Mending Direct Primary Care Silver 2300 ($0 DPC + $0 PCP + $0 Mental Health)

Note: This overview of plan benefits applies to a vast majority of members purchasing On-Exchange or Off-Exchange Silver Direct Primary Care plans. Benefits may differ in very special circumstances if you qualify for CSR, ZCS or LCS versions of this plan.

Introduction

Mending allows you to spend less and get more from your health insurance. While traditional health plans focus on helping patients when they're sick, Mending provides **extraordinary primary care** to keep you healthy, to help things go right from the start.

Offering new and innovative health insurance plans on the ACA Health Insurance Marketplace, Mending gives you more access to better care at a lower cost, including **unlimited $0 primary care** with a wide network of doctors, including Direct Primary Care (DPC) providers or a more traditional PCP.

This plan is designed to give members free and easy access to 80-90% of your everyday healthcare needs, while providing a safety net for any major medical costs. Beyond primary care, there are transparent and low Copays associated with common services including specialist visits.

What is Direct Primary Care (DPC)?

DPC is a better form of primary care where you receive all-access membership to a concierge-like, board certified doctor in your community. With this plan, you can choose to receive a free DPC membership!

Mending DPC doctors see fewer patients to ensure more time and flexibility for you. These doctors provide personalized care during unrushed visits – typically 45 minutes long – which ultimately helps you build a more trusted relationship. You can visit your DPC doctor in-person, over video (telemedicine), or call, email, and even text. If you are sick, you can get same or next day access with a doctor you know instead of visiting Urgent Care. All DPC office visits come with a $0 Copay and no Member Cost-Share.

	Mending Mending DPC Doctor	Traditional Primary Care Doctor
Cost per visit	$0	$75 - 150
Time spent with doctor	45 min	5–10 min
Time until appointment	1 day	14 days
Patients per doctor	500 patients	2500 patients
In-person office visits	Yes	Yes
Text or call your doctor	Yes	No

Plan Year 2025	
In-Network Deductible	$2,300 Individual $4,600 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	This includes Direct Primary Care or a traditional Primary Care provider With Direct Primary Care, you can receive unlimited, same or next day access, 45 minute visits, video/call/text communication all included
Specialist Office Visit	Up to $75 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 $75 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 $50 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 deductible	When temporarily out of the 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	$50 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	$50 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	Covered in full	

Diabetes Self-Management Training, Diabetes Education, Diabetes Care Management		
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	$70 Copay not subject to deductible	
Tier 3 Non-Preferred Drugs	$100 Copay not 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

Network Directory – You can search for In-Network doctors, providers, facilities, and hospitals on our website at network.mending.com

Prescription Drug Benefits Formulary – You can search for any drug in our formulary on our website at formulary.mending.com

Other Resources and Forms – You can view a full list of policy documents including the Summary of Benefits and Coverage (SBC), Schedule of Benefits (SOB), and Evidence of Coverage (EOC) at mending.com/oklahoma/members/resources