

PLAN 80-50/2000

SDHP SCHEDULE OF BENEFITS

Effective July 1, 2005

Self Directed Account*

Reimbursements under the Self Directed Account (SDA) are limited to Covered Services indicated in this Schedule of Benefits and the Certificate as SDA-eligible expenses and are subject to the conditions and limitations of the Policy. In all cases, reimbursements will be limited to substantiated qualified medical expenses. Covered Expenses for SDA-eligible medical services apply toward the Plan Year Deductible.

SDA Covered Services: The following is a summary of SDA Covered Services. Please note that this is not a complete list. Refer to the Certificate for additional plan information, including exclusions and limitations. Covered Expenses reimbursable under the SDA include the following: Physician office visits including Antibiotic Injections, Breast and Pelvic Cancer Screening including Mammography Screening, Colorectal Cancer Screening, Detection of Osteoporosis, associated Diagnostic laboratory services, associated Diagnostic radiology services limited to standard plain x-ray films, Prostate Screening, and Periodic Health Evaluations. If a Covered Person has a question regarding a specific SDA Covered Service, he or she should contact Customer Service at the number located on their ID card.

The Self Directed Account Maximum and Rollover Per Plan Year is subject to increase due to the Covered Person's participation in designated PacifiCare Wellness Programs.

Self Directed Account Maximum per Plan Year	
Individual	\$1,000 per Plan Year benefit
Family	\$2,000 per Plan Year benefit
Self Directed Account Rollover per Plan Year	
Individual	\$1,000 per Plan Year eligible for Rollover
Family	\$2,000 per Plan Year eligible for Rollover

Deductibles & Policy Maximums

	Participating Providers	Non-Participating Providers ¹
Plan Year Deductible		
Individual		\$2,000
Family maximum		\$4,000
Additional Deductibles² (per occurrence) <i>Services are subject to applicable Plan Year Deductible, Coinsurance, and benefit maximums</i>		
Inpatient 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
Coinsurance Maximum		
Individual	\$3,000	\$6,000
Family maximum	\$6,000	\$12,000
Your Policy Maximum While Insured		\$5,000,000

Inpatient Benefits	Participating Providers	Non-Participating Providers^{1,3}
Emergency Room Services	80% of Covered Expense after satisfying the Deductible	
Inpatient Alcohol, Drug or Other Substance Abuse Detoxification³	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible up to \$200 maximum benefit per day
Maximum benefit	\$2,500 Inpatient maximum per Plan Year	
Inpatient Hospice Care	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible up to \$1,000 maximum benefit per day
Maximum benefit	\$10,000 combined maximum for Inpatient and Outpatient benefits while insured	
Inpatient Hospital Services	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible up to \$1,000 maximum benefit per day
Inpatient Maternity and Newborn Care Labor, delivery and postnatal hospital services	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible up to \$1,000 maximum benefit per day
Inpatient Mental Illness Services³ <i>(other than SMI and SED)</i>	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible up to \$200 maximum benefit per day
Maximum benefit	\$2,500 Inpatient maximum per Plan Year	
Inpatient Rehabilitation Care	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible up to \$1,000 maximum benefit per day
Inpatient Skilled Nursing Facilities	80% of Covered Expense after satisfying the Deductible	Covered Person responsible for all charges over \$200 maximum benefit per day
Maximum benefit	Up to 90 days Inpatient per Plan Year	
Organ Transplant and Transplant Services Bone marrow, stem cell and organ transplants Donor maximum National preferred transplant facility Company authorized transplant facility Maximum benefit while insured	80% of Covered Expense after satisfying the Deductible	Not Covered
	\$15,000 per occurrence \$5,000 per occurrence	
	Up to Policy Maximum	
Severe Mental Illness (SMI) Services <i>(including Serious Emotional Disturbance of a Child (SED))</i> Specified diagnosis only	80% of Covered Expense after satisfying the Deductible	Not Covered

