



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> ?                                | \$2,300/Individual or \$4,600/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, Tier 2 and Tier 3 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> ? | \$10,150/Individual or \$20,300/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 <a href="#">provider's office or clinic</a>                                                                                                                           | Primary care visit to treat an injury or illness       | No Charge; <a href="#">Deductible</a> does not apply                               | Not covered                                        | None                                                                                                                                                                                                                                           |
|                                                                                                                                                                                                  | <a href="#">Specialist</a> visit                       | Up to \$75 <a href="#">copay</a> /visit; <a href="#">Deductible</a> does not apply | Not covered                                        | None                                                                                                                                                                                                                                           |
|                                                                                                                                                                                                  | <a href="#">Preventive care/screening/immunization</a> | No Charge; <a href="#">Deductible</a> does not apply                               | Not covered                                        | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for                                                       |
| If you have a test                                                                                                                                                                               | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 50% coinsurance subject to <a href="#">deductible</a>                              | Not covered                                        | <a href="#">Cost sharing</a> driven by provider/setting                                                                                                                                                                                        |
|                                                                                                                                                                                                  | Imaging (CT/PET scans, MRIs)                           | 50% coinsurance subject to <a href="#">deductible</a>                              | Not covered                                        | <a href="#">Preauthorization</a> may be required                                                                                                                                                                                               |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.mending.com/">www.mending.com/</a> | Generic drugs                                          | \$25 <a href="#">copay</a> ; <a href="#">Deductible</a> 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 <a href="#">cost sharing</a> amount. Narcotics are limited to a 30-day supply.                                                  |
|                                                                                                                                                                                                  | Preferred brand drugs                                  | \$75 <a href="#">copay</a> ; <a href="#">Deductible</a> does not apply             | Not covered                                        |                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                  | Non-preferred brand drugs                              | \$100 <a href="#">copay</a> ; <a href="#">Deductible</a> does not apply            | Not covered                                        | Your cost for covered insulin drugs will not exceed \$35 per 30-day supply or \$105 per 90-day supply. <a href="#">Preauthorization</a> /step therapy may be required. If you don't get <a href="#">preauthorization</a> payment may be denied |
|                                                                                                                                                                                                  | <a href="#">Specialty drugs</a>                        | 50% coinsurance subject to <a href="#">deductible</a>                              | Not covered                                        | Limited to a 30-day supply. <a href="#">Preauthorization</a> /step therapy may be required. If you don't get <a href="#">preauthorization</a> payment may be denied                                                                            |
| If you have outpatient surgery                                                                                                                                                                   | Facility fee (e.g., ambulatory surgery center)         | 50% coinsurance subject to <a href="#">deductible</a>                              | Not covered                                        | <a href="#">Preauthorization</a> may be required                                                                                                                                                                                               |
|                                                                                                                                                                                                  | Physician/surgeon fees                                 | 50% coinsurance subject to <a href="#">deductible</a>                              | Not covered                                        | <a href="#">Preauthorization</a> 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)          |                                                                                                                                                                                                                                                                                  |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 50% coinsurance subject to <u>deductible</u>                     | 50% 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> | 50% coinsurance subject to <u>deductible</u>                     | 50% 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                                                                                                                                                |
|                                                                           | <a href="#">Urgent care</a>                      | \$100 <u>copay</u> /visit; <u>Deductible</u> does not apply      | \$100 <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)               | 50% coinsurance subject to <u>deductible</u>                     | Not covered                                                 | <u>Preauthorization</u> is required                                                                                                                                                                                                                                              |
|                                                                           | Physician/surgeon fees                           | 50% 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                              | No charge; <u>Deductible</u> does not apply                      | Not covered                                                 | <u>Preauthorization</u> may be required for outpatient non-office services.                                                                                                                                                                                                      |
|                                                                           | Inpatient services                               | 50% coinsurance subject to <u>deductible</u>                     | Not covered                                                 | <u>Preauthorization</u> is required                                                                                                                                                                                                                                              |
| If you are pregnant                                                       | Office visits                                    | Up to \$75 <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        | 50% coinsurance subject to <u>deductible</u>                     | Not covered                                                 |                                                                                                                                                                                                                                                                                  |
|                                                                           | Childbirth/delivery facility services            | 50% 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>                 | 50% coinsurance subject to <u>deductible</u>                     | Not covered                                                 | <u>Preauthorization</u> is required                                                                                                                                                                                                                                              |
|                                                                           | <a href="#">Rehabilitation services</a>          | \$50 <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 the treatment of Autism Spectrum Disorder      |
|                                                                           | <a href="#">Habilitation services</a>            | \$50 <u>copay</u> /visit; <u>Deductible</u> does not apply       | 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) |                                                                                                                                                                                |
|                                        | <a href="#">Skilled nursing care</a>      | 50% coinsurance subject to <u>deductible</u> | Not covered                                        | 150 Days per Benefit Period. <u>Preauthorization</u> is required                                                                                                               |
|                                        | <a href="#">Durable medical equipment</a> | 50% 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 |
|                                        | <a href="#">Hospice services</a>          | 50% 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>Bariatric Surgery</li> <li>Cosmetic Surgery</li> </ul>                                                                                | <ul style="list-style-type: none"> <li>Dental Care (Adult)</li> <li>Infertility Treatment</li> <li>Long-Term Care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>Routine Eye Care (Adult)</li> <li>Routine Foot Care</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 (to save the life of the pregnant woman)</li> <li>Chiropractic Care (subject to hab/rehab limits)</li> </ul>                                      | <ul style="list-style-type: none"> <li>Hearing Aids (1 hearing aid per ear every 48 months)</li> </ul>                                                                                   | <ul style="list-style-type: none"> <li>Private Duty Nursing (85 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: Oklahoma Insurance Department, 400 NE 50th Street, Oklahoma City, OK 73105 at 800-522-0071 or <https://www.oid.ok.gov>, or contact Mending Taro 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](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$2,300 |
| ■ <a href="#">Specialist</a> <a href="#">copayment</a>          | \$75    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 50%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

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

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,300        |
| <a href="#">Copayments</a>        | \$90           |
| <a href="#">Coinsurance</a>       | \$3,800        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$6,250</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> | \$2,300 |
| ■ <a href="#">Specialist</a> <a href="#">copayment</a>          | \$75    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 50%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <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>        | \$700          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,620</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> | \$2,300 |
| ■ <a href="#">Specialist</a> <a href="#">copayment</a>          | \$75    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 50%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <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.