Schedule of Benefits

Mending Health • Mending Direct Primary Care Bronze 4950 ($0 DPC + $0 PCP + $0 Mental Health) • Oklahoma

58944OK0010002-01

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 Primary Care Provider, whether that be a Direct Primary Care (DPC) provider or a more traditional PCP. You have access to both the "Mending Health Oklahoma HCH Network" and the "Mending Health Oklahoma DPC Network". The DPC Network is unique to this Plan and Mending's most popular benefit. Your overall Network includes providers and facilities throughout the state of Oklahoma. However, there are hospitals, health care facilities, physicians or other health care providers that are not included in this Plan's Network. Please check Mending's Network Directory to check if a provider is In-Network with Mending in your Plan. 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.

A Note About Direct Primary Care

Mending's Network of Primary Care providers includes Direct Primary Care providers (DPCs), which is a higher access and more relationship-based model of care. DPCs typically have a small patient panel which affords much more time and flexibility for their patients, like You. Mending's DPCs provide tailored care during unrushed visits, which ultimately helps build a more trusted doctor-patient relationship. Once You select the DPC that best fits You and Your needs, You will see the same provider consistently, whether it is in-person, over video (Telemedicine), or other modes of communication like phone calls, email, or even text. There is no Member Cost-Share for any of these visits or communications – including the monthly membership fee of being part of a DPC practice. In-Network Primary Care visits are covered in full by Mending Health.

To take full advantage of this unique benefit, please reach out to our care guide team at 1-877-522-5151 and We will help you set up a relationship with one of our Direct Primary Care (DPC) providers.

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	$4,950 Individual $9,900 Family
In-Network Maximum Out of Pocket	$10,150 Individual $20,300 Family

Medical Benefits

Service	In-Network Cost-Share	Limits/Explanations
Primary Care Office Visit	Covered in full	
Specialist Office Visit	Up to $155 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	Up to $155 Copay not subject to deductible	
Routine Labs and Diagnostic Testing	50% Coinsurance subject to deductible	
Diagnostic Imaging Includes X-rays, Ultrasound, Echo	50% Coinsurance subject to deductible	
Advanced Imaging and Radiology Includes CT Scans, MRI, PET Scans	50% Coinsurance subject to deductible	Preauthorization may be required
Chiropractic Care	Up to $75 Copay not subject to deductible	30 visits per Benefit Period. Limit is combined with Speech Therapy, Occupational Therapy, Physical Therapy, and Muscle Manipulations.
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 In-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	$100 Copay not subject to	When temporarily out of the

	deductible	Service Area, Non-Network Urgent Care services are covered and the In-Network cost-sharing amount
Inpatient Care (Including Facility and Physician charges)	50% Coinsurance subject to deductible	This Inpatient Care benefit also includes mental health and substance use disorder benefits. Preauthorization Required
Skilled Nursing Facility	50% Coinsurance subject to deductible	Limited to 30 days per Plan Year. Preauthorization Required
Outpatient Mental Health Care, Serious Mental Illness, and Chemical Dependency	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	$75 Copay not subject to deductible	Limited to 30 Visits per Benefit Period, combined. Visit limits do not apply to the treatment of Autism Spectrum Disorder
Habilitation Services Physical Therapy, Occupational Therapy, Speech Therapy	$75 Copay not subject to deductible	
Home Health Care	50% Coinsurance subject to deductible	Limited to 30 visits per Plan Year. Preauthorization required
Hospice Care	50% Coinsurance subject to deductible	
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	1 hearing aid per ear every 48 months

Pediatric Vision	Covered in full	Covered up to age 19 for 1 check up and 1 prescribed lenses and frames per Benefit Period
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	$25 Copay not subject to deductible	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.
Tier 2 Preferred Brand Name Drugs	$150 Copay not subject to deductible	
Tier 3 Non-Preferred Drugs	50% Coinsurance subject to deductible	
Tier 4 Specialty Pharmacy Drugs and Oral Anticancer Medications	50% Coinsurance 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 Oklahoma Insurance Department to obtain information on companies, coverage, rights or complaints at 405-521-2828 or https://www.oid.ok.gov/. You may write the Oklahoma Insurance Department at: 400 NE 50th Street Oklahoma City, OK 73105.