**Participating
Providers**

**Non-Participating
Providers¹**

Outpatient Benefits

<p>Physician Office Visits <i>Services include the detection and treatment of an Injury or Sickness during a Physician Office Visit including associated Covered diagnostic Laboratory and Radiology services</i> Allergy Testing and Treatment (<i>this Physician Office Visit Covered Service is not eligible for reimbursement under the SDA</i>) Antibiotic injections Breast and pelvic cancer screening including mammogram Screening Detection of osteoporosis Colorectal cancer screenings Prostate cancer screening Periodic health evaluations for children (<i>through age 18</i>) including age appropriate immunizations, laboratory tests, height and weight evaluation, vision screening Periodic health evaluations (<i>age 19 and over</i>) including hearing screening, vision screening, immunizations and adult boosters, routine laboratory tests (<i>age and gender appropriate</i>), weight evaluation</p>	<p>100% to SDA maximum, then 80% of Covered Expense after satisfying the Deductible</p>	<p>100% of Limited Fee Schedule to SDA maximum, then 50% of Limited Fee Schedule after satisfying the Deductible</p>
<p>Acupuncture Services Maximum benefit</p>	<p>80% of Covered Expense after satisfying the Deductible</p>	<p>50% of Limited Fee Schedule after satisfying the Deductible</p>
<p>\$1,000 combined per Plan Year Maximum</p>		
<p>Alcohol, Drug or Other Substance Abuse³ Maximum benefit</p>	<p>80% of Covered Expense after satisfying the Deductible</p>	<p>50% of Limited Fee Schedule after satisfying the Deductible</p>
<p>1 visit per day, 20 visits per Plan Year</p>		
<p>Ambulance <i>(Emergency services and specified transfers)</i></p>	<p>70% of Covered Expense after satisfying the Deductible</p>	
<p>Corrective Appliances Maximum benefit</p>	<p>80% of Covered Expense after satisfying the Deductible</p>	<p>50% of Limited Fee Schedule after satisfying the Deductible</p>
<p>\$500 combined per Plan Year Maximum; \$1,000 while insured</p>		
<p>Durable Medical Equipment Rental, purchase or repair Maximum benefit</p>	<p>80% of Covered Expense after satisfying the Deductible</p>	<p>50% of Limited Fee Schedule after satisfying the Deductible</p>
<p>\$2,000 combined per Plan Year Maximum</p>		
<p>Home Health Care Maximum benefit</p>	<p>80% of Covered Expense after satisfying the Deductible</p>	<p>50% of Limited Fee Schedule after satisfying the Deductible</p>
<p>100 visits combined maximum per Plan Year</p>		
<p>Hospice Services Home care for crisis period and acute care management Maximum benefit</p>	<p>80% of Covered Expense after satisfying the Deductible</p>	<p>50% of Limited Fee Schedule after satisfying the Deductible</p>
<p>\$10,000 combined maximum for Inpatient & Outpatient benefits while insured</p>		
<p>Infertility Services Maximum benefit</p>	<p>80% of Covered Expense after satisfying the Deductible</p>	<p>50% of Limited Fee Schedule after satisfying the Deductible</p>
<p>\$2,000 combined maximum for Inpatient and Outpatient benefits while insured</p>		

Outpatient Benefits (continued)	Participating Providers	Non-Participating Providers¹
Infusion Therapy Infusion Therapy Drugs	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible Covered Person responsible for all charges over \$500 maximum benefit per day
Injectable Drugs	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
Laboratory Services <i>(other than Physician Office Visits)</i>	80% 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	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
Medical Rehabilitation Therapy Speech, physical, occupational therapy Maximum benefit	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
	\$2,000 combined per Plan Year Maximum	
Mental Illness Services³ <i>(other than SMI and SED)</i> Maximum benefit	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
	1 visit per day, 20 visits per Plan Year	
Neuromuscular Skeletal Services Maximum benefit	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
	\$1,000 combined per Plan Year Maximum	
Outpatient Surgery Same day services performed at a Hospital or free standing surgical center	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible up to \$750 maximum benefit per day ³
Prosthetics Maximum benefit	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
	\$2,000 combined per Plan Year Maximum	
Radiology Services <i>(other than Physician Office Visits)</i>	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
Severe Mental Illness (SMI) Services <i>(including Serious Emotional Disturbance of a Child (SED))</i> Specified diagnosis only	80% of Covered Expense after satisfying the Deductible	Not Covered
Specialized Footwear Maximum benefit	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
	\$500 combined per Plan Year Maximum; \$1,000 while insured	
Specialized Scanning, Imaging and Laboratory Services CT, SPECT, PET, MRA, MRI, ultrasounds, EKG, EEG, EMG and nuclear medicine studies	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
Urgent Care Services <i>(per occurrence)</i>	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible

