Services*	Calendar Year		
Substance Abuse Disorder Inpatient Services* Outpatient Rehabilitation Outpatient Rehabilitation Habilitation Services Chiropractic Services Chiropractic Services Deductible per Visit Durable Medical Equipment Durable Medical Equipment Hearing Aids for Adults (1 per ear every 3 years) Inpatient Services and 100% of Allowable Amount after Calendar Year Deductible per Hearing Aid Monor Amount after Calendar Year Deductible per Hearing Aid Monor Amount after Calendar Year Deductible per Hearing Aid Inpatient Services No coverage for Out-of-Network Services	·	Deductible	Services	
Substance Abuse Disorder Inpatient Services* Amount after Calendar Year Deductible per Stay Outpatient Rehabilitation Outpatient Rehabilitation Outpatient Rehabilitation Habilitation Services Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible per Visit Out-of-Network Services Chiropractic Services Limited to 35 visits per year Durable Medical Equipment Durable Medical Equipment Hearing Aids for Adults (1 per ear every 3 years) Hearing Aid or Cochlear Implant, related services and Amount after Calendar Year Deductible per Visit Out-of-Network Services No coverage for Out-of-Network Services 100% of Allowable Amount after Calendar Year Deductible No coverage for Out-of-Network Services 100% of Allowable Amount after Calendar Year Deductible Per Hearing Aid No coverage for Out-of-Network Services 100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount		100% of Allowable		100% of Allowed
Inpatient Services*	Substance Abuse Disorder			
Outpatient Rehabilitation Outpatient Rehabilitation Outpatient Rehabilitation Amount after Calendar Year Deductible per Visit Out-of-Network Services Indow of Allowable Amount after Calendar Year Deductible per Visit Out-of-Network Services No coverage for Out-of-Network Services 100% of Allowed Amount No coverage for Out-of-Network Services 100% of Allowed Amount No coverage for Out-of-Network Services 100% of Allowed Amount 100% of Allowed Amount No coverage for Out-of-Network Services 100% of Allowed Amount				1
Outpatient Rehabilitation In the services and a services of the services of t	pausik servises	-	Services	
Outpatient Rehabilitation Amount after Calendar Year Deductible per Visit Habilitation Services Chiropractic Services Chiropractic Services Chiropractic Services Limited to 35 visits per year Durable Medical Equipment Durable Medical Equipment Durable Medical Equipment Hearing Aids for Adults (1 per ear every 3 years) Hearing Aid or Cochlear Implant, related services and Amount after Calendar Year Deductible per Visit No coverage for Out-of-Network Services 100% of Allowed Amount No coverage for Out-of-Network Services 100% of Allowed Amount 100% of Allowed Amount No coverage for Out-of-Network Services 100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount				100% of Allowed
Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible per Visit Chiropractic Services Limited to 35 visits per year Durable Medical Equipment Durable Medical Equipment Hearing Aids for Adults (1 per ear every 3 years) Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible per Hearing Aid Hearing Aid or Cochlear Implant, related services and Calendar Year Deductible Per Visit 100% of Allowable Amount after Calendar Year Deductible Per Hearing Aid No coverage for Out-of-Network Services No coverage for Out-of-Network Services No coverage for Out-of-Network Services 100% of Allowable Amount after Calendar Year Deductible Per Hearing Aid No coverage for Out-of-Network Services 100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount	Outpatient Rehabilitation			
Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible Deductible Amount after Calendar Year Deductible De	Outpatient Renabilitation		Out-of-Network	Amount
Habilitation Services In the properties and the properties of the			Services	
Habilitation Services Amount after Calendar Year Deductible per Visit Chiropractic Services Limited to 35 visits per year Durable Medical Equipment Hearing Aids for Adults (1 per ear every 3 years) Amount after Calendar Year Deductible per Hearing Aid or Cochlear Implant, related services and Amount after Calendar Year Deductible per Visit No coverage for Out-of-Network Services 100% of Allowed Amount No coverage for Out-of-Network Services 100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount				100% of Allowed
Calendar Year Deductible per Visit Chiropractic Services Limited to 35 visits per year Durable Medical Equipment Durable Medical Equipment Hearing Aids for Adults (1 per ear every 3 years) Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible per Hearing Aid Hearing Aid or Cochlear Implant, related services Calendar Year Deductible Per Visit 100% of Allowable Amount after Calendar Year Deductible per Hearing Aid No coverage for Out-of-Network Services No coverage for Out-of-Network Services 100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount			No coverage for	
Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible Per Visit 100% of Allowable Amount after Calendar Year Deductible Hearing Aids for Adults (1 per ear every 3 years) Hearing Aid or Cochlear Implant, related services and Deductible Per Visit 100% of Allowable Amount after Calendar Year Deductible per Hearing Aid No coverage for Out-of-Network Services 100% of Allowable No coverage for Out-of-Network Services 100% of Allowable Amount after Calendar Year Deductible per Hearing Aid 100% of Allowable Amount Services 100% of Allowable Amount Out-of-Network Services	Habilitation Services		Out-of-Network	Amount
