
 **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 Health Plans at 800-895-2421. 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.mercycarehealthplans.com](http://www.mercycarehealthplans.com) or call 1-800-895-2421 to request a copy.

| Important Questions  | Answers  | Why This Matters:  |
|--|--|--|
| <b>What is the overall deductible?</b>                             | \$2,700 Single/ \$5,400 Family   | See the Common Medical Events chart below for your costs for services this plan covers. Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .   |
| <b>Are there services covered before you meet your deductible?</b> | Yes. <u>Preventative care</u> services, and ambulance services] are covered before you meet your <u>deductible</u> .   | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                     |
| <b>Are there other deductibles for specific services?</b>          | No   | You don't have to meet <u>deductibles</u> for specific services.   |
| <b>What is the out-of-pocket limit for this plan?</b>              | \$2,700 Single/ \$5,400 Family   | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.  |
| <b>What is not included in the out-of-pocket limit?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.  | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .   |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="https://mercycarehealthplans.com/provider-directory/">https://mercycarehealthplans.com/provider-directory/</a> or call 1-800-895-2421 for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <b>Do you need a referral to see a specialist?</b>                 | No   | You can see the <u>specialist</u> you choose without a <u>referral</u> .   |

 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<br>(You will pay the least) | Non-Participating Provider<br>(You will pay the most) |  |
| <b>If you visit a health care provider's office or clinic</b>   | Primary care visit to treat an injury or illness   | 0% coinsurance                                     | Not covered   | ---none---   |
|   | <u>Specialist</u> visit  | 0% coinsurance                                     | Not covered   | ---none---   |
|   | <u>Preventive care/screening/immunization</u>  | 100% covered                                       | Not covered   | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.  |
| <b>If you have a test</b>   | <u>Diagnostic test</u> (x-ray, blood work)   | 0% coinsurance                                     | Not covered   | ---none---   |
|   | Imaging (CT/PET scans, MRIs)   | 0% coinsurance                                     | Not covered   | Prior authorization is required for PET scans, and MRIs. Non-compliance may result in <u>claim</u> denial.   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <u>prescription drug coverage</u> is available at <a href="https://mercyarehealthplans.com/pharmacy-programs/">https://mercyarehealthplans.com/pharmacy-programs/</a> | Tier 1 (Preferred generic and limited preferred brand drugs)   | 0% coinsurance                                     | Not covered   | The maximum quantity of medication you may receive in a single prescription is a supply sufficient for 30 days. Prior authorization is required for certain <u>prescription drugs</u> . See <a href="https://mercyarehealthplans.com/pharmacy-programs/">https://mercyarehealthplans.com/pharmacy-programs/</a> for the prescription drug formulary and a list of drugs that require prior authorization. Failure to obtain prior authorization may result in <u>claim</u> denial. |
|   | Tier 2 (Preferred brand and select generic drugs)  | 0% coinsurance                                     | Not covered   |  |
|   | Tier 3 (Non-preferred brand drugs and clinically-appropriate non-formulary drugs with prior approval)  | 0% coinsurance                                     | Not covered   |  |
|   | Tier 4 ( <u>Specialty drugs</u> , select generic and brand drugs, and clinically-appropriate non-formulary <u>specialty drugs</u> with prior approval) | 0% coinsurance                                     | Not covered   | \$500 maximum per fill for <u>specialty drugs</u> . The maximum quantity of medication you may receive in a single prescription is a supply sufficient for 30 days. Prior authorization is required for certain <u>prescription drugs</u> . See <a href="https://mercyarehealthplans.com/pharmacy-programs/">https://mercyarehealthplans.com/pharmacy-programs/</a> for the drug formulary and a list of   |

\*For more information about limitations and exceptions, see the plan or policy document at [www.mercyarehealthplans.com](http://www.mercyarehealthplans.com). 58326W10060508

