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 or call 1-800-895-2421 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 single /$500 family deductible per contract period	See the Common Medical Events chart below for your costs for services this plan covers. 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. Preventative care services; primary and specialty care visits; chiropractic care; outpatient mental health and substance abuse services; physical, speech, and occupational therapy; prescription drugs; children's eye exams and urgent care are covered before you meet you 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?	$1,500 single / $3,000 family per contract period	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, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://mercycarehealthplans.com/provider-directory/ or call 1-800-	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

	895-2421 for a list of network providers.	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	$5 copay/visit. Deductible does not apply.	Not covered	---none---
	Specialist visit	$10 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 you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	5% coinsurance	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	5% coinsurance	Not covered	Prior authorization is required for PET scans, and MRIs. Non-compliance may result in claim denial.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **https://mercycarehealthplans.com/pharmacy-programs/**	Tier 1 (Preferred generic and limited preferred brand drugs)	$5 copay/ prescription 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 authorization is required for certain prescription drugs. See https://mercycarehealthplans.com/pharmacy-programs/ for the drug formulary and a list of prescription drugs that require prior authorization. Failure to obtain prior authorization may result in claim denial.
	Tier 2 (Preferred brand and select generic drugs)	$10 copay/ prescription Deductible does not apply.	Not covered	
	Tier 3 (Non-preferred brand drugs and clinically-appropriate non-covered drugs with prior approval)	$25 copay/ prescription Deductible does not apply.	Not covered	
	Tier 4 (Specialty drugs, select generic and brand drugs, and clinically appropriate non-covered specialty drugs with	25% coinsurance Deductible does not apply.	Not covered	

*For more information about limitations and exceptions, see the plan or policy document at www.mercycarehealthplans.com

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)	
	prior approval)			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance	Not covered	Prior authorization is required. Non-compliance may result in claim denial.
	Physician/surgeon fees	5% coinsurance	Not covered	Prior authorization is required. Non-compliance may result in claim denial.
If you need immediate medical attention	Emergency room care	5% coinsurance	5% coinsurance	Co-pay waived if admitted.
	Emergency medical transportation	5% coinsurance	5% coinsurance	---none---
	Urgent care	$25 copay/visit. Deductible does not apply.	$40 copay/visit. Deductible does not apply.	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance	Not covered	Prior authorization is required. Non-compliance may result in claim denial.
	Physician/surgeon fees	5% coinsurance	Not covered	Prior authorization is required. Non-compliance may result in claim denial.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$5 copay/visit. Deductible does not apply.	Not covered	Prior authorization is required. *See the Prior Authorization Provision in the Obtaining Services section. Non-compliance may result in claim denial.
	Inpatient services	5% coinsurance	Not covered	
If you are pregnant	Office visits	5% coinsurance	Not covered	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	5% coinsurance	Not covered	
	Childbirth/delivery facility services	5% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	5% coinsurance	Not covered	Limited to 60 visits per contract period. Prior authorization is required. Non-compliance may result in claim denial.
	Rehabilitation services	$5 copay/visit. Deductible does not	Not covered	Limited to 30 visits per contract period for speech, occupational & physical therapy.

*For more information about limitations and exceptions, see the plan or policy document at www.mercycarehealthplans.com

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)	
		apply.		Pulmonary therapy is limited to 30 visits per contract period. 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	5% coinsurance	Not covered	Prior authorization is required. Non-compliance may result in claim denial. Coverage is limited per WI Autism statute. *See the Autism Treatment provision in the Medical Benefit Provisions section. Other habilitation services limited to 30 visits per contract period for each type of speech, occupational & physical therapy.
	Skilled nursing care	5% coinsurance	Not covered	Limited to 30 days per confinement. Prior authorization is required. Non-compliance may result in claim denial.
	Durable medical equipment	5% 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	5% 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	$10 copay/visit. Deductible does not apply.	Not covered	---none---
	Children's glasses	5% coinsurance	Not covered	1 item per year
	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.)

- Abortion (except in cases of sexual assault, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care (except for persons with diabetes or peripheral vascular disease)
- Weight loss programs

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

- Chiropractic care
- Hearing aids

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 Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa. 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 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**
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.

*For more information about limitations and exceptions, see the plan or policy document at www.mercycarehealthplans.com

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, kwiijigo holne' 1-800-895-2421.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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	$250
Specialist copayment	$10
Hospital (facility) coinsurance	5%
Other coinsurance	5%

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:

Cost Sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$1,950
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,760**

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

The plan's overall deductible	$250
Specialist copayment	$10
Hospital (facility) coinsurance	5%
Other coinsurance	5%

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:

Cost Sharing	
Deductibles	$750
Copayments	$815
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,992**

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

The plan's overall deductible	$250
Specialist copayment	$10
Hospital (facility) coinsurance	5%
Other coinsurance	5%

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:

Cost Sharing	
Deductibles	$702
Copayments	$90
Coinsurance	$175
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$969**

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