Chiropractic Services Limited to 35 visits per year Deductible per Visit Durable Medical Equipment Hearing Aids for Adults (1 per ear every 3 years) 100% of Allowable Amount after Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible 100% of Allowable Amount after Calendar Year Deductible No coverage for Out-of-Network Services No coverage for Out-of-Network Services 100% of Allowed Amount No coverage for Out-of-Network Services 100% of Allowed Amount			Services	
Chiropractic Services Limited to 35 visits per year Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible Amount after Calendar Year Deductible Amount after Calendar Year Deductible 100% of Allowable Amount after Calendar Year Deductible 100% of Allowable Amount after Calendar Year Deductible 100% of Allowable Amount after Calendar Year Deductible Amount after Calendar Year Deductible per Hearing Aid or Cochlear Implant, related services and Amount No coverage for Out-of-Network Services 100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount				4000/ - £ All
Limited to 35 visits per year Calendar Year Deductible per Visit 100% of Allowable Amount after Calendar Year Deductible Amount after Calendar Year Deductible Hearing Aids for Adults (1 per ear every 3 years) Hearing Aid or Cochlear Implant, related services and Amount after Calendar Year Deductible No coverage for Out-of-Network Services No coverage for Out-of-Network Services 100% of Allowed Amount No coverage for Out-of-Network Services 100% of Allowed Amount Amount 100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount	Obj		No coverage for	
Durable Medical Equipment Durable Medical Equipment Durable Medical Equipment Durable Medical Equipment Deductible Amount after Calendar Year Deductible Hearing Aids for Adults (1 per ear every 3 years) Hearing Aid or Cochlear Implant, related services and Calendar Year Deductible Province Calendar Year Deductible Province Calendar Year Deductible Province Calendar Year Out-of-Network Services No coverage for Out-of-Network Services Amount 100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount	· ·			Amount
Durable Medical Equipment 100% of Allowable Amount after Calendar Year Deductible	Limited to 35 visits per year			
Durable Medical Equipment Amount after Calendar Year Deductible Hearing Aids for Adults (1 per ear every 3 years) Hearing Aid or Cochlear Implant, related services and Amount after Calendar Year Deductible per Hearing Aid Amount after Out-of-Network Services No coverage for Out-of-Network Services 100% of Allowed Amount No coverage for Out-of-Network Services 100% of Allowed Amount				1000/ 6411
Durable Medical Equipment Calendar Year Deductible 100% of Allowable Amount after Calendar Year Deductible Amount after Calendar Year Calendar Year Calendar Year Deductible per Hearing Aid or Cochlear Implant, related services and Amount after Calendar Year Deductible per Hearing Aid Out-of-Network Services 100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount			No coverage for	
Hearing Aids for Adults (1 per ear every 3 years) Hearing Aid or Cochlear Implant, related services and Calendar Year Deductible Amount after Calendar Year Deductible per Hearing Aid Services No coverage for Out-of-Network Services No coverage for Out-of-Network Services 100% of Allowed Amount	Durable Medical Equipment			Amount
Hearing Aids for Adults (1 per ear every 3 years) Hearing Aid or Cochlear Implant, related services and Deductible 100% of Allowable Amount after Calendar Year Deductible per Hearing Aid	Barabie Medical Equipment			
Hearing Aids for Adults (1 per ear every 3 years) Amount after Calendar Year Deductible per Hearing Aid Amount after Out-of-Network Services Hearing Aid 100% of Allowed Amount				
Hearing Aids for Adults (1 per ear every 3 years) Calendar Year Deductible per Hearing Aid Hearing Aid or Cochlear Implant, related services and Calendar Year Out-of-Network Services Hearing Aid Out-of-Network Services Amount		100% of Allowable		100% of Allowed
ear every 3 years) Deductible per Hearing Aid Hearing Aid or Cochlear Implant, related services and Calendar Year Dut-of-Network Services Hearing Aid 100% of Allowed Amount	Hearing Aids for Adults (1 per	Amount after	No coverage for	Amount
Hearing Aid or Cochlear Implant, related services and Implant, related services and Implant, related services and Implant, related services and Implant Implan	` .	Calendar Year	Out-of-Network	
Hearing Aid or Cochlear 100% of Allowed Implant, related services and Amount	ear every 5 years)	Deductible per	Services	
Implant, related services and Amount		Hearing Aid		
·	Hearing Aid or Cochlear			100% of Allowed
supplies, if medically 100% of Allowable	Implant, related services and			Amount
	I	100% of Allowable		
necessary for all covered Amount after No coverage for		Amount after	No coverage for	
individuals including Calendar Vear NO coverage for		Calendar Year	•	
individuals who are 18 years Deductible per Out-of-Network	_	Deductible per		
of age or younger. Please Hearing Aid or Services	=	-	Services	
contact Sendero Customer Cochlear Implant		•		
Service Department at 1-844-		.1		
800-4693 to obtain the cost	ı ·			

