This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **mercy.healthspanproviders.org,** or by calling HealthSpan at **1-800-686-7100**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Tier 1: **$1,200** individual/ **$2,400** family; Tier 2: **$2,000** individual / **$4,000** family; Tier 3: **$5,000** individual / **$10,000** family; Services not subject to deductible: Tiers 1 & 2 preventive Services; Tiers 2 & 3: Services with a copayment; All Tiers: Prescription Drugs	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. Tier 1: **$3,000** individual / **$6,000** family; Tier 2: **$5,000** individual / **$10,000** family; Tier 3: **Unlimited** **Your prescription drug out-of-pocket maximums for all Tiers are $1,600 individual/$3,200 family.**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	All Tiers: Out-of-Network expenses, premiums, penalties, balance-billed charges, prescription drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **plan providers** see **mercy.healthspanproviders.org**; or call **1-800-686-7100**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, preferred, or **participatin** for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	Tier 1: This plan will pay some or all of the costs to see a **specialist** fo covered services but only if you have the plan's permission before you see the **specialist**. Tiers 2 & 3: You can see the **specialist** you choose without permission from this plan.

Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 14. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if th plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and th **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Domestic Tier 1	In-Network Tier 2	Out-of- Network Provider Tier 3	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 per visit	30% coinsurance	60% coinsurance (plus difference between charged and allowed amounts)	Bariatric surgery is only covered under Domestic Network Tier 1 providers (limitations apply)

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Domestic Tier 1	In-Network Tier 2	Out-of- Network Provider Tier 3	
	Specialist visit	$35 per visit	30% coinsurance	60% coinsurance(plus difference between charged and allowed amounts)	
	Other practitioner office visits.	0% coinsurance	0% coinsurance	Not Covered	Chiropractic care is limited to 15 visits in calendar year. This applies to manipulations only.
	Preventive care/screening/ immunization:	No Charge	No Charge	Not Covered	Women's preventive care contraceptives a excluded
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	60% coinsurance(plus difference between charged and allowed amounts)	Precertification is required for any genetic testing covered by the plan. Failure to comply with precertification requirements will results in a $500 penalty for inpatient services and $250 penalty for outpatient(n considered an eligible expense nor applied your deductible or out-of-pocket maximu
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	60% coinsurance (plus difference between charged and allowed amounts)	Precertification required for virtual colonoscopy and PET scan. Failure to comply with precertification requirements will results in a $500 penalty for inpatient services and $250 penalty for outpatient(n considered an eligible expense nor applied your deductible or out-of-pocket maximu

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Domestic Tier 1	In-Network Tier 2	Out-of- Network Provider Tier 3	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **mercy.healthspanproviders.org**	Generic drugs	30 day supply Retail pharmacy or In-house pharmacy: Up to a $10 maximum 90 day supply Mail order pharmacy or In-house pharmacy: Up to a $25 maximum			Toledo employees must utilize the Mercy In-house pharmacy unless prior authorization is obtained.
	Formulary brand drugs	30 day supply Retail pharmacy or In-house pharmacy: 20% coinsurance with a $25 minimum and $100 maximum 90 day supply Mail order pharmacy or In-house pharmacy: 20% coinsurance with a $65 minimum and $250 maximum			Preventive drugs mandated by PPACA=No Charge. Women's preventive care medications are covered, except for contraceptives.
	Non-Formulary brand drugs	30 day supply Retail pharmacy or In-house pharmacy: 30% coinsurance with a $40 minimum and $150 maximum 90 day supply Mail order pharmacy or In-house pharmacy: 30% coinsurance with a $100 minimum and $375 maximum			Request for brand medication when generic is available will require you to pay the applicable brand copay plus the difference in cost between generic and brand. The Rx out-of-pocket maximum is $1,600 individual/$3,200 family. This does not include excluded, limited, and not covered drugs.

