



This is only a summary. If you want more detail about your coverage and costs, get the complete terms of your policy or plan at www.meritusaz.com or by calling 1-855-755-2700.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$800 person, \$1,600 family Doesn't apply to preventative care, outpatient radiology, pathology, lab, PCP, specialist and urgent care visits, and prescription drugs	You must pay yearly costs up to the <u>deductible</u> amount before this plan begins to pay for covered services. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). The chart 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. There are no other specific <u>deductibles</u> .	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. \$5,500 person, \$11,000 family	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, alternative benefits and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network</u> of <u>providers</u> ?	Yes. See www.meritusaz.com or call 1-855-755-2700 for a list of in-network providers.	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 starting 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, written referral is required for Allergist, Cardiac surgeon, Dermatologist, Genetics, Pain management, Plastics, Radiology and Imaging Rehabilitation services, Sleep studies, Transplant surgeon.	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 specialist.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 1-855-755-2700 or visit us at www.meritusaz.com. If you aren't clear about any of the underlined terms in this form, see the glossary. You can view the Glossary of underlined terms at www.ccio.cms.gov or call 1-855-755-2700 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** (coins.) is *your* share of the covered service costs, calculated as a percent of the **allowed amount** for the service after your deductible has been met. For example, if the **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200.
- 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 (called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost for an In-Network Provider	Your Cost for an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$0 copay	Not covered	_____none_____
	Specialist visit	\$50 copay per visit	Not covered	_____none_____
	Other practitioner office visit	\$0 copay	Not covered	_____none_____
	Preventive care per screening per immunization	\$0 copay	Not covered	_____none_____
If you have a test	Diagnostic test (x-ray, blood work)	\$25 copay per test	Not covered	_____none_____
	Imaging (CT per PET scans, MRIs)	\$125 copay per test	Not covered	_____none_____

Common Medical Event	Services You May Need	Your Cost for an In-Network Provider	Your Cost for an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.meritusaz.com	Generic drugs, Non-Maintenance	\$5 copay retail 30-day supply \$15 copay mail order 90-day supply.	Not covered	_____none_____
	Generic Drugs, Maintenance	\$0 copay retail 30-day supply \$0 copay mail order 90-day supply		
	Preferred brand drugs	\$35 copay retail 30-day supply \$105 copay mail order 90-day supply	Not covered	_____none_____
	Non-preferred brand drugs	\$75 copay retail 30-day supply \$225 copay mail order 90-day supply	Not covered	_____none_____
	Specialty drugs	20% coinsurance retail 30-day supply and mail order 90-day supply	Not covered	_____none_____
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$200 copay per visit	Not covered	_____none_____
	Physician per surgeon fees	\$0 copay	Not covered	_____none_____
If you need immediate medical attention	Emergency room services	\$500 copay per visit	Not covered	If not admitted.
	Emergency medical transportation	\$0 copay	Not covered	_____none_____
	Urgent care	\$75 copay per visit	Not covered	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 copay per admit	Not covered	After deductible
	Physician per surgeon fee	\$0 copay	Not covered	After deductible

Questions: Call 1-855-755-2700 or visit us at www.meritusaz.com. If you aren't clear about any of the underlined terms in this form, see the glossary. You can view the Glossary of **underlined** terms at www.cciio.cms.gov or call 1-855-755-2700 to request a copy.

If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$25 copay per visit	Not covered	First 3 visits no charge, then \$25 per visit visit
	Mental/Behavioral health inpatient services	\$500 copay per admit	Not covered	After deductible
	Substance use disorder outpatient services	\$25 copay per visit	Not covered	First 3 visits no charge, then \$25 per visit
	Substance use disorder inpatient services	\$500 copay per admit	Not covered	After deductible
If you are pregnant	Prenatal and postnatal care	\$0 copay	Not covered	—————none—————
	Delivery and all inpatient services	\$500 copay per admit	Not covered	After deductible
If you need help recovering or have other special needs	Home health care	\$25 copay per visit	Not covered	Limited to 42 visits per year
	Rehabilitation services	\$25 copay per visit	Not covered	Limited to 60 visits per year
	Habilitation services	\$25 copay per visit	Not covered	—————none—————
	Skilled nursing care	\$25 copay per visit	Not covered	Limited to 90 days per year
	Durable medical equipment	\$25 copay per visit	Not covered	—————none—————
	Hospice service	\$25 copay per visit	Not covered	—————none—————
	Transplants	\$500 copay per admit	Not covered	After deductible
If your child needs dental or eye care	Eye exam	\$25 copay per visit	Not covered	1 visit per year
	Glasses	\$25 copay per visit	Not covered	1 item per year
	Dental check-up	\$0 copay	Not covered	1 visit every 6 months

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 <u>excluded services</u> .)		
• Cosmetic surgery • Infertility treatment	• Long-term care • Non-emergency care when travelling outside of the U.S.	• Private nursing duty • Weight loss programs
Other Covered Services (This isn't a complete list. Check your policy document for other covered services and your costs.)		
• Bariatric surgery • Dental care (adult)	• Hearing aids • Routine eye care (adult)	• Routine foot care

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
- We stop offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact us at 1-855-755-2700. You may also contact the Arizona Department of Insurance at (602) 364-2499 in Phoenix or (800) 325-2548 outside of Phoenix or consumers@azinsurance.gov.

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 Customer Care at 1-855-755-2700. You may also contact the Arizona Department of Insurance at (602) 364-2499 in Phoenix or (800) 325-2548 outside of Phoenix or consumers@azinsurance.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Arizona Department of Insurance at (602) 364-2499 in Phoenix or (800) 325-2548 outside of Phoenix or consumers@azinsurance.gov.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-755-2700.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-755-2700.

—————*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:** Data not available
- **Plan pays:** Data not available
- **Patient pays:** Data not available

Sample care costs: Data not available

Hospital charges (mother)	
Routine obstetric care	
Hospital charges (baby)	
Anesthesia	
Laboratory tests	
Prescriptions	
Radiology	
Vaccines, other preventive	
Total	

Patient pays: Data not available

Deductibles	
Copays	
Coinsurance	
Limits or exclusions	
Total	

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

- **Amount owed to providers:** Data not available
- **Plan pays:** Data not available
- **Patient pays:** Data not available

Sample care costs: Data not available

Prescriptions	
Medical Equipment and Supplies	
Office Visits and Procedures	
Education	
Laboratory tests	
Vaccines, other preventive	
Total	

Patient pays: Data not available

Deductibles	
Copays	
Coinsurance	
Limits or exclusions	
Total	

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 might 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. They are for comparative purposes only. Your own costs will depend 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.

Should I consider other costs 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.