MercyCare Health Plans™

SMALL GROUP 2020 – PLATINUM PLAN

PLAN: IL-HMO CO-90 $250 DEDUCTIBLE

HIOS NUMBER: 54322IL0060302

	Network Providers You Pay	Non-Network Providers You Pay
Deductible	$250 Single, $500 Family	N/A
Coinsurance	10 % coinsurance	N/A
Office visit charge (PCP/Specialist)	$30/$60 Copay	Not Covered
Maximum Out of Pocket (Medical & Rx)	$2,000 Single, $4,000 Family	N/A
Preventive Services	$0	Not Covered
Diagnostic Services (lab and x-ray)	10 % coinsurance	Not Covered
Hospital inpatient services*	10 % coinsurance	Not Covered
Hospital outpatient services*	10 % coinsurance	Not Covered
Emergency room charge (waived upon admission)	$200 Copay	$200 Copay
Ambulance	$0	$0
Urgent care charge	$60 Copay	$75 Copay
Mental Health inpatient*	10 % coinsurance	Not Covered
Mental Health day treatment*	10 % coinsurance	Not Covered
Mental Health outpatient	$30 Copay	Not Covered
Durable medical equipment	10 % coinsurance	Not Covered
Physical, Speech and Occupational therapy	$30 Copay	Not Covered
Chiropractic	$30 Copay	Not Covered
* Prior authorization required for these services		
Prescription drug coverage		
Tier 1	$10 Copay	Not Covered
Tier 2	$25 Copay	Not Covered
Tier 3	$50 Copay	Not Covered
Tier 4	50% Coinsurance ($500 Maximum)	Not Covered

These benefits are a partial outline of health services under the Policy. Refer to your Schedule of Benefits for applicable limits to these health services. If differences exist between this Summary and the Certificate of Coverage, the Certificate governs.