Healthstyles Benefit Plans

Effective September 1, 2007

	Classic '08	Secure Advantage '08	Active '08
Benefit Plan Basics			
Health Plan Networks*	**University Physicians Healthcare Group** **Care1st Health Plan of Arizona** **Mercy Healthcare Group**	**University Physicians Healthcare Group** **Care1st Health Plan of Arizona** **Mercy Healthcare Group**	**University Physicians Healthcare Group** **Care1st Health Plan of Arizona** **Mercy Healthcare Group**
Deductible Options ***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.***	Individual: $500, $1000, $2000, $3000 Family: Equal to 2 times Individual •Deductibles and benefit limits are calculated on a calendar year basis and may not correspond to a member's anniversary date. •Co-pays do not apply towards meeting the annual deductible. •A Family deductible is equal to 2 times the Individual deductible, and is accumulated across all family members. •The deductible applies to all covered services except: - Physician Office Visit (E&M only) - Preventive Care/Mammography[1] - Basic Lab and X-ray (see list) - Emergency Care - Urgent Care - Prescription Drugs	Individual: $500, $1000, $2000 Family: Equal to 2 times Individual •Deductibles and benefit limits are calculated on a calendar year basis and may not correspond to a member's anniversary date. •Co-pays do not apply towards meeting the annual deductible. •A Family deductible is equal to 2 times the Individual deductible, and is accumulated across all family members. •The deductible applies to all covered services except: - Physician Office Visit (E&M only) - Preventive Care/Mammography[1] - Basic Lab and X-ray (see list) - Emergency Care - Urgent Care - Prescription Drugs	Individual: $500, $1500 Family: Equal to 2 times Individual •Deductibles and benefit limits are calculated on a calendar year basis and may not correspond to a member's anniversary date. •Co-pays do not apply towards meeting the annual deductible. •A Family deductible is equal to 2 times the Individual deductible, and is accumulated across all family members. •The deductible applies to all covered services except: - Physician Office Visit (E&M only) - Preventive Care/Mammography[1] - Basic Lab and X-ray (see list) - Emergency Care - Urgent Care - Prescription Drugs
Out-of-Pocket Maximum	None	None	None
Health Savings Account	Not available.	Not available.	Not available.
Out-of-Network Benefit	•A member is Out-of-Network when receiving services from a provider or health care facility not contracted with their health plan. •Only emergency care and emergency transportation are covered when a member is Out-of-Network or Out-of-State. •A coinsurance of 20% applies to any emergency admission in an Out-of-Network or Out-of-State hospital. •A member is personally responsible for 100% of the cost of non-emergency care received Out-of-Network or Out-of-State.	•A member is Out-of-Network when receiving services from a provider or health care facility not contracted with their health plan. •Only emergency care and emergency transportation are covered when a member is Out-of-Network or Out-of-State. •A coinsurance of 20% applies to any emergency admission in an Out-of-Network or Out-of-State hospital. •A member is personally responsible for 100% of the cost of non-emergency care received Out-of-Network or Out-of-State.	•A member is Out-of-Network when receiving services from a provider or health care facility not contracted with their health plan. •Only emergency care and emergency transportation are covered when a member is Out-of-Network or Out-of-State. •A coinsurance of 20% applies to any emergency admission in an Out-of-Network or Out-of-State hospital. •A member is personally responsible for 100% of the cost of non-emergency care received Out-of-Network or Out-of-State.
Lifetime Maximum	$2,000,000	$2,000,000	$2,000,000
Primary and Preventive Care			
Physician's Office Visit *	Primary care: $25 co-pay each visit. Specialist care: $35 co-pay each visit. *(Not subject to deductible.)*	Primary care: $25 co-pay each visit. Specialist care: $35 co-pay each visit. *(Not subject to deductible.)*	Primary care: $25 co-pay each visit. Specialist care: $35 co-pay each visit. *(Not subject to deductible.)*
Preventive and Wellness Care	Member pays $25 co-pay.[1] *(Not subject to deductible.)*	Member pays $25 co-pay.[1] *(Not subject to deductible.)*	Member pays $25 co-pay.[1] *(Not subject to deductible.)*
Mammography Screening	No co-pay for covered services.[1] *(Not subject to deductible.)*	No co-pay for covered services.[1] *(Not subject to deductible.)*	No co-pay for covered services.[1] *(Not subject to deductible.)*
Urgent Care	Member pays $40 co-pay each visit. *(Not subject to deductible.)*	Member pays $40 co-pay each visit. *(Not subject to deductible.)*	Member pays $40 co-pay each visit. *(Not subject to deductible.)*
Hospitalization			
Emergency Medical Services *(Co-pay waived if admitted.)*	In-Network: Member pays $300 co-pay Out-of-Network: 20% coinsurance *(Not subject to deductible.)*	In-Network: Member pays $300 co-pay Out-of-Network: 20% coinsurance *(Not subject to deductible.)*	Member pays 20% coinsurance. *(Not subject to deductible.)*
Emergency Medical Transportation**	Member pays $25 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.