Outpatient Prescription Drugs²

Participating Retail Pharmacy

Non-Participating Pharmacy

<i>Copayment applies per Prescription Unit or up to 30 days supply</i>	100% after Copayment of:	80% after Copayment of:
Generic Formulary Copayment	\$10 Copayment	\$10 Copayment
Brand-Name Formulary Copayment	\$25 Copayment	\$25 Copayment
Non-Formulary Copayment	\$50 Copayment	\$50 Copayment
Prescription Drug Deductible	None	
Mail Service Program	100% after 2 Copayments per 3 Prescription Units or up to a 90-day supply	

SDA Non-Covered Services: Covered Expenses not eligible for reimbursement under the SDA include, but are not limited to the following: Allergy Testing/Serum and Treatment, Ambulance, Colonoscopy or flexible sigmoidoscopy except for qualified individuals as part of Colorectal Cancer Screening, Durable medical equipment, Emergency room, Family Planning Services, Genetic Testing and Counseling, Hearing Aids and Hearing Devices, Hospice Services, Infusion Therapy, Infertility Treatment, Injectable or Intravenous drugs (other than antibiotics and immunization injections, Inpatient and Outpatient Alcohol, Drug or Other Substance Abuse, Inpatient and Outpatient Hospital Services, Inpatient and Outpatient Maternity and Newborn Care (Labor, Delivery and Postnatal Hospital Services), Inpatient and Outpatient Rehabilitation Care, Inpatient Hospice Care, Inpatient Skilled Nursing Facilities, Laboratory Services (other than those under Physician Office Visits), Mental Illness Services, Neuromuscular Skeletal Services, Organ Transplantation Services (Bone Marrow, Stem Cell and Organ Transplants), Outpatient or Physician office based surgery, Physician services (other than physician office visits), Prescription drugs, Prosthetics and Corrective Appliances, Radiology Services (other than standard x-rays), Specialized scanning, imaging, and diagnostic procedures such as Computed Tomography (CT), Single Photon Emission Computerized Tomography Radionuclide Scanning (SPECT), Positron Emission Tomography (PET), Magnetic Resonance Angiography (MRA) and Magnetic Resonance Imaging (MRI) (with or without oral, rectal, injected or infused contrast media), Electrocardiogram (EKG), Electro-encephalography (EEG), Electromyograph (EMG) and nuclear medicine studies, Sterilization, Therapeutic services, Transplants, Ultrasounds, Urgent care facility services, and any service shown as not applicable or not covered. Nontraditional or non-Covered Services are also not eligible for reimbursement under the SDA. Please refer to the *Certificate* for additional plan information, including exclusions and limitations.

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 Copayments or Additional Deductibles for Covered Expenses do not apply toward the Plan Year Deductible.

3 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.

Important PPO Information

NOTE: This Policy has certain benefit maximums, some are Plan 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 Plan Year Deductible or Coinsurance 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 Plan 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
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. These charges do not apply toward satisfying the Coinsurance Maximum.
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. These charges do not apply toward satisfying the Coinsurance Maximum.
Balance Billing by Non-Participating Hospital-based Providers, when Providing Covered Services at a Participating Hospital Non-Participating Hospital-based Providers – include emergency room, radiology, anesthesiology, pathology	Does not apply	Yes Covered Person responsible for 100% of charges that exceed the Covered Expense. These charges do not apply toward satisfying the Coinsurance 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.

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PCA152132-000

GHC-SM-SOB-04-CA
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