



Healthstyles Non-Grandfathered Benefit Plan Summary

Effective January 1, 2011

	Silver	Copper
Benefit Plan Basics		
Health Plan Networks*	Mercy Healthcare and University Physicians	Mercy Healthcare and University Physicians
Deductible <i>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.</i>	<ul style="list-style-type: none"> •\$3,000 Deductible. •Deductibles and benefit limits are calculated on a calendar year and may not correspond to a member's anniversary date. •Co-pays do not apply toward meeting the annual deductible. •A Family deductible is equal to two times (2X) the Individual deductible, and is accumulated across all family members. •The deductible applies to all covered services except: <ul style="list-style-type: none"> - Recommended Preventive Services ¹ - Physician Office Visit (Evaluative & Management only) - Basic Lab and X-ray - Emergency Medical Services - Urgent Care Clinic Visits - Prescription Drugs 	<ul style="list-style-type: none"> •\$1,500 Deductible. •Deductibles and benefit limits are calculated on a calendar year and may not correspond to a member's anniversary date. •Co-pays do not apply toward meeting the annual deductible. •A Family deductible is equal to two times (2X) the Individual deductible, and is accumulated across all family members. •The deductible applies to all covered services except: <ul style="list-style-type: none"> - Recommended Preventive Services ¹ - Physician Office Visit (Evaluative & Management only) - Basic Lab and X-ray - Emergency Medical Services - Urgent Care Clinic Visits - Prescription Drugs
Out-of-Pocket Limits	None	None
Out-of-Network Benefit	<ul style="list-style-type: none"> •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 100% of the cost of non-emergency care received Out-of-Network or Out-of-State. 	<ul style="list-style-type: none"> •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 100% of the cost of non-emergency care received Out-of-Network or Out-of-State.
Benefit Maximums	Lifetime or annual dollar limits: None	Lifetime or annual dollar limits: None
Primary and Preventive Care		
Physician's Office Visit *	<p><u>Primary care:</u> \$25 co-pay each visit. <u>Specialist:</u> \$35 co-pay each visit. <i>(Eval & Mgmt not subject to deductible.)</i></p>	<p><u>Primary care:</u> \$25 co-pay each visit. <u>Specialist:</u> \$35 co-pay each visit. <i>(Eval & Mgmt not subject to deductible.)</i></p>
Wellness Care¹	No co-pay for covered services. <i>(Only applies to specific services. Not subject to deductible.)</i>	No co-pay for covered services. <i>(Only applies to specific services. Not subject to deductible.)</i>
Recommended Preventive Services ¹	No co-pay for covered services. ¹ <i>(Not subject to deductible.)</i>	No co-pay for covered services. ¹ <i>(Not subject to deductible.)</i>
Urgent Care Clinic	Member pays \$40 co-pay each visit. <i>(Not subject to deductible.)</i>	Member pays \$40 co-pay each visit. <i>(Not subject to deductible.)</i>
Hospitalization		
Emergency Medical Services <i>(co-pay waived if admitted)</i>	Member pays \$400 (In Network and Out-of-Network). <i>(Not subject to deductible.)</i>	Member pays 20% coinsurance (In Network and Out-of-Network). <i>(Not subject to deductible.)</i>
Emergency Medical Transportation**	Member pays 20% coinsurance. <i>(After deductible.)</i>	Member pays 20% coinsurance. <i>(After deductible.)</i>
Inpatient Hospital Services ** <i>(each admission)</i>	Mercy: Member pays \$800 co-pay <i>(After deductible.)</i> . UPH: Member pays \$500 co-pay <i>(After deductible.)</i> . <i>(Out-of-network emergency admissions covered only until patient is stabilized.)</i>	Member pays 20% coinsurance. <i>(After deductible.)</i>
Organ Transplants**	Kidney and Cornea only. Subject to Inpatient benefit.	Kidney and Cornea only. Subject to Inpatient benefit.

Notes: * Women may obtain OB/GYN services without a referral. A pediatrician can be a child's primary care provider. All other Specialist visits require a PCP referral

** Requires or may require Prior Authorization

¹ Benefits have age, gender, diagnosis and frequency limitations. Refer to the GSA and Member Handbook for more information.

This is only a summary of the benefits. A more complete description of the covered benefits and exclusions is contained within the GSA and any Endorsements. Benefits 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. <i>(After deductible.)</i>	Member pays 20% coinsurance. <i>(After deductible.)</i>
Outpatient Lab**	Member pays \$10 co-pay <i>(After deductible except basic lab)</i>	Member pays 20% coinsurance. <i>(After deductible except basic lab)</i>
Outpatient Diagnostic and Treatment**	X-Ray: Member pays 10% coinsurance. Imaging: Member pays 10% coinsurance. All other: Member pays 10% coinsurance. <i>(After deductible except X-ray.)</i>	Member pays 20% coinsurance. <i>(After deductible except X-ray)</i>
Rehabilitation Services** <i>(PT, OT, ST, Cardiac, etc)</i>	Member pays 10% coinsurance. Limit: 24 visits per year. <i>(After deductible.)</i>	Member pays 20% coinsurance. Limit: 24 visits per year. <i>(After deductible.)</i>

Reproductive Care

Maternity Prenatal	Member pays \$25 co-pay first visit only <i>(After deductible.)</i>	No Benefit.
Delivery	Member pays Inpatient Hospital co-pay. <i>(After deductible.)</i>	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% coinsurance. <i>(After deductible.)</i>	Member pays 30% coinsurance. <i>(After deductible.)</i>
Dental Trauma**	Member pays 20% coinsurance. <i>(After deductible.)</i>	Member pays 30% coinsurance. <i>(After deductible.)</i>
Dialysis**	Member pays 10% coinsurance. Limit: No limit on visits per year. <i>(After deductible.)</i>	Member pays 50% coinsurance. Limit: No limit on visits per year. <i>(After deductible.)</i>
Skilled Nursing**	Member pays 20% coinsurance. Limit: 30 days per year. <i>(After deductible.)</i>	No Benefit.
Home Healthcare**	Member pays 20% coinsurance. Limit: 30 visits per year. <i>(After deductible.)</i>	No Benefit.
Hospice Care**	Member pays 20% coinsurance. Limit: 6 months per lifetime. <i>(After deductible.)</i>	No Benefit.
Infusion/Injection - Home**	Member pays 20% coinsurance. Limit: 45 visits per year. <i>(After deductible.)</i>	No Benefit.
Durable Medical Equipment**	Member pays 20% coinsurance. <i>(After deductible.)</i>	Member pays 40% coinsurance. <i>(After deductible.)</i>
Orthotics and Prosthetics**	Included in DME benefit (above).	Included in DME benefit (above).
Routine Dental & Vision	No coverage except covered Recommended Preventive Services ¹ Optional coverage available.	No coverage except covered Recommended Preventive Services ¹ 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) <i>(Not subject to deductible.)</i>	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) <i>(Not subject to deductible.)</i>
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