




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, contact MercyCare HMO, Inc. at 1-800-895-2421 or visit our website at [www.mercycarehealthplans.com](http://www.mercycarehealthplans.com). 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 <http://www.cciio.cms.gov> or call 1-800-895-2421 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$250 single/ \$500 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. <a href="#">Preventive care</a> services primary and specialty care services; chiropractic care; outpatient mental health and substance abuse services; physical, speech, and occupational therapy; <a href="#">prescription drugs</a> ; children's eye exams; and <a href="#">urgent care</a> are covered before you meet your <a href="#">deductible</a> .	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> ?	\$1,500 single/ \$3,000 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> , charges for services when required <a href="#">prior authorization</a> is not obtained, charges above benefit limits if applicable, 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> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://mercyarehealthplans.com/provider-directory/#!/directory">https://mercyarehealthplans.com/provider-directory/#!/directory</a> call 1-800-895-2421 for a list of <a href="#">network providers</a> .	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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$5 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	--none--
	<a href="#">Specialist</a> visit	\$10 <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)	5% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior authorization</a> is required for PET scans, and MRIs. Non-compliance may result in <a href="#">claim</a> denial.
	Imaging (CT/PET scans, MRIs)	5% <a href="#">coinsurance</a>	Not covered	
If you need drugs to treat your illness or condition	Tier 1 (Preferred generic and limited preferred brand drugs)	\$5 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	The maximum quantity of medication you may receive in a single prescription is a supply sufficient for 30 days. <a href="#">Prior</a>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
More information about <a href="https://mercyhealthplans.com/pharmacy-programs/">prescription drug coverage</a> is available at <a href="https://mercyhealthplans.com/pharmacy-programs/">https://mercyhealthplans.com/pharmacy-programs/</a>	Tier 2 (Preferred brand and select generic drugs)	\$10 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	<a href="#">authorization</a> is required for certain <a href="#">prescription drugs</a> . See <a href="https://mercyhealthplans.com/pharmacy-programs/">https://mercyhealthplans.com/pharmacy-programs/</a> for the <a href="#">prescription drug formulary</a> and a list of drugs that require <a href="#">prior authorization</a> . Failure to obtain <a href="#">prior authorization</a> may result in <a href="#">claim denial</a> .
	Tier 3 ( Non-preferred brand drugs and clinically-appropriate non- <a href="#">formulary</a> drugs with prior approval)	\$25 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	
	Tier 4 ( <a href="#">Specialty drugs</a> , select generic and brand drugs, and clinically-appropriate non- <a href="#">formulary</a> <a href="#">Specialty drugs</a> with prior approval)	25% <a href="#">coinsurance</a> . <a href="#">Deductible</a> does not apply.	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	5% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim denial</a> .
	Physician/surgeon fees	5% <a href="#">coinsurance</a>	Not covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	5% <a href="#">coinsurance</a>	5% <a href="#">coinsurance</a>	<a href="#">Copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	5% <a href="#">coinsurance</a>	5% <a href="#">coinsurance</a>	--none--
	<a href="#">Urgent care</a>	\$25 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	\$40 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	--none--
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	5% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim denial</a> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Physician/surgeon fees	5% <a href="#">coinsurance</a>	Not covered	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$5 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	<a href="#">Prior authorization</a> is required for certain services. *See the <a href="#">Prior authorization</a> Provision in the Obtaining Services section. Non-compliance may result in <a href="#">claim</a> denial.
	Inpatient services	5% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim</a> denial.
<b>If you are pregnant</b>	Office visits	5% <a href="#">coinsurance</a>	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . <a href="#">Prior authorization</a> is required for services received outside the service area in the last 30 days of pregnancy. Non-compliance may result in <a href="#">claim</a> denial.
	Childbirth/delivery professional services	5% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	5% <a href="#">coinsurance</a>	Not covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	5% <a href="#">coinsurance</a>	Not covered	Limited to 60 visits per contract period for home health care services. . <a href="#">Prior authorization</a> is required for home health care. Non-compliance may result in <a href="#">claim</a> denial.
	<a href="#">Rehabilitation services</a>	\$5 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	Limited to 30 visits per contract period for all outpatient therapies combined. Phase I & II cardiac rehabilitation limited to 36 visits per contract period. <a href="#">Prior authorization</a> is required for cardiac rehabilitation. Non-compliance may result in <a href="#">claim</a> denial.
	<a href="#">Habilitation services</a>	5% coinsurance	Not covered	<a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim</a> denial. Coverage for autism treatment is limited per WI Autism statute. *See the Autism Treatment provision in the Medical

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
				Benefit Provisions section. Other outpatient <a href="#">habilitation services</a> limited to 30 visits per contract period for all therapies combined.
	<a href="#">Skilled nursing care</a>	5% <a href="#">coinsurance</a>	Not covered	Limited to 30 visits per contract period. <a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim</a> denial.
	<a href="#">Durable medical equipment</a>	5% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim</a> denial. *See the <a href="#">Durable Medical Equipment</a> and Medical Supplies provision in the Medical Benefit Provisions section.
	<a href="#">Hospice services</a>	5% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim</a> denial.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$10 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	Limited to one exam per contract period.
	Children's glasses	5% <a href="#">coinsurance</a>	Not covered	Limited to one pair of glasses per contract period.
	Children's dental check-up	Not covered	Not covered	<a href="#">Excluded Service</a>

**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>• Abortion care</li> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery (Covered for children for correction of congenital deformities or abnormality that results in functional deficit)</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care</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>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care (Covered for persons with diabetes or peripheral vascular disease)</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 [plan](#) document.)**

<ul style="list-style-type: none"><li>• Chiropractic care</li></ul>	<ul style="list-style-type: none"><li>• Hearing Aids (Lipoteat every 3 years; and bone anchored)</li></ul>	<ul style="list-style-type: none"><li>• Reating aids (Adult) every 3 years; and bone anchored)</li></ul>	<ul style="list-style-type: none"><li>• Rea anc</li></ul>
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**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: Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517 or <http://www.oci.wi.gov>; the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>; [www.HealthCare.gov](http://www.HealthCare.gov) or 1-800-318-2596. 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: Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517 or <http://www.oci.wi.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 1-800-895-2421

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-895-2421

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-895-2421

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-895-2421

*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](#) \$250
- [Specialist copayment](#) \$10
- Hospital (facility) [coinsurance](#) 5%
- Other [coinsurance](#) 5%

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>\$12,731</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$30
<a href="#">Coinsurance</a>	\$620
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$960</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$10
- Hospital (facility) [coinsurance](#) 5%
- Other [coinsurance](#) 5%

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>\$7,389</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$345
<a href="#">Coinsurance</a>	\$93
What isn't covered	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$743</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$10
- Hospital (facility) [coinsurance](#) 5%
- Other [coinsurance](#) 5%

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>\$1,925</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$50
<a href="#">Coinsurance</a>	\$71
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$371</b>

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