




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](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 1-877-908-6027 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$2,500 single/\$5,000 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 ;primary and specialty care services; chiropractic care; outpatient mental health and substance abuse services; physical, speech, and occupational therapy; <a href="#">prescription drugs</a> ; children's eye exams; <a href="#">urgent care</a> and <a href="#">emergency room care</a> ; and ambulance 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> ?	\$5,500 single/ \$11,000 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	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

Important Questions	Answers	Why This Matters:
	benefit limits if applicable, and health care this <a href="#">plan</a> doesn't cover.	
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://mercycahealthplans.com/provider-directory/#/directory">https://mercycahealthplans.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.
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 (You will pay the least)	Non-Participating Provider (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	\$30 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	--none--
	<a href="#">Specialist</a> visit	\$60 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	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)	20% <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)	20% <a href="#">coinsurance</a>	Not covered	
If you need drugs to treat your illness or condition	Tier 1 (Preferred generic and limited preferred brand drugs)	\$20 copay/visit. <a href="#">Deductible</a> does not apply.	Not covered	The maximum quantity of medication you may receive in a single prescription is a supply sufficient for 30 days. <a href="#">Prior</a>

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)	
More information about <a href="https://mercyhealthplans.com/pharmacy-programs/">prescription drug coverage</a> is available at <a href="https://mercyhealthplans.com/pharmacy-programs/">https://mercyhealthplans.com/pharmacy-programs/</a>	Tier 2 (Preferred brand and select generic drugs)	\$40 copay/visit. Deductible does not apply.	Not covered	<a href="#">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 <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 denial</a> .
	Tier 3 ( Non-preferred brand drugs and clinically-appropriate non- <a href="#">formulary</a> drugs with prior approval)	\$75 copay/visit. Deductible does not apply.	Not covered	
	Tier 4 ( <a href="#">Specialty drugs</a> , select generic and brand drugs, and clinically-appropriate non- <a href="#">formulary</a> <a href="#">Specialty drugs</a> with prior approval)	50% <a href="#">coinsurance</a> . <a href="#">Deductible</a> does not apply.	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim denial</a> .
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$250 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	\$250 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	<a href="#">Copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	No charge. <a href="#">Deductible</a> does not apply.	No charge. <a href="#">Deductible</a> does not apply.	--none--
	<a href="#">Urgent care</a>	\$60 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	\$75 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	--none--

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 have a hospital stay	Facility fee (e.g., hospital room)	20% <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	20% <a href="#">coinsurance</a>	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	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	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim</a> denial.
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Cost sharing</a> does not apply for <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 professional services	20% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	Not covered	--none--
	<a href="#">Rehabilitation services</a>	\$30 copay/visit. Deductible does not apply.	Not covered	Limited to 60 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>	20% coinsurance	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

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)	
				outpatient <a href="#">habilitation services</a> limited to 60 visits per contract period for all therapies combined.
	<a href="#">Skilled nursing care</a>	20% <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>	20% <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.
	<a href="#">Hospice services</a>	20% <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	\$60 copay/visit. Deductible does not apply.	Not covered	Limited to one exam per contract period.
	Children's glasses	20% <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:**

<b>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>.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Dental care</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Weight loss programs</li> </ul>

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>		
<ul style="list-style-type: none"> <li>• Abortion care</li> <li>• Bariatric surgery</li> <li>• Chiropractic care (Limited to 25 visits per contract period)</li> </ul>	<ul style="list-style-type: none"> <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>• <a href="#">Home health care</a></li> <li>• Infertility treatment</li> <li>• Private-duty nursing (outpatient only)</li> <li>• Routine eye care (Adult)</li> </ul>

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

- Hearing aids (1 per ear every 3 years; and bone anchored)
- 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](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: 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? 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 1-877-908-6027.

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, kwijigo 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](#) \$2,500
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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>\$12,775</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,500
<a href="#">Copayments</a>	\$140
<a href="#">Coinsurance</a>	\$2,480
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,180</b>

**Managing Joe's Type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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>\$7,583</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,489
<a href="#">Copayments</a>	\$1,500
<a href="#">Coinsurance</a>	\$372
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$3,417</b>

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$83
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$21
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$404</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services