

\$20-40/400a
 Managed Care Schedule of Benefits

General Features

Calendar Year Deductible	None
Lifetime Benefit Maximum <i>(Does not apply to Chemical Dependency)</i> <i>(\$5000.00 Annual Restoration)</i>	\$2,000,000
Out of Pocket Maximum <i>Family Maximum is three times the Individual Maximum</i>	\$3,500
Office Visits <i>(including women's health care services)</i> Primary Care Provider	\$20 Copayment
Specialist	\$40 Copayment
Emergency Room Services <i>Copayment waived if admitted</i>	\$100 Copayment
Urgent Care Services (freestanding facilities)	\$50 Copayment

Benefits Available while Hospitalized as an Inpatient

Family Planning <i>(vasectomy, tubal ligation, cervical caps, IUD, termination of pregnancy)</i>	\$400 Copayment per admission
Hospice Services <i>(6 months with an available extension of 6 months)</i>	100%
Hospital Care <i>(room charges, anesthesia, blood, laboratory, radiology, medications)</i>	\$400 Copayment per admission
Neurodevelopmental Therapy <i>(age 6 and under)</i> <i>(Occupational therapy, speech therapy and physical therapy)</i>	\$400 Copayment per admission
Physician Care while hospitalized (per visit)	100%
Rehabilitation Services	\$400 Copayment per admission
Skilled Nursing Care <i>(100 days per year maximum)</i>	\$200 Copayment per admission
TMJ <i>(\$1,000 per year, \$5,000 lifetime maximum)</i> <i>(Combined Inpatient and Outpatient Maximum)</i>	\$400 Copayment per admission
Transplant Services (subject to \$250,000 lifetime maximum; 12 month waiting period)	\$400 Copayment per admission

Benefits Available on an Outpatient Basis

Allergy Testing Primary Care Provider	\$20 Copayment
Specialist	\$40 Copayment
Ambulance	100%
Complementary Alternative Care <i>(Acupuncture, chiropractic, massage therapy, naturopathy)</i>	\$20 Copayment

Benefits Available on an Outpatient Basis (continued)

Diabetic Management and Treatment Primary Care Provider	\$20 Copayment
Specialist	\$40 Copayment
Durable Medical Equipment and Limited Orthotics (Diabetic supplies and DME provided through Skilled Nursing, Home Health, or Hospice providers and are not subject to the Maximum Benefit) (\$5,000 per calendar year maximum)	100%
Family Planning (vasectomy, tubal ligation, cervical caps, IUD, termination of pregnancy)	
Primary Care Provider	\$20 Copayment
Specialist	\$40 Copayment
Hearing Screening Primary Care Provider	\$20 Copayment
Specialist	\$40 Copayment
Home Health Services (limited to 130 visits per calendar year)	100%
Hospice Services (6 months with an available extension of 6 months)	100%
Hospital Services (outpatient surgery, facility, procedures, blood, anesthesia, laboratory, radiology)	\$200 Copayment
Infertility Services	Not Covered
Injectable Medications (allergy, contraception, immunizations in conjunction with an office visit)	100%
Laboratory Services	100%
Maternity Care, Tests and Procedures (copayment per pregnancy)	
Primary Care Provider	\$20 Copayment
Specialist	\$40 Copayment
Neurodevelopmental Therapy (age 6 & under) 60 visits per calendar year maximum	
Primary Care Provider	\$20 Copayment
Specialist	\$40 Copayment
Periodic Health Evaluation Primary Care Provider	\$20 Copayment
Specialist	\$40 Copayment
Prosthetics and Corrective Appliances (\$5,000 per calendar year maximum*) *Except for Prosthetics resulting from a mastectomy	100%
Rehabilitation Therapy (speech, occupational, physical) (60 visits per calendar year maximum)	\$40 Copayment
Routine Vision Exam one routine vision exam in each year	\$20 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) (co-payment and/or coinsurance applies per procedure)	\$20 Copayment
Standard X-rays	100%

Benefits Available on an Outpatient Basis (continued)

TMJ (\$1,000 per year, \$5,000 lifetime maximum) (Combined Inpatient and Outpatient Maximum)	
Primary Care Provider	\$20 Copayment
Specialist	\$40 Copayment
Transplant Services (12 month waiting period)	
Primary Care Provider	\$20 Copayment
Specialist	\$40 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 1-800-577-7244 or TTY 1-800-221-2832.

Mental Health Services

Inpatient Mental Health (10 days per calendar year)	\$400 Copayment per admission
Residential Mental Health (Each day is equivalent to ½ day of inpatient care for the purposes of a benefit maximum)	\$400 Copayment per admission
Outpatient Care (20 visits per calendar year)	\$40 Copayment

Chemical Dependency Services (Limited to \$15,000 per 24 months)

Inpatient Chemical Dependency	\$400 Copayment per admission
Residential Chemical Dependency	\$400 Copayment per admission
Outpatient Chemical Dependency	\$40 Copayment

Out of Area Dependent

A dependent child/student is eligible for out of area coverage if he/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.

Out of Area Member Benefits

Out of area members live in the United States but outside the PacifiCare service area and more than 30 miles away from the nearest available Primary Care Provider. The out of area member must satisfy a separate deductible and annual copayment maximum than the "in-area" member. After the deductible is met, the benefits for covered services are paid at 80% of the usual and customary rate after the deductible has been satisfied. The member must specifically enroll for this plan. If the out of area member does not enroll for this coverage, they will only be covered for emergency services.

General Features for Out of Area Members

Calendar Year Deductible <i>Family Maximum is three times the Individual Maximum</i>	\$250
Out of Pocket Maximum <i>Family Maximum is three times the Individual Maximum</i>	\$1,500

PRINCIPLE 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 are not covered, (except for Emergency Services or Urgently Needed Services described in this Combined Evidence of Coverage and Disclosure Form, second medical opinions provided by Participating Provider, and obstetrical and gynecological services obtained from a Participating women's health care practitioner).
2. Services obtained from Non-Participating Providers, without authorization from PacifiCare or 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 Washington). 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

- Air Conditioners, Air Purifiers or Other Environmental Equipment
- Artificial Heart(s)
- Communication Devices
- 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
- Recreational, Lifestyle, Educational, or Hypnotic Therapy
- Sexual Dysfunction
- Sex Transformations
- Vision Training
- Weight Alteration Programs (Inpatient or Outpatient)

Limitations

- Alcoholism, Drug Addiction and Other Substance Abuse Rehabilitation
- Behavior Modification and Non-Crisis Mental health Counseling and Treatment
- Biofeedback
- Bloodless Surgery Services
- Bone Marrow and Stem Cell Transplant
- Breast Implants
- Circumcision
- Comfort Items
- Complementary Alternative Care
- 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
- Eye Wear and Corrective Refractive Procedures
- Family Planning
- Follow Up Care: Emergency Services
- Foot Orthotics/Footwear
- Genetic Testing
- Health Care Expenses Incurred Due to Liable Third Party
- Hospice
- Immunizations
- Institutional Services and Supplies
- Medicare Benefits for Medicare Eligible Members

- Mental Health Benefit
- 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
- 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

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).

For further information, call our Customer Service Department at 1-800-932-3004 or TTY 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 (TTY)
www.pacificare.com**

©2007 by PacifiCare Health Systems, Inc.
PWA196699-002