

PLAN 80-50/2000

SDHP SCHEDULE OF BENEFITS

**Self Directed Account<sup>^\*#</sup>**

Reimbursements under the Self Directed Account (SDA) are limited to Covered Services indicated in this Schedule of Benefits as SDA-eligible expenses<sup>\*,#</sup> 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.

<b>Self Directed Account Maximum per Plan Year</b>	
Individual	\$1,000 per Plan Year benefit
Family	\$2,000 per Plan Year benefit
<b>Self Directed Account Rollover per Plan Year</b>	
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 <sup>1</sup>
<b>Plan Year Deductible</b>		
Individual		\$2,000
Family maximum		\$4,000
<b>Additional Deductibles<sup>2</sup> (per occurrence)</b> <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 <i>(Waived if admitted)</i>	\$100	
Failure to obtain Preauthorization of services <i>(Waived with Preauthorization of services)</i>	\$250	\$500
<b>Coinsurance Maximum</b>		
Individual	\$3,000	\$6,000
Family maximum	\$6,000	\$12,000
<b>Your Policy Maximum While Insured</b>	\$5,000,000	

**Inpatient Benefits**

	Participating Providers	Non-Participating Providers <sup>1,3</sup>
<b>Emergency Room Services</b>	80% of Covered Expense after satisfying the Deductible	
<b>Inpatient Alcohol, Drug or Other Substance Abuse Detoxification<sup>3</sup></b>	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	
<b>Inpatient Hospice Care</b>	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	\$5,000 combined maximum for Inpatient and Outpatient benefits while insured	

<b>Inpatient Benefits (continued)</b>	<b>Participating Providers</b>	<b>Non-Participating Providers<sup>1,3</sup></b>
<b>Inpatient Hospital Services</b>	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible up to \$1,000 maximum benefit per day
<b>Inpatient Maternity and Newborn Care</b> 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
<b>Inpatient Mental Illness Services<sup>3</sup></b> <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	
<b>Inpatient Rehabilitation Care</b>	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible up to \$1,000 maximum benefit per day
<b>Inpatient Skilled Nursing Facilities</b>	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	
<b>Organ Transplant and Transplant Services</b> 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	

<b>Outpatient Benefits</b>	<b>Participating Providers</b>	<b>Non-Participating Providers<sup>1</sup></b>
<b>Physician Office Visits</b> <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> 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	100% to SDA maximum <sup>*,#</sup> , then 80% of Covered Expense after satisfying the Deductible	100% to SDA maximum <sup>*,#</sup> , then 50% of Limited Fee Schedule after satisfying the Deductible
<b>Periodic Health Evaluations <i>(age 19 and over)</i></b> Hearing screening Vision screening Immunizations and adult boosters Routine laboratory tests <i>(age and gender appropriate)</i> Weight evaluation	100% to SDA maximum <sup>*,#</sup> , then 80% of Covered Expense after satisfying the Deductible	100% to SDA maximum <sup>*,#</sup> , then 50% of Limited Fee Schedule after satisfying the Deductible

<b>Outpatient Benefits (continued)</b>	<b>Participating Providers</b>	<b>Non-Participating Providers<sup>1</sup></b>
<b>Acupuncture Services</b>	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
Maximum benefit	\$1,000 combined per Plan Year Maximum	
<b>Alcohol, Drug or Other Substance Abuse<sup>3</sup></b>	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
Maximum benefit	1 visit per day, 20 visits per Plan Year	
<b>Ambulance</b> <i>(Emergency services and specified transfers)</i>	70% of Covered Expense after satisfying the Deductible	
<b>Corrective Appliances</b>	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
Maximum benefit	\$500 combined per Plan Year Maximum; \$1,000 while insured	
<b>Durable Medical Equipment</b> Rental, purchase or repair	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
Maximum benefit	\$2,000 combined per Plan Year Maximum	
<b>Home Health Care</b>	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
Maximum benefit	100 visits combined maximum per Plan Year	
<b>Hospice Services</b> Home care for crisis period and acute care management	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
Maximum benefit	\$5,000 combined maximum for Inpatient & Outpatient benefits while insured	
<b>Infertility Services</b>	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
Maximum benefit	\$2,000 combined maximum for Inpatient and Outpatient benefits while insured	
<b>Infusion Therapy</b> 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
<b>Injectable Drugs</b>	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
<b>Laboratory Services</b> <i>(other than Physician Office Visits)</i>	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
<b>Maternity Care</b> 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
<b>Medical Rehabilitation Therapy</b> Speech, physical, occupational therapy	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
Maximum benefit	\$1,000 combined per Plan Year Maximum	
<b>Mental Illness Services<sup>3</sup></b> <i>(other than SMI and SED)</i>	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
Maximum benefit	1 visit per day, 20 visits per Plan Year	
<b>Neuromuscular Skeletal Services</b>	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
Maximum benefit	\$1,000 combined per Plan Year Maximum	