	Classic '08	Secure Advantage '08	Active '08
Inpatient Hospital Services ** *(each admission)*	**UPH/Care1st** In-Network: $500 co-pay **Mercy** In-Network: $800 co-pay Out-of-Network: 20% coinsurance. *(After deductible.)*	In-Network: $50 per day for 1st 10-days, then 50%.*** Out-of-Network: 20% coinsurance. *(After deductible.)*	In-Network: 20% coinsurance. Out-of-Network: 20% coinsurance. *(After deductible.)*
Organ Transplants**	Kidney and Cornea only. Subject to Inpatient benefit.	Kidney and Cornea only. Subject to Inpatient benefit.	Kidney and Cornea only. Subject to Inpatient benefit.
	Outpatient Care		
Outpatient Surgery**	Member pays 10% coinsurance. *(After deductible.)*	Member pays 20% coinsurance. *(After deductible.)*	Member pays 20% coinsurance. *(After deductible.)*
Outpatient Diagnostic and Treatment**	Lab: $10 co-pay X-Ray: $25 co-pay Imaging: 10% coinsurance All other: 10% coinsurance *(After deductible except basic Lab and X-ray.)*	Lab: 10% coinsurance X-Ray: 10% coinsurance Imaging: 20% coinsurance All other:: 20% coinsurance *(After deductible except basic Lab and X-ray.)*	Lab: 20% coinsurance X-Ray: 20% coinsurance Imaging: 20% coinsurance All other:: 20% coinsurance *(After deductible except basic Lab and X-ray.)*
Rehabilitation Services** *(PT, OT, ST, Cardiac, etc)*	Member pays 10% coinsurance. 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.)*
	Reproductive Care		
1st Contract Year All Services	Maximum benefit of $500 for maternity. Claims paid in order of receipt. *(After deductible.)*	No Benefit.	No Benefit.
2nd Year & Beyond Prenatal	Member pays $25 co-pay first visit only *(After deductible.)*	No Benefit.	No Benefit.
Delivery	Member pays Inpatient Hospital co-pay/ coinsurance. *(After deductible.)*	No Benefit.	No Benefit.
Family Planning	See physician office visit for PCP.	See physician office visit for PCP.	See physician office visit for PCP.
Sterilization	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.
	Support and Ancillary Care		
Reconstructive and Plastic Surgery**	Member responsibility determined by site of care	Member responsibility determined by site of care	Member responsibility determined by site of care
Oral Surgery**	Member pays $20 co-pay each visit. *(After deductible.)*	Member pays 20% coinsurance. *(After deductible.)*	Member pays 20% coinsurance. *(After deductible.)*
Dental Trauma**	Member pays $20 co-pay each visit. *(After deductible.)*	Member pays 20% coinsurance. *(After deductible.)*	Member pays 20% coinsurance. *(After deductible.)*
Dialysis**	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.)*
Skilled Nursing**	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.)*
Home Healthcare**	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.)*
Hospice Care**	No co-pay. Limit: 60 days per year. *(After deductible.)*	No Benefit.	No Benefit.
Infusion/Injection - Home**	No co-pay. Limit: 45 visits per year. *(After deductible.)*	No Benefit.	No Benefit.
Durable Medical Equipment**	Member pays 10% coinsurance. 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.)*
Orthotics and Protheses**	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.)*
Routine Dental & Vision	Optional coverage available	Optional coverage available	Optional coverage available
	Prescription Drugs		
Prescription Drugs	**Tier 1: $10** co-pay (most Generics) **Tier 2: $35** co-pay (more expensive Generics and most preferred) **Tier 3: $55** co-pay (non-preferred) *(Not subject to deductible.)*	**Tier 1: $10** co-pay (most Generics) **Tier 2: $35** co-pay (more expensive Generics and most preferred) **Tier 3: $55** co-pay (non-preferred) *(Not subject to deductible.)*	**Tier 1: $10** co-pay (most Generics) **Tier 2: $35** co-pay (more expensive Generics and most preferred) **Tier 3: $55** co-pay (non-preferred) *(Not subject to deductible.)*

Notes:

* Specialist Visits Require a PCP Referral.

** Requires or May Require Prior Authorization.

*** Member pays $50 per day for the first 10 days per calendar year, thereafter member pays 50% coinsurance.

[1] Benefits have age, sex, diagnosis and frequency limitations. Refer to the GSA and member handbook for more information.