The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>https://ambettermeridian.com/2024-brochures.html</u>, or call 1-833-993-2426 (TTY Relay 711). For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <u>https://www.healthcare.gov/sbc-glossary</u> or call 1-833-993-2426 (TTY Relay 711) to request a copy.

| Important Questions   | Answers   | Why This Matters:  |
|---|---|--|
| What is the overall<br><u>deductible</u> ?                                | \$8,450 individual / \$16,900 family.   | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u><br>amount before this <u>plan</u> begins to pay. If you have other family members on the<br><u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total<br>amount of <u>deductible</u> expenses paid by all family members meets the overall<br>family <u>deductible</u> .  |
| Are there services<br>covered before you meet<br>your <u>deductible</u> ? | Yes. <u>Preventive care</u> services, primary care,<br><u>specialist</u> , and <u>urgent care</u> office visits, children's<br>eye exam and glasses, lab-work, and generic<br>drugs are covered before you meet your<br><u>deductible</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u> .  |
| Are there other<br>deductibles<br>for specific<br>services?               | No.   | You don't have to meet deductibles for specific services.  |
| What is the <u>out-of-pocket</u><br><u>limit</u> for this <u>plan</u> ?   | For <u>network providers</u> : \$9,250 individual / \$18,500 family. Not applicable for <u>out-of-network providers</u> .   | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.  |
| What is not included in the <u>out-of-pocket limit</u> ?                  | <u>Premiums</u> , <u>balance-billing</u> charges, penalties for<br>failure to obtain <u>preauthorization</u> for services, and<br>health care this <u>plan</u> doesn't cover.   | Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> <u>limit</u> .  |
| Will you pay less if you<br>use a <u>network provider</u> ?               | Yes. See <u>https://ambettermeridian.com/findadoc</u> or call 1-833-993-2426 (TTY Relay 711) for a list of <u>network providers</u> .   | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network</u> <u>provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?                | No.   | You can see the <u>specialist</u> you choose without a <u>referral</u> .   |

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

| Common  |   | What You Will Pay   |  | Limitations, Exceptions, & Other   |  |
|---|---|---|--|--|--|
| Medical Event   | Services You May Need   | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) | Important Information  |  |
| lf ugu uicit e hooldh   | Primary care visit to treat an injury or illness  | \$40 <u>Copay</u> / visit;<br><u>deductible</u> does not apply                                    | Not covered  | Unlimited Virtual 24/7 Care Visits received<br>from Ambetter's designated telehealth<br><u>provider</u> covered at No Charge, <u>providers</u><br>covered in full, <u>deductible</u> does not apply.   |  |
| If you visit a health<br>care <u>provider's</u> office<br>or clinic | <u>Specialist</u> visit   | \$90 <u>Copay</u> / visit;<br><u>deductible</u> does not apply                                    | Not covered  | Covered No Limit.  |  |
| or chinc  | Preventive care/screening/<br>immunization  | No charge; <u>deductible</u><br>does not apply  | Not covered  | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.  |  |
| lf you have a test  | t<br>Diagnostic test (x-ray, blood<br>work)<br>bit<br>Diagnostic test (x-ray, blood<br>bit<br>Diagnostic imaging<br>50% Coinsurance for x-ray & diagnostic imaging<br>50% Coinsurance for<br>laboratory & professional<br>services and x-ray & diagnostic imaging at<br>other places of service |   | Not covered  | Prior authorization may be required. Covered<br>No Limit. Other places of service may<br>include: Hospital, Emergency Room, or<br>Outpatient Facility.<br>Failure to obtain prior authorization for any<br>service that requires prior authorization will<br>result in a denial of benefits. |  |
|   | Imaging (CT/PET scans, MRIs)  | 50% Coinsurance   | Not covered  | Prior authorization may be required. Covered No Limit.   |  |
| If you need drugs to<br>treat your illness or<br>condition          | Generic drugs (Tier 1)  | Preferred Generic Retail:<br>\$3 <u>Copay</u> / prescription;<br><u>deductible</u> does not apply | Not covered  | Prior authorization may be required.<br><u>Prescription drugs</u> are provided up to 30 days<br>retail and up to 90 days through mail order.<br>Mail orders are subject to 2.5x retail <u>cost-</u><br><u>sharing</u> amount.  |  |

