ARIZONA

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PPO Small Group
Plan AX11 Schedule of Benefits

Deductibles & Policy Maximums

Deductibles & Policy Maximums	Participating Providers	Non-Participating Providers**
Calendar Year Deductible *		
Individual	$250	$750
Family Maximum *(3x Individual)*	$750	$2,250
Additional Deductibles *(per occurrence)* *		
Inpatient Hospital Services	$500 per admission	$1,100 per admission
Outpatient Specialized Scanning	$100 per visit	$200 per visit
Outpatient Surgical Services	Not Applicable	$500 per visit
Emergency Room Services *(waived if admitted)*	$75	
Failure to obtain Pre-Authorization of Services *(waived with Pre-Authorization of Services)* per occurrence	$250	$500
Coinsurance Maximum		
Individual	$4,000	$8,000
Family Maximum *(3x Individual)*	3 times individual Coinsurance $12,000	3 times individual Coinsurance $24,000
Policy Maximum While Insured	$2,000,000	

Inpatient Benefits

Inpatient Benefits	Participating Providers	Non-Participating Providers**
Inpatient Hospital Services	$500 Additional Deductible per admission then 80% of Covered Expense after satisfying the Calendar Year Deductible	$1,100 Additional Deductible per admission then 60% of Limited Fee Schedule after satisfying the Calendar Year Deductible. Plan will pay up to $2,000 per day
Inpatient Alcohol, Drug or Other Substance Abuse Detoxification [3]	80% of Covered Expense after satisfying the Calendar Year Deductible	60% of Limited Fee Schedule after satisfying the Calendar Year Deductible
Maximum Benefit	Detoxification up to 3 days per admit. $5,000 combined Inpatient benefit per Calendar Year	
Organ Transplantation Services		Not Covered
Bone Marrow, Stem Cell and Organ Transplants	$500 Additional Deductible per admission then 80% of Covered Expense after satisfying the Calendar Year Deductible	
Donor Maximum	National Preferred Transplant Facility $15,000 per occurrence Other Company Approved transplant Facility $5,000 per occurrence	
Maximum benefit while insured	Up to Policy Maximum	

Marketing Form # PAZ094376-000
Collateral Form # AZSMPPO

Inpatient Benefits

Inpatient Benefits	Participating Providers	Non-Participating Providers**
Inpatient Maternity and Newborn Care Labor, Delivery and Postnatal Hospital Services	$500 Additional Deductible per admission then 80% of Covered Expense after satisfying the Calendar Year Deductible	$1,100 Additional Deductible per admission then 60% of Limited Fee Schedule after satisfying the Calendar Year Deductible. Plan will pay up to $2,000 per day
Inpatient Skilled Nursing Facilities	80% of Covered Expense after satisfying the Calendar Year Deductible	60% of Limited Fee Schedule after satisfying the Calendar Year Deductible. Plan will pay up to $1,000 per day
Maximum Benefit	Up to 45 combined Inpatient Days per Calendar Year	
Inpatient Hospice Care	80% of Covered Expense after satisfying the Calendar Year Deductible	60% of Limited Fee Schedule after satisfying the Calendar Year Deductible. Plan will pay up to $1,000 per day
Maximum Benefit	$10,000 combined maximum for Inpatient and Outpatient benefits while insured	
Inpatient Rehabilitation Care	$500 Additional Deductible per admission then 80% of Covered Expense after satisfying the Calendar Year Deductible	$1,100 Additional Deductible per admission then 60% of Limited Fee Schedule after satisfying the Calendar Year Deductible. Plan will pay up to $2,000 per day
Maximum Benefit	Up to 30 combined Inpatient Days per Calendar Year	
Inpatient Mental Illness	80% of Covered Expense after satisfying the Calendar Year Deductible	60% of Covered Expense after satisfying the Calendar Year Deductible. Plan will pay up to $1,000 per day
Maximum Benefit	15 combined Inpatient Days per Calendar Year. Each Inpatient day may be substituted for 2 half days of Outpatient treatment	

Outpatient Benefits

Outpatient Benefits	Participating Providers	Non-Participating Providers**
Physician Office Visits [1 2] Services include the detection and treatment of an Injury or Sickness during a Physician Office Visit including associated Covered diagnostic X-ray and Laboratory services Allergy Testing and Treatment Breast and Pelvic Cancer Screening including Mammography screening Detection of Osteoporosis Colorectal Cancer Screenings Prostate Cancer Screening Periodic health evaluations for children (through age 18) including age appropriate immunizations, laboratory tests, height and weight evaluation, vision screening	100% of Primary Care Office Visit services after $20 Copayment 100% of Specialty Care Office Visit services after $40 Copayment Outpatient Laboratory and Radiology services provided at Participating freestanding facilities require a separate additional Primary Care Office Visit Copayment per service provider (except as footnoted below)	60% of Limited Fee Schedule after satisfying the Calendar Year Deductible