of hearing aid or cochlear implant.			
Imaging (CT/PET scans, MRIs)	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Preventative Care/Screening/Immunization	100% of Allowed Amount	No coverage for Out-of-Network Services	100% of Allowed Amount
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.	100% of Allowed Amount	No coverage for Out-of-Network Services	100% of Allowed Amount
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	100% of Allowed Amount	No coverage for Out-of-Network Services	100% of Allowed Amount
Bone Mass measurement for the detection of low bone mass to determine risk of osteoporosis and fractures associated with osteoporosis for qualified individuals	100% of Allowed Amount	No coverage for Out-of-Network Services	100% of Allowed Amount
Routine annual prostate cancer detection exam, including a Prostate Specific Antigen test (PSA) for a male Covered Person age 40 or older.	100% of Allowed Amount	No coverage for Out-of-Network Services	100% of Allowed Amount
Routine Foot Care	100% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Routine Eye Exam for Children (1 per year)	100% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount

	· · · · · · · · · · · · · · · · · · ·		
Eye Glasses for Children (1 set of frames with lenses or contact lenses per year)	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Dental Check-Up for Children	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Rehabilitative Speech Therapy	100% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Rehabilitative Occupational and Rehabilitative Physical Therapy	100% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Well Baby Visits and Care	100% of Allowable Amount	No coverage for Out-of-Network Services	100% of Allowed Amount
Laboratory Outpatient and Professional Services	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
The administration of whole blood including cost of blood, blood plasma, and blood plasma expanders are covered services	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
X-rays and Diagnostic Imaging	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Basic Dental-Children	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Orthodontia-Children	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Major Dental Care- Children	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Transplant	20% of Allowable Amount	No coverage for Out-of-Network Services	100% of Allowed Amount
Accidental Dental	100% of Allowable Amount after	No coverage for Out-of-Network Services	100% of Allowed Amount

	Calendar Year		
	Deductible		
	+		1000/ of Allowed
	100% of Allowable	No coverage for	100% of Allowed
Dialysis	Amount after	Out-of-Network	Amount
	Calendar Year	Services	
	Deductible		(000/ 6011
	100% of Allowable	No coverage for	100% of Allowed
Allergy Testing	Amount after	Out-of-Network	Amount
,e.g, . eeg	Calendar Year	Services	
	Deductible		
	100% of Allowable	No coverage for	100% of Allowed
Chemotherapy	Amount after	Out-of-Network	Amount
Chemotherapy	Calendar Year	Services	
	Deductible	OCI VICES	
	100% of Allowable	No soveress for	100% of Allowed
Dediction	Amount after	No coverage for Out-of-Network	Amount
Radiation	Calendar Year		
	Deductible	Services	
	100% of Allowable	No	100% of Allowed
D. I (E.I (.	Amount after	No coverage for	Amount
Diabetes Education	Calendar Year	Out-of-Network	
	Deductible	Services	
	100% of Allowable		100% of Allowed
	Amount after	No coverage for	Amount
Prosthetic Devices	Calendar Year	Out-of-Network	7 11110 01111
	Deductible	Services	
	100% of Allowable		100% of Allowed
	Amount after	No coverage for	Amount
Infusion Therapy	Calendar Year	Out-of-Network	7 1110 0111
	Deductible	Services	
	100% of Allowable		100% of Allowed
Treatment for	Amount after	No coverage for	Amount
Temporomandibular Joint	Calendar Year	Out-of-Network	Amount
Disorders	Deductible	Services	
	100% of Allowed	No coverage for	100% of Allowed
Nutritional Counceling	Amount after a \$5.00	No coverage for Out-of-Network	Amount
Nutritional Counseling	· ·		AIIIOUIIL
	Copayment per Visit	Services	1000/ of Allows d
December of the Comment	20% of Allowable	No coverage for	100% of Allowed
Reconstructive Surgery	Amount	Out-of-Network	Amount
	1000/ -f All	Services	1000/ -f All
Mammagraphy	100% of Allowed	Na assas C	100% of Allowed
	Amount after a	No coverage for	Amount
Mammography	\$250.00 Copayment	Out-of-Network	
	after Calendar Year	Services	
	Deductible		12201
Cardiovascular Disease	100% of Allowable	No coverage for	100% of Allowed
	Amount after	Out-of-Network	Amount
	Calendar Year	Services	
	Deductible	OCI VIOGO	

Osteoporosis	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Diabetes Care Management	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Inherited Metabolic Disorder (PKU)	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Post-Mastectomy Care	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Brain Injury	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Transplant Donor Coverage	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Autism Spectrum Disorders	100% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount

^{*}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.