| Common   |  | What You Will Pay   |  | Limitations, Exceptions, & Other   |  |
|--|--|---|--|--|--|
| Medical Event  | Services You May Need  | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) | Important Information  |  |
| More information about<br>prescription drug<br>coverage is available at            |  | Generic Retail: \$30<br><u>Copay</u> / prescription;<br><u>deductible</u> does not apply  |  |  |  |
| https://ambettermeridi   | Preferred brand drugs (Tier 2)                                   | Retail: 50% Coinsurance   | Not covered  | Prior authorization may be required.   |  |
| an.com/2024formulary   | Non-preferred brand and non-<br>preferred generic drugs (Tier 3) | Retail: 50% Coinsurance   | Not covered  | Prescription drugs are provided up to 30 days retail and up to 90 days through mail order.<br>Mail orders are subject to 2.5x retail <u>cost-sharing</u> amount.   |  |
|  | Specialty drugs (Tier 4)   | Retail: 50% Coinsurance   | Not covered  | Prior authorization may be required.<br><u>Prescription drugs</u> are provided up to 30 days<br>retail and up to 30 days through mail order.   |  |
| If you have outpatient   | Facility fee (e.g., ambulatory<br>surgery center)                | 50% Coinsurance   | Not covered  | Prior authorization may be required. Covered No Limit.   |  |
| surgery  | Physician/surgeon fees   | 50% Coinsurance   | Not covered  | Prior authorization may be required. Covered No Limit.   |  |
|  | Emergency room care  | 50% Coinsurance   | 50% Coinsurance                                    | Covered No Limit.  |  |
| If you need immediate medical attention  | Emergency medical<br>transportation                              | 50% <u>Coinsurance</u>  | 50% <u>Coinsurance</u>                             | Covered No Limit. Note: Prior authorization is<br>not required for emergency transport,<br>however, all non-emergent transport requires<br>prior authorization. If you receive service from<br>an out of <u>network</u> ground/water ambulance<br><u>provider</u> , you may be subject to <u>balance</u><br><u>billing</u> . |  |
|  | <u>Urgent care</u>   | \$50 <u>Copay</u> / visit;<br><u>deductible</u> does not apply  | Not covered  | Covered No Limit.  |  |
| lf you have a hospital   | Facility fee (e.g., hospital room)                               | 50% Coinsurance   | Not covered  | Prior authorization may be required. Covered No Limit.   |  |
| stay   | Physician/surgeon fees   | 50% Coinsurance   | Not covered  | Prior authorization may be required. Covered No Limit.   |  |
| If you need mental<br>health, behavioral<br>health, or substance<br>abuse services | Outpatient services  | Office Visit: \$40 <u>Copay</u> /<br>visit; <u>deductible</u> does not<br>apply;<br>Other Outpatient<br>Services: 50%<br><u>Coinsurance</u> | Not covered  | Prior authorization may be required. Covered<br>No Limit. ( <u>Primary Care Provider</u> (PCP) and<br>other practitioner office visits do not require<br>prior authorization.)   |  |

| Common  |  | What You Will Pay  |  | Limitations, Exceptions, & Other  |  |
|---|--|--|--|---|--|
| Medical Event   | Services You May Need  | Network Provider<br>(You will pay the least)                   | Out-of-Network Provider<br>(You will pay the most) | Important Information   |  |
|   | Inpatient services   | 50% Coinsurance  | Not covered  | Prior authorization may be required. Covered No Limit.  |  |
| lf you are pregnant   | Office visits  | \$40 <u>Copay</u> / visit;<br><u>deductible</u> does not apply | Not covered  | Prior authorization not required for deliveries<br>within the standard timeframe per federal<br>regulation, but may be required for other<br>services. <u>Cost-sharing</u> does not apply for<br><u>preventive services</u> , such as routine pre-natal<br>and post-natal <u>screenings</u> . Depending on the<br>type of services, <u>coinsurance</u> , <u>deductible</u> or<br><u>copayment</u> may apply. Maternity care may<br>include tests and services described<br>elsewhere in the SBC (i.e., ultrasound). |  |
|   | Childbirth/delivery professional services                            | 50% Coinsurance  | Not covered  | Prior authorization may be required. <u>Cost-</u><br><u>sharing</u> does not apply for <u>preventive</u>  |  |
|   | Childbirth/delivery facility services                                | 50% <u>Coinsurance</u>   | Not covered  | <u>services</u> . Depending on the type of services,<br><u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may<br>apply. Maternity care may include tests and<br>services described elsewhere in the SBC<br>(i.e., ultrasound).   |  |
|   | Home health care   | 50% <u>Coinsurance</u>   | Not covered  | Prior authorization may be required. Covered No Limit.  |  |
| If you need help<br>recovering or have<br>other special health<br>needs | er special health Rehabilitation services Inpatient: 50% Coinsurance | Coinsurance<br>Inpatient: 50%                                  | Not covered  | Outpatient: Prior authorization may be<br>required. Outpatient rehabilitation is limited to<br>the following: 30 combined visits per year for<br>physical therapy and occupational therapy<br>(combined with chiropractic care), 30 visits<br>per year for speech therapy and 30 visits per<br>year for pulmonary therapy. Note: Limits do<br>not apply when provided for a mental<br>health/substance use disorder diagnosis.<br>Inpatient: Prior authorization may be<br>required. Covered No Limit.              |  |
|   | Habilitation services  | Outpatient:<br>50% <u>Coinsurance</u><br>Inpatient:            | Not covered  | Outpatient: Prior authorization may be required. Habilitation outpatient services are limited to the following: 30 combined visits  |  |