Outpatient Benefits	Participating Providers	Non-Participating Providers**
Periodic Health Evaluations (age 19 and over) [1 2] Hearing Screening Vision Screening Immunizations and adult boosters Routine Laboratory tests age and gender appropriate Weight Evaluation	100% of Primary Care Office Visit services after $20 Copayment 100% of Specialty Care Office Visit services after $40 Copayment Outpatient Laboratory and Radiology services provided at Participating freestanding facilities require a separate additional Primary Care Office Visit Copayment per service provider (except as footnoted below)	60% of Limited Fee Schedule after satisfying the Calendar Year Deductible
Maximum Benefit	$400 combined per Covered Person per Calendar Year Maximum	
Outpatient Maternity Care [2] Physician Office Visits, Lab and Radiology services Prenatal, Post-partum, maternity care	$40 Copayment for initial visit, then 80% of Covered Expense after satisfying the Calendar Year Deductible	60% of Limited Fee Schedule after satisfying the Calendar Year Deductible
Urgent Care Services [2]	100% of Urgent Care services after $50 Copayment Outpatient Laboratory and Radiology services provided at Participating freestanding facilities require a separate additional Primary Care Office Visit Copayment per service provider (except as footnoted below)	60% of Limited Fee Schedule after satisfying the Calendar Year Deductible
Outpatient Alcohol, Drug or Other Substance Abuse Detoxification [1 3] Counseling	80% of Covered Expense after satisfying the Calendar Year Deductible	60% of Limited Fee Schedule after satisfying the Calendar Year Deductible
Maximum Benefit	24 Visits combined per Calendar Year maximum	
Ambulance *(emergency services and specified transfers)*	70% of Covered Expense after satisfying the Calendar Year Deductible	
Air Ambulance	70% of Covered Expense after satisfying the Calendar Year Deductible	
Air Ambulance Maximum Benefit	$5,000 combined per trip	
Durable Medical Equipment Rental, Purchase or Repair	80% of Covered Expense after satisfying the Calendar Year Deductible	60% of Limited Fee Schedule after satisfying the Calendar Year Deductible
Maximum Benefit	$2,000 combined per Calendar Year	
Home Health Care Visits *(In lieu of Hospital and Facility Services)*	80% of Covered Expense after satisfying the Calendar Year Deductible	60% of Limited Fee Schedule after satisfying the Calendar Year Deductible
Maximum Benefit	30 Visits combined Calendar Year Maximum	

Outpatient Benefits

Outpatient Benefits	Participating Providers	Non-Participating Providers**
Outpatient Hospice Services Home care for crisis period and acute care management	80% of Covered Expense after satisfying the Calendar Year Deductible	60% of Limited Fee Schedule after satisfying the Calendar Year Deductible
Maximum Benefit	$10,000 combined maximum for Inpatient and Outpatient benefit while insured	
Laboratory Services *(other than Physician Office Visits)*	80% of Covered Expense after satisfying the Calendar Year Deductible	60% of Limited Fee Schedule after satisfying the Calendar Year Deductible
Radiology Services *(other than Physician Office Visits)*	80% of Covered Expense after satisfying the Calendar Year Deductible	60% of Limited Fee Schedule after satisfying the Calendar Year Deductible
Specialized Scanning, Imaging and Laboratory Services [1] CT, SPECT, PET, MRA, MRI, ultrasounds, EKG, EEG, EMG and nuclear medicine studies	$100 Additional Deductible per visit then 80% of Covered Expense after satisfying the Calendar Year Deductible	$200 Additional Deductible per visit then 60% of Limited Fee Schedule after satisfying the Calendar Year Deductible
Outpatient Medical Rehabilitative Therapy [1] Speech, Physical, Occupational therapy	80% of Covered Expense after satisfying the Calendar Year Deductible	60% of Limited Fee Schedule after satisfying the Calendar Year Deductible
Maximum Benefit	$2,000 combined per Calendar Year	
Prosthetics and Corrective Appliances	80% of Covered Expense after satisfying the Calendar Year Deductible	60% of Limited Fee Schedule after satisfying the Calendar Year Deductible
Maximum Benefit	$2,000 combined per Calendar Year	
Mental Illness [1]	80% of Covered Expense after satisfying the Calendar Year Deductible	60% of Limited Fee Schedule after satisfying the Calendar Year Deductible
Maximum Benefit	20 combined Outpatient Visits per Calendar Year	
Neuromuscular Skeletal Services [1]	80% of Covered Expense after satisfying the Calendar Year Deductible	60% of Limited Fee Schedule after satisfying the Calendar Year Deductible
Maximum Benefit	$500 combined per Calendar Year	
Outpatient and Physician office based surgery [1]	80% of Covered Expense after satisfying the Calendar Year Deductible	$500 Additional Deductible then 60% of Limited Fee Schedule after satisfying the Calendar Year Deductible. Plan will pay up to $750 per visit
Temporomandibular Joint Syndrome (TMJ) [1]	50% of Covered Expense after satisfying the Calendar Year Deductible	50% of Limited Fee Schedule after satisfying the Calendar Year Deductible
Maximum Benefit	$1,000 combined per Calendar Year	

