



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 deductible ?	\$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or \$7,500 Individual or \$15,000 family	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes. Primary Care, Specialist visit, Urgent Care, Mental health visit, Hab/Rehab, Chiro, Tier 1 Drugs	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$10,000 Individual or \$20,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance billing and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.mending.com or call 1-877-522-5151 for a list of network providers.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use a non-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use a non-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



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
		IHCP (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Non-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	No Charge	\$50 copay; <u>Deductible</u> does not apply	Not covered	<u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>
	<u>Specialist</u> visit	No Charge	\$100 copay; <u>Deductible</u> does not apply	Not covered	<u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>
	<u>Preventive care/screening/immunization</u>	No Charge	No Charge; <u>Deductible</u> does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	50% coinsurance after <u>deductible</u>	Not covered	<u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>
	Imaging (CT/PET scans, MRIs)	No Charge	50% coinsurance after <u>deductible</u>	Not covered	<u>Preauthorization</u> may be required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://formulary.mending.com/oklahoma	Generic drugs	No Charge	\$25 copay; <u>Deductible</u> does not apply	Not covered	Up to 30-day supply Retail and up to 90-day supply Retail & Mail Order, except narcotics and Specialty Drugs. Insulin will not exceed \$30 for a 30-day supply and \$90 for a 90-day supply. <u>Preauthorization/step therapy</u> may be required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>
	Preferred brand drugs	No Charge	\$50 copay after <u>deductible</u>	Not covered	
	Non-preferred brand drugs	No Charge	\$100 copay after <u>deductible</u>	Not covered	
	<u>Specialty drugs</u>	No Charge	\$500 copay after <u>deductible</u>	Not covered	Up to 30-day supply Retail only. <u>Preauthorization/step therapy</u> may be required. If you don't get <u>preauthorization</u> payment may be denied. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>
If you have	Facility fee (e.g., ambulatory surgery)	No Charge	50% coinsurance after	Not covered	<u>Preauthorization</u> may be required. <u>Cost sharing</u> waived at non-IHCP with IHCP

* 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
		IHCP (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Non-Network Provider (You will pay the most)	
outpatient surgery	center)		<u>deductible</u>		<u>referral</u>
	Physician/surgeon fees	No Charge	50% coinsurance after <u>deductible</u>	Not covered	<u>Preauthorization</u> may be required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>
If you need immediate medical attention	Emergency room care	No Charge	50% coinsurance after <u>deductible</u>	40% coinsurance after <u>deductible</u>	<u>Non-Network</u> Emergency Room services are covered if the services are for an emergency condition. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>
	Emergency medical transportation	No Charge	50% coinsurance after <u>deductible</u>	40% coinsurance after <u>deductible</u>	Emergency Transportation services by a <u>Non-Network provider</u> are covered if the services are for an emergency condition. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>
	Urgent care	No Charge	\$75 copay/visit; <u>Deductible</u> does not apply	\$60 copay/ visit; <u>Deductible</u> does not apply	When temporarily out of the Service Area, <u>Non-Network Urgent Care</u> services are covered. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	50% coinsurance after <u>deductible</u>	Not covered	<u>Preauthorization</u> is required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>
	Physician/surgeon fees	No Charge	50% coinsurance after <u>deductible</u>	Not covered	<u>Preauthorization</u> is required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	\$50 copay; <u>Deductible</u> does not apply	Not covered	<u>Preauthorization</u> may be required for outpatient non-office services. Outpatient Mental Health Office Visit <u>cost sharing</u> applies for services to treat Autism. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>
	Inpatient services	No Charge	50% coinsurance after <u>deductible</u>	Not covered	<u>Preauthorization</u> is required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>
If you are pregnant	Office visits	No Charge	\$100 copay; <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

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		IHCP (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Non-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	No Charge	50% coinsurance after <u>deductible</u>	Not covered	<u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>
	Childbirth/delivery facility services	No Charge	50% coinsurance after <u>deductible</u>	Not covered	
If you need help recovering or have other special health needs	Home health care	No Charge	50% coinsurance after <u>deductible</u>	Not covered	30 Visits per Benefit Period. Limit does not apply to Private Duty Nursing; Private Duty Nursing is limited to 85 visits per Benefit Period. <u>Preauthorization</u> is required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>
	Rehabilitation services	No Charge	\$50 copay; <u>Deductible</u> does not apply	Not covered	Limited to 25 Visits per Benefit Period, combined. Visit limits do not apply to the treatment of Autism Spectrum Disorder. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>
	Habilitation services	No Charge	\$50 copay; <u>Deductible</u> does not apply	Not covered	
	Skilled nursing care	No Charge	50% coinsurance after <u>deductible</u>	Not covered	30 Days per Benefit Period. <u>Preauthorization</u> is required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>
	Durable medical equipment	No Charge	50% coinsurance after <u>deductible</u>	Not covered	<u>Preauthorization</u> may be required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>
	Hospice services	No Charge	50% coinsurance after <u>deductible</u>	Not covered	<u>Preauthorization</u> is required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>
If your child needs dental or eye care	Children's eye exam	No Charge	No charge; <u>Deductible</u> does not apply	Not covered	Limited to one exam every 12 months from last date of service. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>
	Children's glasses	No Charge	No charge; <u>Deductible</u> does not apply	Not covered	Limited to one prescribed lenses and frames per Benefit Period. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>
	Children's dental check-up	Not Covered	Not Covered	Not covered	<u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>

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

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 • Bariatric Surgery • Cosmetic Surgery	• Dental Care (Adult) • Infertility Treatment • Long-Term Care • Non-emergency care when traveling outside the U.S.	• Routine Eye Care (Adult) • Routine Foot Care • Weight Loss Programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion (to save the life of the pregnant woman) • Chiropractic Care (subject to hab/rehab limits)	• Hearing Aids (1 hearing aid per ear every 48 months)	• Private Duty Nursing (85 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: Oklahoma Insurance Department, 400 NE 50th Street, Oklahoma City, OK 73105 at 800-522-0071 or <https://www.oid.ok.gov>, 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 the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318- 2596.

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: <https://www.oid.ok.gov>.

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 plan's overall deductible	\$7,500
■ Specialist copayment	\$100
■ Hospital (facility) coinsurance	50%
■ Other coinsurance	50%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$7,500
Copayments	\$0
Coinsurance	\$1,700
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$9,200

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$7,500
■ Specialist copayment	\$100
■ Hospital (facility) coinsurance	50%
■ Other coinsurance	50%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$900
Copayments	\$1,100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,020

Mia's Simple Fracture

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

■ The plan's overall deductible	\$7,500
■ Specialist copayment	\$100
■ Hospital (facility) coinsurance	50%
■ Other coinsurance	50%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,100
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,600

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