SILVERCANYON

SCHEDULE OF BENEFITS

THE UNIVERSITY OF ARIZONA
HEALTH PLANS

CANYON PLANS

University Healthcare Marketplace

SILVERCANYON

Standard Benefit Plan

Individual Comprehensive
HMO Insurance Policy
2015

THE UNIVERSITY OF ARIZONA
HEALTH PLANS
University Healthcare Marketplace

Health Insurance Marketplace

SCHEDULE OF BENEFITS

Individual Comprehensive HMO Insurance Policy

Policy Number: [0000000]

Policy Effective Date: [January 1, 2015]

Policyowner: [John Doe]

Policy Anniversary Date: [January 1 of each Year]

Issuer Age: [00]

Initial Premium: [$000.00]

Type of Coverage: [Indv/Family]

Mode of Payment: [Monthly]

Benefit Period: Calendar Year

Premium Due Date: [The first day of each month]

Benefit Plan: Silver Canyon – Standard Benefit Plan

If coverage was purchased through an Exchange and an Advance Premium Tax Credit was received, any Deductible, Copayment, Coinsurance, and/or Annual Out-of-Pocket Maximum shown below may change without notice. The Exchange will determine if a change is to be made. We will make the change as directed by the Exchange.

BENEFIT INFORMATION	IN-NETWORK
Maximum Lifetime Benefit • Per Covered Person	Unlimited
Maximum Annual Benefit • Per Covered Person	Unlimited
Medical Deductible • Individual Medical Deductible (*per Covered Person per Calendar Year)* • Family Medical Deductible *(per family per Calendar Year)*	$2,300 $4,600
Prescription Drug Deductible • Individual Prescription Drug Deductible (*per Covered Person per Calendar Year)* • Family Medical Deductible *(per family per Calendar Year)*	$0 $0

Annual Out-of-Pocket Maximum • Individual Annual Out-of-Pocket Maximum *(per Covered Person per Calendar Year)* • Family Annual Out-of-Pocket Maximum *(per family per Calendar Year)*	$6,600 $13,200
Coinsurance • *The Coinsurance amount applies to all Covered Services, unless otherwise specified in this Schedule of Benefits.*	20%

SCHEDULE OF BENEFITS

Individual Comprehensive HMO Insurance Policy

COVERED SERVICES

This Policy will pay Covered Medical Expenses incurred for Covered Benefits provided in *Section 5, Covered Benefits*: (1) based on the Allowable Fee; and (2) unless otherwise indicated below, subject to the Deductible, Coinsurance, and Annual Out-of-Pocket Maximum amounts shown under the *Benefit Information* section of this Schedule of Benefits. For a complete description of Covered Benefits and Exclusions and Limitations, refer to Sections 5 and 7. Please read Your entire Policy for all terms, conditions, and requirements of this Policy. If You need help understanding a Covered Benefit, please call Our Customer Care Department at [1-855-231-9236].

COVERED SERVICE	YOUR COST: IN-NETWORK
• **INPATIENT FACILITY BENEFIT – NON-MATERNITY** • Maximum Number of Days for Charging an Inpatient Copay – 1 day per Inpatient Admission	$500 Copay per day, after Medical Deductible

• **Medical**
  • Maximum Number of Days per Calendar Year –Unlimited
  • Includes Inpatient Professional Services Visits
  • Maximum Number of Days for Charging an Inpatient Copay – 1 day per Inpatient Admission
	$500 Copay per day, after Medical Deductible

• **Medical – Newborn Infant Care Other than Newborn Infant Care During Maternity Birth Delivery Stay**
  • Maximum Number of Days per Calendar Year –Unlimited
  • Includes Inpatient Professional Services Visits
  • Maximum Number of Days for Charging an Inpatient Copay – 1 day per Inpatient Admission
 	
(These benefits are independent of the mother's maternity stay. See "Inpatient Facility Benefit – Maternity" for newborn infant care during birth deliveries.)
	$500 Copay per day, after Medical Deductible

• **Surgical Benefit**
  • Maximum Number of Days per Calendar Year –Unlimited
  • Includes Surgeon and Anesthesia Professional Services
  • Maximum Number of Days for Charging an Inpatient Copay – 1 day per Inpatient Admission
	$500 Copay per day, after Medical Deductible

