




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, MercyCare Health Plan at 1-877-908-6027 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 <https://www.healthcare.gov/sbc-glossary> or call 1-877-908-6027 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p><b>Participating <a href="#">Provider</a>:</b>                      \$4,500 Single / \$9,000 Family</p>	<p>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>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a>.</p>	<p>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>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>Not Applicable.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p><b>Participating <a href="#">Provider</a>:</b>                      \$4,500 Single / \$9,000 Family</p>	<p>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.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p><a href="#">Premiums</a>, <a href="#">copayments</a> on certain services, <a href="#">out-of-network coinsurance</a>, <a href="#">deductibles</a>, charges for services when required <a href="#">prior authorization</a> is not obtained, and health care this <a href="#">plan</a> does not cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>	<p>Yes. See <a href="https://mercycarehealthplans.com/provider-directory/#!/directory">https://mercycarehealthplans.com/provider-directory/#!/directory</a> or call 1-877-908-6027 for a list of <a href="#">network providers</a>.</p>	<p>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.</p>

Important Questions	Answers	Why This Matters:
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the specialist.

 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	Not covered.	None.
	<a href="#">Specialist</a> visit	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	Not covered.	None.
	<a href="#">Preventive care/screening/immunization</a>	No charge.	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)	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	Not covered.	None.
	Imaging (CT/PET scans, MRIs)	<a href="#">Deductible</a> then 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.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.mercycarehealthplans.com">www.mercycarehealthplans.com</a>	Tier 1 (Preferred generic and limited preferred brand drugs)	<a href="#">Deductible</a> then 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://mercycarehealthplans.com/pharmacy-programs/">https://mercycarehealthplans.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</a> denial.
	Tier 2 (Preferred brand and select generic drugs)	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	Not covered.	
	Tier 3 (Non-preferred brand drugs and clinically-appropriate non- <a href="#">formulary</a> drugs with prior approval)	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	Not covered.	

\* For more information about limitations and exceptions, see [plan](#) or policy document at [www.mercycarehealthplans.com](http://www.mercycarehealthplans.com)  
MCIL\_INDHMO\_SBC\_2024 54322IL0090006-04

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Tier 4 ( <a href="#">Specialty drugs</a> , select generic and brand drugs, and clinically-appropriate non- <a href="#">formulary Specialty drugs</a> with prior approval)	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	Not covered.	<a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim</a> denial.
	Physician/surgeon fees	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	Not covered.	<a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim</a> denial.
If you need immediate medical attention	<a href="#">Emergency room care</a>	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	<a href="#">Copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	None.
	<a href="#">Urgent care</a>	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	Not covered.	<a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim</a> denial.
	Physician/surgeon fees	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	Not covered.	<a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim</a> denial.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<a href="#">Deductible</a> then 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</a> denial.
	Inpatient services	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	Not covered.	<a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim</a> denial.

\* For more information about limitations and exceptions, see [plan](#) or policy document at [www.mercycarehealthplans.com](http://www.mercycarehealthplans.com)  
 MCIL\_INDHMO\_SBC\_2024 54322IL0090006-04

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	<a href="#">Deductible</a> then 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</a> denial.
	Childbirth/delivery professional services	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	Not covered.	
	Childbirth/delivery facility services	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	Not covered.	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	Not covered.	<a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim</a> denial.
	<a href="#">Rehabilitation services</a>	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	Not covered.	Limited to <b>60 visits</b> per contract period combined. PT/SP/OT Visits not combined with <a href="#">habilitative</a> therapy visits. Phase I & II cardiac rehabilitation limited to <b>36 visits</b> per contract period. <a href="#">Prior authorization</a> is required for cardiac rehabilitation. Non-compliance may result in <a href="#">claim</a> denial.
		<b>Cardiac Rehabilitation</b> <a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .		
	<a href="#">Habilitation services</a>	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> for PT/OT/ST. <a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> for inpatient/skilled nursing.	Not covered.	Limited to <b>60 visits</b> per Contract Period combined. Visit limits not combined with <a href="#">Rehabilitative</a> therapy visits. <a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim</a> denial.
	<a href="#">Skilled nursing care</a>	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	Not covered.	<a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim</a> denial.
	<a href="#">Durable medical equipment</a>	<a href="#">Deductible</a> then 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>	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	Not covered.	<a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim</a> denial.	

\* For more information about limitations and exceptions, see [plan](#) or policy document at [www.mercycarehealthplans.com](http://www.mercycarehealthplans.com)  
MCIL\_INDHMO\_SBC\_2024 54322IL0090006-04

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	Not covered.	Limited to one exam per contract period.
	Children's glasses	<a href="#">Deductible</a> then 0% <a href="#">Coinsurance</a> .	Not covered.	Limited to one pair of glasses or contacts per contract period for children under the age of 19.
	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>Acupuncture</li> <li>Dental Care (Adult)</li> <li>Long-Term Care</li> </ul>	<ul style="list-style-type: none"> <li>Non-Emergency Care When Traveling Outside the U.S.</li> <li>Private-Duty Nursing</li> </ul>	<ul style="list-style-type: none"> <li>Routine Eye Care (Adult)</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>Abortion Care</li> <li>Bariatric Surgery</li> <li>Chiropractic Care (25 visit)</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic Surgery</li> <li>Hearing Aids (one aid per ear every 24 months)</li> </ul>	<ul style="list-style-type: none"> <li>Infertility Treatment</li> <li>Private-Duty Nursing (Outpatient Only)</li> <li>Routine Footcare</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: Illinois Department of Insurance at 1-877-527-9431; 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: Illinois Department of Insurance, Office of Consumer Health Insurance, Complaints Department, 320 W. Washington Street, Springfield, IL 62767 or 1-877-827-9431 or <http://insurance.illinois.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](#).

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

**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 1-877-908-6027.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-908-6027.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-908-6027.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-908-6027.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy 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](#) \$4,500
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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>	\$12,700
---------------------------	----------

In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$4,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,560</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$4,500
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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>	\$5,600
---------------------------	---------

In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$4,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$4,520</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$4,500
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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>	\$2,800
---------------------------	---------

In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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