



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 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/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$2,500/Individual or \$5,000/family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Primary Care, Specialist visits, Urgent Care, Mental Health Visit, Hab/Rehab, Chiro, Preventive Care, Rx Drugs	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$5,000/Individual or \$10,000/family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance billing</u> and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.mending.com or call 1-877-522-5151 for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay /visit; Deductible does not apply	Not covered	First PCP visit covered in full
	Specialist visit	\$50 copay /visit; Deductible does not apply	Not covered	None
	Preventive care/screening /immunization	No Charge; Deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance subject to deductible	Not covered	Cost sharing driven by provider/setting
	Imaging (CT/PET scans, MRIs)	30% coinsurance subject to deductible	Not covered	Preauthorization may be required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.mending.com/	Generic drugs	\$25 copay ; Deductible 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 cost sharing amount. Narcotics are limited to a 30-day supply. Your cost for covered insulin drugs will not exceed \$35 per 30-day supply or \$105 per 90-day supply. Preauthorization /step therapy may be required. If you don't get preauthorization payment may be denied
	Preferred brand drugs	\$50 copay ; Deductible does not apply	Not covered	
	Non-preferred brand drugs	30% coinsurance up to \$300; Deductible does not apply	Not covered	Limited to a 30-day supply. Preauthorization /step therapy may be required. If you don't get preauthorization payment may be denied
	Specialty drugs	50% coinsurance up to \$300; Deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance subject to deductible	Not covered	Preauthorization may be required
	Physician/surgeon fees	30% coinsurance subject to deductible	Not covered	Preauthorization may be required

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	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
	Emergency medical transportation	30% coinsurance subject to <u>deductible</u>	30% coinsurance subject to <u>deductible</u>	Emergency Transportation services by an <u>Out-of-Network provider</u> are covered if the services are for an emergency condition
	Urgent care	\$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	\$20 <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	\$50 <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	Home health care	30% coinsurance subject to <u>deductible</u>	Not covered	<u>Preauthorization</u> is required
	Rehabilitation services	\$30 <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 provider/setting. Visit limits do not apply to
	Habilitation services	\$30 <u>copay</u> /visit; <u>Deductible</u> does not	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		apply		the treatment of Autism Spectrum Disorder
	Skilled nursing care	30% coinsurance subject to <u>deductible</u>	Not covered	150 Days per Benefit Period. <u>Preauthorization</u> is required
	Durable medical equipment	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% coinsurance after <u>deductible</u> . <u>Preauthorization</u> may be required
	Hospice services	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
• Acupuncture • Long-Term Care • Routine Eye Care (Adult)	• Cosmetic Surgery • Non-emergency care when traveling outside the U.S. • Routine Foot Care	• Dental Care (Adult) • Private Duty Nursing • Weight Loss Programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion • Hearing Aids (1 hearing aid per ear every 3 years; up to \$3,000 per ear)	• Bariatric Surgery (limited to surgery for an intestinal bypass, gastric bypass, or gastroplasty) • Infertility Treatment	• Chiropractic Care (40 visits per Year)

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 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, 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.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 plan's overall deductible	\$2,500
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	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*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing

Deductibles	\$2,500
Copayments	\$60
Coinsurance	\$2,200

What isn't covered

Limits or exclusions	\$60
----------------------	------

The total Peg would pay is	\$4,820
-----------------------------------	----------------

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$2,500
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	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*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing

Deductibles	\$900
Copayments	\$800
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$20
----------------------	------

The total Joe would pay is	\$1,720
-----------------------------------	----------------

Mia's Simple Fracture

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

■ The plan's overall deductible	\$2,500
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	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*)

Total Example Cost	\$2,800
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing

Deductibles	\$2,100
Copayments	\$300
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$0
----------------------	-----

The total Mia would pay is	\$2,400
-----------------------------------	----------------

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