



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.meritain.com or by calling Meritain Health, Inc. at **(866) 300-8449**.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	For participating providers : \$300 person / \$900 family; For non-participating providers : \$1,200 person / \$3,600 family	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?	No.	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. For participating providers : \$4,000 person / \$8,000 For non-participating providers : Unlimited	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 health care this plan doesn't cover.	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 <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers ?	Yes. Blue Cross® Blue Shield® of Arizona. See www.azblue.com or call (800) 232-2345 for a list of participating providers .	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 starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

Questions: Call Meritain Health, Inc. at **(866) 300-8449** or visit us at www.meritain.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call **(866) 300-8449** 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** 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 a non-participating **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-participating **provider** 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 participating **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or an illness	\$25 copay/visit	50% coinsurance	Deductible does not apply for participating providers. Copay applies per visit regardless of what services are rendered.
	Specialist visit	\$35 copay/visit	50% coinsurance	
	Other practitioner office visit	\$25 copay/visit for chiropractor	50% coinsurance for chiropractor	Deductible does not apply for participating providers. Limited to 20 visits per year.
	Preventive care/screening/immunization	Preventive services: No charge Routine care: No charge for the first \$300 per year, then 90% Flu vaccines/pneumonia & shingles vaccinations: No charge Hearing exam: \$25 copay/exam	No charge for flu vaccines, pneumonia and shingles vaccinations Hearing exam: 50% coinsurance All other routine care: Not covered	Deductible does not apply for participating providers. No deductible for flu vaccines, pneumonia and shingles vaccinations for non-participating providers. Hearing exams limited to 1 per year.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	50% coinsurance	For any tests performed at a participating provider freestanding laboratory, you pay \$25 copay with no deductible.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	50% coinsurance	Precertification required. Failure to precertify will result in a 20% penalty.
If you need drugs to treat	Generic drugs	\$15 copay (retail) / \$30 copay (mail order)	Not Covered	Deductible does not apply. Covers up to a 30-day supply (retail prescription); 90-day supply (available only by mail)