| Common                                 |                            | What You Will Pay                              |  | Limitations, Exceptions, & Other   |  |
|--|----------------------------|--|--|--|--|
| Medical Event                          | Services You May Need      | Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) | Important Information  |  |
|  |                            | 50% <u>Coinsurance</u>                         |  | per year for physical therapy and<br>occupational therapy (combined with<br>chiropractic care), 30 visits per year for<br>speech therapy, and 30 visits per year for<br>pulmonary therapy. Note: Limits do not apply<br>when provided for a mental health/substance<br>use disorder diagnosis. Inpatient: Prior<br>authorization may be required. Covered No<br>Limit. |  |
|  | Skilled nursing care       | 50% Coinsurance                                | 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.   |  |
| lf                                     | Children's eye exam        | No charge; <u>deductible</u><br>does not apply | Not covered  | Limited to 1 visit per year.   |  |
| If your child needs dental or eye care | Children's glasses         | No charge; <u>deductible</u><br>does not apply | 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 when the life of the mother is endangered)
- Acupuncture
- Cosmetic surgery
- Dental care (Adult)

- Dental care (Children)
- Hearing aids
- Long-term care

- 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 <u>plan</u> document.)

- Bariatric surgery (Limited to 1 surgery per lifetime.)
- Infertility treatment (Limited to services for diagnostic tests to find the cause of infertility)
- Routine foot care

 Weight loss programs (Weight loss programs under the supervision of a physician & obesity counseling)

• Chiropractic care (Limited to 30 combined visits per year (combined for occupational therapy, physical therapy and chiropractic care).)

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 Relay 711); Department of Insurance and Financial Services, 530 W. Allegan Street, 7th Floor, Lansing, MI 48933, Phone No. 1-877-999-6442; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); Michigan Health Options at 1-877-527-9431; Office of Personnel Management Multi State Plan Program at https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/. 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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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

# 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 Relay 711). Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-993-2426 (TTY 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 Relay 711). Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijgo holne' 1-833-993-2426 (TTY Relay 711).

To see examples of how this <u>plan</u> might cover costs for a sample medical situation, see the next section.



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

| <b>Peg is Having a Baby</b><br>(9 months of in-network pre-natal care and<br>a hospital delivery)   |                   |  |
|---|-------------------|--|
| The plan's overall deductib   | <u>le</u> \$8,450 |  |
| Specialist copayment  | \$90              |  |
| Hospital (facility) <u>coinsurance</u> 50   |                   |  |
| ■ Other <u>coinsurance</u> 50%  |                   |  |
| This EXAMPLE event includes services like:Specialistoffice visits (prenatal care)Childbirth/Delivery Professional ServicesChildbirth/Delivery Facility ServicesDiagnostic tests (ultrasounds and blood work)Specialist visit (anesthesia) |                   |  |
| Total Example Cost \$12,700   |                   |  |

|       | _      | -      | _   |       |      |
|-------|--------|--------|-----|-------|------|
| In th | is exa | ample. | Pea | would | pav: |

|                            | · J ·   |  |  |
|----------------------------|---------|--|--|
| Cost Sharing               |         |  |  |
| <u>Deductibles</u>         | \$8,450 |  |  |
| <u>Copayments</u>          | \$600   |  |  |
| Coinsurance                | \$200   |  |  |
| What isn't covered         |         |  |  |
| Limits or exclusions       | \$60    |  |  |
| The total Peg would pay is | \$9,310 |  |  |

| Managing Joe's Type 2 Diabetes<br>(a year of routine in-network care of a well-<br>controlled condition)   |                   |  |
|--|-------------------|--|
| The plan's overall deductib  | <u>le</u> \$8,450 |  |
| Specialist copayment   | \$90              |  |
| Hospital (facility) coinsurance  |                   |  |
| Other coinsurance  |                   |  |
| This EXAMPLE event includes services like:Primary care physicianoffice visits (including<br>disease education)Diagnostic tests(blood work)Prescription drugsDurable medical equipment(glucose meter) |                   |  |
| Total Example Cost   | \$5,600           |  |

