Mending Standard Silver 4000 HSA Plan
(No Direct Primary Care, For DPC select Mending Direct Primary Care Silver)

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?	$4,000 Individual or $8,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventative Care	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?	$7,000 Individual or $14,000 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
		Network Provider (You will pay the least)	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	20% coinsurance after deductible	Not covered	None
	Specialist visit	20% coinsurance after deductible	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)	20% coinsurance after deductible	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after 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 https://formulary.mending.com/oklahoma	Generic drugs	$25 copay after deductible	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. Preauthorization/ step therapy may be required
	Preferred brand drugs	$50 copay after deductible	Not covered	
	Non-preferred brand drugs	$100 copay after deductible	Not covered	
	Specialty drugs	$250 copay after deductible	Not covered	Up to 30-day supply Retail only. Preauthorization/step therapy may be required. If you don't get preauthorization payment may be denied
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Not covered	Preauthorization may be required
	Physician/surgeon fees	20% coinsurance after deductible	Not covered	Preauthorization may be required
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	20% coinsurance after deductible	Non-Network Emergency Room services are covered if the services are for an emergency condition

* 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)	Non-Network Provider (You will pay the most)	
	Emergency medical transportation	40% coinsurance after deductible	20% coinsurance after deductible	Emergency Transportation services by a Non-Network provider are covered if the services are for an emergency condition
	Urgent care	20% coinsurance after deductible	20% coinsurance after deductible	When temporarily out of the Service Area, Non-Network Urgent Care services are covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	Not covered	Preauthorization is required
	Physician/surgeon fees	20% coinsurance after deductible	Not covered	Preauthorization is required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	Not covered	Preauthorization may be required for outpatient non-office services
	Inpatient services	20% coinsurance after deductible	Not covered	Preauthorization is required
If you are pregnant	Office visits	20% coinsurance after deductible	Not covered	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 in the SBC (i.e., ultrasound)
	Childbirth/delivery professional services	20% coinsurance after deductible	Not covered	
	Childbirth/delivery facility services	20% coinsurance after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	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. Preauthorization is required
	Rehabilitation services	20% coinsurance after deductible	Not covered	Limited to 30 Visits per Benefit Period, combined. Visit limits do not apply to the treatment of Autism Spectrum Disorder
	Habilitation services	20% coinsurance after deductible	Not covered	
	Skilled nursing care	20% coinsurance after deductible	Not covered	30 Days per Benefit Period. Preauthorization is required
	Durable medical equipment	20% coinsurance after deductible	Not covered	Preauthorization may be required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Hospice services	20% coinsurance after deductible	Not covered	Preauthorization is required
If your child needs dental or eye care	Children's eye exam	No charge; Deductible does not apply	Not covered	Limited to one exam every 12 months from last date of service.
	Children's glasses	No charge; Deductible does not apply	Not covered	Limited to one prescribed lenses and frames per Benefit Period.
	Children's dental check-up	Not Covered	Not covered	None

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:

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

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	$4,000
Specialist *copayment*	20%
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

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	$4,000
Copayments	$10
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,770**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	$4,000
Specialist *copayment*	20%
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

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	$4,000
Copayments	$200
Coinsurance	$70
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,290**

Mia's Simple Fracture

(in-network emergency room visit and follow

The plan's overall deductible	$4,000
Specialist *copayment*	20%
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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