

# Meridian Choice “Bronze 2”: Meridian Health Plan

## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 1/1/2014-12/31/2014

Coverage for: Individual | Plan Type: HMO



**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.mhplan.com/meridianchoice](http://www.mhplan.com/meridianchoice) or by calling 1-855-537-9746.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$ 4,700</b> Does not apply to preventive care or prescription drugs.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1 <sup>st</sup> ). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes, <b>\$6,350</b>	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and services not covered by Meridian Choice.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <u>network</u> of providers?	Yes. For a list of participating providers, see <a href="http://www.mhplan.com/meridianchoice/providerdirectory">www.mhplan.com/meridianchoice/providerdirectory</a> or call 1-855-537-9746.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	Yes. Referral by your Primary Care Provider is required, either orally or in writing to Meridian Choice, before you see a specialist.	This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the plan's permission before you see the <u>specialist</u> .
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for information about <u>excluded services</u> .

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Corrected on May 11, 2012

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- **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 requires you to obtain services from in-network providers unless otherwise noted. You will be responsible for all costs incurred by out-of-network providers unless you obtain pre-certification 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	No charge and not subject to deductible for up to three (3) visits per year. Subsequent visits subject to deductible and 50% coinsurance/visit.	Not covered	None.
	Specialist visit	50% coinsurance/visit	Not covered	Pre-Certification required or no coverage provided.
	Other practitioner office visit	50% coinsurance	Not covered	Pre-Certification 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)	50% coinsurance/test	Not covered	Pre-Certification required or no coverage provided
	Imaging (CT/PET scans, MRIs)	50% coinsurance/test	Not covered	Pre-Certification required

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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
<b>If you need drugs to treat your illness or condition</b>  More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.mhplan.com/meridianchoice">www.mhplan.com/meridianchoice</a> .	Generic drugs	\$35 copay	Not covered	Coverage and Pre-Certification requirements indicated on formulary.
	Preferred brand drugs	\$100 copay/prescription	Not covered	
	Non-preferred brand drugs	\$200 copay/prescription	Not covered	
	Specialty drugs	\$200 copay/prescription	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	Not covered	Pre-Certification required or not covered
	Physician/surgeon fees	50% coinsurance	Not covered	
<b>If you need immediate medical attention</b>	Emergency room services	50% coinsurance/visit	50% coinsurance/visit	None
	Emergency medical transportation	50% coinsurance/trip	50% coinsurance/trip	
	Urgent care	50% coinsurance/visit	50% coinsurance/visit	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	50% coinsurance/stay	Not covered	Pre-Certification required or not covered
	Physician/surgeon fee	50% coinsurance	Not covered	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	50% coinsurance/visit	Not covered	Pre-Certification required or not covered
	Mental/Behavioral health inpatient services	50% coinsurance/stay	Not covered	
	Substance use disorder outpatient services	50% coinsurance/visit	Not covered	
	Substance use disorder inpatient services	50% coinsurance/stay	Not covered	
<b>If you are pregnant</b>	Prenatal and postnatal care	50% coinsurance/visit or service	Not covered	Pre-Certification required or not covered
	Delivery and all inpatient services	50% coinsurance/stay	50% coinsurance/stay	None

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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
<b>If you need help recovering or have other special health needs</b>	Home health care	50% coinsurance/service	Not covered	Pre-Certification required or not covered.
	Rehabilitation services	50% coinsurance/service	Not covered	Pre-Certification required or not covered. Limited to 30 visits per year for each of the following categories: physical/occupational therapy; speech therapy; and cardiac/pulmonary therapy.
	Habilitation services	50% coinsurance/service	Not covered	Pre-Certification required or not covered.
	Skilled nursing care	50% coinsurance/service	Not covered	Pre-Certification required or not covered. Coverage limited to 45 days per year.
	Durable medical equipment	50% coinsurance/service	Not covered	Pre-Certification required or not covered.
	Hospice service	50% coinsurance/service	Not covered	Pre-Certification required or not covered. Coverage limited to 45 days per year.
<b>If your child needs dental or eye care</b>	Eye exam	50% coinsurance/visit	Not covered	Only available for those Enrollees aged 17 or younger. Pre-Certification is required. Limit one routine eye exam per year.
	Glasses	50% coinsurance/pair of frames and lenses	Not covered	Only available for those Enrollees aged 17 or younger. Pre-Certification 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

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## 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](http://www.michigan.gov/HICAP).

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## 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?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

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## Coverage Examples

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## 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 \$1,390
- Patient pays \$6,150

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$4,700
Copays	\$20
Coinsurance	\$1,280
Limits or exclusions	\$150
<b>Total</b>	<b>\$6,150</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$1,510
- Patient pays \$3,890

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$2,420
Copays	\$1,390
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$3,890</b>

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## 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.

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