# In this example, Joe would pay:

| •                  |  |  |
|--------------------|--|--|
| Cost Sharing       |  |  |
| \$3,900            |  |  |
| \$800              |  |  |
| \$0                |  |  |
| What isn't covered |  |  |
| \$20               |  |  |
| \$4,720            |  |  |
|                    |  |  |

# Mia's Simple Fracture

|        | follow up care)                             |          |
|--------|---|----------|
| )      | The <u>plan's</u> overall <u>deductible</u> | \$8,450  |
| )      | Specialist copayment                        | \$90     |
| ,<br>0 | Hospital (facility) <u>coinsurance</u>      | 50%      |
| Ď      | Other <u>coinsurance</u>                    | 50%      |
|        | This EXAMPLE event includes services        |          |
|        | Emergency room care (including medical si   | upplies) |
|        | Diagnostic tests (x-ray)                    |          |
|        | Durable medical equipment (crutches)        |          |
|        | Rehabilitation services (physical therapy)  |          |

| Total Example Cost | \$2,800 |
|--------------------|---------|
|--------------------|---------|

# In this example, Mia would pay:

| Cost Sharing               |         |  |
|----------------------------|---------|--|
| <u>Deductibles</u>         | \$2,500 |  |
| <u>Copayments</u>          | \$300   |  |
| Coinsurance                | \$0     |  |
| What isn't covered         |         |  |
| Limits or exclusions       | \$0     |  |
| The total Mia would pay is | \$2,800 |  |