<b>Outpatient Benefits (continued)</b>	<b>Participating Providers</b>	<b>Non-Participating Providers<sup>1</sup></b>
<b>Outpatient Surgery</b> 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 <sup>3</sup>
<b>Prosthetics</b>	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
Maximum benefit	\$2,000 combined per Plan Year Maximum	
<b>Radiology Services</b> <i>(other than Physician Office Visits)</i>	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
<b>Severe Mental Illness (SMI) Services</b> <i>(including Serious Emotional Disturbance of a Child (SED))</i> Specified diagnosis only	80% of Covered Expense after satisfying the Deductible	Not Covered
<b>Specialized Footwear</b>	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
Maximum benefit	\$500 combined per Plan Year Maximum; \$1,000 while insured	
<b>Specialized Scanning, Imaging and Laboratory Services</b> CT, SPECT, PET, MRA, MRI, ultrasounds, EKG, EEG, AMG and nuclear medicine studies	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
<b>Urgent Care Services</b> <i>(per occurrence)</i>	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible

<b>Outpatient Prescription Drugs<sup>2</sup></b>	<b>Participating Retail Pharmacy</b>	<b>Non-Participating Pharmacy</b>
<i>Copayment applies per Prescription Unit or up to 30 days</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	

^ 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.

\* 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. SDA Covered Services are made up of a compilation of services commonly performed during a routine office visit, subject to a proprietary medical coding table, which include: physician office visits, physician home visits, physician consultations, annual physical exams, well-baby, well-child, well-woman, immunizations and injections (except allergy injections), colonoscopy (as part of Colorectal Cancer Screening), office radiology including, but not limited to CAT scans, mammograms, MRIs, X-rays, office pathology and laboratory, office-based diagnostic procedures, including but not limited to ambulatory blood pressure monitoring, recording and analysis, electrocardiograms, eye refractions and exams, basic and comprehensive metabolic panel, muscle range-of-motion testing, pacemaker analysis, pap smears, prostate exams, sigmoidoscopy, and vascular and breathing analysis. If a Covered Person has a question regarding a specific SDA service, he or she should contact Customer Service at the number located on their ID card.

# SDA Non-Covered Services: The following is a summary of SDA non-covered services. Please note that this is not a complete list. Please refer to the *Certificate* for additional plan information, including exclusions and limitations. SDA non-covered services include: ambulance, hospital, urgent care and facility services, emergency room, durable medical equipment, physician services (other than physician office visits), maternity care, electroencephalogram (EEG), antigen and immunotherapy services, allergy testing and treatment (including allergy injections and serum), colonoscopy (except as part of Colorectal Cancer Screening), therapeutic services, chiropractic services, mental health related visits, chemical dependency visits, surgical procedures, transplants, sterilization, rehabilitative services, prosthetic devices, and oxygen.

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*.**

<b>Effect on Benefits by Choice of Provider</b>		
	<b>Participating Provider Services</b>	<b>Non-Participating Provider Services</b>
<b>Coinsurance Benefit</b> Percentage of Covered Expenses payable by the plan under the Policy	Higher	Lower
<b>Coinsurance Maximum</b> Your out-of-pocket costs, less any applicable Deductibles or Copayments	Lower	Higher
<b>Negotiated Fees for Covered Services</b> Hospitals Physicians	Yes Yes	No No
<b>Balance Billing by Provider for Covered Services</b> 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
<b>Balance Billing by Provider for Services Not Covered Under the Plan</b> 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
<b>Balance Billing by Non-Participating Hospital-based Providers, when Providing Covered Services at a Participating Hospital</b> 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

**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.

**PacifiCare Health Plan Administrators**  
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