MercyCare Health Plans™

SMALL GROUP 2020 – GOLD PLAN
PLAN: IL-HMO CO-100 $2,700 DED.
HIOS NUMBER: 54322IL0060308

	Network Providers You Pay	Non-Network Providers You Pay
Deductible (Embedded)	$2,700 Single, $5,400 Family	N/A
Coinsurance	0 % coinsurance after deductible	N/A
Office visit charge	0 % coinsurance after deductible	Not Covered
Maximum Out of Pocket (Medical & Rx) (Embedded)	$2,700 Single, $5,400 Family	N/A
Preventive Services	$0	Not Covered
Diagnostic Services (lab and x-ray)	0 % coinsurance after deductible	Not Covered
Hospital inpatient services*	0 % coinsurance after deductible	Not Covered
Hospital outpatient services*	0 % coinsurance after deductible	Not Covered
Emergency room charge	0 % coinsurance after deductible	0 % coinsurance after deductible
Ambulance	0 % coinsurance after deductible	0 % coinsurance after deductible
Urgent care charge	0 % coinsurance after deductible	0 % coinsurance after deductible
Mental Health inpatient*	0 % coinsurance after deductible	Not Covered
Mental Health day treatment*	0 % coinsurance after deductible	Not Covered
Mental Health outpatient	0 % coinsurance after deductible	Not Covered
Durable medical equipment	0 % coinsurance after deductible	Not Covered
Physical, Speech and Occupational therapy	0 % coinsurance after deductible	Not Covered
Chiropractic	0 % coinsurance after deductible	Not Covered
* Prior authorization required for these services		
Prescription drug coverage		
Tier 1	0 % coinsurance after deductible	Not Covered
Tier 2	0 % coinsurance after deductible	Not Covered
Tier 3	0 % coinsurance after deductible	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.