• **Psychiatric Benefit**
  • Maximum Number of Days per Calendar Year –Unlimited
  • Includes Inpatient Professional Services Visits
  • Maximum Number of Days for Charging an Inpatient Copay – 1 day per Inpatient Admission
	$500 Copay per day, after Medical Deductible

SCHEDULE OF BENEFITS (continued)

Individual Comprehensive HMO Insurance Policy

COVERED SERVICE	YOUR COST: IN-NETWORK
• **INPATIENT FACILITY BENEFIT – NON-MATERNITY** *(continued)*	

• **Alcohol and Drug Abuse**
  • Number of Days per Calendar Year –Unlimited
  • Includes Inpatient Professional Services Visits
  • Maximum Number of Days for Charging an Inpatient Copay – 1 day per Inpatient Admission
	$500 Copay per day, after Medical Deductible

• **INPATIENT FACILITY BENEFIT – MATERNITY**	$500 Copay per day, after Medical Deductible

• **Maternity Stays for Birth Deliveries**
  • Maximum Number of Days per Calendar Year –Unlimited
  • Includes Professional Services
 	
(This benefit includes Inpatient Facility care provided for both mother and newborn child for at least 48 hours stay for a vaginal delivery or 96 hours stay for a Caesarean Section delivery. See the "Maternity Care Services benefit in Section 5, Covered Benefits for more details.)
	$500 Copay per day, after Medical Deductible

• **Maternity Care Services other than Birth Deliveries** • Maximum Number of Days per Calendar Year –Unlimited • Includes Professional Services *(This benefit includes other medical, surgical and hospital care for maternity care as follows: (1) during the term of pregnancy; (2) spontaneous abortion (miscarriage); (3) complications of pregnancy; and (4) maternal risk.)*	$500 Copay per day, after Medical Deductible
• **SKILLED NURSING FACILITY**	$200 Copay per day, after Medical Deductible
• **OUTPATIENT FACILITY**	
• **Emergency Room** • Includes Emergency Room Visits and Observation Care	$250 Copay per visit after Medical Deductible
• **Surgery**	20% after Medical Deductible

COVERED SERVICE	YOUR COST: IN-NETWORK
• **OUTPATIENT FACILITY** *(continued)*	
• **Cardiovascular**	20% after Medical Deductible
• **Physical Therapy, Occupational Therapy, and Speech Therapy**	20% after Medical Deductible
• **Psychiatric/Autism Services not provided by a PCP**	20% after Medical Deductible
• **Alcohol and Drug Abuse Services not provided by a PCP**	20% after Medical Deductible
• **Preventive Care Services** *(Benefits include, but are not limited to: Cancer Screenings, Counseling Services, Diabetes Management and Supplies, Immunizations, Well Baby Care. Refer to Preventive Health Care Services Benefit in Section 5.)*	0%, No Deductible
• **Other Outpatient Facility**	20% after Medical Deductible
• **PROFESSIONAL SERVICES**	
• **Outpatient Surgery**	
• Outpatient Facility	20% after Medical Deductible
• Office Visit	20% after Medical Deductible
• Anesthesia	20% after Medical Deductible
• **Office Visits And Miscellaneous Services**	
• Office Visits and Home Visits - Primary Care Physician (*Benefits include autism, mental health and substance abuse services when provided by a PCP.)*	$10 Copay per visit, No Deductible
• Office Visits and Home Visits - Physician Specialist	$50 Copay per visit after Medical Deductible
• Urgent Care Benefit	20% after Medical Deductible

COVERED SERVICE	YOUR COST: IN-NETWORK
• **PROFESSIONAL SERVICES** *(continued)*	
• Office Administered Drugs	20% after Medical Deductible
• Allergy Testing	20% after Medical Deductible
• Allergy Immunotherapy	20% after Medical Deductible
• Miscellaneous Medical	20% after Medical Deductible
• Preventive Health Care Services Benefit *(Benefits include, but are not limited to: Cancer Screenings, Counseling Services, Diabetes Management and Supplies, Immunizations, Well Baby Care. Refer to Preventive Health Care Services Benefit in Section 5.)*	0%, No Deductible
• **OTHER PROFESSIONAL SERVICES**	
• **Consultations**	
• Primary Care Physician (*Benefits include autism, mental health and substance abuse services when provided by a PCP.)*	$10 Copay per visit, No Deductible
• Physician Specialist	$50 Copay per visit after Medical Deductible
• **Pediatric Vision Services** • Maximum Number of Exams per Calendar Year – 1 exam • Maximum Number of Pairs of Eyeglasses per Calendar Year – 1 pair of Eyeglasses	20% after Medical Deductible
• **Hearing and Speech Exams** • Maximum Number of Hearing exams per Calendar Year – 1 exam	20% after Medical Deductible
• **Physical Therapy**	20% after Medical Deductible
• **Cardiovascular**	20% after Medical Deductible

