

 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/2025-brochures.html>, or call 1-833-993-2426 (TTY 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 Relay 711) to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall <u>deductible</u> ? | \$0 | See the Common Medical Events chart below for your cost for services this <u>plan</u> covers. |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. | 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. |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ? | Not Applicable. | This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses. |
| What is not included in the <u>out-of-pocket limit</u> ? | Not Applicable. | This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses. |
| Will you pay less if you use a <u>network provider</u> ? | Yes. See https://ambettermeridian.com/find-adoc 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 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 [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 |
|--|---|--|--|---|
| | | Indian Health Care Provider (IHCP) & Non-IHCP In-Network Provider (You will pay the least) | Non-IHCP 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 | No charge | Not covered | Unlimited Virtual 24/7 Care Visits received from Ambetter's designated telehealth provider covered at No Charge, providers covered in full. |
| | Specialist visit | No charge | Not covered | None |
| | 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) | No charge for laboratory & professional services No charge for x-ray & diagnostic imaging No charge 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. |
| | Imaging (CT/PET scans, MRIs) | No charge | Not covered | Prior authorization may be required. Covered No Limit. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://ambettermeridian.com/2025formulary | Generic drugs | Tier 1a - Preferred Generic Retail: No charge Tier 1b - Generic Retail: No charge | Not covered | Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. |
| | Preferred brand drugs | Tier 2 - Retail: No charge | Not covered | Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. |
| | Non-preferred brand drugs and Non-preferred generic drugs | Tier 3 - Retail: No charge | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|--|--|--|
| | | Indian Health Care Provider (IHCP) & Non-IHCP In-Network Provider (You will pay the least) | Non-IHCP Out-Of-Network Provider (You will pay the most) | |
| | Specialty drugs | Tier 4 - Retail: No charge | Not covered | Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 30 days through mail order. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | 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 immediate medical attention | Emergency room care | No charge | No charge | None |
| | Emergency medical transportation | No charge | No charge | Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization. If you receive service from an out of network ground/water ambulance provider , you may be subject to balance billing . |
| | Urgent care | No charge | Not covered | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | 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 | No charge | Not covered | Prior authorization may be required. Covered No Limit. (Primary Care Provider (PCP) and other practitioner office visits do not require prior authorization.) |
| | Inpatient services | No charge | Not covered | Prior authorization may be required. Covered No Limit. |
| If you are pregnant | Office visits | No charge | 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 |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|--|--|
| | | Indian Health Care Provider (IHCP) & Non-IHCP In-Network Provider (You will pay the least) | Non-IHCP Out-Of-Network Provider (You will pay the most) | |
| | | | | 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 services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery facility services | No charge | Not covered | Prior authorization may be required. Covered No Limit. |
| If you need help recovering or have other special health needs | Home health care | No charge | Not covered | Outpatient: 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 and 30 visits per year for pulmonary therapy. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Covered No Limit. |
| | Rehabilitation services | Outpatient: No charge Inpatient: No charge | Not covered | Outpatient: Prior authorization may be required. Habilitation outpatient services are 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, and 30 visits per year for pulmonary therapy. Note: Limits do not apply |
| | Habilitation services | Outpatient: No charge Inpatient: No charge | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|--|---|
| | | Indian Health Care Provider (IHCP) & Non-IHCP In-Network Provider (You will pay the least) | Non-IHCP Out-Of-Network Provider (You will pay the most) | |
| | | | | when provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Covered No Limit. |
| | Skilled nursing care | No charge | Not covered | Prior authorization may be required. Limited to 45 days per year. |
| | Durable medical equipment | No charge | Not covered | Prior authorization may be required. Covered No Limit. |
| | Hospice services | No charge | 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 .) | | |
|--|--|--|
| <ul style="list-style-type: none"> Abortion (Except in cases when the life of the member is endangered) Acupuncture Cosmetic surgery Dental care (Adult) | <ul style="list-style-type: none"> Dental care (Children) Hearing aids Long-term care | <ul style="list-style-type: none"> 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.) | | |
|---|--|---|
| <ul style="list-style-type: none"> 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)) | <ul style="list-style-type: none"> Infertility treatment (Limited to services for diagnostic tests to find the cause of infertility) Routine foot care | <ul style="list-style-type: none"> Weight loss programs (Weight loss programs under the supervision of a physician & obesity counseling) |

