



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://ambetterhealth.com/en/mi/2026-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 <a href="#">deductible</a> ?                                | \$0 individual / \$0 family.                                                                                                                                                                                                                                                     | See the Common Medical Events chart below for your cost for services this <a href="#">plan</a> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> services, primary care, <a href="#">specialist</a> , and <a href="#">urgent care</a> visits, and certain <a href="#">prescription drugs</a> are covered before you meet your <a href="#">deductible</a> (see additional information below). | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                                                                                                                              | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For <a href="#">network providers</a> : \$6,500 individual / \$13,000 family. Not applicable for <a href="#">out-of-network providers</a> .                                                                                                                                      | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, penalties for failure to obtain <a href="#">preauthorization</a> for services, and health care this <a href="#">plan</a> doesn't cover.                                                                      | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="https://ambetterhealth.com/en/mi/fi/ndadoc">https://ambetterhealth.com/en/mi/fi/ndadoc</a> or call 1-833-993-2426 (TTY Relay 711) for a list of <a href="#">network providers</a> .                                                                            | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.                                                                                                                                                                                                                                                                              | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

 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<br>(You will pay the least)                                                                                                                                                                                                                                           | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                               |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                                                                                                | Primary care visit to treat an injury or illness       | \$5 <a href="#">Copay</a> / visit                                                                                                                                                                                                                                                      | Not covered                                        | Unlimited Virtual 24/7 Care Visits received from Ambetter's designated telehealth <a href="#">provider</a> covered at No Charge, <a href="#">providers</a> covered in full.                                                                                                   |
|                                                                                                                                                                                                                                                       | <a href="#">Specialist</a> visit                       | \$60 <a href="#">Copay</a> / visit                                                                                                                                                                                                                                                     | Not covered                                        | None                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                       | <a href="#">Preventive care/screening/immunization</a> | No charge                                                                                                                                                                                                                                                                              | Not covered                                        | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.                                                                                     |
| If you have a test                                                                                                                                                                                                                                    | <a href="#">Diagnostic test</a> (x-ray, blood work)    | \$40 <a href="#">Copay</a> / visit for laboratory & professional services<br>\$75 <a href="#">Copay</a> / visit for x-ray & diagnostic imaging<br>\$200 <a href="#">Copay</a> / visit 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.<br>Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits. |
|                                                                                                                                                                                                                                                       | Imaging (CT/PET scans, MRIs)                           | \$75 <a href="#">Copay</a> / visit                                                                                                                                                                                                                                                     | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                        |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://ambetterhealth.com/en/mi/2026formulary">https://ambetterhealth.com/en/mi/2026formulary</a> | Generic drugs                                          | Tier 1a - Preferred Generic Retail: \$3 <a href="#">Copay</a> / prescription<br>Tier 1b - Generic Retail: \$15 <a href="#">Copay</a> / prescription                                                                                                                                    | Not covered                                        | Prior authorization may be required. <a href="#">Prescription drugs</a> are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail <a href="#">cost-sharing</a> amount.                                                   |
|                                                                                                                                                                                                                                                       | Preferred brand drugs                                  | Tier 2 - Retail: \$50 <a href="#">Copay</a> / prescription                                                                                                                                                                                                                             | Not covered                                        | Prior authorization may be required. <a href="#">Prescription drugs</a> are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail                                                                                        |
|                                                                                                                                                                                                                                                       | Non-preferred brand drugs and Non-preferred generic    | Tier 3 - Retail: 45% <a href="#">Coinsurance</a>                                                                                                                                                                                                                                       | Not covered                                        |                                                                                                                                                                                                                                                                               |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                                                                                  |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Network Provider<br>(You will pay the least)                                                                       | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                |
|                                                                           | drugs.                                           |                                                                                                                    |                                                    | <a href="#">cost-sharing</a> amount.                                                                                                                                                                                                                                                                                           |
|                                                                           | <a href="#">Specialty drugs</a>                  | Tier 4 - Retail: 50% <a href="#">Coinsurance</a>                                                                   | Not covered                                        | Prior authorization may be required. <a href="#">Prescription drugs</a> 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)   | \$200 <a href="#">Copay</a> / visit                                                                                | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                         |
|                                                                           | Physician/surgeon fees                           | \$200 <a href="#">Copay</a> / visit                                                                                | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                         |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 30% <a href="#">Coinsurance</a>                                                                                    | 30% <a href="#">Coinsurance</a>                    | None                                                                                                                                                                                                                                                                                                                           |
|                                                                           | <a href="#">Emergency medical transportation</a> | 30% <a href="#">Coinsurance</a>                                                                                    | 30% <a href="#">Coinsurance</a>                    | 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 <a href="#">network</a> ground/water ambulance <a href="#">provider</a> , you may be subject to <a href="#">balance billing</a> . |
|                                                                           | <a href="#">Urgent care</a>                      | \$35 <a href="#">Copay</a> / visit                                                                                 | Not covered                                        | None                                                                                                                                                                                                                                                                                                                           |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 30% <a href="#">Coinsurance</a>                                                                                    | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                         |
|                                                                           | Physician/surgeon fees                           | 30% <a href="#">Coinsurance</a>                                                                                    | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                         |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | Office Visit: \$5 <a href="#">Copay</a> / visit;<br>Other Outpatient Services: \$200 <a href="#">Copay</a> / visit | Not covered                                        | Prior authorization may be required. Covered No Limit. ( <a href="#">Primary Care Provider</a> (PCP) and other practitioner office visits do not require prior authorization.)                                                                                                                                                 |
|                                                                           | Inpatient services                               | 30% <a href="#">Coinsurance</a>                                                                                    | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                         |
| If you are pregnant                                                       | Office visits                                    | \$5 <a href="#">Copay</a> / visit                                                                                  | Not covered                                        | Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> , such as routine pre-                                                                       |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                                                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                      |
|----------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | Network Provider<br>(You will pay the least)                                                 | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                |                                           |                                                                                              |                                                    | natal and post-natal <a href="#">screenings</a> . Depending on the type of services, <a href="#">coinsurance</a> , <a href="#">deductible</a> or <a href="#">copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).                                                                                                                                                                                      |
|                                                                | Childbirth/delivery professional services | 30% <a href="#">Coinsurance</a>                                                              | Not covered                                        | Prior authorization may be required. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).                                                                                                             |
|                                                                | Childbirth/delivery facility services     | 30% <a href="#">Coinsurance</a>                                                              | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | 30% <a href="#">Coinsurance</a>                                                              | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                | <a href="#">Rehabilitation services</a>   | Outpatient: \$50 <a href="#">Copay</a> / visit<br>Inpatient: 30% <a href="#">Coinsurance</a> | 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.<br>Inpatient: Prior authorization may be required. Covered No Limit. |
|                                                                | <a href="#">Habilitation services</a>     | Outpatient: \$50 <a href="#">Copay</a> / visit<br>Inpatient: 30% <a href="#">Coinsurance</a> | 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 when provided for a mental health/substance                                                                                     |