COVERED SERVICE	YOUR COST: IN-NETWORK
• **OTHER PROFESSIONAL SERVICES** *(continued)*	
• **Diagnostic Testing, Laboratory and Radiology Services**	
• Pathology/Laboratory Services • Office Visit	20% after Medical Deductible
• Radiology *(Benefits includes Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET).)*	30% after Medical Deductible
• **Chiropractor** (Maximum Visits per Calendar Year – 20 visits)	20% after Medical Deductible
• **Outpatient Psychiatric/Autism Services**	20% after Medical Deductible
• **Outpatient Alcohol and Drug Abuse Services**	20% after Medical Deductible
• **OTHER SERVICES**	
• **Private Duty Nursing**	20% after Medical Deductible
• **Home Health Care Services**	20% after Medical Deductible
• **Ambulance Services**	20% after Medical Deductible
• **Durable Medical Equipment and Supplies**	20% after Medical Deductible
• **Hearing Aid Benefit** • Maximum Number of Hearing Aids per Calendar Year – 1 hearing aid per Ear per Calendar Year. No Annual Maximum.	20% after Medical Deductible
• **Prosthetics Services**	20% after Medical Deductible
• **PRESCRIPTION DRUG BENEFIT**	
• Select Non-Preferred Brand and Specialty Drugs	40% after Prescription Drug Deductible

COVERED SERVICE	YOUR COST: IN-NETWORK
• **PRESCRIPTION DRUG BENEFIT** *(continued)*	
• Select Preferred Brand Drugs	30% after Prescription Drug Deductible
• Generic Drugs	$6 Copay per drug, after Prescription Drug Deductible
• Specialty Drugs Coinsurance Maximum	N/A

GOLD CANYON

SCHEDULE OF BENEFITS

THE UNIVERSITY OF ARIZONA
HEALTH PLANS

CANYON PLANS

University Healthcare Marketplace

GOLD CANYON

Standard Benefit Plan

Individual Comprehensive
HMO Insurance Policy
2015

THE UNIVERSITY OF ARIZONA
HEALTH PLANS
University Healthcare Marketplace

Health Insurance Marketplace

SCHEDULE OF BENEFITS

Individual Comprehensive HMO Insurance Policy

Policy Number: [0000000]

Policy Effective Date: [January 1, 2015]

Policyowner: [John Doe]

Policy Anniversary Date: [January 1 of each Year]

Issuer Age: [00]

Initial Premium: [$000.00]

Type of Coverage: [Indv/Family]

Mode of Payment: [Monthly]

Benefit Period: Calendar Year

Premium Due Date: [The first day of each month]

Benefit Plan: Gold Canyon – Standard Benefit Plan

If coverage was purchased through an Exchange and an Advance Premium Tax Credit was received, any Deductible, Copayment, Coinsurance, and/or Annual Out-of-Pocket Maximum shown below may change without notice. The Exchange will determine if a change is to be made. We will make the change as directed by the Exchange.

BENEFIT INFORMATION	IN-NETWORK
Maximum Lifetime Benefit • Per Covered Person	Unlimited
Maximum Annual Benefit • Per Covered Person	Unlimited
Medical Deductible • Individual Medical Deductible (*per Covered Person per Calendar Year)* • Family Medical Deductible *(per family per Calendar Year)*	 $600 $1,200
Prescription Drug Deductible • Individual Prescription Drug Deductible (*per Covered Person per Calendar Year)* • Family Medical Deductible *(per family per Calendar Year)*	$0 $0

Annual Out-of-Pocket Maximum • Individual Annual Out-of-Pocket Maximum *(per Covered Person per Calendar Year)* • Family Annual Out-of-Pocket Maximum *(per family per Calendar Year)*	 $6,600 $13,200
Coinsurance • *The Coinsurance amount applies to all Covered Services, unless otherwise specified in this Schedule of Benefits.*	 15%

