

\$10/100

Managed Care Schedule of Benefits

General Features

Calendar Year Deductible	None
Lifetime Benefit Maximum	\$2,000,000
Out-of-Pocket Maximum	\$1,000
Family Maximum is three times the Individual Maximum	
Office Visits (including women's health care services)	
Primary Care Provider	\$10 Copayment
Specialist	\$10 Copayment
Emergency Room Services (Copayment waived if admitted)	\$75 Copayment
Urgent Care Services (free-standing facilities)	\$35 Copayment

Benefits Available While Hospitalized as an Inpatient

Family Planning (vasectomy, tubal ligation, cervical caps, IUD, termination of pregnancy)	100% Coinsurance
Hospice Services	100% Coinsurance
Hospital Care (room charges, anesthesia, blood, laboratory, radiology, medications)	100% Coinsurance
Provider Care While Hospitalized (per visit)	100% Coinsurance
Rehabilitation Services	100% Coinsurance
Skilled Nursing Care (100 days per year maximum)	100% Coinsurance
TMJ (\$1,000 per year, \$5,000 lifetime maximum) (Combined Inpatient and Outpatient Maximum)	100% Coinsurance
Transplant Services (subject to \$250,000 lifetime maximum 12-month waiting period with credit for prior coverage)	100% Coinsurance

Benefits Available on an Outpatient Basis

Allergy Testing	
Primary Care Provider	\$10 Copayment
Specialist	\$10 Copayment
Ambulance	100% Coinsurance
Diabetic Management and Treatment	
Primary Care Provider	\$10 Copayment
Specialist	\$10 Copayment
Durable Medical Equipment (\$5,000 per calendar year maximum)	100% Coinsurance
Family Planning (vasectomy, tubal ligation, cervical caps, IUD, termination of pregnancy)	
Primary Care Provider	\$10 Copayment
Specialist	\$10 Copayment

Benefits Available on an Outpatient Basis (continued)

Hearing Screening	
Primary Care Provider	\$10 Copayment
Specialist	\$10 Copayment
Home Health Services (limited to 130 visits per calendar year)	100% Coinsurance
Hospice Services (six months with an available extension of six months)	100% Coinsurance
Hospital Services (outpatient surgery, facility, procedures, blood, anesthesia, laboratory, radiology)	100% Coinsurance
Infertility Services	Not Covered
Injectable Medications (allergy, contraception, immunizations in conjunction with an office visit)	100% Coinsurance
Laboratory Services and Standard X-rays	100% Coinsurance
Maternity Care, Tests and Procedures (copayment per pregnancy)	
Primary Care Provider	\$50 Copayment
Specialist	\$50 Copayment
Periodic Health Evaluation	
Primary Care Provider	\$10 Copayment
Specialist	\$10 Copayment
Prosthetics and Corrective Appliances	100% Coinsurance
Rehabilitation Therapy (speech, occupational, physical) (60 visits per calendar year maximum)	\$10 Copayment
Routine Vision Exam one routine vision exam in each year	\$10 Copayment
Self Injectable Medications (a single copayment applies to a 30-day supply or treatment plan, whichever is shorter)	\$50 Copayment
Specialized Scanning (MRI, MRA, CT Scan, PET Scan, SPECT Scan) (copayment and/or coinsurance applies per procedure)	\$10 Copayment
TMJ (\$1,000 per year, \$5,000 lifetime maximum) (Combined Inpatient and Outpatient Maximum)	
Primary Care Provider	\$10 Copayment
Specialist	\$10 Copayment
Transplant Services (12-month waiting period)	
Primary Care Provider	\$10 Copayment
Specialist	\$10 Copayment

Behavioral Health Services

All mental health and chemical dependency services (behavioral health) require preauthorization for services to be covered. To initiate services, you must call PacifiCare Behavioral Health at 1-800-577-7244 or TDHI 1-800-221-2832.

Mental Health Services

Inpatient Mental Health	100% Coinsurance
Residential Care/Day Treatment	100% Coinsurance
Outpatient Mental Health	\$10 Copayment

Chemical Dependency Services

Inpatient Chemical Dependency	100% Coinsurance
Residential Chemical Dependency	100% Coinsurance
Outpatient Chemical Dependency	\$10 Copayment

Out-of-Area Dependent

A dependent child/student is eligible for out-of-area coverage if he or she does not reside within the service area, but meets the other eligibility requirements of the subscriber's PacifiCare plan. This includes students who are attending a college or university on a full-time basis, as well as dependents that permanently live outside the PacifiCare service area. The out-of-area student/dependents must specifically enroll for this plan. If the student/dependent does not enroll for this coverage, they will only be covered for emergency services. This benefit provides coverage at the same copayment levels as the subscriber's plan.

Principal Exclusions and Limitations of Benefits

Unless described as a Covered Service in an attached supplement, all services and benefits described below are excluded from coverage or limited under this Health Plan. Any supplement must be an attachment to the Combined Evidence of Coverage and Disclosure Form. (NOTE: Additional exclusions and limitations may be included with the explanation of your Supplemental Benefits.)

General Exclusions

Services that are not Medically Necessary, as defined in the “Definitions” section of the Combined Evidence of Coverage and Disclosure Form, are not covered.

Services not specifically included in the Combined Evidence of Coverage and Disclosure Form, or any supplement purchased by your employer, are not covered.

