



# Healthstyles Benefit Plans

Effective October 1, 2006 through March 31, 2007

	Classic	Secure Advantage	Active
<b>Benefit Plan Basics</b>			
<b>Health Plan Networks*</b>	University Physicians Healthcare Group Care1st Health Plan of Arizona Mercy Healthcare Group	University Physicians (effective 10/1/06) Care1st Health Plan (effective 12/1/06) Mercy Healthcare Group (effective 1/1/07)	University Physicians Healthcare Group Care1st Health Plan of Arizona Mercy Healthcare Group
<b>Deductible Options</b>  <i>With the exception of those services listed at right, the deductible must be met each calendar year before a health plan network will begin making payment for covered services.</i>	Individual: Choose \$500, \$1000, \$2000 Family: Equal to 2 times Individual  <ul style="list-style-type: none"> <li>•Deductibles and benefit limits are calculated on a calendar year basis and may not correspond to a member's anniversary date.</li> <li>•Co-pays do not apply towards meeting the annual deductible.</li> <li>•A Family deductible is equal to 2 times the Individual deductible, and is accumulated across all family members.</li> <li>•The deductible applies to all covered services except: <ul style="list-style-type: none"> <li>- Preventive Care/Mammography<sup>1</sup></li> <li>- Emergency Care</li> <li>- Urgent Care</li> <li>- Prescription Drugs</li> </ul> </li> </ul>	Individual: Choose \$500, \$1000 Family: Equal to 2 times Individual  <ul style="list-style-type: none"> <li>•Deductibles and benefit limits are calculated on a calendar year basis and may not correspond to a member's anniversary date.</li> <li>•Co-pays do not apply towards meeting the annual deductible.</li> <li>•A Family deductible is equal to 2 times the Individual deductible, and is accumulated across all family members.</li> <li>•The deductible applies to all covered services except: <ul style="list-style-type: none"> <li>- Preventive Care/Mammography<sup>1</sup></li> <li>- Emergency Care</li> <li>- Urgent Care</li> <li>- Prescription Drugs</li> </ul> </li> </ul>	Individual: Choose \$500 Family: Equal to 2 times Individual  <ul style="list-style-type: none"> <li>•Deductibles and benefit limits are calculated on a calendar year basis and may not correspond to a member's anniversary date.</li> <li>•Co-pays do not apply towards meeting the annual deductible.</li> <li>•A Family deductible is equal to 2 times the Individual deductible, and is accumulated across all family members.</li> <li>•The deductible applies to all covered services except: <ul style="list-style-type: none"> <li>- Preventive Care/Mammography<sup>1</sup></li> <li>- Emergency Care</li> <li>- Urgent Care</li> <li>- Prescription Drugs</li> </ul> </li> </ul>
<b>Out-of-Pocket Maximum</b>	None	None	None
<b>Health Savings Account</b>	Not available.	Not available.	Not available.
