

PLAN 35/80-50/1000
PPO SCHEDULE OF BENEFITS

Deductibles & Policy Maximums	Participating Providers	Non-Participating Providers*
Calendar Year Deductible		
Individual		\$1,000
Family maximum (3x individual)		\$3,000
Additional Deductibles (per occurrence)		
Inpatient services	Not applicable	Not applicable
Outpatient surgical services	Not applicable	Not applicable
Emergency room services (waived if admitted)	\$75 then 80% of Covered Expense after satisfying the Deductible	
Failure to obtain Preauthorization of services (waived with Preauthorization of services)	\$250	\$500
Coinsurance Maximum		
Individual	\$2,000	\$4,000
Family maximum (2x individual)	\$4,000	\$8,000
Your Policy Maximum While Insured	\$2,000,000	

Inpatient Benefits	Participating Providers	Non-Participating Providers*
Inpatient Hospital Services	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible; up to \$500 maximum benefit per day (covered expenses for these services do not apply to the Coinsurance Maximum ²)
Inpatient Alcohol, Drug or Other Substance Abuse Detoxification	Not covered	Not covered
Inpatient Alcohol, Drug or Other Substance Abuse Rehabilitation	Not covered	Not covered
Organ Transplantation Services³	80% of Covered Expense after satisfying the Deductible	Not covered
Bone marrow, stem cell and organ transplants		
Donor maximum	\$15,000 per occurrence	
National preferred transplant facility Company authorized transplant facility	\$15,000 per occurrence	
Maximum benefit while insured	Up to policy maximum	
Inpatient Maternity and Newborn Care	80% of Covered Expense after satisfying the Deductible; coverage is limited to newborn care (Deductible waived) and complications of pregnancy	50% of Covered Expense after satisfying the Deductible; coverage is limited to newborn care (Deductible waived) and complications of pregnancy
Inpatient Skilled Nursing Facilities	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible
Maximum	Up to 30 days per Calendar Year	
Inpatient Hospice Care	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible
Maximum	30 day maximum while insured inpatient and outpatient combined	

Inpatient Benefits

	Participating Providers	Non-Participating Providers*
Inpatient Mental Illness Services <i>(including Biologically Based Mental Illness)</i>	50% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible; up to \$200 maximum benefit per day ²
Maximum	\$2,500 maximum per Calendar Year	
Inpatient Rehabilitation Care	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible
Maximum	30 day maximum while insured	

Outpatient Benefits

	Participating Providers	Non-Participating Providers*
Physician Office Visits¹ <i>Services include the detection and treatment of an Injury or Sickness during a physician office visit including associated covered diagnostic X-ray and laboratory services</i> Allergy testing and treatment Breast and pelvic cancer screening including mammography screening Detection of osteoporosis Colorectal cancer screenings Prostate cancer screening Preventive care for children including immunizations (birth through 12 years of age): <i>Age 0 through 12 months: 1 newborn home visit, 5 well-child visits and 1 PKU test</i> <i>Age 1 through 2 years: 2 well-child visits</i> <i>Age 3 through 6 years: 3 well-child visits</i> <i>Age 7 through 12 years: 3 well-child visits</i> Preventive care for children 13 through 18 years: 1 age appropriate health service per Calendar Year.	100% of physician office visit services after \$35 Copayment 80% of Covered Expense after satisfying the Deductible for Participating Outpatient lab and radiology services	50% of Covered Expense after satisfying the Deductible
	Mammography screening is not subject to any Deductibles. Prostate cancer screening is not subject to any Deductibles. Preventive care for children (birth through 12 years of age) are not subject to any Deductibles.	
Periodic Health Evaluations <i>(age 19 and over)¹</i> Hearing screening Vision screening Immunizations and adult boosters Routine laboratory tests age and gender appropriate Weight evaluation Maximum benefit	100% of physician office visit services after \$35 Copayment 80% of Covered Expense after satisfying the Deductible for Participating Outpatient lab and radiology services	50% of Covered Expense after satisfying the Deductible
	\$300 combined per Covered Person per Calendar Year maximum	
Outpatient Maternity Care Physician office visits, lab and radiology services Prenatal, post-partum, maternity care	Not covered	Not covered
Urgent Care Services <i>(per occurrence)</i>	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible
Outpatient Alcohol, Drug or Other Substance Abuse	Not covered	Not covered
Ambulance <i>(Emergency services and specified transfers)</i>	60% of Covered Expense after satisfying the Deductible	