SCHEDULE OF BENEFITS

Individual Comprehensive HMO Insurance Policy

COVERED SERVICES

This Policy will pay Covered Medical Expenses incurred for Covered Benefits provided in *Section 5, Covered Benefits*: (1) based on the Allowable Fee; and (2) unless otherwise indicated below, subject to the Deductible, Coinsurance, and Annual Out-of-Pocket Maximum amounts shown under the *Benefit Information* section of this Schedule of Benefits. For a complete description of Covered Benefits and Exclusions and Limitations, refer to Sections 5 and 7. Please read Your entire Policy for all terms, conditions, and requirements of this Policy. If You need help understanding a Covered Benefit, please call Our Customer Care Department at [1-855-231-9236].

COVERED SERVICE	YOUR COST: IN-NETWORK
• **INPATIENT FACILITY BENEFIT – NON-MATERNITY** • Maximum Number of Days for Charging an Inpatient Copay – 1 day per Inpatient Admission	$250 Copay per day, after Medical Deductible

• **Medical**
  • Maximum Number of Days per Calendar Year –Unlimited
  • Includes Inpatient Professional Services Visits
  • Maximum Number of Days for Charging an Inpatient Copay – 1 day per Inpatient Admission
	$250 Copay per day, after Medical Deductible

• **Medical – Newborn Infant Care Other than Newborn Infant Care During Maternity Birth Delivery Stay**
  • Maximum Number of Days per Calendar Year –Unlimited
  • Includes Inpatient Professional Services Visits
  • Maximum Number of Days for Charging an Inpatient Copay – 1 day per Inpatient Admission
 	
(These benefits are independent of the mother's maternity stay. See "Inpatient Facility Benefit – Maternity" for newborn infant care during birth deliveries.)
	$250 Copay per day, after Medical Deductible

• **Surgical Benefit**
  • Maximum Number of Days per Calendar Year –Unlimited
  • Includes Surgeon and Anesthesia Professional Services
  • Maximum Number of Days for Charging an Inpatient Copay – 1 day per Inpatient Admission
	$250 Copay per day, after Medical Deductible

• **Psychiatric Benefit**
  • Maximum Number of Days per Calendar Year –Unlimited
  • Includes Inpatient Professional Services Visits
  • Maximum Number of Days for Charging an Inpatient Copay – 1 day per Inpatient Admission
	$250 Copay per day, after Medical Deductible

COVERED SERVICE	YOUR COST: IN-NETWORK
• **INPATIENT FACILITY BENEFIT – NON-MATERNITY** *(continued)*	
• **Alcohol and Drug Abuse** • Maximum Number of Days per Calendar Year –Unlimited • Includes Inpatient Professional Services Visits • Maximum Number of Days for Charging an Inpatient Copay – 1 day per Inpatient Admission	$250 Copay per day, after Medical Deductible
• **INPATIENT FACILITY BENEFIT – MATERNITY**	$250 Copay per day, after Medical Deductible
• **Maternity Stays for Birth Deliveries** • Maximum Number of Days per Calendar Year –Unlimited • Includes Professional Services *(This benefit includes Inpatient Facility care provided for both mother and newborn child for at least 48 hours stay for a vaginal delivery or 96 hours stay for a Caesarean Section delivery. See the "Maternity Care Services benefit in Section 5, Covered Benefits for more details.)*	$250 Copay per day, after Medical Deductible
• **Maternity Care Services other than Birth Deliveries** • Maximum Number of Days per Calendar Year –Unlimited • Includes Professional Services *(This benefit includes other medical, surgical and hospital care for maternity care as follows: (1) during the term of pregnancy; (2) spontaneous abortion (miscarriage); (3) complications of pregnancy; and (4) maternal risk.)*	$250 Copay per day, after Medical Deductible
• **SKILLED NURSING FACILITY**	$100 Copay per day, after Medical Deductible
• **OUTPATIENT FACILITY**	
• **Emergency Room** • Includes Emergency Room Visits and Observation Care	$200 Copay per visit after Medical Deductible
• **Surgery**	15% after Medical Deductible
• **Cardiovascular**	15% after Medical Deductible

