This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.meridianchoice.com or by calling 1-855-537-9746

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,200 Individual/$4,400 Family** Does not apply to preventive care or prescription drugs.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	**$1,000 Individual/$2,000 Family** for prescription drug expenses	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes, **$3,500 Individual/$7,000 Family**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and services not covered by Meridian Choice.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, see www.meridianchoice.com or call **1-855-537-9746**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. Prior Authorization is required before seeing a specialist.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network providers by charging you lower **deductibles**, **copayments** and **coinsurance** amounts. You will be responsible for all costs incurred by out-of-network providers unless you obtain Prior Authorization from the plan.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit.	Not covered	None
	Specialist visit	$35 copay/visit	Not covered	Prior Authorization required or no coverage provided
	Other practitioner office visit	20.00% Coinsurance after deductible	Not covered	Prior Authorization required or no coverage provided
	Preventive care/screening/immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance/test	Not covered	Prior Authorization required or no coverage provided
	Imaging (CT/PET scans, MRIs)	20% coinsurance/test	Not covered	Prior Authorization required or no coverage provided

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.meridianchoice.com	Generic drugs	$8 copay/prescription	Not covered	Coverage and Prior Authorization requirements indicated on formulary
	Preferred brand drugs	$20 copay/prescription after deductible has been met	Not covered	
	Non-preferred brand drugs	35% coinsurance per prescription	Not covered	
	Specialty drugs	35% coinsurance per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Prior Authorization required or not covered
	Physician/surgeon fees	20% coinsurance	Not covered	
If you need immediate medical attention	Emergency room services	20% coinsurance/visit	0% coinsurance/visit	None
	Emergency medical transportation	20% coinsurance/trip	0% coinsurance/trip	
	Urgent care	20% coinsurance/visit	0% coinsurance/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance/stay	Not covered	Prior authorization required or not covered
	Physician/surgeon fee	20% coinsurance	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance /visit	Not covered	Prior Authorization required or not covered
	Mental/Behavioral health inpatient services	20% coinsurance /stay	Not covered	
	Substance use disorder outpatient services	20% coinsurance /visit	Not covered	
	Substance use disorder inpatient services	20% coinsurance/stay	Not covered	
If you are pregnant	Prenatal and postnatal care	20% coinsurance/visit or service	Not covered	Prior Authorization required or not covered
	Delivery and all inpatient services	20% coinsurance/stay	20% coinsurance/stay	None

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance/service	Not covered	Prior Authorization required or not covered
	Rehabilitation services	20% coinsurance/service	Not covered	Prior Authorization required or not covered. Limited to 30 visits per year for each of the following: physical/occupational therapy; speech therapy; and cardiac/pulmonary therapy.
	Habilitation services	20% coinsurance/service	Not covered	Prior Authorization required or not covered
	Skilled nursing care	20% coinsurance/service	Not covered	Prior Authorization required or not covered. Coverage limited to 45 days per year.
	Durable medical equipment	20% coinsurance/service	Not covered	Prior Authorization required or not covered
	Hospice service	20% coinsurance/service	Not covered	Prior Authorization required or not covered. Hospice care provided in a hospice care facility is limited to 45 days per year. Hospice care provided in the home is not subject to the 45 day limitation.
If your child needs dental or eye care	Eye exam	20% coinsurance/visit	Not covered	Only available for those Enrollees aged 17 or younger. Prior Authorization is required. Limit one routine eye exam per year.
	Glasses	20% coinsurance/pair of frames and lenses	Not covered	Only available for those Enrollees aged 17 or younger. Prior Authorization is required. Limit one pair of prescription frames and lenses per year.
	Dental check-up	Not covered. Stand-alone dental plans are available on the Exchange.	Not covered	N/A

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Dental check-up for children
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the United States
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care (subject to 30 visit limitation on physical/occupational therapy)
- Bariatric surgery (once per lifetime)
- Weight loss programs

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-537-9746. You may also contact your State insurance department at 1-877-999-6442.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Member Services at 1-855-537-9746. Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) operated by the Michigan Department of Insurance and Financial Services at 1-877-999-6442. More information about HICAP is available at www.michigan.gov/HICAP.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 855-537-9746.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-537-9746.]

[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**855-537-9746.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 855-537-9746.]

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $110
- **Patient pays** $7,430

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,220
Copays	$0
Coinsurance	1,010
Limits or exclusions	$150
Total	**$3,380**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $50
- **Patient pays** $5,350

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$3,200
Copays	$220
Coinsurance	$40
Limits or exclusions	$80
Total	**$3,540**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.