



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 <u>deductible</u>?	\$0 at Indian Health Care <u>Provider</u> (IHCP) or with IHCP <u>referral</u> at non-IHCP; or \$6,000 individual / \$12,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> services, primary care, <u>specialist</u> , and <u>urgent care</u> visits, and certain <u>prescription drugs</u> are covered before you meet your <u>deductible</u> (see additional information below).	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
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>?	For <u>network providers</u> : \$8,900 individual / \$17,800 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 failure to obtain <u>preauthorization</u> for services, and 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 limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See https://ambetterhealth.com/en/mi/findadoc 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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	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	\$40 Copay / visit; deductible does not apply	Not covered	Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
	Specialist visit	No charge	\$80 Copay / visit; deductible does not apply	Not covered	None Cost sharing waived at non-IHCP with IHCP referral .
	Preventive care/screening/immunization	No charge	No charge; deductible does not apply	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	40% Coinsurance for laboratory & professional services 40% Coinsurance for x-ray & diagnostic imaging 40% Coinsurance for laboratory & professional services and x-ray & diagnostic imaging at other places of service	Not covered	Prior authorization may be required. Covered No Limit. Other places of service may include: Hospital, Emergency Room, or Outpatient Facility. Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits. Cost sharing waived at non-IHCP with IHCP referral .
	Imaging (CT/PET)	No charge	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
	scans, MRIs)				Cost sharing waived at non-IHCP with IHCP referral .
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://ambetterhealth.com/en/mi/2026formulary	Generic drugs	No charge	Tier 1a - Preferred Generic Retail: \$20 Copay / prescription; deductible does not apply Tier 1b - Generic Retail: \$20 Copay / prescription; deductible does not apply	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount. Cost sharing waived at non-IHCP with IHCP referral .
	Preferred brand drugs	No charge	Tier 2 - Retail: \$40 Copay / prescription; deductible does not apply	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount. Cost sharing waived at non-IHCP with IHCP referral .
	Non-preferred brand drugs and Non-preferred generic drugs	No charge	Tier 3 - Retail: \$80 Copay / prescription	Not covered	
	Specialty drugs	No charge	Tier 4 - Retail: \$350 Copay / prescription	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 30 days through mail order. Cost sharing waived at non-IHCP with IHCP referral
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
	Physician/surgeon fees	No charge	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
If you need	Emergency room	No charge	40% Coinsurance	40%	None Cost sharing waived at non-IHCP with IHCP

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
immediate medical attention	care			Coinsurance	referral .
	Emergency medical transportation	No charge	40% Coinsurance	40% Coinsurance	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 . Cost sharing waived at non-IHCP with IHCP referral .
	Urgent care	No charge	\$60 Copay / visit; deductible does not apply	Not covered	None Cost sharing waived at non-IHCP with IHCP referral .
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
	Physician/surgeon fees	No charge	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Office Visit: \$40 Copay / visit; deductible does not apply; Other Outpatient Services: 40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. (Primary Care Provider (PCP) and other practitioner office visits do not require prior authorization.) Cost sharing waived at non-IHCP with IHCP referral .
	Inpatient services	No charge	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
If you are pregnant	Office visits	No charge	\$40 Copay / visit; deductible does not apply	Not covered	Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. Cost-sharing does not apply for preventive services , such as routine pre-natal and post-natal screenings . Depending on the type of

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
					services, coinsurance , deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Cost sharing waived at non-IHCP with IHCP referral .
	Childbirth/delivery professional services	No charge	40% Coinsurance	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). Cost sharing waived at non-IHCP with IHCP referral
	Childbirth/delivery facility services	No charge	40% Coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
	Rehabilitation services	No charge	Outpatient: \$40 Copay / visit; deductible does not apply Inpatient: 40% Coinsurance	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. Cost sharing waived at non-IHCP with IHCP referral .
	Habilitation services	No charge	Outpatient: \$40 Copay / visit; deductible does not apply Inpatient: 40% Coinsurance	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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
					Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
	Skilled nursing care	No charge	40% Coinsurance	Not covered	Prior authorization may be required. Limited to 45 days per year. Cost sharing waived at non-IHCP with IHCP referral .
	Durable medical equipment	No charge	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
	Hospice services	No charge	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
If your child needs dental or eye care	Children's eye exam	No charge	No charge; deductible does not apply	Not covered	Limited to 1 visit per year. Cost sharing waived at non-IHCP with IHCP referral .
	Children's glasses	No charge	No charge; deductible does not apply	Not covered	Limited to 1 item per year. Cost sharing waived at non-IHCP with IHCP referral .
	Children's dental check-up	Not covered	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
- Abortion (Except in cases of rape, incest, or when the life of the member is endangered) - Acupuncture - Cosmetic surgery	- Dental care (Children) - Hearing aids - Long-term care	- Non-emergency care when traveling outside the U.S. - Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
Bariatric surgery (Limited to 1 surgery per lifetime)	Infertility treatment (Limited to services for diagnostic tests to find the cause of infertility)	- Routine foot care - Weight loss programs (Weight loss programs)

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

- Chiropractic care (Limited to 30 combined visits per year (combined for occupational therapy, physical therapy and chiropractic care))
- Routine eye care (Adult-one visit, one frame, and one pair of lenses. Dollar allowances apply to hardware.)
- Dental care (Adult-visit & item limits apply per year. \$1,000 annual dollar limit per year per person.)
- 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); 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 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): Dine'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	\$6,000
■ Specialist copayment	\$80
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
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	\$6,000
■ Specialist copayment	\$80
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
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	\$6,000
■ Specialist copayment	\$80
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$0

Note: These numbers assume the patient received care from an IHCP [provider](#) or with IHCP [referral](#) at a non-IHCP. If you receive care from a non-IHCP [provider](#) without a [referral](#) from an IHCP your costs may be higher.

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



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 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).
Arabic:	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).
Chinese:	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)。
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).
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 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).
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).
Korean:	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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