| Common Medical Event   | Services You May Need                          | What You Will Pay                                  |   | Limitations, Exceptions, & Other Important Information  |
|--|--|--|---|---|
|  |  | Participating Provider<br>(You will pay the least) | Non-Participating Provider<br>(You will pay the most) |   |
|  |  |  |   | <u>prescription drugs</u> that require prior authorization. Failure to obtain prior authorization may result in <u>claim</u> denial.  |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center) | 0% coinsurance                                     | Not covered   | Prior authorization is required. Non-compliance may result in <u>claim</u> denial.  |
|  | Physician/surgeon fees                         | 0% coinsurance                                     | Not covered   |   |
| <b>If you need immediate medical attention</b>                                   | <u>Emergency room care</u>                     | 0% coinsurance                                     | 0% coinsurance  | <u>Copay</u> waived if admitted.  |
|  | <u>Emergency medical transportation</u>        | 0% coinsurance                                     | 0% coinsurance  | ---none---  |
|  | <u>Urgent care</u>                             | 0% coinsurance                                     | 0% coinsurance  | ---none---  |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)             | 0% coinsurance                                     | Not covered   | Prior authorization is required. Non-compliance may result in <u>claim</u> denial.  |
|  | Physician/surgeon fees                         | 0% coinsurance                                     | Not covered   |   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                            | 0% coinsurance                                     | Not covered   | Prior authorization is required for certain services. *See the Prior Authorization Provision in the Obtaining Services section. Non-compliance may result in <u>claim</u> denial.   |
|  | Inpatient services                             | 0% coinsurance                                     | Not covered   |   |
| <b>If you are pregnant</b>   | Office visits                                  | 0% coinsurance                                     | Not covered   | Prior authorization is required for services received outside the service area in the last 30 days of pregnancy. Non-compliance may result in <u>claim</u> denial.  |
|  | Childbirth/delivery professional services      | 0% coinsurance                                     | Not covered   |   |
|  | Childbirth/delivery facility services          | 0% coinsurance                                     | Not covered   |   |
| <b>If you need help recovering or have other special health needs</b>            | <u>Home health care</u>                        | 0% coinsurance                                     | Not covered   | Limited to 60 visits per contract period. Prior authorization is required. Non-compliance may result in <u>claim</u> denial.  |
|  | <u>Rehabilitation services</u>                 | 0% coinsurance                                     | Not covered   | Limited to 30 visits per contract period for each type of speech, occupational & physical therapy. Pulmonary therapy is limited to 30 visits per contract period. Phase I & II cardiac rehabilitation limited to 36 visits per contract period. Prior authorization is required for |

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| Common Medical Event                          | Services You May Need            | What You Will Pay                                  |   | Limitations, Exceptions, & Other Important Information   |
|---|----------------------------------|--|---|--|
|   |                                  | Participating Provider<br>(You will pay the least) | Non-Participating Provider<br>(You will pay the most) |  |
|   |                                  |  |   | cardiac rehabilitation. Non-compliance may result in <u>claim</u> denial.  |
|   | <u>Habilitation services</u>     | 0% coinsurance                                     | Not covered   | Prior authorization is required. Non-compliance may result in <u>claim</u> denial. Coverage for autism treatment is limited per WI Autism statute. *See the Autism Treatment provision in the Medical Benefit Provisions section. Other habilitation services limited to 30 visits per contract period for each type of speech, occupational & physical therapy. |
|   | <u>Skilled nursing care</u>      | 0% coinsurance                                     | Not covered   | Limited to 30 days per confinement. Prior authorization is required. Non-compliance may result in <u>claim</u> denial.   |
|   | <u>Durable medical equipment</u> | 0% coinsurance                                     | Not covered   | Prior authorization is required. Non-compliance may result in <u>claim</u> denial. *See the Durable Medical Equipment and Medical Supplies provision in the Medical Benefit Provisions section.  |
|   | <u>Hospice services</u>          | 0% coinsurance                                     | Not covered   | Prior authorization is required. Non-compliance may result in <u>claim</u> denial.   |
| <b>If your child needs dental or eye care</b> | Children's eye exam              | 0% coinsurance                                     | Not covered   | ---none---   |
|   | Children's glasses               | 0% coinsurance                                     | Not covered   | ---none---   |
|   | Children's dental check-up       | Not covered  | Not covered   | <u>Excluded Service</u>  |

### 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.)

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Abortion (except in cases of sexual assault, incest, or when the life of the mother is endangered)</li> <li>• Acupuncture</li> </ul> | <ul style="list-style-type: none"> <li>• Dental care</li> <li>• Infertility treatment</li> <li>• Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>• Private duty nursing</li> <li>• Routine foot care (except for persons with diabetes or peripheral vascular disease)</li> </ul> |
|---|--|---|

\*For more information about limitations and exceptions, see the plan or policy document at [www.mercycarehealthplans.com](http://www.mercycarehealthplans.com). 58326W10060508

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Bariatric surgery
- Non-emergency care when traveling outside the U.S.
- Weight loss programs
- Cosmetic surgery

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Chiropractic care
- Hearing aids
- Routine eye care (Adult) – Exam only

**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 Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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 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**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

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 \$2,700
- Specialist [copayment][coinsurance] N/A
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$2,700        |
| Copayments                        | \$0            |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$2,760</b> |

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$2,700
- Specialist [copayment][coinsurance] N/A
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$2,700        |
| Copayments                        | \$0            |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$55           |
| <b>The total Joe would pay is</b> | <b>\$2,755</b> |

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$2,700
- Specialist [copayment][coinsurance] N/A
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,925        |
| Copayments                        | \$0            |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,925</b> |

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

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