



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.mending.com](http://www.mending.com) or call us at 1-877-522-5151. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-855-756-4448 to request a copy.

| Important Questions                                                             | Answers                                                                                                                            | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$4,000/Individual or \$8,000/family                                                                                               | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                            |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. Primary Care, Specialist visits, Urgent Care, Mental Health Visit, Hab/Rehab, Chiro, Preventive Care, Tier 1 and Tier 2 Drugs | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$8,500/Individual or \$17,000/family                                                                                              | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance billing</a> and health care this <a href="#">plan</a> doesn't cover.                | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.mending.com">www.mending.com</a> or call 1-877-522-5151 for a list of network providers.              | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.                                                                                                                                | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event                                                                                                                                                                    | Services You May Need                            | What You Will Pay                                          |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                         |                                                  | Network Provider<br>(You will pay the least)               | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                              |
| If you visit a health care <b>provider's</b> office or clinic                                                                                                                           | Primary care visit to treat an injury or illness | \$40 <b>copay</b> /visit; <b>Deductible</b> does not apply | Not covered                                        | First PCP visit covered in full                                                                                                                                                                                              |
|                                                                                                                                                                                         | <b>Specialist</b> visit                          | \$60 <b>copay</b> /visit; <b>Deductible</b> does not apply | Not covered                                        | None                                                                                                                                                                                                                         |
|                                                                                                                                                                                         | <b>Preventive care/screening</b> /immunization   | No Charge; <b>Deductible</b> does not apply                | Not covered                                        | You may have to pay for services that aren't preventive. Ask your <b>provider</b> if the services needed are preventive. Then check what your <b>plan</b> will pay for                                                       |
| If you have a test                                                                                                                                                                      | <b>Diagnostic test</b> (x-ray, blood work)       | 30% coinsurance subject to <b>deductible</b>               | Not covered                                        | <b>Cost sharing</b> driven by provider/setting                                                                                                                                                                               |
|                                                                                                                                                                                         | Imaging (CT/PET scans, MRIs)                     | 30% coinsurance subject to <b>deductible</b>               | Not covered                                        | <b>Preauthorization</b> may be required                                                                                                                                                                                      |
| If you need drugs to treat your illness or condition<br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.mending.com/">www.mending.com/</a> | Generic drugs                                    | \$25 <b>copay</b> ; <b>Deductible</b> does not apply       | Not covered                                        | Retail is limited to a 30-day supply. Mail Order is limited to a 90-day supply and is subject to 3x the retail <b>cost sharing</b> amount. Narcotics are limited to a 30-day supply.                                         |
|                                                                                                                                                                                         | Preferred brand drugs                            | \$50 <b>copay</b> ; <b>Deductible</b> does not apply       | Not covered                                        |                                                                                                                                                                                                                              |
|                                                                                                                                                                                         | Non-preferred brand drugs                        | \$100 <b>copay</b> subject to <b>deductible</b>            | Not covered                                        | Your cost for covered insulin drugs will not exceed \$35 per 30-day supply or \$105 per 90-day supply. <b>Preauthorization</b> /step therapy may be required. If you don't get <b>preauthorization</b> payment may be denied |
|                                                                                                                                                                                         | <b>Specialty drugs</b>                           | \$250 <b>copay</b> subject to <b>deductible</b>            | Not covered                                        | Limited to a 30-day supply. <b>Preauthorization</b> /step therapy may be required. If you don't get <b>preauthorization</b> payment may be denied                                                                            |
| If you have outpatient surgery                                                                                                                                                          | Facility fee (e.g., ambulatory surgery center)   | 30% coinsurance subject to <b>deductible</b>               | Not covered                                        | <b>Preauthorization</b> may be required                                                                                                                                                                                      |
|                                                                                                                                                                                         | Physician/surgeon fees                           | 30% coinsurance                                            | Not covered                                        | <b>Preauthorization</b> may be required                                                                                                                                                                                      |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.mending.com](http://www.mending.com).

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                          |                                                            | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                           |
|---------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Network Provider<br>(You will pay the least)               | Out-of-Network Provider<br>(You will pay the most)         |                                                                                                                                                                                                                                                                                  |
|                                                                           |                                                  | subject to <u>deductible</u>                               |                                                            |                                                                                                                                                                                                                                                                                  |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 30% coinsurance subject to <u>deductible</u>               | 30% coinsurance subject to <u>deductible</u>               | <u>Out-of-Network</u> Emergency Room services are covered if the services are for an emergency condition                                                                                                                                                                         |
|                                                                           | <a href="#">Emergency medical transportation</a> | 30% coinsurance subject to <u>deductible</u>               | 30% coinsurance subject to <u>deductible</u>               | Emergency Transportation services by an <u>Out-of-Network</u> provider are covered if the services are for an emergency condition                                                                                                                                                |
|                                                                           | <a href="#">Urgent care</a>                      | \$40 <u>copay</u> /visit; <u>Deductible</u> does not apply | \$40 <u>copay</u> /visit; <u>Deductible</u> does not apply | When temporarily out of the service area, <u>Out-of-Network Urgent Care</u> services are covered. <u>Cost sharing</u> is driven by provider/setting                                                                                                                              |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 30% coinsurance subject to <u>deductible</u>               | Not covered                                                | <u>Preauthorization</u> is required                                                                                                                                                                                                                                              |
|                                                                           | Physician/surgeon fees                           | 30% coinsurance subject to <u>deductible</u>               | Not covered                                                | <u>Preauthorization</u> is required                                                                                                                                                                                                                                              |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$40 <u>copay</u> /visit; <u>Deductible</u> does not apply | Not covered                                                | First Mental Health visit covered in full. <u>Preauthorization</u> may be required for outpatient non-office services.                                                                                                                                                           |
|                                                                           | Inpatient services                               | 30% coinsurance subject to <u>deductible</u>               | Not covered                                                | <u>Preauthorization</u> is required                                                                                                                                                                                                                                              |
| If you are pregnant                                                       | Office visits                                    | \$60 <u>copay</u> /visit; <u>Deductible</u> does not apply | Not covered                                                | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound) |
|                                                                           | Childbirth/delivery professional services        | 30% coinsurance subject to <u>deductible</u>               | Not covered                                                |                                                                                                                                                                                                                                                                                  |
|                                                                           | Childbirth/delivery facility services            | 30% coinsurance subject to <u>deductible</u>               | Not covered                                                |                                                                                                                                                                                                                                                                                  |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | 30% coinsurance subject to <u>deductible</u>               | Not covered                                                | <u>Preauthorization</u> is required                                                                                                                                                                                                                                              |
|                                                                           | <a href="#">Rehabilitation services</a>          | \$40 <u>copay</u> /visit; <u>Deductible</u> does not apply | Not covered                                                | <u>Rehab/Hab</u> covered with shared limits for physical therapy, occupational therapy, and speech therapy. 60 visits combined per calendar year. <u>Cost sharing</u> is driven by                                                                                               |
|                                                                           | <a href="#">Habilitation services</a>            | \$40 <u>copay</u> /visit;                                  | Not covered                                                |                                                                                                                                                                                                                                                                                  |