1 Copayment based services exclude and do not include or apply to office based Outpatient Surgery, Neuromuscular Skeletal services, Outpatient Medical Rehabilitation Therapy services other than a Physician Office Visit, Alcohol, Drug or other Substance Abuse Services, Infertility services, Cancer Clinical Trial services, TMJ services, Injectable or Intravenous drugs (other than antibiotic, immunizations, allergy serum), Specialized Scanning, Imaging, and Laboratory Services such as CT, SPECT, PET, MRA, and MRI (with or without oral, rectal, injected or infused contrast media), EKG, EEG, EMG and nuclear medicine studies, ultrasounds except for maternity care, or any service shown on the Schedule of Benefits as not covered.

2 Copayments for this type of Covered Expense do not apply toward the Calendar Year Deductible.

3 Coinsurance for this type of Covered Expense does not apply toward the Coinsurance Maximum, and the Percentage Payable for this type of Covered Expense does not increase to 100% due to satisfaction of any Coinsurance Maximum.

* Calendar Year Deductible and Additional Deductibles do not apply toward the Coinsurance Maximum.

** The Limited Fee Schedule is the allowable amount of Covered Expenses based on Medicareís Resource Based Relative Value System (RBRVS) and dollar amount conversion factor or comparable amount as determined by the Company. The Covered Person is responsible for any charges in excess of the allowable Covered Expense.

NOTE: This Policy has certain benefit maximums, some are Calendar Year maximums and some are benefit maximums while insured. Please review this information carefully to understand the benefits under this plan.

Pre-Authorization is required prior to obtaining certain benefits. Failure to Pre-Authorize services will result in a reduction in the benefits payable for Covered Expenses under the Policy. The Company will conduct a retroactive review to determine the Medical Necessity of the service, and services deemed not Medically Necessary will not be eligible for benefits under the Policy. Additional out-of-pocket expenses incurred by the Covered Person for not Pre-Authorizing services will not apply toward the Covered Person's Calendar Year Deductible or Coinsurance Maximum. To avoid any penalty, please refer to "Pre-Authorization Requirements."

Maximum Covered Expenses for Non-Participating Providers will not exceed the Limited Fee Schedule. Please refer to the *Certificate* Definitions Section for an explanation of the Limited Fee Schedule.

IMPORTANT PPO INFORMATION

OFFICE VISIT COPAYMENTS. The Group Policyholder may have purchased a Policy for Covered Persons requiring different Copayments for participating Primary Care and Specialty Care services. This means that a participating Primary Care provider will require a lower Copayment than if treatment is sought from a participating Specialty Care provider. If the Participating Provider that is used for Primary Care elects to practice as a Specialty Care provider and is identified in our Participating Provider Directory as both a Primary Care and Specialty Care provider, the Specialty Care Copayment will apply. Please see the Policy, *Certificate of Coverage*, *Schedule of Benefits* and any supplemental materials to determine the exact terms and conditions of coverage.

EFFECT ON BENEFITS. Pre-Authorization is required prior to obtaining certain services. Failure to obtain Pre-Authorization may result in additional expense by the Covered Person under the Policy as shown on this *Schedule of Benefits*. No benefits are payable unless the Company determines that Covered Services are Medically Necessary. The Policy has certain coverage maximums, some are Calendar Year maximums and some are benefit maximums while insured. Please review the *Schedule of Benefits* carefully to determine coverage.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Policy provides benefits for Covered Services obtained from both Participating Providers and Non-Participating Providers. Participating Providers are those Providers who have agreed to participate in the Company's Preferred Provider Organization and provide health care at negotiated fees. Non-Participating Providers have not agreed to negotiated fees or arrangements.

PRIMARY CARE. A Participating Provider who is a physician trained in family practice, osteopathic medicine, general practice, internal medicine, doctor of medicine, osteopathic manipulation medicine, or pediatrics. Primary Care will include services rendered by a physician assistant or registered nurse practitioner working under the direct supervision of the Primary Care physician.

SPECIALTY CARE. A Participating Provider whose professional attention and services are limited to a particular specialty or subject area, other than Primary Care as defined.

