

**ARIZONA**

**\$15/100% PLAN 2**

**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 <i>(Includes OB/GYN)</i> | You pay \$15 per visit |
| Specialist Office Visit                                      | You pay \$15 per visit |

**Outpatient Benefits**

|  |                                    |
|--|------------------------------------|
| Allergy Testing  | You pay \$15 per visit             |
| Allergy Treatment <i>(includes serum)</i>  | You pay \$0 per visit              |
| Breast Cancer Screening and Diagnosis <i>(Mammogram)</i>   | You pay \$15 per visit             |
| Cancer Clinical Trials   | Copayment matches place of service |
| Chiropractic <i>(Limited to 12 self-referred visits per Year)</i>  | You pay \$10 per visit             |
| Colorectal Screening   | Copayment matches place of service |
| Diabetic Self Management Items <i>(Equipment &amp; Supplies)</i>   | You pay \$0 per visit              |
| Diabetic Management and Treatment  | You pay \$15 per visit             |
| Dialysis   | You pay \$15 per visit             |
| Digestive Disorders - Phenylketonuria (PKU) Testing and Treatment<br><i>(Limited to \$5,000 per Year for medically necessary special food products for the treatment of inherited metabolic diseases per Year)</i> | You pay 50%                        |
| Hearing Screening <i>(Limited to one per Year)</i>   | You pay \$15 per visit             |
| Home Health Care Visits <i>(Limited to 100 days per Year)</i>  | You pay \$15 per visit             |
| Infusion Therapy <i>(including but not limited to home infusion and chemotherapy)</i>  | You pay \$15 per visit             |
| Injectable Drugs - Self-Injectable Medications – <i>30-day supply or prescribed course of treatment, whichever is shorter (Insulin is covered under your pharmacy plan copayments)</i>                             | You pay \$50                       |
| Laboratory Services <i>(Includes cytologic screening)</i>  | You pay \$0 per visit              |
| Outpatient Medical Rehabilitation Therapy - Physical, occupational and speech therapy <i>(Limited to 40 visits per Year)</i>   | You pay \$15 per visit             |
| Outpatient Medical Rehabilitation Therapy - Cardiac Rehabilitation <i>(Unlimited)</i>  | You pay \$15 per visit             |
| Outpatient Surgery <i>(Anesthesia, Physician Services, Surgeon, Assistant Surgeon)</i>   | You pay \$0 per outpatient visit   |
| Periodic Health Evaluation   | You pay \$15 per visit             |
| Radiation Therapy  | You pay \$15 per visit             |
| Radiology Services - X-rays and other Tests  | You pay \$15 per visit             |
| Radiology Services - Specialized Scanning and Imaging <i>(Including but not limited to MRIs, MRAs, CTs, PETs, IMRTs, SPECTs)</i>   | You pay \$100 per visit            |
| Refractions <i>(Limited to one per Year)</i>   | You pay \$15 per visit             |
| Temporomandibular (TMJ) <i>(Limited to \$1,000 per lifetime)</i>   | You pay 20%                        |
| Well-Baby Care <i>(Including routine immunizations)</i>  | You pay \$15 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 \$0 per inpatient admit |
| Acute Inpatient Rehabilitation Care ( <i>Limited to 30 days per Year; Inpatient Cardiac Rehabilitation unlimited</i> ) | You pay \$0 per inpatient admit |
| 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> )<br><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 \$15 per visit          |
| Maternity Care Inpatient Care and Delivery                                    | You pay \$0 per inpatient admit |

## Family Planning

|   |                         |
|---|-------------------------|
| Infertility Services Outpatient (Basic) - Diagnosis | Not Covered             |
| Infertility Services - Treatment                    | Not Covered             |
| Tubal Ligation                                      | You pay \$250 per visit |
| Vasectomy   | You pay \$100 per visit |

## Alcohol, Drug, or Other Substance Abuse Detoxification

|                                      |                                 |
|--------------------------------------|---------------------------------|
| Outpatient office visits             | You pay \$15 per visit          |
| Inpatient ( <i>short-term only</i> ) | You pay \$0 per inpatient admit |

## Mental Health Services

|   |                                 |
|---|---------------------------------|
| Outpatient office visits ( <i>Limited to 20 visits per Year</i> ) | You pay \$15 per visit          |
| Inpatient ( <i>Limited to 7 days per Year</i> )                   | You pay \$0 per inpatient admit |

## Durable Medical Equipment

|   |              |
|---|--------------|
| Standard<br>( <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> )<br>( <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 | \$2,000 per Year |
| Family Copayment & Coinsurance Maximum     | \$6,000 per Year |
| Maximum While Insured                      | Unlimited        |

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