| Common Medical Event                   | Services You May Need                     | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                     |
|----------------------------------------|-------------------------------------------|----------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                                           | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                            |
|                                        |                                           | <u>Deductible</u> does not apply             |                                                    | provider/setting. Visit limits do not apply to the treatment of Autism Spectrum Disorder                                                                                                   |
|                                        | <a href="#">Skilled nursing care</a>      | 30% coinsurance subject to <u>deductible</u> | Not covered                                        | 150 Days per Benefit Period. <u>Preauthorization</u> is required                                                                                                                           |
|                                        | <a href="#">Durable medical equipment</a> | 30% coinsurance subject to <u>deductible</u> | Not covered                                        | <u>Cost-sharing</u> for prosthetic devices to replace arms and legs, in whole or in part, is 20% <u>coinsurance</u> subject to <u>deductible</u> . <u>Preauthorization</u> may be required |
|                                        | <a href="#">Hospice services</a>          | 30% coinsurance subject to <u>deductible</u> | Not covered                                        | Respite care covered for up to a 48-hour period. <u>Preauthorization</u> is required                                                                                                       |
| If your child needs dental or eye care | Children's eye exam                       | No charge; <u>Deductible</u> does not apply  | Not covered                                        | Limited to one exam per Year                                                                                                                                                               |
|                                        | Children's glasses                        | No charge; <u>Deductible</u> does not apply  | Not covered                                        | Child frames and lenses or contact lenses covered once every 24 months.                                                                                                                    |
|                                        | Children's dental check-up                | Not Covered                                  | Not covered                                        | Pediatric dental coverage can be purchased separately as a stand-alone policy                                                                                                              |

#### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                                                                                                                                                       |                                                                                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Long-Term Care</li> <li>• Routine Eye Care (Adult)</li> </ul>                                                                     | <ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Routine Foot Care</li> </ul>                       | <ul style="list-style-type: none"> <li>• Dental Care (Adult)</li> <li>• Private Duty Nursing</li> <li>• Weight Loss Programs</li> </ul> |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                      |                                                                                                                                                                                       |                                                                                                                                         |
| <ul style="list-style-type: none"> <li>• Abortion</li> <li>• Hearing Aids (1 hearing aid per ear every 3 years; up to \$3,000 per ear)</li> </ul>                                                 | <ul style="list-style-type: none"> <li>• Bariatric Surgery (limited to surgery for an intestinal bypass, gastric bypass, or gastroplasty)</li> <li>• Infertility Treatment</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic Care (40 visits per Year)</li> </ul>                                              |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Maine Bureau of Insurance, Department of Professional and Financial Regulation, 34 State House Station, Augusta, ME 04333-0334, (800) 300- 5000, or contact Mending at the number on the back of your ID card. Other coverage options may be available to you too, including buying individual insurance coverage through CoverMe.gov. For more information about the CoverMe.gov, visit [www.CoverMe.gov](http://www.CoverMe.gov) or call 1-866-636-0355.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also

provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Maine Bureau of Insurance, Department of Professional and Financial Regulation, 34 State House Station, Augusta, ME 04333-0334, (800) 300-5000 Consumers for Affordable Health Care, 12 Church Street, PO Box 2490, Augusta, ME 04338-2490, (800) 965-7476, [www.maine cahc.org](http://www.maine cahc.org), [consumerhealth@maine cahc.org](mailto:consumerhealth@maine cahc.org).

**Does this plan provide Minimum Essential Coverage?** Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards?** Not Applicable

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-522-5151.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4,000 |
| ■ <a href="#">Specialist</a> <a href="#">copayment</a>          | \$60    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$4,000        |
| <a href="#">Copayments</a>        | \$90           |
| <a href="#">Coinsurance</a>       | \$1,800        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$5,950</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4,000 |
| ■ <a href="#">Specialist</a> <a href="#">copayment</a>          | \$60    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$900          |
| <a href="#">Copayments</a>        | \$1,000        |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,920</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4,000 |
| ■ <a href="#">Specialist</a> <a href="#">copayment</a>          | \$60    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,100        |
| <a href="#">Copayments</a>        | \$400          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,500</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.