PPO & PPO HSA Plans

Exclusions and Limitations

These Outlines of Coverage are only a brief summary of the major benefits. For more information, please refer to the Schedule of Benefits, the Comprehensive Health Insurance Policy, or call Meritus at 602-957-2113. In the event of an error, the Schedule of Benefits and Comprehensive Health Insurance Policy will prevail.

Meritus products and services are provided through Meritus Mutual Health Partners – PPO and Meritus Health Partners – HMO. A licensed health insurance producer may contact you to discuss enrollment in a Meritus health plan. Meritus Mutual Health Partners – PPO and Meritus Health Partners – HMO are licensed only in Arizona and are Qualified Health Plan issuers in the Health Insurance Marketplace.

All prescription drugs must be prescribed by a Physician and purchased at a Preferred Pharmacy (retail) or the Preferred Mail Order Pharmacy. No benefits are provided for prescription drugs purchased from a Non-Preferred Pharmacy or Non-Preferred Mail Order Pharmacy.

A Covered Person is not required to go to a Preferred Provider. At the time of services, the Covered Person my obtain treatment from a Preferred Provider or a Non-Preferred provider. However, to maximize the benefit reimbursement level under a policy, a Preferred Provider must be used. The insured will incur higher out-of-pockets costs if they chose to receive services from an out-of-network provider, and will be responsible for the difference between billed charges and the amount allowed by Meritus, other than copayments, coinsurance or any amounts that may remain on your annual deductible.

INDIVIDUAL AND GROUP PPO – EXCLUSIONS AND LIMITATIONS

No benefits will be paid for the following:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care for military service disabilities treatable through governmental services if the Member is legally entitled to such treatment and facilities are reasonably available.
3. Treatment of an illness or Injury which is due to war, declared or undeclared.
4. Charges for which the Covered Person is not obligated to pay or for which the Covered Person is not billed or would not have been billed except that he or she was covered under this Policy.
5. Assistance in the activities of daily living, including, but not limited to, eating, bathing, dressing or other custodial or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
6. Any Services and Supplies which are experimental, investigational or unproven. These services may be related to medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Plan to be:
   a. Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations; or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
   b. The subject of review or approval by an Institutional Review Board for the proposed use;
   c. The subject of an ongoing clinical trial that meets the definition of a phase I, II or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight (except as set forth in the Cancer Clinical Trials provision of this plan under Covered Benefits and Supplies; or
   d. Not demonstrated, through existing peer reviewed literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

7. Cosmetic surgery or surgical procedures primarily for the purpose of altering appearance, except for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. The exclusions include surgical excision or reformation of any sagging skin on any part of the body, including, the eyelids, face, neck, abdomen, arms, legs or buttocks; and services performed in connection with the enlargement, reduction, implantation, or change in appearance of portion of the body, including, the breast, face, lips, jaw, chin, nose, ears or genital; hair transplantation; chemical face peels or abrasion of the skin; electrolysis depilation; or any other surgical or non-surgical procedures which are primarily for the purpose of altering appearance. This does not exclude services or benefits that are primarily for the purpose of restoring normal bodily function such as surgery required to repair bodily damage a person receives from an injury. Non-life threatening complications of a non- covered cosmetic surgery are not covered. This includes, but is not limited to, subsequent surgery for reversal, revision or repair related to the procedure.
8. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics including braces, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies for a continuous course of dental treatment started within six months of an accidental injury to sound natural teeth are covered. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
9. The following bariatric procedures are excluded: open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, laparoscopic sleeve gastrectomy, and open adjustable gastric banding.
10. Unless otherwise included as a covered expense, reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
11. Court ordered treatment or hospitalization, unless such treatment is being sought by a Physician or otherwise covered under the Plan under Covered Benefits and Supplies.
12. Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
13. Treatment of erectile dysfunction and sexual dysfunction.
14. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Plan.
15. Non-medical ancillary services including, but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety, and services, training or educational therapy for learning disabilities, developmental delays, and mental retardation.
16. Therapy to improve general physical condition including, but not limited to, routine long term care.
17. Consumable medical supplies, including but not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the Inpatient Hospital Services, Outpatient Facility Services, Home Health Services, Diabetic Services and Supplies, or Breast Reconstruction, Ostomy Supplies and Breast Prostheses.
18. Private hospital rooms and/or private duty nursing are only available during inpatient stays and determined to be medically appropriate by the Plan. Private duty nursing is available only in an inpatient setting when skilled nursing is not available from the facility. Custodial Nursing is not covered by the Plan.
19. Personal or comfort items such as television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of Illness or Injury.
20. The following services and supplies are excluded: (a) elastic/compression stockings; (b) garter belts; (c) corsets; (d) dentures; (c) wigs; (d) hair pieces; (e) hair transplants; and (f) treatment of alopecia or hair loss.
21. Except as provided for Pediatric Vision Care in this Policy, no coverage will be provided for: (a) eyeglass lenses and frames and contact lenses (except for the first pair of contacts for treatment of keratoconus or post-cataract surgery); (b) routine refraction; and (c) eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
22. Acupuncture treatment unless shown as a Covered Benefit in the Schedule of Benefits.
23. Except as otherwise provided under this Policy, all

