PacifiCare
SignatureOptions℠
*Health Savings Account Compatible Plans*

# Qualified High Deductible Health Plan (HSA-Compatible)
# Small Group Plan 3: 100-50/5000
# PPO Schedule of Benefits

| **Deductibles & Policy Maximums** | **Participating Providers** | **Non-Participating Providers**[1] |
|---|---|---|
| **Calendar Year Deductible** | | |
| Individual (Self Only) | $5,000 | $10,000 |
| Aggregate Family maximum *(Amount of Deductible that the Family must pay on a combined basis before benefits become payable under the Policy for any of the Family members)* | $10,000 | $20,000 |
| **Additional Deductibles**[2] *(per occurrence)* *Services are subject to applicable Calendar Year Deductible, Coinsurance, and benefit maximums* | | |
| Inpatient hospital services | Not applicable | Not applicable |
| Outpatient surgical services | Not applicable | Not applicable |
| Emergency room services *(Waived if admitted)* | $100 | |
| Failure to obtain Preauthorization of services *(Waived with Preauthorization of services)* | $250 | $500 |
| Outpatient Complex Radiology | $100 | $200 |
| **Out-of-Pocket Maximum** | | |
| Individual (Self only) | $5,000 | $20,000 |
| Aggregate Family maximum | $10,000 | $40,000 |
| **Your Policy Maximum While Insured** | $2,000,000 | |

| **Inpatient Benefits** | **Participating Providers** | **Non-Participating Providers**[1] |
|---|---|---|
| **Emergency Room Services** | 100% of Covered Expense after satisfying the Deductible | |
| **Inpatient Alcohol, Drug or Other Substance Abuse** | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible |
| Maximum Benefit | Detoxification up to 3 days per admit. $5,000 combined Inpatient benefit per Calendar Year | |
| **Inpatient Hospice Care** | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible |
| Maximum benefit | $10,000 combined maximum for Inpatient and Outpatient benefits while insured | |
| **Inpatient Hospital Services** | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible |
| **Inpatient Maternity and Newborn Care** Labor, delivery and postnatal hospital services | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible |

## Inpatient Benefits (continued)

| Inpatient Benefits (continued) | Participating Providers | Non-Participating Providers[1] |
|---|---|---|
| **Inpatient Mental Illness Services** | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible up to $1,000 maximum benefit per day |
| Maximum benefit | 15 combined Inpatient days per Calendar Year. Each Inpatient day may be substituted for 2 half days of Outpatient treatment | |
| **Inpatient Rehabilitation Care** | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible |
| **Inpatient Skilled Nursing Facilities** | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible |
| Maximum benefit | Limited to 45 days Inpatient per Calendar Year | |
| **Organ Transplant and Transplant Services**<br>Bone marrow, stem cell and organ transplants | 100% of Covered Expense after satisfying the Deductible | Not covered |
| Donor maximum<br>National preferred transplant facility<br>Company authorized transplant facility | <br>$15,000 per occurrence<br>$5,000 per occurrence | |
| Maximum benefit while insured | Up to Policy Maximum | |

## Outpatient Benefits

| Outpatient Benefits | Participating Providers | Non-Participating Providers[1] |
|---|---|---|
| **Physician Office Visits**<br>*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*<br>Allergy Testing and Treatment<br>Breast and pelvic cancer screening including mammogram Screening<br>Detection of osteoporosis<br>Colorectal cancer screenings<br>Prostate cancer screening<br>Periodic health evaluations for children *(through age 18)* including age appropriate immunizations, laboratory tests, height and weight evaluation, vision screening | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible |
| **Periodic Health Evaluations** *(age 19 and over)*<br>Hearing screening<br>Vision screening<br>Immunizations and adult boosters<br>Routine laboratory tests *(age and gender appropriate)*<br>Weight evaluation | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible |
| Maximum benefit | $400 per Calendar Year Maximum | |

## Outpatient Benefits (continued)

| Benefit | Participating Providers | Non-Participating Providers[1] |
|---|---|---|
| **Alcohol, Drug or Other Substance Abuse** | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible |
| Maximum benefit | 24 visits combined maximum per Calendar Year | |
| **Ambulance** *(Emergency services and specified transfers)* | 80% of Covered Expense after satisfying the Deductible | |
| **Corrective Appliances** | See Prosthetics | |
| **Durable Medical Equipment** Rental, purchase or repair | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible |
| Maximum benefit | $2,000 combined per Calendar Year Maximum | |
| **Home Health Care** | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible |
| Maximum benefit | 30 visits combined per Calendar Year Maximum | |
| **Hospice Services** Home care for crisis period and acute care management | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible |
| Maximum benefit | $10,000 combined maximum for Inpatient & Outpatient benefits while insured | |
| **Infertility Services** | Not covered | Not covered |
| Maximum benefit | Not applicable | |
| **Infusion Therapy** | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible |
| Infusion Therapy Drugs | | Covered Person responsible for all charges over $500 maximum benefit per day |
| **Injectable Drugs** | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible |
| **Laboratory Services** *(other than Physician Office Visits)* | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible |
| **Maternity Care** Physician office visits, lab and radiology services; Prenatal, post-partum, maternity care | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible |
| **Medical Rehabilitation Therapy** Speech, physical, occupational therapy | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible |
| Maximum benefit | $2,000 combined per Calendar Year Maximum | |
| **Mental Illness Services** | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible |
| Maximum benefit | 20 visits combined per Calendar Year Maximum | |
| **Neuromuscular Skeletal Services** | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible |
| Maximum benefit | $1,000 combined per Calendar Year Maximum | |
| **Outpatient Surgery** Same day services performed at a Hospital or free standing surgical center | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible |

