



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 Plan 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> ?                                | \$6,500 single/ \$13,000 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 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> ? | \$8,550 single/ \$17,100 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> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="https://mercycarehealthplans.com/provider-directory/#/directory">https://mercycarehealthplans.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. |

| Important Questions  | Answers | Why This Matters:  |
|--|---------|--|
| 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<br>(You will pay the least)    | Non-Participating Provider<br>(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  | 40% <a href="#">coinsurance</a>                       | Not covered   | --none--  |
|   | <a href="#">Specialist</a> visit  | 40% <a href="#">coinsurance</a>                       | 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)   | 40% <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)  | 40% <a href="#">coinsurance</a>                       | Not covered   |   |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> 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)  | 40% <a href="#">coinsurance</a>                       | Not covered   | The maximum quantity of medication you may receive in a single prescription is a supply sufficient for 30 days. <a href="#">Prior authorization</a> is required for certain <a href="#">prescription drugs</a> . See <a href="https://mercyarehealthplans.com/pharmacy-programs/">https://mercyarehealthplans.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</a> denial.<br>\$500 maximum per fill for specialty drugs |
|   | Tier 2 (Preferred brand and select generic drugs)   | 40% <a href="#">coinsurance</a>                       | Not covered   |   |
|   | Tier 3 ( Non-preferred brand drugs and clinically-appropriate non- <a href="#">formulary</a> drugs with prior approval) | 40% <a href="#">coinsurance</a>                       | Not covered   |   |
|   | Tier 4 ( <a href="#">Specialty drugs</a> , select generic and brand drugs, and  | 40% <a href="#">coinsurance</a>                       | Not covered   |   |

| 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) |   |
|  | clinically-appropriate non- <a href="#">formulary Specialty drugs</a> with prior approval) |  |   | medication you may receive in a single prescription is a supply sufficient for 30 days. <a href="#">Prior 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 drug <a href="#">formulary</a> and a list of <a href="#">prescription drugs</a> that require <a href="#">prior authorization</a> . Failure to obtain <a href="#">prior authorization</a> may result in <a href="#">claim</a> denial. |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center)   | 40% <a href="#">coinsurance</a>                    | Not covered   | <a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim</a> denial.   |
|  | Physician/surgeon fees   | 40% <a href="#">coinsurance</a>                    | Not covered   |   |
| <b>If you need immediate medical attention</b>                                   | <a href="#">Emergency room care</a>  | 40% <a href="#">coinsurance</a>                    | 40% <a href="#">coinsurance</a>                       | <a href="#">Copay</a> waived if admitted.   |
|  | <a href="#">Emergency medical transportation</a>   | 40% <a href="#">coinsurance</a>                    | 40% <a href="#">coinsurance</a>                       | --none--  |
|  | <a href="#">Urgent care</a>  | 40% <a href="#">coinsurance</a>                    | 40% <a href="#">coinsurance</a>                       | --none--  |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)   | 40% <a href="#">coinsurance</a>                    | Not covered   | <a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim</a> denial.   |
|  | Physician/surgeon fees   | 40% <a href="#">coinsurance</a>                    | Not covered   |   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services  | 40% <a href="#">coinsurance</a>                    | 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   | 40% <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  | 40% <a href="#">coinsurance</a>                    | Not covered   | <a href="#">Cost sharing</a> does not apply for   |

| 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) |  |
|   | Childbirth/delivery professional services | 40% <a href="#">coinsurance</a>                    | Not covered   | <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 facility services     | 40% <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>          | 40% <a href="#">coinsurance</a>                    | Not covered   | Limited to 60 visits per contract period. <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>   | 40% <a href="#">coinsurance</a>                    | 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>     | 40% <a href="#">coinsurance</a>                    | 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 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>      | 40% <a href="#">coinsurance</a>                    | Not covered   | <a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim</a> denial.  |
|   | <a href="#">Durable medical equipment</a> | 40% <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.   |

| 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) |   |
|   | <a href="#">Hospice services</a> | 40% <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              | 40% <a href="#">coinsurance</a>                    | Not covered   | Limited to one exam per contract period.  |
|   | Children's glasses               | 40% <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 (Only for correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)</li> </ul> | <ul style="list-style-type: none"> <li>• Dental care</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Private-duty nursing (outpatient only)</li> </ul> | <ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Routine foot care (only for persons with diabetes)</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 <a href="#">plan</a> document.) |   |  |
|--|---|--|
| <ul style="list-style-type: none"> <li>• Chiropractic care (Limited to 25 visits per contract period)</li> </ul>                             | <ul style="list-style-type: none"> <li>• Hearing aids (1 per ear every 3 years; and bone anchored)</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> </ul> |

**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.w.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.w.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? 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, kwijjigo 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](#) \$6,500
- [Specialist coinsurance](#) 40%
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

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>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$3,590        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$4,960        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$8,610</b> |

**Managing Joe's Type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$6,500
- [Specialist coinsurance](#) 40%
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

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>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$4,310        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$2,874        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$55           |
| <b>The total Joe would pay is</b> | <b>\$7,239</b> |

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$6,500
- [Specialist coinsurance](#) 40%
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

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>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,155        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$770          |
| <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