| English:    | If you, or someone you are helping, have questions about Ambetter from Meridian, and are not proficient in English, you have the right to get help and information in your language at no cost and in a timely manner. If you, or someone you are helping, have an auditory and/or visual condition that impedes communication, you have the right to receive auxiliary aids and services at no cost and in a timely manner. To receive translation or auxiliary services, please contact Member Services at 1-833-993-2426 (TTY Relay 711).  |
|-------------|---|
| Spanish:    | Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Meridian y no domina el inglés, tiene derecho<br>a obtener ayuda e información en su idioma sin costo alguno y de manera oportuna. Si usted, o alguien a quien está ayudando,<br>tiene un impedimento auditivo o visual que le dificulta la comunicación, tiene derecho a recibir ayuda y servicios auxiliares sin<br>costo alguno y de manera oportuna. Para recibir servicios auxiliares o de traducción, comuníquese con Servicios para Miembros<br>al 1-833-993-2426 (TTY Relay 711).  |
| Arabic:     | إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Meridian، ولم تكن بار عًا باللغة الإنكليزية، فلديك الحق في الحصول على المساعدة والمعلومات بلغتك من دون<br>أي تكلفة وفي الوقت المناسب. إذا كنت أنت أو أي شخص تساعده تعاني من حالة سمعية و/أو بصرية تعيق التواصل، فلديك الحق في تلقي مساعدات وخدمات إضافية من دون أي تكلفة<br>وفي الوقت المناسب. لتلقي خدمات الترجمة أو خدمات إضافية، يرجى الاتصال بـ خدمات الأعضاء على (TTY Relay 711) 2426-1833-914.   |
| 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,且不精通英語,您有權利免費並及時以您的母語獲幫<br>助和訊息。如果您,或您正在協助的對象有聽力和/或視力上的問題,阻礙了溝通,您有權利免費並及時獲得輔助支援與服務。若要<br>取得翻譯或輔助服務,請聯絡會員服務部,電話是 1-833-993-2426 (TTY Relay 711)。   |
| Syriac:     | کی کانو، کی شند نصف ایک منوب یا کارش مولی حضوری حمد Ambetter from Meridian میک مولی کا چاری یا جاری ادجاب آدیک د<br>حضنیایک میجانی حقیقی منوبی کارش مولی حضیتی جاروی کارش کار بینی نحضانی مولی کارش کارش کارش کارش کارش کارش مولی ک<br>مرکب الموجوع کار مولی موانیک از مولی مولیو کار مولو محکم حض حضانی مولیو کارش مولی کارش مولو کردی کارش مولی مولی<br>مرکب الموجوع مودی مودی مودی مولیو مولیو کار مولیو مولی مولیو کار مولیو کار مولیو کار مولیو کارش مولیو کار مولی  |
| Vietnamese: | Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter from Meridian và không thành thạo tiếng Anh, quý vị có<br>quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí và kịp thời. Nếu quý vị hoặc người mà quý vị đang giúp<br>đỡ mắc bệnh về thính giác và/hoặc thị giác gây cản trở giao tiếp, quý vị có quyền được nhận các hỗ trợ và dịch vụ phụ trợ miễn<br>phí và kịp thời. Để nhận dịch vụ thông dịch hoặc dịch vụ phụ trợ, vui lòng liên hệ bộ phận Dịch Vụ Thành Viên theo số<br>1-833-993-2426 (TTY Relay 711).  |
| Albanian:   | Nëse ju, ose dikush që po ndihmoni, keni pyetje rreth Ambetter from Meridian dhe nuk e zotëroni gjuhën angleze, ju gëzoni të<br>drejtën të merrni ndihmë dhe informacione në gjuhën tuaj, falas dhe menjëherë. Nëse ju, ose dikush që po ndihmoni, keni një<br>problem me dëgjimin dhe/ose shikimin, që ju pengon komunikimin, ju gëzoni të drejtën të merrni mjete dhe shërbime ndihmëse,<br>falas dhe menjëherë. Për të marrë shërbime përkthimi ose ndihmëse, kontaktoni Shërbimet e anëtarëve në numrin<br>1-833-993-2426 (TTY Relay 711).  |
| Korean:     | 귀하 또는 귀하의 도움을 받는 분이 Ambetter from Meridian에 대한 질문이 있는 경우 영어에 능숙하지 않으시면 해당 언어로<br>시의적절하게 무료 지원과 정보를 받을 권리가 있습니다. 귀하 또는 귀하의 도움을 받는 분이 청각 및/또는 시각적으로 의사소통에<br>장애가 있는 경우 시의적절하게 무료 보조 도구 및 서비스를 받을 권리가 있습니다. 번역 또는 보조 서비스를 받으시려면<br>1-833-993-2426(TTY Relay 711)번으로 가입자 서비스부에 연락해주십시오.   |
| Bengali:    | আপনি অথবা অন্য কেউ যাকে আপনি সাহায্য করছেন তার Ambetter from Meridian নিয়ে প্রশ্ন থেকে থাকলে ও ইংরাজিতে সড়গড় না<br>হলে আপনার নিখরচায় ও সময় মতো আপনার নিজের ভাষাতে সাহায্য ও তথ্য পাওয়ার অধিকার রয়েছে। আপনি বা অন্য কেউ যাকে<br>আপনি সাহায্য করছেন তার শ্রবণ এবং/অথবা দৃশ্যগত অবস্থা থেকে থাকে যা কমিউনিকেশনকে বিলম্বিত করে সে ক্ষেত্রে আপনার<br>নিখরচায় ও সময় মতো সহায়ক ও পরিষেবা পাওয়ার অধিকার রয়েছে। অনুবাদ ও সহায়ক পরিষেবা পেতে অনুগ্রহ করে 1-৪33-993-2426<br>(TTY Relay 711)-এ সদস্য পরিষেবাসমূহ-এর সাথে যোগাযোগ করুন।   |
| Polish:     | Jeśli Ty lub osoba, której pomagasz, macie pytania dotyczące Ambetter from Meridian, ale nie posługujecie się biegle językiem<br>angielskim, macie prawo do uzyskania pomocy i informacji w swoim języku bez dodatkowych kosztów i w odpowiednim czasie. Jeśli<br>Ty lub osoba, której pomagasz, macie problemy ze słuchem i/lub wzrokiem, które utrudniają komunikację, macie prawo do otrzymania<br>pomocy i usług pomocniczych bez dodatkowych kosztów i w odpowiednim czasie. Aby uzyskać tłumaczenie lub usługi pomocnicze,<br>należy skontaktować się z Usługi członkowskie pod numerem 1-833-993-2426 (TTY Relay 711). |
| German:     | Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Meridian hat und nicht Englisch spricht, haben Sie das Recht,<br>kostenlos und zeitnah Hilfe und Informationen in Ihrer Sprache zu erhalten. Falls Sie oder jemand, dem Sie helfen, eine<br>Hör- und/oder Sehbeeinträchtigung hat, die die Kommunikation beeinflusst, haben Sie das Recht, kostenlos und zeitnah<br>zusätzliche Hilfe und Dienstleistungen zu erhalten. Um eine Übersetzung oder zusätzliche Dienstleistungen zu erhalten, wenden<br>Sie sich an den Kundendienst unter 1-833-993-2426 (TTY Relay 711).  |