| **Outpatient Benefits (continued)** | **Participating Providers** | **Non-Participating Providers**[1] |
|---|---|---|
| **Prosthetics** | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible |
| Maximum benefit | $2,000 combined per Calendar Year Maximum | |
| **Radiology Services** *(other than Physician Office Visits)* | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible |
| **Specialized Footwear** | See Prosthetics | |
| **Specialized Scanning, Imaging and Laboratory Services** CT, SPECT, PET, MRA, MRI, ultrasounds, EKG, EEG, EMG and nuclear medicine studies | $100 Additional Deductible per visit then 100% of Covered Expense after satisfying the Calendar Year Deductible | $200 Additional Deductible per visit then 50% of Limited Fee Schedule after satisfying the Calendar Year Deductible |
| **Urgent Care Services** *(per occurrence)* | 100% of Covered Expense after satisfying the Deductible | 50% of Limited Fee Schedule after satisfying the Deductible |
| **Outpatient Prescription Drugs** | | |
| Generic Drugs | 100% of Covered Expense after satisfying the Deductible (per Prescription Unit or up to 30-day supply) | 50% of Covered Expense after satisfying the Deductible (per Prescription Unit or up to 30-day supply) |
| Brand Drugs | 100% of Covered Expense after satisfying the Deductible (per Prescription Unit or up to 30-day supply) | 50% of Covered Expense after satisfying the Deductible (per Prescription Unit or up to 30-day supply) |
| Mail Service | 100% of Covered Expense after satisfying the Deductible (per Prescription Unit or up to 90-day supply) | |

1 Maximum Covered Expenses for Non-Participating Providers will not exceed the Limited Fee Schedule. Please refer to the Definitions Section in the *Certificate* for an explanation of the Limited Fee Schedule.

2 Additional Deductibles for Covered Expenses do not apply toward the Calendar Year Deductible.

## 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 Out-of-Pocket Maximum. To avoid any penalty, please refer to "Preauthorization Requirements in your *Certificate*."

**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.

**USE OF HOSPITAL BASED PROVIDERS.** The Policy provides benefits for Covered Services obtained from both Participating Providers and Non-Participating Providers. Certain hospital based providers including Emergency Room, Radiology, Anesthesiology and Pathology providers, may not contract to provide Participating Provider services under the Policy. To reduce your costs, Covered Services obtained from Non-Participating hospital based providers at a Participating Hospital, may be considered as a Participating Provider benefit up to the Usual and Customary Charge (or Limited Fee Schedule if applicable) under the Policy. Under these circumstances, the Non-Participating Provider may bill the Covered Person for charges over Covered Expenses paid by the Policy. The Covered Person is responsible for any charges that exceed the Covered Expense under the Policy.

**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.

**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** |
|---|---|---|
| **Percentage Payable**<br>Percentage of Covered Expenses payable by the plan under the Policy | Higher | Lower |
| **Out-of-Pocket Maximum**<br>Your out-of-pocket costs, including applicable Deductibles or Copayments | Lower | Higher |
| **Negotiated Fees for Covered Services**<br>Hospitals<br>Physicians | <br>Yes<br>Yes | <br>No<br>No |
| **Balance Billing by Provider for Covered Services**<br>Hospitals<br>Physicians<br>(Other than Non-Participating Hospital-based Providers identified below) | <br>No<br>No | <br>Yes<br>Yes<br>Covered person is responsible for 100% of the charges that exceed the Covered Expense. These charges do not apply toward satisfying the Out-of-Pocket Maximum. |
| **Balance Billing by Provider for Services Not Covered Under the Plan**<br>Hospitals<br>Physicians | <br>Yes<br>Yes<br>Covered Person is responsible for 100% of charges that are not Covered Services under the plan | <br>Yes<br>Yes<br>Covered Person is responsible for 100% of charges that are not Covered Services under the plan. These charges do not apply toward satisfying the Out-of-Pocket Maximum. |
| **Balance Billing by Non-Participating Hospital-based Providers, when Providing Covered Services at a Participating Hospital**<br>Non-Participating Hospital-based Providers include - emergency room, radiology, anesthesiology, pathology | Does not apply | Yes<br>Covered Person responsible for 100% of charges that exceed the Covered Expense. These charges do not apply toward satisfying the Out-of-Pocket Maximum. |

**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.

This *Schedule of Benefits* is a brief outline of the Covered Services provided under the Policy. Please review the *Certificate of Coverage* in addition to the *Schedule of Benefits* for a complete explanation of Comprehensive Major Medical Coverage to determine coverage.

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PAZ142408-000

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