Schedule of Benefits

Mending Health • Clear Choice Bronze 7500 (No Direct Primary Care/DPC) • Maine
54879ME0010007-01

Overview

The Schedule of Benefits (SOB) is a summary of benefit limits and Cost-Sharing amounts You must pay for certain Covered Benefits. However, it is intended to help you compare covered benefits and is a summary only. Please see Your Evidence of Coverage or reach out to customer service at 1-877-522-5151 for additional coverage details.

This is a HMO network Plan where it is highly encouraged to establish a relationship with a singular, traditional Primary Care Provider (PCP). As a reminder, Direct Primary Care providers (DPCs) are not covered under this policy. You have access to both the "Mending Health Maine MP Network". This Network includes providers and facilities throughout the states of Maine and New Hampshire. However, there are hospitals, health care facilities, physicians or other health care providers that are not included in this Plan's Network. All services and supplies must be provided by a Mending Network Provider, unless:

- The services are for Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center; or
- Are authorized by Mending.

Prior Authorization

Coverage for certain benefits requires Prior Authorization. If you do not receive Prior Authorization when required, payment for care may be denied. To verify Prior Authorization requirements, call Customer Service at 1-877-522-5151, or refer to the Prior Authorization List at mendinghealth.com.

Plan Year 2026	
In-Network Deductible	$7,500 Individual $15,000 Family
In-Network Maximum Out of Pocket	$10,000 Individual $20,000 Family

Medical Benefits

Service	In-Network Cost-Share	Limits/Explanations
Primary Care Office Visit	$45 Copay not subject to deductible	First visit covered in full
Specialist Office Visit	$80 Copay not subject to deductible	
Preventive Care Visits Including, but not limited to, Routine Annual Physical Exam, Immunizations, Well-Baby Care, Well-Child Care, Cancer Screening Mammography, Prostate Cancer Screening Exam, Colorectal Cancer Screening Exam, Ovarian and Cervical Cancer Screening Exam, Prenatal Visits	Covered in full	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.
Allergy Testing, Serum, and Injections	$80 Copay not subject to deductible	The benefit also includes injections. Cost-Share driven by provider / setting
Routine Labs and Diagnostic Testing	50% coinsurance subject to deductible	
Diagnostic Imaging Includes X-rays, Ultrasound, Echo	50% coinsurance subject to deductible	Cost-Share driven by provider / setting
Advanced Imaging and Radiology Includes CT Scans, MRI, PET Scans	50% coinsurance subject to deductible	Preauthorization may be required
Chiropractic Care	$45 Copay not subject to deductible	Limited to 40 Visits per Year, combined with Manipulative Therapy. Cost-Share is driven by provider/setting
Outpatient Procedure (Including Facility charges)	50% coinsurance subject to deductible	Preauthorization may be required
Outpatient Physician Services	50% coinsurance subject to deductible	Preauthorization may be required
Emergency Care	50% coinsurance subject to deductible	Non-Network Emergency Room and Ambulance services are covered at the Network Cost-Sharing amount if the services are for an emergency condition as defined in your Plan
Ambulance Transportation	50% coinsurance subject to deductible	
Urgent Care	$60 Copay not subject to deductible	When temporarily out of the State, Non-Network Urgent Care services are covered at the Network

		Cost-Sharing amount. Cost-Share is driven by provider/setting
Inpatient Care (Including Facility and Physician charges)	50% coinsurance subject to deductible	Preauthorization Required
Skilled Nursing Facility	50% coinsurance subject to deductible	Limited to 150 days per Year. Preauthorization Required
Outpatient Mental Health Care, Serious Mental Illness, and Chemical Dependency	$45 Copay not subject to deductible	First visit covered in full
Maternity Care Childbirth/Delivery Professional Services	50% coinsurance subject to deductible	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere (i.e., ultrasound)
Outpatient Rehabilitation Services Physical Therapy, Occupational Therapy, Speech Therapy	$45 Copay not subject to deductible	Rehab/Hab covered with shared limits for Physical Therapy, Occupational Therapy, and Speech Therapy. 60 visits combined per calendar year. Cost share driven by provider/setting. Visit limits do not apply to treatment of Autism Spectrum Disorder
Habilitation Services Physical Therapy, Occupational Therapy, Speech Therapy	$45 Copay not subject to deductible	
Home Health Care	50% coinsurance subject to deductible	Preauthorization required
Hospice Care	50% coinsurance subject to deductible	Members can receive benefits for Hospice Care services by a Home Health Agency covered up to 24 hours during each day of care. Respite Care covered for up to a 48-hour period
Durable Medical Equipment (DME)	50% coinsurance subject to deductible	Preauthorization may be required
Diabetes Management Diabetes Self-Management Training, Diabetes Education, Diabetes Care Management	Covered in full	
Diabetes Equipment and Supplies	50% coinsurance subject to deductible	
Hearing Aids and Cochlear Implants	50% coinsurance subject to deductible	Limited to $3,000 per hearing aid for each hearing-impaired ear every 36 months

Pediatric Vision	Covered in full	Covered up to age 19 for 1 Exam per Year and 1 prescribed frames and lenses or contact lenses covered once every 24 months
Fertility Treatment Diagnostic Care, Preservation Services, Treatment	50% coinsurance subject to deductible	IVF, GIFT, ZIFT and FET limited to two lifetime cycles. Storage of reproductive material covered from time of cryopreservation for up to 5 years. Preauthorization may be required
All Other Covered Medical Benefits (Not specified herein)	50% coinsurance subject to deductible	Preauthorization may be required

Pharmacy Benefits

	In-Network Cost-Share	Limits/Explanations
Retail Pharmacy (30 Day Supply)		
Tier 1 Generic Drugs	$30 copay not subject to deductible	90-day supply for Maintenance Drugs and Mail Order is subject to 3x retail Cost-Sharing amount. Narcotics are limited to a 30-day supply. Your cost for a covered insulin drug will not exceed $35 per 30-day supply for $105 per 90-day supply. Preauthorization/step therapy may be required
Tier 2 Preferred Brand Name Drugs	$50 copay subject to deductible	
Tier 3 Non-Preferred Drugs	$100 copay subject to deductible	
Tier 4 Specialty Pharmacy Drugs and Oral Anticancer Medications	$250 copay subject to deductible	No 90-day supply available for Maintenance Drugs or Mail Order. Preauthorization may be required

Eligible American Indians are exempt from Cost-Sharing requirements when Covered Services are rendered by an Indian Health Service, Indian Tribe, Tribal Organization or Urban Indian Organization, or through Referral under contract health services.

You may contact the Maine Bureau of Insurance to obtain information on companies, coverage, rights or complaints at 1-800-300-5000 or https://www.maine.gov/pfr/insurance/home. You may write the Maine Bureau of Insurance at: 34 State House Station, Augusta, Maine 04333.