EMERGENCY SERVICES. When a Covered Person receives Emergency services from a Non-Participating Provider, the Emergency services will be paid as if rendered by a Participating Provider. Once the Covered Person can be safely transferred to a Participating Provider, the Covered Person must be transferred in order to continue receiving the Participating Provider level of benefits. If the Covered Person chooses not to transfer to a Participating Provider, all additional Covered Expenses incurred will be paid at the Non-Participating Provider level.

USE OF HOSPITAL BASED PROVIDERS. The Policy provides benefits for Covered Services obtained from both Participating Providers and Non-Participating Providers. Certain hospital based providers including Emergency Room, Radiology, Anesthesiology and Pathology providers, may not contract to provide Participating Provider services under the Policy. To reduce costs, Covered Services obtained from Non-Participating hospital based providers at a Participating Hospital, may be considered as a Participating Provider benefit up to the Usual and Customary Charge (or Limited Fee Schedule if applicable) under the Policy. Under these circumstances, the Non-Participating Provider may bill the Covered Person for charges over Covered Expenses paid by the Policy. The Covered Person is responsible for any charges that exceed the Covered Expense under the Policy.

USING A PARTICIPATING PROVIDER MAY LOWER COSTS. Covered Services from a Non-Participating Provider may cost the Covered Person more than Covered Services from a Participating Provider. Covered Expenses for a Non-Participating Provider's services may be substantially lower than the actual charges. The Covered Person's responsibility includes the portion of Covered Expense not payable under the Policy, plus all of the Non-Participating Provider's charges that exceed the Covered Expense.

APPLICATION OF ADDITIONAL DEDUCTIBLES. Additional Deductibles are separate Deductibles applied per occurrence for services specified on the *Schedule of Benefits*. Additional Deductibles are in addition to, and do not apply toward satisfaction of any Calendar Year Deductibles under the Policy. The Covered Person is responsible for any Additional Deductibles applied per occurrence.

To minimize out-of-pocket costs, the Covered Person should consider the effect on benefits by selection of provider type. The following chart depicts the effect on benefits under a typical PPO plan. To determine Covered Services under the Policy, consult the *Certificate* and *Schedule of Benefits*.

Effect on benefits by choice of provider	**PARTICIPATING PROVIDER SERVICES**	**NON-PARTICIPATING PROVIDER SERVICES**
Coinsurance Benefit Percentage of Covered Expenses Payable by the plan under the Policy	Higher	Lower
Coinsurance Maximum Out of pocket costs, less any applicable Deductibles or Copayments	Lower	Higher
Negotiated Fees for Covered Services Hospitals Physicians	Yes Yes	No No
Balance Billing by Provider for Covered Services Hospitals Physicians *(Other than Non-Participating hospital based providers identified below)*	No No	Yes Yes Covered Person is responsible for 100% of charges that exceed the Covered Expense
Balance Billing by Provider for services not covered under the plan Hospitals Physicians	Yes Yes Covered Person is responsible for 100% of charges that are not Covered Services under the plan	Yes Yes Covered Person is responsible for 100% of charges that are not Covered Services under the plan
Balance Billing by Non-Participating hospital based providers, when providing Covered Services at a Participating Hospital Non-Participating hospital based providers include - Emergency Room, Radiology, Anesthesiology, Pathology	Does Not Apply	Yes Covered Person responsible for 100% of charges that exceed the Covered Expense

CHANGE IN PARTICIPATION. If, while a Covered Person is confined in a Facility which is a Participating Provider, that Facility ceases to remain a Participating Provider, coverage will be provided throughout the period of confinement at the negotiated rate for that Facility before it ceased to be a Participating Provider.

If a Covered Person obtains authorization for services to be rendered by a Participating Provider, and the Participating Provider subsequently ceases to be a Participating Provider, coverage will be provided for the pre-authorized services at the negotiated rate for that Provider before the Provider ceased to be a Participating Provider.

NON-PARTICIPATING PROVIDERS. If there is not a Participating Provider that provides a particular Covered Service, that Covered Service will be deemed to be provided by a Participating Provider in determining the amount of benefits payable under the Policy.

LIMITED FEE SCHEDULE. The Company offers Covered Persons a wide range of health care options within its Preferred Provider Organization (PPO). Covered Persons have access to quality care through our network and enjoy maximum subscriber savings. Although Covered Persons may choose a Non-Participating provider, the Company uses a Limited Fee Schedule to determine the Covered Expense for services or supplies outside our network which may result in a higher Coinsurance payment, reduced benefits and higher out-of-pocket expenses. Please refer to the Definitions list in Section 5 of the *Certificate* for further information on the Limited Fee Schedule.

This *Schedule of Benefits* is a brief outline of the Covered Services provided under the Policy. Please review the *Certificate of Coverage* in addition to the *Schedule of Benefits* for a complete explanation of Comprehensive Major Medical Coverage to determine coverage.

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