<b>Out-of-Network Benefit</b>	<ul style="list-style-type: none"> <li>•A member is Out-of-Network if they receive services from a provider or health care facility that does not contract with their health plan.</li> <li>•Only emergency care and emergency transportation is covered when a member is Out-of-Network or Out-of-State.</li> <li>•A member is personally responsible for 100% of the cost of non-emergency care received Out-of-Network or Out-of-State.</li> </ul>	<ul style="list-style-type: none"> <li>•A member is Out-of-Network if they receive services from a provider or health care facility that does not contract with their health plan.</li> <li>•Only emergency care and emergency transportation is covered when a member is Out-of-Network or Out-of-State.</li> <li>•A member is personally responsible for 100% of the cost of non-emergency care received Out-of-Network or Out-of-State.</li> </ul>	<ul style="list-style-type: none"> <li>•A member is Out-of-Network if they receive services from a provider or health care facility that does not contract with their health plan.</li> <li>•Only emergency care and emergency transportation is covered when a member is Out-of-Network or Out-of-State.</li> <li>•A member is personally responsible for 100% of the cost of non-emergency care received Out-of-Network or Out-of-State.</li> </ul>
<b>Lifetime Maximum</b>	\$2,000,000	\$2,000,000	\$2,000,000
<b>Primary and Preventive Care</b>			
<b>Physician's Office Visit ***</b>	Primary care: \$20 co-pay each visit. Specialist care: \$20 co-pay each visit. (After deductible.)	Primary care: \$15 co-pay each visit. Specialist care: \$25 co-pay each visit. (After deductible.)	Primary care: \$10 co-pay each visit. Specialist care: \$30 co-pay each visit. (After deductible.)
<b>Preventive and Wellness Care</b>	Member pays \$20 co-pay. <sup>1</sup> (Not subject to deductible.)	Member pays \$10 co-pay. <sup>1</sup> (Not subject to deductible.)	Member pays \$10 co-pay. <sup>1</sup> (Not subject to deductible.)
<b>Mammography Screening</b>	No co-pay for covered services. <sup>1</sup> (Not subject to deductible.)	No co-pay for covered services. <sup>1</sup> (Not subject to deductible.)	No co-pay for covered services. <sup>1</sup> (Not subject to deductible.)
<b>Urgent Care</b>	Member pays \$40 co-pay each visit. (Not subject to deductible.)	Member pays \$40 co-pay each visit. (Not subject to deductible.)	Member pays \$20 co-pay each visit. (Not subject to deductible.)
<b>Hospitalization</b>			
<b>Emergency Medical Services</b> <i>(Co-pay waived if admitted.)</i>	Member pays \$100 co-pay for In-Network Member pays \$150 co-pay for Out-of-Network. (Not subject to deductible.)	Member pays \$75 co-pay each visit. (Not subject to deductible.)	Member pays 20% coinsurance. (Not subject to deductible.)
<b>Inpatient Hospital Services**</b>	Member pays \$100 co-pay each admission (After deductible.)	Member pays \$50 co-pay per day for maximum of 10 days each year, thereafter 50% coinsurance. (After deductible.)	Member pays 20% coinsurance. (After deductible.)
<b>Emergency Medical Transportation**</b>	No co-pay. (After deductible.)	Member pays \$25 co-pay. (After deductible.)	Member pays 20% coinsurance. (After deductible.)