1. Services that are rendered without authorization from the Member’s Participating Medical Group or PacifiCare (except for Emergency Services described in this Combined Evidence of Coverage and Disclosure Form, and for obstetrical and gynecological Provider services obtained directly from an OB/GYN, Family Practice Provider or surgeon designated by the Member’s Participating Medical Group as providing OB/GYN services), are not covered.
2. Services obtained from Non-Participating Providers or Participating Providers who are not affiliated with the Member’s Participating Medical Group, when such services were offered or Preauthorized by the Member’s Participating Medical Group and the Member refused to obtain the services as offered by the Member’s Participating Medical Group, are not covered.
3. Services rendered prior to the Member’s effective date of enrollment or after the effective date of disenrollment are not covered (Inpatient are covered until date of discharge).
4. PacifiCare does not cover the cost of services that result from a treatment plan for a non-Covered Service and that are the sole, direct and predictable consequence of a non-Covered Service (as recognized by the organized medical community in the State of Oregon). However, PacifiCare will cover Medically Necessary services required to treat an illness or injury that may be a consequence of non-Covered Services but are not predictable in advance, such as unexpected, life-threatening complications of cosmetic surgery.
5. Services performed by immediate relatives or members of your household are not covered.
6. Services obtained outside the Service Area are not covered except for Emergency Services or Urgently Needed Services.
7. Treatment for an injury or condition sustained as a result of the Member’s commission of a felony or attempt to commit a felony is not covered. This exclusion does not apply to injuries or conditions resulting from an act of domestic violence, or a physical or mental condition.

Specific Exclusions

<ul style="list-style-type: none"> ▪ Acupuncture & Acupressure(unless provided by a supplemental rider)] ▪ Air Conditioners, Air Purifiers or Other Environmental Equipment ▪ Artificial Heart(s) ▪ Chiropractic Care (unless provided by a supplemental rider) ▪ Communication Devices ▪ Complementary and Alternative Medicine (unless provided by a supplemental rider) 	<ul style="list-style-type: none"> ▪ Cosmetic Services and Surgery ▪ Elective Enhancement ▪ Exercise Equipment and Services ▪ Hearing Aids and Hearing Devices (unless provided as a Supplemental Benefit) ▪ Infertility Reversal ▪ Infertility Services (unless provided as a Supplemental Benefit) ▪ Nursing, Private Duty ▪ Obesity Treatment 	<ul style="list-style-type: none"> ▪ Recreational, Lifestyle, Educational, or Hypnotic Therapy ▪ Sexual Dysfunction ▪ Sex Transformations ▪ Vision Training ▪ Weight Alteration Programs (Inpatient or Outpatient)
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Limitations

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| <ul style="list-style-type: none"> ▪ Biofeedback ▪ Bloodless Surgery Services ▪ Bone Marrow and Stem Cell Transplant ▪ Breast Implants ▪ Circumcision ▪ Dental Care, Dental Appliances and Orthodontics ▪ Dental Treatment Anesthesia ▪ Dialysis ▪ Disabilities connected to Military Services ▪ Drugs and Prescription Medication (Outpatient) ▪ Durable Medical Equipment ▪ Education Services for Developmental Delays and Learning Disabilities ▪ Experimental and/or Investigational Procedures, Items and Treatments ▪ Eyewear and Corrective Refractive Procedures ▪ Family Planning ▪ Follow-Up Care: Emergency Services | <ul style="list-style-type: none"> ▪ Foot Orthotics/Footwear ▪ Genetic Testing ▪ Government Services and Treatment ▪ Health Care Expenses Incurred Due to Liable Third Party ▪ Hospice ▪ Immunizations ▪ Institutional Services and Supplies ▪ Medicare Benefits for Medicare Eligible Members ▪ Midwife Services ▪ Nutritional Supplements or Formulas ▪ Outpatient Medical Rehabilitation Therapy ▪ Off-Label Drug Use ▪ Oral Surgery and Dental Services ▪ Oral Surgery and Dental Services; Dental Treatment Anesthesia ▪ Organ Donor Services ▪ Organ Transplant ▪ Phenylketonuria (PKU) Testing and Treatment ▪ Physical or Psychological Examinations | <ul style="list-style-type: none"> ▪ Private Rooms and comfort Items ▪ Prosthetics and Corrective Appliances ▪ Public Facility Care ▪ Pulmonary Programs ▪ Reconstructive Surgery ▪ Rehabilitation Services and Therapy ▪ Respite Care ▪ Services in the Home ▪ Surrogacy ▪ Temporomandibular Joint Syndrome (TMJ) ▪ Transportation ▪ Transplants ▪ Usual, Customary, or Reasonable (UCR) ▪ Veterans Administration Services ▪ Ventricular Assist Devices (VADs) ▪ Vision Care ▪ Weight Alteration Programs (Inpatient or Outpatient) |
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This schedule summarizes your PacifiCare coverage. For exact coverage terms and conditions, refer to your Combined Evidence of Coverage and Disclosure Form or the Employer Group Agreement which is available through your Employer or PacifiCare. The coverage described in this brochure is only for care provided by, or arranged and authorized by your Primary Care Provider or Contracting Medical Group (except in emergencies or for Out-of-Area Child/Student Dependents).

Note this is not a contract; this is the Schedule of Benefits and it only constitutes a summary of the health plan. The contract must be consulted to determine the exact terms and conditions of coverage.

For further information, call our Customer Service department at 1-800-932-3004 or TDHI 1-800-786-7387, Monday to Friday, 7:00 a.m. to 9:00 p.m.

**P.O. Box 6092
Cypress, CA 90630**

**Customer Service:
800-932-3004
800-786-7387 (TDHI)
www.pacificare.com**

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