Healthstyles Benefit Plan Summary

Effective August 1, 2008, for all newly-enrolling groups
Effective September 1, 2008, for all current groups

	Classic	Active
	Benefit Plan Basics	
Health Plan Networks*	**Available health plans are listed in your Group Service Agreement**	**Available health plans are listed in your Group Service Agreement**
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.***	• Available deductible options can be found on the HCG Premium Rate Charts. • 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 (2X) the Individual deductible, and is accumulated across all family members. • The deductible applies to all covered services except: - Physician Office Visit (Evaluative & Management only) - Preventive Care/Mammography[1] - Basic Lab and X-ray - Emergency Medical Services - Urgent Care Clinic Visits - Prescription Drugs	• Available deductible options can be found on the HCG Premium Rate Charts. • 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 (2X) the Individual deductible, and is accumulated across all family members. • The deductible applies to all covered services except: - Physician Office Visit (Evaluative & Management only) - Preventive Care/Mammography[1] - Basic Lab and X-ray - Emergency Medical Services - Urgent Care Clinic Visits - Prescription Drugs
Health Savings Account	Not available.	Not available.
Out-of-Network Benefit	• Members are Out-of-Network when receiving services from a provider or health care facility not contracted with their health plan. • When a member is Out-of-Network or Out-of-State, ONLY emergency transportation and emergency services are covered. • Members are responsible for 30% coinsurance for any inpatient services resulting from an emergency admission in an Out-of-Network or Out-of-State facility. • Members are responsible for 100% of the cost of non-emergency care received Out-of-Network or Out-of-State.	• Members are Out-of-Network when receiving services from a provider or health care facility not contracted with their health plan. • When a member is Out-of-Network or Out-of-State, ONLY emergency transportation and emergency services are covered. • Members are responsible for 30% coinsurance for any inpatient services resulting from an emergency admission in an Out-of-Network or Out-of-State facility. • Members are responsible for 100% of the cost of non-emergency care received Out-of-Network or Out-of-State.
Benefit Maximums	First consecutive 12 month benefit maximum: $100,000 Lifetime benefit maximum: $2,000,000	First consecutive 12 month benefit maximum: $100,000 Lifetime benefit maximum: $2,000,000
	Primary and Preventive Care	
Physician's Office Visit *	Primary care: $25 co-pay each visit. Specialist: $35 co-pay each visit. *(Eval & Mgmt not subject to deductible.)*	Primary care: $25 co-pay each visit. Specialist: $35 co-pay each visit. *(Eval & Mgmt 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.)*
Mammography Screening	No co-pay for covered services.[1] *(Not subject to deductible.)*	No co-pay for covered services.[1] *(Not subject to deductible.)*
Urgent Care Clinic	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: 30% coinsurance *(Not subject to deductible.)*	In-Network: Member pays 20% coinsurance. Out-of-Network: 30% coinsurance *(Not subject to deductible.)*
Emergency Medical Transportation**	Member pays $100 co-pay. *(After deductible.)*	Member pays 20% coinsurance. *(After deductible.)*
Inpatient Hospital Services ** *(each admission)*	**Mercy**: In-Network: $800 co-pay **UPH/Care1st**: In-Network: $500 co-pay *(After deductible.)*	In-Network: 20% coinsurance. *(After deductible.)*
Organ Transplants**	Kidney and Cornea only. Subject to Inpatient benefit.	Kidney and Cornea only. Subject to Inpatient benefit.

This is only a summary of the benefits. A more complete description of the covered benefits and exclusions are contained within the GSA and any Endorsements. Benefits, deductible levels and plan options are subject to change. For the most current information, contact HCG or visit www.hcgaz.com.

Outpatient Care		
Outpatient Surgery**	Member pays 10% 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: 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.)*
Reproductive Care		
Member's 1st 12 Months **All Services**	Maximum benefit of $500 for maternity. Claims paid in order of receipt. *(After deductible.)*	No Benefit.
13 Months & Beyond **Prenatal**	Member pays $25 co-pay first visit only *(After deductible.)*	No Benefit.
Delivery	Member pays Inpatient Hospital co-pay/ coinsurance. *(After deductible.)*	No Benefit.
Family Planning	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.
Support and Ancillary Care		
Reconstructive Surgery**	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.)*
Dental Trauma**	Member pays $20 co-pay each visit. *(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.)*
Skilled Nursing**	No co-pay. Limit: 30 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.)*
Hospice Care**	No co-pay. Limit: 60 days per year. *(After deductible.)*	No Benefit.
Infusion/Injection - Home**	No co-pay. Limit: 45 visits per year. *(After deductible.)*	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.)*
Orthotics and Prosthetics**	Included in DME benefit (above).	Member pays 40% coinsurance. Limit: $1000 benefit per year paid by plan. *(After deductible.)*
Routine Dental & Vision	Optional coverage available.	Optional coverage available.
Prescription Drugs		
Prescription Drugs – Formulary Subject to Change	**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, gender, diagnosis and frequency limitations. Refer to the GSA and Member Handbook for more information.