Benefits are subject to change. For current benefits contact Healthcare Group or visit the Healthcare Group website at [www.hcgaz.com](http://www.hcgaz.com).

Revised 08/25/06

	Classic	Secure Advantage	Active
<b>Organ Transplants**</b>	Kidney and Cornea only. Subject to Inpatient benefit.	Kidney and Cornea only. Subject to Inpatient benefit.	Kidney and Cornea only. Subject to Inpatient benefit.
<b>Outpatient Care</b>			
<b>Outpatient Surgery**</b>	Member pays \$100 co-pay each admission. (After deductible.)	Member pays 20% coinsurance. (After deductible.)	Member pays 20% coinsurance. (After deductible.)
<b>Outpatient Diagnostic and Treatment**</b>	No co-pay. (After deductible.)	Member pays 10% coinsurance. (After deductible.)	Member pays 20% coinsurance. (After deductible.)
<b>Rehabilitation Services**</b> <i>(PT, OT, ST, Cardiac, etc)</i>	Member pays \$15 co-pay each visit. Limit: 24 visits per year. (After deductible.)	Member pays 20% coinsurance. Limit: 24 visits per year. (After deductible.)	Member pays 20% coinsurance. Limit: 24 visits per year. (After deductible.)
<b>Reproductive Care</b>			
<b>Prenatal Care</b>	Member pays \$20 co-pay for first prenatal visit only. (After deductible.)	No Benefit.	No Benefit.
<b>Delivery</b>	Member pays \$100 co-pay at admission. (After deductible.)	No Benefit.	No Benefit.
<b>Family Planning</b>	Member pays \$20 co-pay.	Member pays \$15 co-pay.	Member pays 20% coinsurance.
<b>Sterilization</b>	Vasectomy and Tubal Ligation only - Member responsibility determined by site of care.	Vasectomy and Tubal Ligation only - Member responsibility determined by site of care.	Vasectomy and Tubal Ligation only - Member responsibility determined by site of care.
<b>Support and Ancillary Care</b>			
<b>Reconstructive and Plastic Surgery**</b>	Member responsibility determined by site of care	Member responsibility determined by site of care	Member responsibility determined by site of care
<b>Oral Surgery**</b>	Member pays \$20 co-pay each visit. (After deductible.)	Member pays 20% coinsurance. (After deductible.)	Member pays 20% coinsurance. (After deductible.)
<b>Dental Trauma**</b>	Member pays \$20 co-pay each visit. (After deductible.)	Member pays 20% coinsurance. (After deductible.)	Member pays 20% coinsurance. (After deductible.)
<b>Dialysis**</b>	No co-pay. Limit: No limit on visits per year. (After deductible.)	Member pays 50% coinsurance. Limit: No limit on visits per year. (After deductible.)	Member pays 50% coinsurance. Limit: No limit on visits per year. (After deductible.)
<b>Skilled Nursing**</b>	No co-pay. Limit: 30 days per year. (After deductible.)	Member pays 20% coinsurance. Limit: 15 days per year. (After deductible.)	Member pays 20% coinsurance. Limit: 15 days per year. (After deductible.)
<b>Home Healthcare**</b>	No co-pay. Limit: 30 visits per year. (After deductible.)	Member pays 40% coinsurance. Limit: 10 visits per year. (After deductible.)	Member pays 40% coinsurance. Limit: 10 visits per year. (After deductible.)
<b>Hospice Care**</b>	No co-pay. Limit: 60 days per year. (After deductible.)	No Benefit.	No Benefit.
<b>Infusion/Injection - Home**</b>	No co-pay. Limit: 45 visits per year. (After deductible.)	No Benefit.	No Benefit.
<b>Durable Medical Equipment**</b>	No co-pay. Limit: \$2500 benefit per year paid by plan. (After deductible.)	Member pays 40% coinsurance. Limit: \$1000 benefit per year paid by plan. (After deductible.)	Member pays 40% coinsurance. Limit: \$1000 benefit per year paid by plan. (After deductible.)
<b>Orthotics and Protheses**</b>	Included in DME benefit (above).	Member pays 40% coinsurance. Limit: \$1000 benefit per year paid by plan. (After deductible.)	Member pays 40% coinsurance. Limit: \$1000 benefit per year paid by plan. (After deductible.)
<b>Routine Dental</b>	Optional coverage available	Optional coverage available	Optional coverage available
<b>Routine Vision</b>	Optional coverage available	Optional coverage available	Optional coverage available
<b>Prescription Drugs</b>			
<b>Prescription Drugs</b>	<b>\$10</b> co-pay for Generic <b>\$30</b> co-pay for preferred drug <b>\$50</b> co-pay for non-preferred drug (Not subject to deductible.)	<b>\$10</b> co-pay for Generic <b>\$30</b> co-pay for preferred drug <b>\$50</b> co-pay for non-preferred drug (Not subject to deductible.)	<b>\$10</b> co-pay for Generic <b>\$30</b> co-pay for preferred drug <b>\$50</b> co-pay for non-preferred drug (Not subject to deductible.)

Notes:

\* Prior to 1/1/2007, Secure Advantage will not be available in all 3 health plans. Please review "Health Plan Network" on for specific effective dates.

\*\* Requires or May Require Prior Authorization.

\*\*\* Specialist Visits Require a PCP Referral

<sup>1</sup> Benefits have age, sex, diagnosis and frequency limitations. Refer to the GSA and member handbook for more information.