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
your illness or condition. More information about <u>prescription drug coverage</u> is available at www.myCatamaranrx.com	Preferred drugs	20% copay (\$25 min, \$80 max)(retail) / 20% copay (\$50 min, \$175 max) (mail order)	Not Covered	order). Copay applies per prescription. Plan requires pharmacies to dispense generic drugs when available. If you choose a preferred or non-preferred drug over a generic equivalent, you will be responsible for the cost difference between the generic & preferred or non-preferred drug as well as the preferred or non-preferred copay, even if a DAW prescription is written by the physician. No charge or deductible for preventive drugs. Diabetic medications will have \$5 copay (retail) /\$10 copay (mail order) for generic and \$10 copay (retail)/\$30 copay (mail order) for brand name when enrolled in the Catamaran Diabetic Sense Program. This plan will allow maintenance medications to be filled at retail in 30 day quantities only and will be subject to appropriate copay upon each 30 day refill. Member must choose mail order to receive a 90 day quantity on a maintenance drug and benefit from paying only 2 copays for a 3 month (90 day supply).
	Non-preferred drugs	30% copay (\$40 min, \$110 max) (retail) / 30% copay (\$80 min, \$225 max) (mail order)	Not Covered	
	Specialty drugs	20% copay (\$100 min, \$150 max)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	50% coinsurance	Precertification required unless performed in an office setting. Failure to precertify will result in a 20% penalty. For participating physician office surgery under \$1,000 cost is \$25 copay/occurrence (PCP) or \$35 copay/occurrence (specialist) with no deductible. Surgery over \$1,000 cost is 15% coinsurance after deductible (PCP & specialist).
	Physician/surgeon fees	15% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room services	15% coinsurance (medical and non-medical emergency)	15% coinsurance (medical emergency) / 50% coinsurance (non-medical emergency)	Non-participating providers paid at the participating provider level of benefits for medical emergency only.
	Emergency medical transportation	15% coinsurance per trip (ground) / \$200 copay/trip + 15% coinsurance (air)	15% coinsurance per trip (ground) / \$200 copay/trip + 15% coinsurance (air)	Non-participating providers paid at the participating provider level of benefits.
	Urgent Care	\$50 copay/visit + 15% coinsurance	\$50 copay/visit + 50% coinsurance	Deductible does not apply for participating providers.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 copay/admission + 15% coinsurance	\$300 copay/admission + 50% coinsurance	Deductible does not apply for participating provider facility fees. Precertification required. Failure to precertify will result in a 20% penalty.
	Physician/surgeon fee	15% coinsurance	50% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	15% coinsurance (facility charge)/ \$25 copay/visit (office visit)	50% coinsurance	Deductible does not apply to office visits for participating providers.
	Mental/Behavioral health inpatient services	\$250 copay/admission + 15% coinsurance (facility charge) / 15% coinsurance (professional fees)	\$300 copay/admission + 50% coinsurance (facility charge) 50% coinsurance (professional fees)	Deductible does not apply to facility fees for participating providers. Precertification required. Failure to precertify will result in a 20% reduction penalty.
	Substance use disorder outpatient services	15% coinsurance (facility charge)/\$25 copay/visit (office visit)	50% coinsurance	Deductible does not apply to office visits for participating providers.
	Substance use disorder inpatient services	\$250 copay/admission + 15% coinsurance (facility charge) / 15% coinsurance (professional fees)	\$300 copay/admission + 50% coinsurance (facility charge) 50% coinsurance (professional fees)	Deductible does not apply to facility fees for participating providers. Precertification required. Failure to precertify will result in a 20% reduction penalty.
If you are pregnant	Prenatal and postnatal care	15% coinsurance	50% coinsurance	There is no charge for preventive prenatal care and certain breastfeeding support and supplies from a participating provider.
	Delivery and all inpatient services	15% coinsurance (professional fees) / \$250 copay/admission + 15% coinsurance (facility charges)	50% coinsurance (professional fees) / \$300 copay/admission + 50% (facility charges)	Deductible does not apply for participating provider facility fees. Precertification required for inpatient Hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs. (C-section). Failure to precertify will result in a 20% s penalty. Baby counts towards the mother's expense.
If you need help recovering or have other special health needs	Home health care	15% coinsurance	50% coinsurance	Limited to 60 visits per calendar year. Home health care supplies not subject to the calendar year maximum.
	Rehabilitation services	\$25 copay/visit	50% coinsurance	Deductible does not apply for participating providers. Includes physical, speech & occupational therapy. Limited to 60 visits per year per type of therapy.
	Habilitation services	Not Covered	Not Covered	This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism and to expenses covered as a preventive service.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Skilled nursing care	\$250 copay/admission + 15% coinsurance	\$300 copay/admission + 50% coinsurance	Deductible does not apply for participating providers. Limited to 60 days per 12 months. Precertification required. Failure to precertify will result in a 20% penalty.
	Durable medical equipment	15% coinsurance	50% coinsurance	Precertification required for any item in excess of \$1,500. Failure to precertify will result in a 20% penalty.
	Hospice service	15% coinsurance (outpatient) / \$250 copay/admission + 15% coinsurance (inpatient)	50% coinsurance (outpatient) / \$300 copay/admission + 50% coinsurance (inpatient)	Deductible does not apply for participating provider inpatient services. Bereavement counseling is not covered. Precertification of hospice services required. Failure to precertify will result in a 20% penalty.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Covered under stand alone vision plan.
	Glasses	Not Covered	Not Covered	Covered under stand alone vision plan.
	Dental check-up	Not Covered	Not Covered	Covered under stand alone dental plan.

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
- Bereavement counseling
- Cosmetic surgery
- Dental care (covered under stand alone dental plan)
- Glasses (covered under stand alone vision plan)
- Habilitation services (except autism & preventive services)
- Infertility treatment (except diagnosis)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (except for home health care & hospice)
- Routine eye care (covered under stand alone vision plan)
- Routine foot care
- Weight loss programs

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.)

- Bariatric surgery (for the treatment of morbid obesity only)
- Chiropractic care
- Hearing aids

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact Meritain Health, Inc. at (866) 300-8449. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.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 Meritain Health, Inc. at (866) 300-8449.

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.**

Language Access Services:

(Español): Para obtener asistencia en Español, llame al 1-800-378-1179.

(Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.

(Chinese): (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-378-1179.

(Dine): Dinek'ehgo shika at'ohwol ninisingo, kwüijigo holne' 1-800-378-1179.

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 \$5,820
- Patient pays \$1,720

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	\$300
Copays	\$290
Coinsurance	\$980
Limits or exclusions	\$150
Total	\$1,720

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

- Amount owed to providers: \$5,400
- Plan pays \$3,870
- Patient pays \$1,360

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	\$300
Copays	\$990
Coinsurance	\$160
Limits or exclusions	\$80
Total	\$1,530

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.
- Coverage examples are based on single coverage only.
- 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 participating **providers**. If the patient had received care from non-participating **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.

Questions: Call Meritain Health, Inc. at (866) 300-8449 or visit us at www.meritain.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call (866) 300-8449 to request a copy.