| Italian:        | Se Lei o una persona a cui sta fornendo assistenza ha domande su Ambetter from Meridian e non ha una perfetta padronanza della lingua inglese, ha il diritto di ricevere aiuto e informazioni nella Sua lingua gratuitamente e tempestivamente. Se Lei o una persona a cui sta fornendo assistenza presenta una condizione uditiva e/o visiva che impedisce la comunicazione, ha il diritto di ricevere servizi ausiliari gratuitamente e tempestivamente. Per ricevere una traduzione o un servizio ausiliario, contatti i Servizi per i membri al numero 1-833-993-2426 (TTY Relay 711).   |
|-----------------|--|
| Japanese:       | ご自身やあなたが介護している他の人が、Ambetter from Meridianについてご質問をお持ちの場合、英語に自信がなくても無料<br>かつタイムリーにご希望の言語でヘルプや情報を得ることができます。ご自身や、あなたが介護している他の人の聴覚や視覚   |
|                 | がリダイムゲーにこ布主の日間でベルジャド情報を得ることができます。こ日ダヤ、めなたが分岐している他の人の応見や祝見の状態のためやり取りが難しい場合でも、無料かつタイムリーに補助サービスを受けることができます。翻訳や補助サービス  |
|                 | を受けるには、1-833-993-2426 (TTY Relay 711)のメンバーサービスにご連絡ください。  |
| Russian:        | Если у вас или у лица, которому вы помогаете, возникли какие-либо вопросы о программе страхования Ambetter from<br>Meridian, при этом вы недостаточно хорошо владеете английским языком, вы имеете право на бесплатную и<br>своевременную помощь и информацию на своем родном языке. Если у вас или у лица, которому вы помогаете,<br>наблюдается какое-либо нарушение слуха и/или зрения, которое препятствует коммуникации, вы имеете право на<br>бесплатные и своевременные вспомогательные услуги и помощь. Для получения услуг перевода или вспомогательных<br>услуг обратитесь в отдел обслуживания участников программы страхования по номеру 1-833-993-2426 (TTY Relay 711). |
| Serbo-Croatian: | Ako Vi, ili neko kome pomažete, imate pitanja u vezi sa Ambetter from Meridian, a ne govorite engleski jezik, imate pravo na besplatnu<br>i blagovremenu pomoć i informacije na sopstvenom jeziku. Ako Vi, ili neko kome pomažete, imate neki poremećaj sluha i/ili vida zbog<br>kojeg je onemogućena komunikacija, imate pravo da besplatno i blagovremeno dobijete pomagala i pomoćne usluge. Obratite se<br>odeljenju za pružanje usluga članovima pozivom na broj 1-833-993-2426 (TTY Relay 711) da biste dobili usluge prevoda ili pomoćne<br>usluge.   |
| Tagalog:        | Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter from Meridian, at hindi ka mahusay sa Ingles,<br>may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos at sa maagap na paraan. Kung ikaw, o<br>ang iyong tinutulungan, ay may kondisyon sa pandinig at/o paningin na nakakaapekto sa komunikasyon, may karapatan kang<br>makatanggap ng mga karagdagang tulong at serbisyo nang walang gastos at sa maagap na paraan. Para makatanggap ng mga<br>serbisyo sa pagsasalin o mga karagdagang serbisyo, mangyaring makipag-ugnayan sa Mga Serbisyo para sa Miyembro sa<br>1-833-993-2426 (TTY Relay 711).                |

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### Statement of Non-Discrimination

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If you, or someone you are helping, have questions about Ambetter of Meridian, and are not proficient in English, you have the right to get help and information in your language at no cost and in a timely manner. If you, or someone you are helping, have an auditory and/or visual condition that impedes communication, you have the right to receive auxiliary aids and services at no cost and in a timely manner. To receive translation or auxiliary services, please contact Member Services at 1-833-993-2426 (TTY Relay 711). If you believe that Meridian Health Plan of Michigan, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, or sex characteristics), please contact Member Services at 1-833-993-2426 (TTY Relay 711). For information on filing a discrimination complaint directly with the U.S. Department of Health and Human Services, Office of Civil Rights, please visit <u>https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf</u>.

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