COVERED SERVICE	YOUR COST: IN-NETWORK
• **OUTPATIENT FACILITY** *(continued)*	
• **Physical Therapy, Occupational Therapy, and Speech Therapy**	15% after Medical Deductible
• **Psychiatric/Autism Services not provided by a PCP**	15% after Medical Deductible
• **Alcohol and Drug Abuse Services not provided by a PCP**	15% after Medical Deductible
• **Preventive Care Services** *(Benefits include, but are not limited to: Cancer Screenings, Counseling Services, Diabetes Management and Supplies, Immunizations, Well Baby Care. Refer to Preventive Health Care Services Benefit in Section 5.)*	0%, No Deductible
• **Other Outpatient Facility**	15% after Medical Deductible
• **PROFESSIONAL SERVICES**	
• **Outpatient Surgery**	
• Outpatient Facility	15% after Medical Deductible
• Office Visit	15% after Medical Deductible
• Anesthesia	15% after Medical Deductible
• **Office Visits And Miscellaneous Services**	
• Office Visits and Home Visits - Primary Care Physician (*Benefits include autism, mental health and substance abuse services when provided by a PCP.)*	$10 Copay per visit, No Deductible
• Office Visits and Home Visits - Physician Specialist	$50 Copay per visit after Medical Deductible
• Urgent Care Benefit	15% after Medical Deductible

COVERED SERVICE	YOUR COST: IN-NETWORK
• **PROFESSIONAL SERVICES** *(continued)*	
• Office Administered Drugs	15% after Medical Deductible
• Allergy Testing	15% after Medical Deductible
• Allergy Immunotherapy	15% after Medical Deductible
• Miscellaneous Medical	15% after Medical Deductible
• Preventive Health Care Services Benefit *(Benefits include, but are not limited to: Cancer Screenings, Counseling Services, Diabetes Management and Supplies, Immunizations, Well Baby Care. Refer to Preventive Health Care Services Benefit in Section 5.)*	0%, No Deductible
• **OTHER PROFESSIONAL SERVICES**	
• **Consultations**	
• Primary Care Physician (*Benefits include autism, mental health and substance abuse services when provided by a PCP.)*	$10 Copay per visit, No Deductible
• Physician Specialist	$50 Copay per visit after Medical Deductible
• **Pediatric Vision Services** • Maximum Number of Exams per Calendar Year – 1 exam • Maximum Number of Pairs of Eyeglasses per Calendar Year – 1 pair of Eyeglasses	15% after Medical Deductible
• **Hearing and Speech Exams** • Maximum Number of Hearing exams per Calendar Year – 1 exam	15% after Medical Deductible
• **Physical Therapy**	15% after Medical Deductible
• **Cardiovascular**	15% after Medical Deductible

COVERED SERVICE	YOUR COST: IN-NETWORK
• **OTHER PROFESSIONAL SERVICES** *(continued)*	
• **Diagnostic Testing, Laboratory and Radiology Services**	
• Pathology/Laboratory Services • Office Visit	15% after Medical Deductible
• Radiology *(Benefits includes Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET).)*	25% after Medical Deductible
• **Chiropractor** (Maximum Visits per Calendar Year – 20 visits)	15% after Medical Deductible
• **Outpatient Psychiatric/Autism Services**	15% after Medical Deductible
• **Outpatient Alcohol and Drug Abuse Services**	15% after Medical Deductible
• **OTHER SERVICES**	
• **Private Duty Nursing**	15% after Medical Deductible
• **Home Health Care Services**	15% after Medical Deductible
• **Ambulance Services**	15% after Medical Deductible
• **Durable Medical Equipment and Supplies**	15% after Medical Deductible
• **Hearing Aid Benefit** • Maximum Number of Hearing Aids per Calendar Year – 1 hearing aid per Ear per Calendar Year. No Annual Maximum.	15% after Medical Deductible
• **Prosthetics Services**	15% after Medical Deductible
• **PRESCRIPTION DRUG BENEFIT**	
• Select Non-Preferred Brand and Specialty Drugs	30% after Prescription Drug Deductible
• Select Preferred Brand Drugs	20% after Prescription Drug Deductible

COVERED SERVICE	YOUR COST: IN-NETWORK
• **PRESCRIPTION DRUG BENEFIT** *(continued)*	
• Generic Drugs	$4 Copay per drug, after Prescription Drug Deductible
• Specialty Drugs Coinsurance Maximum	N/A