

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%.

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|--|------------------------|
| 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

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|--|------------------------------------|
| 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 & 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 <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

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|--|---------------------------------|
| 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

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|---|-------------------------|
| 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

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| 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

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|---|-------------------------|
| 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

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

Mental Health Services

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|---|---------------------------------|
| 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

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|---|--------------|
| 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

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|--|------------------|
| Individual Copayment & Coinsurance Maximum | \$2,000 per Year |
| Family Copayment & Coinsurance Maximum | \$6,000 per Year |
| Maximum While Insured | Unlimited |

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