Common Medical Event	Services You May Need	Your cost if you use a Domestic Tier 1	In-Network Tier 2	Out-of- Network Provider Tier 3	Limitations & Exceptions
					Fertility drugs will be paid at 50% with a $2,500 maximum The RX out-of-pocket maximum is $1,6(individual. /$3,200 family. This does not include excluded drugs.
	Specialty drugs	Paid as stated above, based on type of drug.			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	60% coinsurance (plus difference between charged and allowed amounts)	Precertification is required for Blepharoplasty, Rhinoplasty, Septoplasty, Sclerotherapy for varicose veins, vein surge

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Domestic Tier 1	In-Network Tier 2	Out-of- Network Provider Tier 3	
	Physician/surgeon fees	10% coinsurance	30% coinsurance	60% coinsurance (plus difference between charged and allowed amounts)	scar revisions, TMJ treatment, breast reconstruction (other than following a surgery to treat cancer), any covered cosmet services, prophylactic mastectomies and oophorectomies, covered oral surgery procedures, chemotherapy, radiation therap dental procedures (including confinements for concurrent medical conditions), sleep disorder treatment, and transplant evaluatio & surgery. . Failure to comply with precertification requirements will results in $500 penalty for inpatient services and $25 penalty for outpatient(not considered an eligible expense nor applied to your deductible or out-of-pocket maximum)
If you need immediate medical attention	Emergency room services	$200 Copay, then 10%			Not subject to the overall deductible
	Emergency medical transportation	10% coinsurance	20% coinsurance	20% coinsurance (plus difference between charged and allowed amounts)	----------None----------
	Urgent care	$35 per visit	$50 per visit	60% coinsurance (plus difference between charged and allowed amounts)	----------None----------

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Domestic Tier 1	In-Network Tier 2	Out-of- Network Provider Tier 3	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	$500 copay per admit, then 30% coinsurance (no deductible)	60% coinsurance (plus difference between charged and allowed amounts)	Bariatric surgery is only covered under Domestic Network Tier 1 providers (limitations apply) Precertification is required for Inpatient confinements (including Skilled Nursing Facilities Rehabilitation, Mental Health and Substance Abuse) with the exception of childbirth admissions of less than 48 hours for vaginal delivery or 96 hours for cesarean delivery. Failure to comply with precertification requirements will results in a $500 penalty for inpatient services and $250 penalty for outpatient(not considered an eligible expense nor applied to your deductible or out-of-pocket
	Physician/surgeon fee	10% coinsurance	30% coinsurance	60% coinsurance (plus difference between charged and allowed amounts)	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 copay per visit	30% coinsurance	60% coinsurance (plus difference between charged and allowed amounts)	Precertification required for intensive outpatient program. Failure to comply wi precertification requirements will result in $500 penalty for inpatient services and $25 penalty for outpatient (not considered eligible expense nor applied to your deductible or out-of pocket maximum

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Domestic Tier 1	In-Network Tier 2	Out-of- Network Provider Tier 3	
	Mental/Behavioral health inpatient services	10% coinsurance	$500 copay per admit, then 30% coinsurance (no deductible)	60% coinsurance (plus difference between charged and allowed amounts)	Precertification is required for Inpatient confinements (including Skilled Nursing Facilities Rehabilitation, Mental Health and Substance Abuse). Failure to comply with precertification requirements will results in a $500 penalty for inpatient services and $250 penalty for outpatient(not considered an eligible expense nor applied to your deductible or out-of-pocket
	Substance use disorder outpatient services	$10 copay per visit	30% coinsurance	60% coinsurance (plus difference between charged and allowed amounts)	Precertification required for intensive outpatient program. Failure to comply wi precertification requirements will result in $500 penalty for inpatient services and $25 penalty for outpatient (not considered eligible expense nor applied to your deductible or out-of pocket maximum
	Substance use disorder inpatient services	10% coinsurance	$500 copay per admit, then 30% coinsurance	60% coinsurance (plus difference between charged and allowed amounts)	Precertification is required for Inpatient confinements (including Skilled Nursing Facilities Rehabilitation, Mental Health and Substance Abuse). Failure to comply with precertification requirements will results in a $500 penalty for inpatient services and $250 penalty for outpatient(not considered an eligible expense nor applied to your deductible or out-of-pocket

