Ambetter from Meridian:
Ambetter Essential Care: $0 Medical Deductible

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, visit https://ambettermeridian.com/2022-brochures.html, or call 1-833-993-2426 (TTY/TDD Relay 711). 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 1-833-993-2426 (TTY/TDD Relay 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 individual / $0 family.	See the Common Medical Events chart below for your cost for services this plan covers.
Are there services covered before you meet your deductible?	Yes, except for Non-Preferred Brand (Tier 3) and Specialty drugs (Tier 4).	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?	Yes, $3,800 individual / $7,600 family for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers: $8,700 individual / $17,400 family. Not applicable for out-of-network providers.	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://ambettermeridian.com/findadoc or call 1-833-993-2426 (TTY/TDD Relay 711) 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	$45 Copay / visit	Not covered	Unlimited Virtual Care Visits received from Ambetter Telehealth covered at No Charge, providers covered in full.
	Specialist visit	$115 Copay / visit	Not covered	Covered No Limit.
	Preventive care/screening/ immunization	No charge	Not covered	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)	$60 Copay / test for laboratory & professional services 50% Coinsurance for x-ray & diagnostic imaging 50% Coinsurance for laboratory & professional services and x-ray & diagnostic imaging at other places of service	Not covered	Prior authorization may be required. Covered No Limit. Other places of service may include Hospital, Emergency Room, or Outpatient Facility. Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits. See your policy for more details.
	Imaging (CT/PET scans, MRIs)	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at **https://ambettermeridian.com/2022formulary** .	Generic drugs (Tier 1)	Preferred Generic Retail: $5 Copay / prescription Generic Retail: $35 Copay / prescription	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount.
	Preferred brand drugs (Tier 2)	Retail: $195 Copay / prescription	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount.
	Non-preferred brand drugs (Tier 3)	Retail: $250 Copay / prescription; subject to Rx drug deductible	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount. $3,800 individual / $7,600 family Rx drug deductible for non-preferred brand and specialty drugs.
	Specialty drugs (Tier 4)	Retail: 50% Coinsurance; subject to Rx drug deductible	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 30 days through mail order. $3,800 individual / $7,600 family Rx drug deductible for non-preferred brand and specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need immediate medical attention	Emergency room care	$2,500 Copay / visit ($1,250 Copay / visit for facility; $1,250 Copay / visit for physician fee)	$2,500 Copay / visit; deductible does not apply ($1,250 Copay / visit; deductible does not apply for facility; $1,250 Copay / visit; deductible does	Covered No Limit.

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)	
			not apply for physician fee)	
	Emergency medical transportation	50% Coinsurance	50% Coinsurance; deductible does not apply	Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization.
	Urgent care	$60 Copay / visit	Not covered	Covered No Limit.
If you have a hospital stay	Facility fee (e.g., hospital room)	$3,000 Copay per Day	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	No charge	Not covered	Prior authorization may be required. Covered No Limit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$45 Copay/Office Visit; 50% Coinsurance for other outpatient services	Not covered	Prior authorization may be required. Covered No Limit. (PCP and other practitioner visits do not require prior authorization).
	Inpatient services	$3,000 Copay per Day	Not covered	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	$45 Copay / visit	Not covered	Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. Cost-sharing does not apply for preventive services, such as routine pre-natal and post-natal screenings. Depending on the type of services, coinsurance, deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	Prior authorization may be required. Cost-sharing does not apply for preventive services. Depending on the type of services, copayment, coinsurance or deductible may apply. Maternity care may include tests and
	Childbirth/delivery facility services	$3,000 Copay per Day	Not covered	

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)	
				services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	Home health care	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Rehabilitation services	50% Coinsurance	Not covered	Prior authorization may be required. Outpatient rehabilitation is limited to the following: 30 combined visits per year for physical therapy and occupational therapy (combined with chiropractic care), 30 visits per year for speech therapy, 30 visits per year for cardiac therapy and 30 visits per year for pulmonary therapy. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.
	Habilitation services	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Skilled nursing care	$3,000 Copay per Day	Not covered	Prior authorization may be required. Limited to 45 days per year.
	Durable medical equipment	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Hospice services	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to 1 visit per year.
	Children's glasses	No charge	Not covered	Limited to 1 item per year.
	Children's dental check-up	Not covered	Not covered	-----None-----

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 rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Cosmetic surgery
- Dental care
- Hearing aids
- Long-Term Care (Long Term Acute Care is a covered benefit. Long Term Nursing Care/ Custodial Care is not a covered benefit.)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)

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

- Bariatric surgery (Limited to 1 surgery per lifetime.)
- Chiropractic care (Limited to 30 combined visits per year (combined for occupational therapy, physical therapy and chiropractic care).)
- Infertility treatment (Coverage is provided for diagnostic, counseling, and planning services for treatment of an underlying cause of infertility.)
- Routine foot care (Coverage is limited to diabetes care only.)
- Weight loss programs

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: Ambetter from Meridian at 1-833-993-2426 (TTY/TDD Relay 711); Department of Insurance and Financial Services, 530 W. Allegan Street, 7th Floor, Lansing, MI 48933, Phone No. 1-877-999-6442 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: Department of Insurance and Financial Services, 530 W. Allegan Street, 7th Floor, Lansing, MI 48933, Phone No. 1-877-999-6442 Additionally, a consumer assistance program can help you file your appeal. Contact

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 Minimum Value Standards? Not Applicable.
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 1-833-993-2426 (TTY/TDD Relay 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-993-2426 (TTY/TDD Relay 711).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-993-2426 (TTY/TDD Relay 711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-993-2426 (TTY/TDD Relay 711).