Outpatient Benefits (continued)	Participating Providers	Non-Participating Providers*
Durable Medical Equipment Rental, purchase or repair Maximum benefit	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible
	\$2,000 combined per Calendar Year maximum	
Home Health Care Maximum benefit	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible
	60 visits combined maximum per Calendar Year	
Outpatient Hospice Services Home care for crisis period and acute care management Maximum benefit	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible
	30 day maximum while insured inpatient and outpatient combined	
Outpatient Mental Illness Services (including <i>Biologically Based Mental Illness</i>) ^{1,2}	50% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible
	\$500 maximum benefit per Calendar year; applies toward inpatient \$2,500 Calendar year benefit	
Laboratory Services	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible
Radiology Services	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible
Specialized Scanning, Imaging and Laboratory Services CT, SPECT, PET, MRA, MRI, ultrasounds, EKG, EEG, AMG and nuclear medicine studies	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible
Outpatient Medical Rehabilitative Therapy ¹ Speech, physical, occupational therapy Maximum benefit	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible
	\$2000 combined per Calendar Year maximum For children born with congenital defects and birth abnormalities, from birth to age 5 years, 20 visits each for physical, speech and occupational therapy per Calendar Year. For children with autism, from birth to age 5 years, 20 visits each for physical, speech and occupational therapy per Calendar Year.	
Prosthetics and Corrective Appliances (other than prosthetic arms and legs)	80% of Covered Expense after satisfying the Deductible up to the durable medical equipment maximum.	50% of Covered Expense after satisfying the Deductible up to the durable medical equipment maximum.
Prosthetic Arms and Legs	Prosthetic arms and legs will not be limited to the durable medical equipment maximum; 80% of Covered Expense after satisfying the Deductible.	
Biologically Based Mental Illness ¹ Specified diagnosis only	Covered under outpatient mental illness	Covered under outpatient mental illness
Neuromuscular Skeletal Services ¹ Maximum benefit	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible
	\$1000 combined per Calendar Year maximum	
Outpatient Surgery ¹ Same day services performed at a Hospital or free standing surgical center	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible

1 Copayment based services exclude and do not include or apply to office based Outpatient Surgery, Neuromuscular Skeletal Services, Outpatient Medical Rehabilitation Therapy services other than a Physician Office Visit, Alcohol, Drug or Other Substance Abuse services, Biologically Based Mental Illness services, injectable or intravenous drugs (other than antibiotic, immunizations, allergy serum), Diagnostic Laboratory, Diagnostic Radiology or any service shown on the *Schedule of Benefits* as not covered.

2 Coinsurance for this type of Covered Expense does not apply toward the Coinsurance Maximum, and the percentage payable for this type of Covered Expense does not increase to 100% due to satisfaction of any Coinsurance Maximum.

- 3 A 6-month exclusionary period will apply to all covered transplant services for all Covered Persons initially enrolling under the Policy. This exclusionary period will be reduced or eliminated based upon prior creditable coverage. Consult your Certificate for further details impacting coverage.
- * The Limited Fee Schedule is the allowable amount of Covered Expenses based on Medicare's Resource Based Relative Value System (RBRVS) and dollar amount conversion factor or comparable amount as determined by the Company. The Covered Person is responsible for any charges in excess of the allowable Covered Expense.

Important PPO Information

NOTE: This Policy has certain benefit maximums, some are Calendar Year maximums and some are benefit maximums while insured. Please review this information carefully so you will understand your benefits under this plan.