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 [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

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, kwijigo holne' 1-833-993-2426 (TTY 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 coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|------------|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$0 |

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 coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|------------|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$0 |

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

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

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, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|------------|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$0 |

Korean:

귀하 또는 귀하의 도움을 받는 분이 Ambetter from Meridian에 대한 질문이 있는 경우 영어에 능숙하지 않으시면 해당 언어로 시의적절하게 무료 지원과 정보를 받을 권리가 있습니다. 귀하 또는 귀하의 도움을 받는 분이 청각 및/또는 시각적으로 의사소통에 장애가 있는 경우 시의적절하게 무료 보조 도구 및 서비스를 받을 권리가 있습니다. 번역 또는 보조 서비스를 받으시려면 1-833-993-2426 (TTY Relay 711)번으로 가입자 서비스부에 연락해주시요.

Bengali:

আপনি অথবা অন্য কেউ যাকে আপনি সাহায্য করছেন তার Ambetter from Meridian নিয়ে প্রশ্ন থেকে থাকলে ও ইংরাজিতে সড়গড় না হলে নিখরচায় ও সময় মতো আপনার নিজের ভাষাতে সাহায্য ও তথ্য পাওয়ার অধিকার রয়েছে। আপনি বা অন্য কেউ যাকে আপনি সাহায্য করছেন তার শ্রবণ এবং/অথবা দৃশ্যগত রোগাবস্থা থেকে থাকে যা কমিউনিকেশনকে বিলম্বিত করে সে ক্ষেত্রে আপনার নিখরচায় ও সময় মতো সহায়ক ও পরিষেবা পাওয়ার অধিকার রয়েছে। অনুবাদ ও সহায়ক পরিষেবা পেতে অনুগ্রহ করে 1-833-993-2426 (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 angielskim, macie prawo do uzyskania pomocy i informacji w swoim języku bez dodatkowych kosztów i w odpowiednim czasie. Jeśli Ty lub osoba, której pomagasz, macie problemy ze słuchem i/lub wzrokiem, które utrudniają komunikację, macie prawo do otrzymania pomocy i usług pomocniczych bez dodatkowych kosztów i w odpowiednim czasie. Aby uzyskać tłumaczenie lub usługi pomocnicze, należy skontaktować się z Usługami 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, kostenlos und zeitnah Hilfe und Informationen in Ihrer Sprache zu erhalten. Falls Sie oder jemand, dem Sie helfen, eine Hör- und/oder Sehbeeinträchtigung hat, die die Kommunikation beeinflusst, haben Sie das Recht, kostenlos und zeitnah zusätzliche Hilfe und Dienstleistungen zu erhalten. Um eine Übersetzung oder zusätzliche Dienstleistungen zu erhalten, wenden 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 Meridian, при этом вы недостаточно хорошо владеете английским языком, вы имеете право на бесплатную и своевременную помощь и информацию на своем родном языке. Если у вас или у лица, которому вы помогаете, наблюдается какое-либо нарушение слуха и/или зрения, которое препятствует коммуникации, вы имеете право на бесплатные и своевременные вспомогательные услуги и помощь. Для получения услуг перевода или вспомогательных 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 i blagovremenu pomoć i informacije na sopstvenom jeziku. Ako Vi, ili neko kome pomažete, imate neki poremećaj sluha i/ili vida zbog kojeg je onemogućena komunikacija, imate pravo da besplatno i blagovremeno dobijete pomagala i pomoćne usluge. Obratite se odeljenju za pružanje usluga članovima pozivom na broj 1-833-993-2426 (TTY Relay 711) da biste dobili usluge prevoda ili pomoćne usluge.

Tagalog:

Kung ikaw, o ang iyong tinutulongan, ay may mga katanungan tungkol sa Ambetter from Meridian, at hindi ka mahusay sa Ingles, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos at sa maagap na paraan. Kung ikaw, o ang iyong tinutulongan, ay may kondisyon sa pandinig at/o pannikin na nakakaapekto sa komunikasyon, may karapatan kang makatanggap ng mga karagdagang tulong at serbisyo nang walang gastos at sa maagap na paraan. Para makatanggap ng mga serbisyo sa pagsasalin o mga karagdagang serbisyo, mangyaring makipag-ugnayan sa Mga Serbisyo para sa Miyembro sa 1-833-993-2426 (TTY Relay 711).

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