| Common Medical Event                   | Services You May Need                     | What You Will Pay                                    |                                                    | Limitations, Exceptions, & Other Important Information                                    |
|----------------------------------------|-------------------------------------------|------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------|
|                                        |                                           | Network Provider<br>(You will pay the least)         | Out-of-Network Provider<br>(You will pay the most) |                                                                                           |
|                                        |                                           |                                                      |                                                    | use disorder diagnosis. Inpatient: Prior authorization may be required. Covered No Limit. |
|                                        | <a href="#">Skilled nursing care</a>      | 30% <a href="#">Coinsurance</a>                      | Not covered                                        | Prior authorization may be required. Limited to 45 days per year.                         |
|                                        | <a href="#">Durable medical equipment</a> | 30% <a href="#">Coinsurance</a>                      | Not covered                                        | Prior authorization may be required. Covered No Limit.                                    |
|                                        | <a href="#">Hospice services</a>          | 30% <a href="#">Coinsurance</a>                      | Not covered                                        | Prior authorization may be required. Covered No Limit.                                    |
| If your child needs dental or eye care | Children's eye exam                       | No charge; <a href="#">deductible</a> does not apply | Not covered                                        | Limited to 1 visit per year.                                                              |
|                                        | Children's glasses                        | No charge; <a href="#">deductible</a> 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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)                      |                                                                                                                        |                                                                                                                                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Abortion (Except in cases of rape, incest, or when the life of the member is endangered)</li> <li>Acupuncture</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>Dental care (Children)</li> <li>Hearing aids</li> <li>Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> <li>Routine eye care (Adult)</li> </ul> |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                                                                            |                                                                                                                                                                                |                                                                                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Bariatric surgery (Limited to 1 surgery per lifetime)</li> <li>Chiropractic care (Limited to 30 combined visits per year (combined for occupational therapy, physical therapy and chiropractic care))</li> </ul> | <ul style="list-style-type: none"> <li>Infertility treatment (Limited to services for diagnostic tests to find the cause of infertility)</li> <li>Routine foot care</li> </ul> | <ul style="list-style-type: none"> <li>Weight loss programs (Weight loss programs under the supervision of a physician &amp; obesity counseling)</li> </ul> |

