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 or call 1-800-895-2421 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 7,500 Single/ $15,000 Family	**Deductible-** Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventative care services are covered before you meet you deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes $7,900 Single / $15,800 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://mercycarehealthplans.com/provider-directory/ or call 1-800-895-2421 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill).
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$45/ visit	Not covered	---none---
	Specialist visit	$100/ visit	Not covered	---none---
	Preventive care/screening/ immunization	No charge	Not covered	Full coverage if required by Federal law
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance after deductible	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	40% coinsurance after deductible	Not covered	Prior authorization is required for PET scans, and MRIs.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://mercycarehealthplans.com/pharmacy-programs/	Generic drugs	$45/prescription	Not covered	The maximum quantity of medication you may receive in a single prescription is a supply sufficient for 30 days.
	Preferred brand drugs	40% coinsurance after deductible	Not covered	The maximum quantity of medication you may receive in a single prescription is a supply sufficient for 30 days.
	Non-preferred brand drugs	40% coinsurance after deductible	Not covered	The maximum quantity of medication you may receive in a single prescription is a supply sufficient for 30 days.
	Specialty	40% coinsurance after deductible	Not covered	The maximum quantity of medication you may receive in a single prescription is a supply sufficient for 30 days.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance after deductible	Not covered	Prior authorization is required
	Physician/surgeon fees	40% coinsurance after deductible	Not covered	Prior authorization is required
If you need immediate medical attention	Emergency room care	40% coinsurance after deductible	20% coinsurance after deductible	Co-pay waived if admitted
	Emergency medical	No charge	No charge	---none---

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	transportation			
	Urgent care	$100/ visit	$115/ visit	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance after deductible	Not covered	Prior authorization is required
	Physician/surgeon fees	40% coinsurance after deductible	Not covered	Prior authorization is required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	40% coinsurance after deductible	Not covered	Prior authorization is required
	Inpatient services	40% coinsurance after deductible	Not covered	Prior authorization is required
If you are pregnant	Office visits	40% coinsurance after deductible	Not covered	---none---
	Childbirth/delivery professional services	40% coinsurance after deductible	Not covered	Prior authorization is required
	Childbirth/delivery facility services	40% coinsurance after deductible	Not covered	Prior authorization is required
If you need help recovering or have other special health needs	Home health care	40% coinsurance after deductible	Not covered	Coverage is limited to 60 visits per contract year. Prior authorization is required.
	Rehabilitation services	$45/ visit	Not covered	Coverage is limited to 30 visits per contract year for Speech, Occupational & Physical therapy
	Habilitation services	40% coinsurance after deductible	Not covered	Coverage is limited per WI Autism statute. Prior authorization is required.
	Skilled nursing care	40% coinsurance after deductible	Not covered	Coverage is limited to 30 days per confinement. Prior authorization is required.
	Durable medical equipment	40% coinsurance after deductible	Not covered	Prior authorization is required
	Hospice services	20% coinsurance after deductible	Not covered	Prior authorization is required
If your child needs dental or eye care	Children's eye exam	$75/ visit	Not covered	---none---
	Children's glasses	40% coinsurance after	Not covered	1 item per year

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		deductible		
	Children's dental check-up	Not covered	Not covered	---none---

"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 for."

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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

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

- Chiropractic care
- Hearing aides
- Routine eye care (glasses) children only
- Routine eye care (exam)
- Routine foot care

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: [WI, HHS, DOL, and Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.]. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit 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: MercyCare Health Plans at 1-800-895-2421 or the Department of Labor's Employee Benefits Security Administration at 1-866-44-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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, kwiijigo holne' 1-800-895-2421.

———————————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*———————————

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	$7,500
Specialist copayment	$100
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)*

Total Example Cost	$12,731

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,940
Copayments	$0
Coinsurance	$4,960
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$7,960

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

The plan's overall deductible	$7,500
Specialist copayment	$100
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)*

Total Example Cost	$8,310

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,266
Copayments	$1,955
Coinsurance	$2,177
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$7,454

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

The plan's overall deductible	$7,500
Specialist copayment	$100
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)*

Total Example Cost	$1,952

In this example, Mia would pay:

Cost Sharing	
Deductibles	$62
Copayments	$480
Coinsurance	$42
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$584

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