
 **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](http://www.mercycarehealthplans.com) or call 1-800-895-2421 to request a copy.

| Important Questions   | Answers   | Why This Matters:  |
|---|---|--|
| <b>What is the overall <u>deductible</u>?</b>                             | \$ 5,000/\$10,000 deductible per contract year  | <b>No deductible-</b> See the Common Medical Events chart below for your costs for services this plan covers.  |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. Preventative care services are covered before you meet your 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.   |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | No  | You don't have to meet <b><u>deductibles</u></b> for specific services.  |
| <b>What is the <u>out-of-pocket limit</u> for this plan?</b>              | \$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.   |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | Premiums, balance-billed charges, and health care this plan doesn't cover.  | Even though you pay these expenses, they don't count toward the <b><u>out-of-pocket limit</u></b> .  |
| <b>Will you pay less if you use a <u>network provider</u>?</b>            | Yes. See <a href="https://mercycarehealthplans.com/provider-directory/">https://mercycarehealthplans.com/provider-directory/</a> or call 1-800-895-2421 for a list of <b><u>network providers</u></b> . | 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). |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>          | No  | You can see an in-network 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<br>(You will pay the least) | Out-of-Network Provider<br>(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 | \$50/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)              | 50% coinsurance                              | Not covered  | ---none---   |
|  | Imaging (CT/PET scans, MRIs)                     | 50% coinsurance                              | Not covered  | Prior authorization is required for PET scans, and MRIs. |
| If you need drugs to treat your illness or condition<br>More information about <b>prescription drug coverage</b> is available at <a href="https://mercyarehealthplans.com/pharmacy-programs/">https://mercyarehealthplans.com/pharmacy-programs/</a> | Generic drugs                                    | \$20/prescription                            | Not covered  | None   |
|  | Preferred brand drugs                            | \$50/prescription                            | Not covered  | None   |
|  | Non-preferred brand drugs                        | \$100/prescription                           | Not covered  | None   |
|  | Specialty drugs                                  | 50% coinsurance                              | Not covered  | \$500 Maximum  |
| If you have outpatient surgery   | Facility fee (e.g., ambulatory surgery center)   | 50% coinsurance                              | Not covered  | Prior authorization is required                          |
|  | Physician/surgeon fees                           | 50% coinsurance                              | Not covered  | Prior authorization is required                          |
| If you need immediate medical attention  | Emergency room care                              | \$300 copay                                  | \$300 copay  | Co-pay waived if admitted                                |
|  | Emergency medical transportation                 | No charge                                    | No charge  | ---none---   |
|  | Urgent care                                      | \$100 copay                                  | \$115 copay  | ---none---   |
| If you have a hospital stay  | Facility fee (e.g., hospital room)               | 50% coinsurance                              | Not covered  | Prior authorization is required                          |
|  | Physician/surgeon fees                           | 50% coinsurance                              | Not covered  | Prior authorization is required                          |

For more information about limitations and exceptions, see the plan or policy document at [www.mercyarehealthplans.com](http://www.mercyarehealthplans.com)

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| Common Medical Event   | Services You May Need                     | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information   |
|--|---|--|--|--|
|  |   | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$50/visit                                   | Not covered  | Prior authorization is required  |
|  | Inpatient services                        | 50% coinsurance                              | Not covered  | Prior authorization is required  |
| <b>If you are pregnant</b>   | Office visits                             | 50% coinsurance                              | Not covered  | ---none---   |
|  | Childbirth/delivery professional services | 50% coinsurance                              | Not covered  | Prior authorization is required  |
|  | Childbirth/delivery facility services     | 50% coinsurance                              | Not covered  | Prior authorization is required  |
| <b>If you need help recovering or have other special health needs</b>            | <u>Home health care</u>                   | 50% coinsurance                              | Not covered  | Coverage is limited to 60 visits per contract year. Prior authorization is required.                                   |
|  | <u>Rehabilitation services</u>            | \$50/visit                                   | Not covered  | Coverage is limited to 30 visits per contract year for Speech, Occupational & Physical therapy                         |
|  | <u>Habilitation services</u>              | 50% coinsurance                              | Not covered  | Coverage is limited to 60 visits per contract year. Prior authorization is required for a child under 19 years of age. |
|  | <u>Skilled nursing care</u>               | 50% coinsurance                              | Not covered  | Coverage is limited to 30 days per confinement. Prior authorization is required.                                       |
|  | <u>Durable medical equipment</u>          | 50% coinsurance                              | Not covered  | Prior authorization is required  |
|  | <u>Hospice services</u>                   | 50% coinsurance                              | Not covered  | Prior authorization is required  |
| <b>If your child needs dental or eye care</b>                                    | Children's eye exam                       | \$100 /visit                                 | Not covered  | ---none---   |
|  | Children's glasses                        | Not covered                                  | Not covered  | 1 item per year  |
|  | 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      | • Dental care    | • Non-emergency care when traveling outside the U.S. |
| • Cosmetic surgery | • Long-term care |  |

For more information about limitations and exceptions, see the plan or policy document at [www.mercycarehealthplans.com](http://www.mercycarehealthplans.com)

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- 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.)**

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care (exam)
- Routine eye care (glasses) children only
- 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](http://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](http://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](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 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](http://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, 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.*

For more information about limitations and exceptions, see the plan or policy document at [www.mercycarehealthplans.com](http://www.mercycarehealthplans.com)

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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 \$5,000
- Specialist copayment \$100
- Hospital (facility) coinsurance 50%
- Other coinsurance 50%

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>\$12,731</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,720        |
| Copayments                        | \$0            |
| Coinsurance                       | \$6,180        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$7,960</b> |

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

- The plan's overall deductible \$5,000
- Specialist copayment \$100
- Hospital (facility) coinsurance 50%
- Other coinsurance 50%

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> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$931          |
| Copayments                        | \$1,870        |
| Coinsurance                       | \$931          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$55           |
| <b>The total Joe would pay is</b> | <b>\$3,787</b> |

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

- The plan's overall deductible \$5,000
- Specialist copayment \$100
- Hospital (facility) coinsurance 50%
- Other coinsurance 50%

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>\$1,961</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$52         |
| Copayments                        | \$500        |
| Coinsurance                       | \$52         |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$604</b> |

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

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