




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 HMO, Inc. at 1-800-895-242 1 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 1-800-895-2421 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$3,000 single / \$6,000 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 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> ?	\$3,000 single / \$6,000 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 benefit limits if applicable, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://www.mercycarehealthplans.com/provider-directory/#/directory">https://www.mercycarehealthplans.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.

Important Questions	Answers	Why This Matters:
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	0% <a href="#">coinsurance</a>	Not covered	--none--
	<a href="#">Specialist</a> visit	0% <a href="#">coinsurance</a>	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)	0% <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)	0% <a href="#">coinsurance</a>	Not covered	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="https://mercyarehealthplans.com/pharmacy-programs/">https://mercyarehealthplans.com/pharmacy-programs/</a>	<b>Generic Drugs</b> (Tier 1 Preferred generic and limited preferred brand drugs)	0% <a href="#">coinsurance</a>	Not covered	The maximum quantity of medication you may receive in a single prescription is a supply sufficient for 30 days. <a href="#">Prior authorization</a> is required for certain <a href="#">prescription drugs</a> . See <a href="https://mercyarehealthplans.com/pharmacy-programs/">https://mercyarehealthplans.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</a> denial.
	<b>Preferred Brand Drugs</b> (Tier 2 Preferred brand and select generic drugs)	0% <a href="#">coinsurance</a>	Not covered	
	<b>Non-Preferred Drugs</b> (Tier 3 Non-preferred brand drugs and clinically-appropriate non- <a href="#">formulary</a> drugs with prior approval)	0% <a href="#">coinsurance</a>	Not covered	
	<b>Specialty Drugs</b> (Tier 4 <a href="#">Specialty drugs</a> , select generic and brand drugs, and	0% <a href="#">coinsurance</a>	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)	
	clinically-appropriate non-formulary Specialty drugs with prior approval)			<a href="#">authorization</a> is required for certain <a href="#">prescription drugs</a> . See <a href="https://mercycahealthplans.com/pharmacy-programs/">https://mercycahealthplans.com/pharmacy-programs/</a> for the drug <a href="#">formulary</a> and a list of <a href="#">prescription drugs</a> that require <a href="#">prior authorization</a> . Failure to obtain <a href="#">prior authorization</a> may result in <a href="#">claim denial</a> .
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	0% <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	0% <a href="#">coinsurance</a>	Not covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	<a href="#">Copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	--none--
	<a href="#">Urgent care</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a> .	--none--
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	0% <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	0% <a href="#">coinsurance</a>	Not covered	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	0% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior authorization</a> is required for certain services. *See the <a href="#">Prior authorization Provision</a> in the Obtaining Services section. Non-compliance may result in <a href="#">claim denial</a> .
	Inpatient services	0% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim denial</a> .
<b>If you are pregnant</b>	Office visits	0% <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 denial</a> .
	Childbirth/delivery professional services	0% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	0% <a href="#">coinsurance</a>	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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	0% <a href="#">coinsurance</a>	Not covered	Limited to 60 visits per contract period for home health care services. <a href="#">Prior authorization</a> is required for home health care. Non-compliance may result in <a href="#">claim</a> denial.
	<a href="#">Rehabilitation services</a>	0% <a href="#">coinsurance</a>	Not covered	Limited to 30 visits per Contract Period for each type of therapy. Visit limits not combined with Habilitative therapy visits. Non-compliance may result in <a href="#">claim</a> denial.
	<a href="#">Habilitation services</a>	0% <a href="#">coinsurance</a>	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. Limited to 30 visits per Contract Period for each type of therapy. Visit limits not combined with Rehabilitative therapy visits.
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a>	Not covered	Limited to 30 visits per contract period. <a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim</a> denial.
	<a href="#">Durable medical equipment</a>	0% <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>	0% <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	0% <a href="#">coinsurance</a>	Not covered	Limited to one exam per contract period.
	Children's glasses	0% <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:**

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> .)		
<ul style="list-style-type: none"> <li>• Abortion care</li> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery (Covered for children for correction of congenital deformities or abnormality that results in functional deficit)</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care (Covered for persons with diabetes or peripheral vascular disease)</li> <li>• Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing Aids (Limited to every 3 years; and bone anchored)</li> </ul>	<ul style="list-style-type: none"> <li>• Reading eyes (Adult) every 3 years; and bone anchored</li> </ul>

**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.wi.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](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: Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517 or <http://www.oci.wi.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 1-800-895-2421

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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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist coinsurance</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,731</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$3,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,060</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist coinsurance</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$7,389</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$3,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$3,055</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist coinsurance</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<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>	\$1,925
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,925</b>

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