Preauthorization is required prior to obtaining certain benefits. Failure to Preauthorize services will result in a reduction in the benefits payable for Covered Expenses under the Policy. The Company will conduct a retroactive review to determine the Medical Necessity of the service, and services deemed not Medically Necessary will not be eligible for benefits under the Policy. Additional out-of-pocket expenses incurred by you for not Preauthorizing services will not apply toward your Calendar Year Deductible or Coinsurance Maximum. To avoid any penalty, please refer to "Preauthorization Requirements."

Effect on Benefits. Preauthorization is required prior to obtaining certain services. Failure to obtain Preauthorization may result in additional expense by the Covered Person under the Policy as shown on this *Schedule of Benefits*. No benefits are payable unless the Company determines that Covered Services are Medically Necessary. The Policy has certain coverage maximums, some are Calendar Year maximums and some are benefit maximums while insured. Please review your Schedule of Benefits carefully to determine coverage.

Participating and Non-Participating Providers. The Policy provides benefits for Covered Services obtained from both Participating Providers and Non-Participating Providers. Participating Providers are those Providers who have agreed to participate in the Company's Preferred Provider Organization and provide health care at negotiated fees. Non-Participating Providers have not agreed to negotiated fees or arrangements.

Emergency Services. When a Covered Person receives Emergency Services from a Non-Participating Provider, the Emergency Services will be paid as if rendered by a Participating Provider. Once the Covered Person can be safely transferred to a Participating Provider, the Covered Person must be transferred in order to continue receiving the Participating Provider level of benefits. If the Covered Person chooses not to transfer to a Participating Provider, all additional Covered Expenses incurred will be paid at the Non-Participating Provider level.

Using a Participating Provider May Lower Costs. Covered Services from a Non-Participating Provider may cost the Covered Person more than Covered Services from a Participating Provider. Covered Expenses for a Non-Participating Provider's services may be substantially lower than the actual charges. The Covered Person's responsibility includes the portion of Covered Expense not payable under the Policy, plus all of the Non-Participating Provider's charges that exceed the Covered Expense.

Application of Additional Deductibles. Additional Deductibles are separate Deductibles applied per occurrence for services specified on the Schedule. Additional Deductibles are in addition to, and do not apply toward satisfaction of any Calendar Year Deductibles (or plan year Deductibles if applicable) under the Policy. The Covered Person is responsible for any additional Deductibles applied per occurrence.

To minimize out-of-pocket costs, the Covered Person should consider the effect on benefits by selection of Provider type. The following chart depicts the effect on benefits under a typical PPO plan. To determine Covered Services under your Policy, consult your *Certificate and Schedule of Benefits*.

Effect on Benefits by Choice of Provider		
	Participating Provider Services	Non-Participating Provider Services
Coinsurance Benefit Percentage of Covered Expenses payable by the plan under the Policy	Higher	Lower
Coinsurance Maximum Your out-of-pocket costs, less any applicable Deductibles or Copayments	Lower	Higher
Negotiated Fees for Covered Services Hospitals Physicians	Yes Yes	No No
Balance Billing by Provider for Covered Services Hospitals Physicians (Other than Non-Participating Hospital-based Providers identified below)	No No	Yes Yes Covered Person is responsible for 100% of the charges that exceed the Covered Expense
Balance Billing by Provider for Services Not Covered Under the Plan Hospitals Physicians	Yes Yes Covered Person is responsible for 100% of charges that are not Covered Services under the plan	Yes Yes Covered Person is responsible for 100% of charges that are not Covered Services under the plan

Change in Participation. If while a Covered Person is confined in a Facility which is a Participating Provider, that Facility ceases to remain a Participating Provider, coverage will be provided throughout the period of confinement at the negotiated rate for that Facility before it ceases to be a Participating Provider.

If a Covered Person obtains authorization for services to be rendered by a Participating Provider, and the Participating Provider subsequently ceases to be a Participating Provider, coverage will be provided for the Preauthorized services at the negotiated rate for that Provider before the Provider ceased to be a Participating Provider.

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