

**ARIZONA**

\$10 - \$25/\$150 PLAN 3

**2005 HMO SUMMARY OF BENEFITS**

**Physician Care**

Office visit copayment includes coverage for immunizations, pneumonia and Hepatitis B. Flu shots are covered 100%.

Primary Care Physician Office Visit (Includes OB/GYN)	You pay \$10 per visit
Specialist Office Visit	You pay \$25 per visit

**Outpatient Benefits**

Allergy Testing	You pay \$10 or \$25 per visit, depending on provider type
Allergy Treatment (includes serum)	You pay \$0 per visit
Breast Cancer Screening and Diagnosis (Mammogram)	You pay \$10 per visit
Cancer Clinical Trials	Copayment matches place of service
Chiropractic (Limited to 12 self-referred visits per Year)	You pay \$10 per visit
Colorectal Screening	Copayment matches place of service
Diabetic Self Management Items (Equipment & Supplies)	You pay \$0 per visit
Diabetic Management and Treatment	You pay \$10 or \$25 per visit, depending on provider type
Dialysis	You pay \$10 per visit
Digestive Disorders - Phenylketonuria (PKU) Testing and Treatment (Limited to \$5,000 per Year for medically necessary special food products for the treatment of inherited metabolic diseases per Year)	You pay 50%
Hearing Screening (Limited to one per Year)	You pay \$25 per visit
Home Health Care Visits (Limited to 100 days per Year)	You pay \$25 per day
Infusion Therapy (including but not limited to home infusion and chemotherapy)	You pay \$25 per visit
Injectable Drugs - Self-Injectable Medications – 30-day supply or prescribed course of treatment, whichever is shorter (Insulin is covered under your pharmacy plan copayments)	You pay \$50
Laboratory Services (Includes cytologic screening)	You pay \$0 per visit
Outpatient Medical Rehabilitation Therapy - Physical, occupational and speech therapy (Limited to 40 visits per Year)	You pay \$25 per visit
Outpatient Medical Rehabilitation Therapy - Cardiac Rehabilitation (Unlimited)	You pay \$10 per visit
Outpatient Surgery (Anesthesia, Physician Services, Surgeon, Assistant Surgeon)	You pay \$100 per outpatient visit
Periodic Health Evaluation	You pay \$10 per visit
Radiation Therapy	You pay \$25 per visit
Radiology Services - X-rays and other Tests	You pay \$10 per visit
Radiology Services - Specialized Scanning and Imaging (Including but not limited to MRIs, MRAs, CTs, PETs, IMRTs, SPECTs)	You pay \$100 per visit
Refractions (Limited to one per Year)	You pay \$25 per visit
Temporomandibular (TMJ) (Limited to \$1,000 per lifetime)	You pay 20%
Well-Baby Care (Including routine immunizations)	You pay \$10 per visit

This Summary of Benefits is a brief outline and does not constitute a contract or policy. Please refer to the Evidence of Coverage for benefit descriptions.

## Inpatient Benefits

Inpatient Hospital Benefits/Acute Care ( <i>Anesthesia, Physician Services, Surgeon, Assistant Surgeon</i> )	You pay \$150 per inpatient day, up to 3 days
Acute Inpatient Rehabilitation Care ( <i>Limited to 30 days per Year; Inpatient Cardiac Rehabilitation unlimited</i> )	You pay \$150 per inpatient day, up to 3 days
Hospice ( <i>Terminally ill care</i> )	You pay \$0 per inpatient admit
Skilled Nursing/Subacute and Transitional Care ( <i>Limited to 30 days per Year</i> )	You pay \$0 per inpatient admit

## Emergency Services

Ambulance ( <i>Medically necessary</i> )	You pay \$0 per trip
Emergency Room ( <i>Not waived if admitted</i> ) <i>Inpatient hospitalization benefits apply if admitted</i>	You pay \$125 per visit
Urgent Care	You pay \$35 per visit

## Maternity Care

Maternity Care Outpatient Tests, Procedures and Genetic Testing office visits	You pay \$10 per visit
Maternity Care Inpatient Care and Delivery	You pay \$150 per inpatient day, up to 3 days

## Family Planning

Infertility Services Outpatient (Basic) - Diagnosis	Not Covered
Infertility Services - Treatment	Not Covered
Tubal Ligation	Copayment matches place of service
Vasectomy	Copayment matches place of service

## Alcohol, Drug, or Other Substance Abuse Detoxification

Outpatient office visits	You pay \$25 per visit
Inpatient ( <i>short-term only</i> )	You pay \$150 per inpatient day, up to 3 days

## Mental Health Services

Outpatient office visits ( <i>Limited to 20 visits per Year</i> )	You pay \$25 per visit
Inpatient ( <i>Limited to 7 days per Year</i> )	You pay \$150 per inpatient day, up to 3 days

## Durable Medical Equipment

Standard ( <i>Limited to \$5,000 per Year combined with Specialty/Custom DME</i> )	Covered 100%
Specialty/Custom ( <i>i.e. wheelchairs, bed lifts, ventilators</i> ) ( <i>Limited to \$5,000 per Year combined with Standard DME</i> )	Covered 100%
Prosthetics ( <i>i.e. arm, eye, leg</i> ) ( <i>Limited to \$5,000 per Year</i> )	Covered 50%
Corrective Appliances	Covered 100%

## Plan Maximums

Individual Copayment & Coinsurance Maximum	\$3,000 per Year
Family Copayment & Coinsurance Maximum	\$9,000 per Year
Maximum While Insured	Unlimited

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