**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 1-877-908-6027 or visit our website at 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 1-877-908-6027 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $3,000 single/ $6,000 family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| Are there services covered before you meet your deductible? | Yes. Preventive care services are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **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?** | $3000 single/ $6000 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, charges for services when required prior authorization is not obtained, charges above benefit limits if applicable, 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/#!/directory call 1-877-908-6027 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 (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Do you need a referral to see a specialist?** | Yes | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |

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 provider's office or clinic** | Primary care visit to treat an injury or illness | 0% coinsurance | Not covered | --none-- |
| | Specialist visit | 0% coinsurance | Not covered | --none-- |
| | Preventive care/screening/ immunization | No charge. Deductible does not apply. | Not covered | 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. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 0% coinsurance | Not covered | Prior authorization is required for PET scans, and MRIs. Non-compliance may result in claim denial. |
| | Imaging (CT/PET scans, MRIs) | 0% coinsurance | Not covered | |
| **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** (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 prescription drugs. See https://mercycarehealthplans.com/pharmacy-programs/ for the prescription drug formulary and a list of drugs that require prior authorization. Failure to obtain prior authorization may result in claim denial. |
| | **Preferred Brand Drugs** (Tier 2 Preferred brand and select generic drugs) | 0% coinsurance | Not covered | |
| | **Non-Preferred Brand Drugs** (Tier 3 Non-preferred brand drugs and clinically-appropriate non-formulary drugs with prior approval) | 0% coinsurance | Not covered | |

| 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) | |
| | **Specialty Drugs** (Tier 4 Specialty drugs, select generic and brand drugs, and clinically-appropriate non-formulary Specialty drugs with prior approval) | 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 prescription drugs. See https://mercycarehealthplans.com/pharmacy-programs/ for the drug formulary and a list of prescription drugs that require prior authorization. Failure to obtain prior authorization may result in claim denial. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 0% coinsurance | Not covered | Prior authorization is required. Non-compliance may result in claim denial. |
| | Physician/surgeon fees | 0% coinsurance | Not covered | |
| **If you need immediate medical attention** | Emergency room care | 0% coinsurance | 0% coinsurance | Copay waived if admitted. |
| | Emergency medical transportation | 0% coinsurance | 0% coinsurance | --none-- |
| | Urgent care | 0% coinsurance | 0% coinsurance | --none-- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 0% coinsurance | Not covered | Prior authorization is required. Non-compliance may result in claim denial. |
| | Physician/surgeon fees | 0% coinsurance | Not covered | |
| **If you need mental health, behavioral health, or substance abuse services** | 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 claim denial. |
| | Inpatient services | 0% coinsurance | Not covered | Prior authorization is required. Non-compliance may result in claim denial. |
| **If you are pregnant** | Office visits | 0% coinsurance | Not covered | Cost sharing does not apply for preventive services. Prior authorization is required for services received outside |
| | Childbirth/delivery professional services | 0% coinsurance | Not covered | |

| 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) | |
| | Childbirth/delivery facility services | 0% coinsurance | Not covered | the service area in the last 30 days of pregnancy. Non-compliance may result in claim denial. |
| **If you need help recovering or have other special health needs** | Home health care | 0% coinsurance | Not covered | --none-- |
| | Rehabilitation services | 0% coinsurance | Not covered | Limited to 60 visits per contract period for all outpatient therapies combined. Prior authorization is required for cardiac rehabilitation. Non-compliance may result in claim denial |
| | Habilitation services | 0% coinsurance | Not covered | Prior authorization is required. Non-compliance may result in claim denial. *See the Autism Treatment provision in the Medical Benefit Provisions section. Other outpatient habilitation services limited to 60 visits per contract period for all therapies combined. |
| | Skilled nursing care | 0% coinsurance | Not covered | Prior authorization is required. Non-compliance may result in claim denial. |
| | Durable medical equipment | 0% coinsurance | Not covered | Prior authorization is required. Non-compliance may result in claim denial. *See the Durable Medical Equipment and Medical Supplies provision in the Medical Benefit Provisions section. |
| | Hospice services | 0% coinsurance | Not covered | Prior authorization is required. Non-compliance may result in claim denial. |
| **If your child needs dental or eye care** | Children's eye exam | 0% coinsurance | Not covered | Limited to one exam per contract period. |
| | Children's glasses | 0% coinsurance | Not covered | Limited to one pair of glasses per contract period. |
| | Children's dental check-up | Not covered | Not covered | Excluded Service |

**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<br>• Dental care | • Long-term care<br>• Non-emergency care when traveling outside the U.S. | • Routine eye care (Adult)<br>• Weight loss programs |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Abortion care<br>• Bariatric surgery<br>• Chiropractic care (Limited to 25 visits per contract period) | • Cosmetic surgery (Only for correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)<br>• Hearing aids (1 per ear every 24 months for children; $2,500 limit per aid for adults every 24 months; and bone anchored) | • Home health care<br>• Infertility treatment<br>• Private-duty nursing (outpatient only)<br>• Routine foot care (only for persons with diabetes) |

**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: Illinois Department of Insurance at 1-877-527-9431; 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 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 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: Illinois Department of Insurance, Office of Consumer Health Insurance, Complaints Department, 320 W. Washington Street, Springfield, IL 62767 or 1-877-827-9431 or http://insurance.illinois.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 1-877-908-6027.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-908-6027.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-908-6027.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-908-6027.

*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 | $3,000 |
| Specialist coinsurance | 0% |
| 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)*

| **Total Example Cost** | **$12,731** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $3,000 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,060** |

## Managing Joe's Type 2 Diabetes

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

| | |
|---|---|
| The plan's overall deductible | $3,000 |
| Specialist coinsurance | 0% |
| 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)*

| **Total Example Cost** | **$7,389** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $3,000 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$3,055** |

## Mia's Simple Fracture

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

| | |
|---|---|
| The plan's overall deductible | $3,000 |
| Specialist coinsurance | 0% |
| 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)*

| **Total Example Cost** | **$1,925** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $1,925 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,925** |

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