




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. 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 deductible? | \$1,500 single/ \$3,000 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 ; primary and specialty care services; chiropractic care; outpatient mental health and substance abuse services; physical, speech, and occupational therapy; prescription drugs ; children’s eye exams; urgent care and emergency room care ; and ambulance 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? | \$6,250 single/ \$12,500 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 | Even though you pay these expenses, they don’t count toward the out-of-pocket limit . |

| Important Questions | Answers | Why This Matters: |
|--|--|---|
| | benefit limits if applicable, and health care this plan doesn't cover. | |
| Will you pay less if you use a network provider ? | Yes. See https://mercycahealthplans.com/provider-directory/#!/directory 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 (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. |
| 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 |
|--|--|---|--|---|
| | | 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 | \$30 copay /visit. Deductible does not apply. | Not covered | --none-- |
| | Specialist visit | \$60 copay /visit. Deductible does not apply. | 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) | 20% coinsurance | Not covered | Prior authorization is required for PET scans, and MRIs. Non-compliance may result in claim denial. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | Not covered | |
| If you need drugs to treat your illness or condition | Tier 1 (Preferred generic and limited preferred brand drugs) | \$20 copay /visit. Deductible does not apply. | Not covered | The maximum quantity of medication you may receive in a single prescription is a supply sufficient for 30 days. Prior |

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

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.mercyhealthplans.com. 58326WI0060704
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| 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% coinsurance | Not covered | Prior authorization is required. Non-compliance may result in claim denial. |
| | Physician/surgeon fees | 20% coinsurance | Not covered | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$30 copay /visit. Deductible does not apply. | 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 | 20% coinsurance | Not covered | Prior authorization is required. Non-compliance may result in claim denial. |
| If you are pregnant | Office visits | 20% coinsurance | Not covered | Cost sharing does not apply for preventive services . Prior authorization is required for services received outside the service area in the last 30 days of pregnancy. Non-compliance may result in claim denial. |
| | Childbirth/delivery professional services | 20% coinsurance | Not covered | |
| | Childbirth/delivery facility services | 20% coinsurance | Not covered | |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | Not covered | Limited to 60 visits per contract period. Prior authorization is required for home health care. Non-compliance may result in claim denial. |
| | Rehabilitation services | \$30 copay /visit. Deductible does not apply. | 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. Prior authorization is required for cardiac rehabilitation. Non-compliance may result in claim denial. |
| | Habilitation services | 20% coinsurance | Not covered | Prior authorization is required. Non-compliance may result in claim denial. Coverage for autism treatment is limited |

| 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) | |
| | | | | per WI Autism statute. *See the Autism Treatment provision in the Medical Benefit Provisions section. Other outpatient habilitation services limited to 30 visits per contract period for all therapies combined. |
| | Skilled nursing care | 20% coinsurance | Not covered | Prior authorization is required. Non-compliance may result in claim denial. |
| | Durable medical equipment | 20% 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 | 20% 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 | \$60 copay /visit. Deductible does not apply. | Not covered | Limited to one exam per contract period. |
| | Children's glasses | 20% 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 .) | | |
|--|--|--|
| <ul style="list-style-type: none"> • Abortion care • Acupuncture • Bariatric surgery • Cosmetic surgery (Only for correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases) | <ul style="list-style-type: none"> • Dental care • Infertility treatment • Long-term care • Private-duty nursing (outpatient only) | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Routine foot care (only for persons with diabetes) • Weight loss programs |

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

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

- Chiropractic care (Limited to 25 visits per contract period)
- Hearing aids (1 per ear every 3 years; and bone anchored)
- Routine eye care (Adult)

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 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: 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, kwijigo 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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of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

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](#) \$1,500
- [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*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,775 |
|---------------------------|-----------------|

In this example, Peg would pay:

| | |
|---------------------|--|
| <i>Cost Sharing</i> | |
|---------------------|--|

| | |
|-----------------------------|---------|
| Deductibles | \$1,500 |
| Copayments | \$140 |
| Coinsurance | \$2,480 |

| | |
|---------------------------|--|
| <i>What isn't covered</i> | |
|---------------------------|--|

| | |
|----------------------|------|
| Limits or exclusions | \$60 |
|----------------------|------|

| | |
|-----------------------------------|----------------|
| The total Peg would pay is | \$4,180 |
|-----------------------------------|----------------|

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,500
- [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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$7,583 |
|---------------------------|----------------|

In this example, Joe would pay:

| | |
|---------------------|--|
| <i>Cost Sharing</i> | |
|---------------------|--|

| | |
|-----------------------------|---------|
| Deductibles | \$1,489 |
| Copayments | \$1,500 |
| Coinsurance | \$372 |

| | |
|---------------------------|--|
| <i>What isn't covered</i> | |
|---------------------------|--|

| | |
|----------------------|------|
| Limits or exclusions | \$55 |
|----------------------|------|

| | |
|-----------------------------------|----------------|
| The total Joe would pay is | \$3,417 |
|-----------------------------------|----------------|

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,500
- [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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$1,925 |
|---------------------------|----------------|

In this example, Mia would pay:

| | |
|---------------------|--|
| <i>Cost Sharing</i> | |
|---------------------|--|

| | |
|-----------------------------|-------|
| Deductibles | \$83 |
| Copayments | \$300 |
| Coinsurance | \$21 |

| | |
|---------------------------|--|
| <i>What isn't covered</i> | |
|---------------------------|--|

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|--------------|
| The total Mia would pay is | \$404 |
|-----------------------------------|--------------|

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