of the following are excluded: (a) non-injectable prescription drugs; (b) non-prescription drugs; and (c) investigational and experimental drugs.
24. Unless Medically Necessary, routine foot care, including: (a) the paring and removing of corns and calluses; or (b) trimming of nails.
25. Membership costs or fees associated with health clubs (unless "Gym Membership Reimbursement" is shown as a Covered Benefit in the Schedule of Benefits), and weight loss programs for persons with a BMI under 25.
26. Amniocentesis, ultrasound, or any other procedures requested solely for gender determination of a fetus, unless Medically Appropriate to determine the existence of a gender-linked genetic disorder.
27. Services rendered by a midwife for the purpose of home delivery.
28. Genetic testing and therapy including germ line and somatic unless determined Medically Appropriate by the Plan for the purpose of making treatment decisions.
29. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in our opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
30. Blood administration for the purpose of general improvement in physical condition.
31. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks, except as otherwise referenced as covered in this Policy.
32. Cosmetics, dietary supplements, nutritional formula (except for treatment of malabsorption syndromes), and health and beauty aids.
33. Expenses incurred for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
34. Phase 3 Cardiac rehabilitation.
35. Massage therapy (unless shown as a Covered Benefit in the Schedule of Benefits), health spas, mineral baths, or saunas.
36. Coverage for any services incurred prior to the effective date of the policy for the Covered Person or after the termination date of the policy for the Covered Person.
37. Charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military service-connected Sickness or Injury.
38. To the extent that payment is unlawful where the Covered Person resides when the expenses are incurred.
39. To the extent of the exclusions imposed by any certification requirement.
40. Charges for supplies, care, treatment or surgery which is not considered essential for the necessary care and treatment of an Injury or Illness, as determined by Our Utilization Review Management Program.
41. Charges made by an assistant surgeon or co-surgeon in excess of the PPO Network contracted rate.
42. Charges made by any Participating Provider who is a member of the Covered Person's family.
43. Manipulations under anesthesia. This does not include reductions of fractures and/or dislocations done under anesthesia.
44. Surgery for correction of Hyperhidrosis.
45. Biofeedback except for Mental Health and Substance Abuse only for pain management.
46. Any medical treatment and/or prescription related to infertility once diagnosed.
47. The following Autism Spectrum Disorder services are excluded: (a) Sensory Integration; (b) LOVAAS Therapy; and (c) Music Therapy.
48. Purchase or rental of durable medical equipment and prosthetics are not covered when due to misuse, damage and replacement when lost.
49. Costs for services while traveling outside the United States.

Circumstances Beyond Our Control

To the extent that:
1. A natural disaster;
2. A riot or civil insurrection;
3, War;
4. An epidemic; or
5. Any other emergency or similar event; not within Our control that results in Our facilities, personnel, or financial resources being unavailable to provide or arrange for:
   1. The provisions of a basic or supplemental health service; or
   2. Supplies in accordance with this Policy.

We will make a good faith effort to provide or arrange for the provision of the services or supplies, taking into account the impact of the event.