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Domestic Tier 1	In-Network Tier 2	Out-of- Network Provider Tier 3	
If you are pregnant	Prenatal and postnatal care	10% coinsurance	30% coinsurance	60% coinsurance (plus difference between charged and allowed amounts)	----------None----------
	Delivery and all inpatient services	10% coinsurance	$500 copay per admit, then 30% coinsurance	60% coinsurance (plus difference between charged and allowed amounts	Precertification provision does not apply to childbirth admissions of less than 48 hours for vaginal delivery or 96 hours for cesarean delivery
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	60% coinsurance (plus difference between charged and allowed amounts	Precertification is required. Failure to comply with precertification requirements will results in a $500 penalty for inpatient services and $250 penalty for outpatient(not considered an eligible expense nor applied your deductible or out-of-pocket
	Rehabilitation services	10% coinsurance	30% coinsurance	60% coinsurance(plus difference between charged and allowed amounts	Precertification is required for electroshock therapy for muscular skeletal treatment. Failure to comply with precertification requirements will results in a $500 penalty for inpatient services and $250 penalty for outpatient(not considered an eligible

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Domestic Tier 1	In-Network Tier 2	Out-of- Network Provider Tier 3	
	Habilitation services	10% coinsurance	30% coinsurance	60% coinsurance(plus difference between charged and allowed amounts	
	Skilled nursing care	10% coinsurance	30% coinsurance	60% coinsurance (plus difference between charged and allowed amounts	Precertification is required for Inpatient confinements (including Skilled Nursing Facilities Rehabilitation, Mental Health and Substance Abuse) with the exception of childbirth admissions of less than 48 hours for vaginal delivery or 96 hours for cesarean delivery. Failure to comply with precertification requirements will results in $500 penalty for inpatient services and $25 penalty for outpatient(not considered an eligible expense nor applied to your deductible or out-of-pocket
	Durable medical equipment	10% coinsurance	30% coinsurance	60% coinsurance (plus difference between charged and allowed amounts	Subject to the overall deductible. Precertification required for: durable medical equipment purchase cost or aggregate rental cost greater than $500, bone growth stimulators, neuromuscular stimulators, and orthotics over $200, prosthetics over $1000, and dual chamber defibrillator pacemaker. Failure to comply with precertification requirements will results in a $500 penalty for inpatient services and $250 penalty for outpatient(not considered an eligible expense nor applied your deductible or out-of-pocket

Common Medical Event	Services You May Need	Your cost if you use a Domestic Tier 1	In-Network Tier 2	Out-of- Network Provider Tier 3	Limitations & Exceptions
	Hospice service	10% coinsurance	30% coinsurance	60% coinsurance (plus difference between charged and allowed amounts	Subject to the overall deductible.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered	----------None----------
	Glasses	Not Covered	Not Covered	Not Covered	----------None----------
	Dental check-up	Not Covered	Not Covered	Not Covered	----------None----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

• Acupuncture	• Glasses	• Private-Duty Nursing
• Chiropractic Care	• Hearing Aids	• Routine Dental Services (Adult)
• Cosmetic Surgery	• Long-Term/Custodial Nursing Home Care	• Routine Foot Care
• Dental Check-up (Child)	• Non-Emergency Care when Traveling Outside the U.S.	• Weight Loss Programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

• Bariatric Surgery	• Chiropractic Services	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep healtl coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-686-7100. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: HealthSpan at 1-800-686-7100, online at **mercy.healthspanproviders.org**, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-788-0616 or TTY/TDD Akron: 1-330-633-1161 Cleveland: 1-800-676-6677 Medicare Eligible: 1-216-479-5003

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-686-7100 or TTY/TDD Akron: 1-330-633-1161 Cleveland: 1-800-676-6677 Medicare Eligible: 1-216-479-5003

Chinese (**中文**): **如果需要中文的帮助**，请拨打这个号码1-800-757-7585 or TTY/TDD Akron: 1-330-633-1161 Cleveland: 1-800-676-6677 Medicare Eligible: 1-216-479-5003

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-686-7100 or TTY/TDD Akron: 1-330-633-1161 Cleveland: 1-800-676-6677 Medicare Eligible: 1-216-479-5003

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans. This example applies to Tier 1 only.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $2,820
- **Patient pays** $4,720

Sample care costs:

Hospital Charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital Charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2100
Copays	$20
Coinsurance	$500
Limits or exclusions	$200
Total	**$4720**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

Tota

- **Amount owed to providers:** $5,400
- **Plan pays** $4,360
- **Patient pays** $1,040

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$900
Coinsurance	$0
Limits or exclusions	$40
Total	**$1040**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** Charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call HealthSpan at **1-800-686-7100** or visit us at **mercy.healthspanproviders.org.**
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at **www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf** or call **1-800-686-7100** to request a copy.