




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>What is the overall <a href="#">deductible</a>?</p>	<p><b>Participating <a href="#">Provider</a>:</b>                      \$0 Single/ \$0 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>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. Children’s Eye Exams; Chiropractic Services; Outpatient Mental Health Services &amp; Substance Abuse Services; <a href="#">Primary Care</a> Office &amp; <a href="#">Specialty Care</a> Office Services; <a href="#">Preventive Care</a>; <a href="#">Urgent Care</a> Service; <a href="#">Prescription Drugs</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>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>Not Applicable.</p>	<p>You don’t have to meet <a href="#">deductibles</a> for specific services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p><b>Participating <a href="#">Provider</a>:</b>                      \$1,800 Single/ \$3,600 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>What is not included in the <a href="#">out-of-pocket limit</a>?</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>

Important Questions	Answers	Why This Matters:
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="https://mercycahealthplans.com/provider-directory/#/directory">https://mercycahealthplans.com/provider-directory/#/directory</a> or call 1-877-908-6027 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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	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)	
<b>If you visit a health care <a href="#">provider's office</a> or clinic</b>	Primary care visit to treat an injury or illness	\$0 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered.	None.
	<a href="#">Specialist</a> visit	\$10 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	<a href="#">Deductible</a> then 25% <a href="#">Coinsurance</a> .	Not covered.	None.
	Imaging (CT/PET scans, MRIs)	<a href="#">Deductible</a> then 25% <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.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug</a>	Tier 1 (Preferred generic and limited preferred brand drugs)	\$0 <a href="#">copay</a> /Rx. <a href="#">Deductible</a> does not apply.	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
	Tier 2 (Preferred brand and select generic drugs)	\$15 <a href="#">copay</a> /Rx. <a href="#">Deductible</a> does not apply.	Not covered.	

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

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)	
<a href="https://www.mercycarehealthplans.com">coverage</a> is available at <a href="https://www.mercycarehealthplans.com">www.mercycarehealthplans.com</a>	Tier 3 (Non-preferred brand drugs and clinically-appropriate non- <a href="#">formulary</a> drugs with prior approval)	\$50 <a href="#">copay</a> /Rx. <a href="#">Deductible</a> does not apply.	Not covered.	<a href="https://www.mercycarehealthplans.com/pharmacy-programs/">https://www.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 4 ( <a href="#">Specialty drugs</a> , select generic and brand drugs, and clinically-appropriate non- <a href="#">formulary Specialty drugs</a> with prior approval)	\$150 <a href="#">copay</a> /Rx. <a href="#">Deductible</a> does not apply.	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	<a href="#">Deductible</a> then 25% <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 25% <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 25% <a href="#">Coinsurance</a> .	<a href="#">Deductible</a> then 25% <a href="#">Coinsurance</a> .	<a href="#">Copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	<a href="#">Deductible</a> then 25% <a href="#">Coinsurance</a> .	<a href="#">Deductible</a> then 25% <a href="#">Coinsurance</a> .	None.
	<a href="#">Urgent care</a>	\$5 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	\$5 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	<a href="#">Deductible</a> then 25% <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 25% <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	\$0 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	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 25% <a href="#">Coinsurance</a> .	Not covered.	<a href="#">Prior authorization</a> is required. Non-compliance may result in <a href="#">claim</a> denial.

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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 25% <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 25% <a href="#">Coinsurance</a> .	Not covered.	
	Childbirth/delivery facility services	<a href="#">Deductible</a> then 25% <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 25% <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>	\$0 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply	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 25% <a href="#">Coinsurance</a> .		
	<a href="#">Habilitation services</a>	\$0 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply for PT/OT/ST. <a href="#">Deductible</a> then 25% <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 25% <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 25% <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 25% <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 the [plan](#) or policy document at [www.mercycarehealthplans.com](http://www.mercycarehealthplans.com)

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)	
<b>If your child needs dental or eye care</b>	Children's eye exam	\$10 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply	Not covered.	Limited to one exam per contract period.
	Children's glasses	<a href="#">Deductible</a> then 25% <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](#).

### 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](#).

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

### 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.*

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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](#) \$0
- [Specialist copayment](#) \$10
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

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
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,800
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,860</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$10
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

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
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$200
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$420</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$10
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

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>	\$2800
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$30
<a href="#">Coinsurance</a>	\$500
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$530</b>

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