**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); Michigan [Health Insurance](#) Consumer Assistance Program, 530 West Allegan Street, 7th Floor, Lansing, MI, 48933, Phone: 1-877-999-6442;; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); Michigan Consumer Assistance Program at 1-877-999-6442; or 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](http://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: Michigan [Health Insurance](#) Consumer Assistance Program, 530 West Allegan Street, 7th Floor, Lansing, MI, 48933, Phone: 1-877-999-6442. Additionally, a consumer assistance program can help you file your [appeal](#). Contact Michigan Consumer Assistance Program at 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 the 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): Dinekehgo 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0  |
| ■ <a href="#">Specialist copayment</a>                          | \$60 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%  |
| ■ Other <a href="#">coinsurance</a>                             | 30%  |

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$600          |
| <a href="#">Coinsurance</a>       | \$2,500        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,160</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |      |
|-----------------------------------------------------------------|------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0  |
| ■ <a href="#">Specialist copayment</a>                          | \$60 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%  |
| ■ Other <a href="#">coinsurance</a>                             | 30%  |

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$1,100        |
| <a href="#">Coinsurance</a>       | \$200          |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,320</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |      |
|-----------------------------------------------------------------|------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0  |
| ■ <a href="#">Specialist copayment</a>                          | \$60 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%  |
| ■ Other <a href="#">coinsurance</a>                             | 30%  |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic tests](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$500          |
| <a href="#">Coinsurance</a>       | \$600          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,100</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

|                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>English:</b>    | 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).                                                                                                           |
| <b>Spanish:</b>    | Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Meridian y no domina el inglés, tiene derecho a obtener ayuda e información en su idioma sin costo alguno y de manera oportuna. Si usted, o alguien a quien está ayudando, tiene un impedimento auditivo o visual que le dificulta la comunicación, tiene derecho a recibir ayuda y servicios auxiliares sin costo alguno y de manera oportuna. Para recibir servicios auxiliares o de traducción, comuníquese con Servicios para Miembros al 1-833-993-2426 (TTY Relay 711).                                                                                       |
| <b>Arabic:</b>     | إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter from Meridian، ولم تكن بارعًا باللغة الإنكليزية، فلديك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أي تكلفة وفي الوقت المناسب. إذا كنت أنت أو أي شخص تساعد تعاني من حالة سمعية و/أو بصرية تعيق التواصل، فلديك الحق في تلقي مساعدات وخدمات إضافية من دون أي تكلفة وفي الوقت المناسب. لتلقي خدمات الترجمة أو خدمات إضافية، يرجى الاتصال بخدمات الأعضاء على 1-833-993-2426 (TTY Relay 711).                                                                                                                                                                                                      |
| <b>Chinese:</b>    | 如果您或您正在協助的對象對 Ambetter from Meridian 所提供的任何服務有問題，且不精通英語，您有權利免費並及時以您的母語獲得幫助和訊資訊。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)。                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Tagalog:</b>    | 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). |
| <b>Vietnamese:</b> | 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 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 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 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 1-833-993-2426 (TTY Relay 711).                                                                                                           |
| <b>German:</b>     | 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).                                                                             |
| <b>Korean:</b>     | 귀하 또는 귀하의 도움을 받는 분이 Ambetter from Meridian에 대한 질문이 있는 경우 영어에 능숙하지 않으면 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. 통역 또는 보조 서비스를 받으시려면 1-833-993-2426 (TTY Relay 711)번으로 가입자 서비스부에 연락해주시요.                                                                                                                                                                                                                                                                                                                                                                              |

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