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**	**$0**
■ **Specialist copayment**	**$115**
■ **Hospital (facility) copayment**	**$3,000**
■ **Other coinsurance**	**50%**
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**

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**	**$115**
■ **Hospital (facility) copayment**	**$3,000**
■ **Other coinsurance**	**50%**
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**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	**$0**
■ **Specialist copayment**	**$115**
■ **Hospital (facility) copayment**	**$3,000**
■ **Other coinsurance**	**50%**
This EXAMPLE event includes services like:	
Emergency room care (*including medical supplies)*	
Diagnostic tests *(x-ray)*	
Durable medical equipment *(crutches)*	
Rehabilitation services *(physical therapy)*	
Total Example Cost	**$2,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles *	$10
Copayments	$3,600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,870**

In this example, Joe would pay:

Cost Sharing	
Deductibles *	$3,500
Copayments	$700
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,620**

In this example, Mia would pay:

Cost Sharing	
Deductibles *	$10
Copayments	$1,100
Coinsurance	$800
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,910**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

Spanish: Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Meridian, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-993-2426 (TTY/TDD Relay 711).

Arabic: إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Meridian ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-833-993-2426 (TTY/TDD Relay 711)

Chinese: 如果您，或是您正在協助的對象，有關於Ambetter from Meridian 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話1-833-993-2426 (TTY/TDD Relay 711).。

Syriac : ان اتلوخن خورنه مبقورى المساعدة يمصيتون متلفلتلن الدوا مشى Ambetter from Meridian يمصيوت مبقريوتن المساعدة.. وخني لا شقلخ زوزة منوخن . ان اتلوخون بارا الأني مندي .وان مترجم رقم تلفون 1-833-993-2426 (TTY/TDD Relay 711).

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Meridian , quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-833-993-2426 (TTY/TDD Relay 711).

Albanian : Nëse ju, apo dikush që ju po ndihmoni, ka pyetje në lidhje me Ambetter from Meridian , ju keni të drejtë të merrni ndihmë dhe informacion në gjuhën tuaj pa asnjë kosto. Për të folur me anë të një përkthyesi, telefononi 1-833-993-2426 (TTY/TDD Relay 711).

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이Ambetter from Meridian 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는1-833-993-2426 (TTY/TDD Relay 711).로 전화하십시오.

Bengali : যদি আপনার, বা আপনি সাহায্য করছেন এমন কোন ব্যক্তির Ambetter from Meridian নিয়ে কোন প্রশ্ন থাকে, তাহলে আপনার বিনামূল্যে সাহায্য পাবার ও আপনার ভাষায় সে ব্যাপারে তথ্য প্রাপ্তির অধিকার রয়েছে। একজন দোভাষীর সঙ্গে কথা বলার জন্য 1-833-993-2426 (TTY/TDD Relay 711) নম্বরে কল করুন।

Polish: Jeżeli ty lub osoba, której pomagasz, macie pytania na temat planów oferowanych za pośrednictwem Ambetter from Meridian , macie prawo poprosić o bezpłatną pomoc i informacje w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer 1-833-993-2426 (TTY/TDD Relay 711).

German: Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Meridian hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-833-993-2426 (TTY/TDD Relay 711).an

Italian: Se lei, o una persona che lei sta aiutando, avesse domande su Ambetter from Meridian, ha diritto a usufruire gratuitamente di assistenza e informazioni nella sua lingua. Per parlare con un interprete, chiami l'1-833-993-2426 (TTY/TDD Relay 711).

Japanese: Ambetter from Meridian について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-833-993-2426 (TTY/TDD Relay 711).までお電話ください。

Russian: В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Meridian вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-833-993-2426 (TTY/TDD Relay 711).

Serbo Croatian: Ako Vi, ili neko kome pomažete, imate pitanja u vezi Ambetter from Meridian, imate pravo na besplatnu pomoć i informaciju na sopstvenom jeziku. Ukoliko želite da pričate sa prevodiocem, pozovite broj 1-833-993-2426 (TTY/TDD Relay 711).

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Meridian, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-833-993-2426 (TTY/TDD Relay 711).

Statement of Non-Discrimination

Ambetter from Meridian complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter from Meridian does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from Meridian:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Ambetter from Meridian at 1-833-993-2426 (TTY/TDD Relay 711).

If you believe that Ambetter from Meridian has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Ambetter from Meridian, Attn: Appeals and Grievances, PO Box 10341 Van Nuys CA, 91410, 1-833-993-2426 (TTY/TDD Relay 711), Fax 1-833-886-7956. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ambetter from Meridian is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.