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 1-800-895-2421 or visit our website at 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 1-800-895-2421 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Participating Provider:** $500 Single/ $1500 Family **Non-Participating Provider:** $750 Single/ $2250 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Embedded: 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. Ambulance; Children's Eye Exams; Chiropractic Services; Emergency Care; Outpatient Mental Health Services & Substance Abuse Services; Primary Care Office & Specialty Care Office Services; Preventive Care; Urgent Care Service; Prescription Drugs.	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?	Not Applicable.	No Deductible**:** You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Coinsurance & Deductible Limit:** Level 1: $1,500 Single /$3,000 Family Level 2: $2,250 Single/$4,300 Family **Medical & Rx MOOP (Ded/Coins/Copays):** Level 1: $3,650 Single /$7,300 Family Level 2: $3,650 Single /$7,300 Family	The out-of-pocket limit is the most you could pay in a year for covered services. Embedded: 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, copayments on certain services, out-of-network	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
	coinsurance, deductibles, charges for services when required prior authorization is not obtained, and health care this plan does not cover.	
Will you pay less if you use a network provider?	Yes. See https://mercycarehealthplans.com/provider-directory/#!/directory or call 1-800-895-2421 for a list of network providers.	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 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
		Network Provider (You will pay the least)	Out-of-Network 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	$15 copay/visit. Deductible does not apply.	Deductible then 35% Coinsurance	None.
	Specialist visit	$15 copay/visit. Deductible does not apply.	Deductible then 35% Coinsurance	None.
	Preventive care/screening/ immunization	No charge.	Deductible then 35% Coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible then 10% Coinsurance	Deductible then 35% Coinsurance	None.
	Imaging (CT/PET scans, MRIs)	Deductible then 10% Coinsurance	Deductible then 35% Coinsurance	Prior authorization is required for PET scans and MRIs. Non-compliance may result in claim denial.
If you need drugs to	Tier 1 (Preferred generic and	$10 copay/Rx. Deductible	Not covered.	The maximum quantity of medication you

* 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
treat your illness or condition More information about **prescription drug coverage** is available at www.mercycarehealthplans.com	limited preferred brand drugs)	does not apply.		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)	$25 copay/Rx. Deductible does not apply.	Not covered.	
	Tier 3 (Non-preferred brand drugs and clinically-appropriate non-formulary drugs with prior approval)	$50 copay/Rx. Deductible does not apply.	Not covered.	
	Tier 4 (Specialty drugs, select generic and brand drugs, and clinically-appropriate non-formulary Specialty drugs with prior approval)	$150 copay/Rx. Deductible does not apply.	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 10% Coinsurance.	Deductible then 35% Coinsurance.	Prior authorization is required. Non-compliance may result in claim denial.
	Physician/surgeon fees	Deductible then 10% Coinsurance.	Deductible then 35% Coinsurance.	Prior authorization is required. Non-compliance may result in claim denial.
If you need immediate medical attention	Emergency room care	$300 copay/visit. Deductible does not apply.	$300 copay/visit. Deductible does not apply.	Copay waived if admitted.
	Emergency medical transportation	Deductible then 10% Coinsurance.	Deductible then 10% Coinsurance.	None.
	Urgent care	$30 copay/visit. Deductible does not apply.	$30 copay/visit. Deductible does not apply.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 10% Coinsurance.	Deductible then 35% Coinsurance.	Prior authorization is required. Non-compliance may result in claim denial.
	Physician/surgeon fees	Deductible then 10% Coinsurance.	Deductible then 35% Coinsurance.	Prior authorization is required. Non-compliance may result in claim 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 need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit. Deductible does not apply.	Deductible then 35% Coinsurance.	Prior authorization is required for certain services. *See the Prior authorization Provision in the Obtaining Services section. Non-compliance may result in claim denial.
	Inpatient services	Deductible then 10% Coinsurance.	Deductible then 35% Coinsurance.	Prior authorization is required. Non-compliance may result in claim denial.
If you are pregnant	Office visits	Deductible then 10% Coinsurance.	Deductible then 35% Coinsurance.	Cost sharing does not apply for preventive services. 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	Deductible then 10% Coinsurance.	Deductible then 35% Coinsurance.	
	Childbirth/delivery facility services	Deductible then 10% Coinsurance.	Deductible then 35% Coinsurance.	
If you need help recovering or have other special health needs	Home health care	Deductible then 10% Coinsurance.	Deductible then 35% Coinsurance.	Limited to **40 visits** per contract period. One visit equals up to 4 hours skilled care. Prior authorization is required. Non-compliance may result in claim denial.
	Rehabilitation services	Deductible then 10% Coinsurance. **Cardiac Rehabilitation** Deductible then 10% Coinsurance.	Deductible then 35% Coinsurance.	Limited to **30 visits** per contract period for each type of therapy. PT/SP/OT Visits not combined with habilitative therapy visits. 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	Deductible then 10% Coinsurance **for PT/OT/ST.** Deductible then 10% Coinsurance **for**	Deductible then 35% Coinsurance.	Limited to **30 visits** per Contract Period for each type of therapy. Visit limits not combined with Rehabilitative therapy visits. Prior authorization is required. Non-compliance may result in claim denial. Coverage for autism treatment is limited per WI Autism statute. *See the

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)	
		inpatient/skilled nursing		Autism Treatment provision in the Medical Benefit Provisions section.
	Skilled nursing care	Deductible then 10% Coinsurance.	Deductible then 35% Coinsurance.	Limited to total of **30 days** per confinement. Prior authorization is required. Non-compliance may result in claim denial.
	Durable medical equipment	Deductible then 10% Coinsurance.	Deductible then 35% Coinsurance.	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	Deductible then 10% Coinsurance.	Deductible then 35% Coinsurance.	Prior authorization is required. Non-compliance may result in claim denial.
If your child needs dental or eye care	Children's eye exam	$15 copay/visit. Deductible does not apply.	Deductible then 35% Coinsurance.	Limited to one exam per contract period.
	Children's glasses	Deductible then 10% Coinsurance.	Deductible then 35% Coinsurance.	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.	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 Care
- Bariatric Surgery
- Dental Care (Adult)
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private Duty Nursing
- Weight Loss Programs

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

- Acupuncture
- Chiropractic Care
- Cosmetic Surgery
- Hearing Aids
- Infertility Treatment
- Private-Duty Nursing (Outpatient Only)
- Routine Eye Care (Adult)
- Routine Footcare

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

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Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-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 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? 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.

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.

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

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	**$500**
Specialist copayments	**$15**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$1000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1570**

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

The plan's overall deductible	**$500**
Specialist copayments	**$15**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$900
Coinsurance	$40
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1460**

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

The plan's overall deductible	**$500**
Specialist copayments	**$15**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1000**

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