

SELF DIRECTED HEALTH PLAN (SDHP)
INDIVIDUAL PLAN 1 70-50/3,000
SDHP SCHEDULE OF BENEFITS

Reimbursements made under the SDA are limited to Covered Services indicated in this *Schedule of Benefits* 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.

Self Directed Account Maximum per Calendar Year	
Individual	\$250 per Calendar Quarter Benefit
Family	\$500 per Calendar Quarter Benefit
Self Directed Account Rollover per Calendar Year	
Individual	\$1,000 per Calendar Year eligible for Rollover
Family	\$2,000 per Calendar Year eligible for Rollover

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 obtain Preauthorization of 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 obtaining Preauthorization of services will not apply toward your Calendar Year Deductible or Coinsurance Maximum. To avoid any penalty, please refer to "Preauthorization Requirements" in your Policy.

Maximum Covered Expenses for Non-Participating Providers will not exceed the Limited Fee Schedule. Please refer to your Policy "Definitions" Section for an explanation of the Limited Fee Schedule.

Schedule of Benefits

Limiting Age for Dependent Children	Through age 18, or through age 23 if a full-time student
Preauthorization List	Inpatient Hospital Services, Transplant Services, Outpatient Surgical Services in a Hospital or Free-Standing Surgical Center, Home Health Care Services
Your Policy Maximum While Insured	\$2,000,000
Calendar Year Deductible	
Individual	\$3,000
Family maximum <i>(2x individual Deductible; Deductible must be satisfied before benefits are paid)</i>	\$6,000
Calendar Year Coinsurance Maximum	
Participating Providers maximum Coinsurance limit	\$3,000 per person/\$6,000 per family <i>(excludes Deductible(s), Copayments and penalties)</i>
Non-Participating Providers maximum Coinsurance limit	\$9,000 per person/\$18,000 per family <i>(excludes Deductible(s), Copayments, penalties and all amounts above the Limited Fee Schedule)</i>

Hospital and Facility Services	Participating Hospitals	Non-Participating Hospitals
Additional Deductible (per occurrence)		
Inpatient services	Not applicable	
Outpatient Hospital and free-standing surgical services	Not applicable	
Failure to Obtain Preauthorization of Services <i>(waived with Preauthorization of services)</i>	\$250	\$500
Inpatient Hospital and Facility Services	70% after Deductible	50% of Limited Fee Schedule after Deductible; up to \$500 maximum benefit per day <i>(Covered Expenses for these services do not apply to Coinsurance Maximum¹)</i>
Outpatient Surgical and Facility Services	70% after Deductible	50% of Limited Fee Schedule after Deductible; up to \$500 maximum benefit per day
Transplant Service	70% after Deductible	Not covered
	\$5,000 donor maximum	
Maximum benefit while insured	\$2,000,000	
Chemical Dependency²	Not covered	
Mental Illness²	Not covered	
Skilled Nursing Facilities	70% after Deductible	50% of Limited Fee Schedule after Deductible
	Up to 30 days per Calendar Year <i>(combined Participating and Non-Participating Facilities)</i>	
Hospice Care	70% after Deductible	50% of Limited Fee Schedule after Deductible
	30-day maximum benefit while insured <i>(combined Participating and Non-Participating Facilities)</i>	
Rehabilitation Services	70% after Deductible	50% of Limited Fee Schedule after Deductible
	30-day maximum benefit while insured <i>(combined Participating and Non-Participating Facilities)</i>	

Outpatient Provider Services	Participating	Non-Participating
Physician Office Visits²	100% to SDA maximum then 70% after Deductible	100% to SDA maximum then 50% of Limited Fee Schedule after Deductible
Physician Services <i>(other than Physician office visits)</i>	70% after Deductible	50% of Limited Fee Schedule after Deductible
Vision Care Eye refraction examination <i>(limited to 1 per Calendar Year)</i>	100% to SDA maximum then 70% after Deductible	100% to SDA maximum then 50% of Limited Fee Schedule after Deductible
Maternity Care	Not covered	
All Laboratory Services	70% after Deductible	50% of Limited Fee Schedule after Deductible
All X-ray Services	70% after Deductible	50% of Limited Fee Schedule after Deductible
All Diagnostic Testing	70% after Deductible	50% of Limited Fee Schedule after Deductible

Wellness and Preventive Care	Participating	Non-Participating
-------------------------------------	----------------------	--------------------------

Wellness and Preventive Care² Children with immunization Mammogram screening Breast and pelvic exams Prostate cancer screening Osteoporosis screening	100% to SDA maximum then 70% after Deductible <i>(including lab and X-ray services)</i>	100% to SDA maximum then 50% of Limited Fee Schedule after Deductible <i>(including lab and X-ray services)</i>
Periodic Health Evaluations² <i>(age 19 and over)</i>	100% to SDA maximum then 70% after Deductible <i>(including lab and X-ray services)</i>	100% to SDA maximum then 50% of Limited Fee Schedule after Deductible <i>(including lab and X-ray services)</i>

Other Outpatient Provider Services	Participating	Non-Participating
Emergency Room Services <i>(waived if admitted)</i>	70% after Deductible and \$100 Copayment per visit	
Ambulance <i>(Medically Necessary transport)</i>	60% after Deductible	
Chemical Dependency²	Not covered	
Mental Illness²	Not covered	
Durable Medical Equipment <i>(includes prosthetic devices)</i> <i>(\$2,000 maximum benefit per Calendar Year; combined Participating and Non-Participating)</i>	70% after Deductible	50% of Limited Fee Schedule after Deductible
Neuromuscular Skeletal Disorders²	Not covered	
Home Health Care <i>(60 visit per Calendar Year; combined Participating and Non-Participating)</i>	70% after Deductible	50% of Limited Fee Schedule after Deductible
Rehabilitation Services² <i>(physical therapy, occupational therapy and speech therapy)</i>	Not covered	
Infertility	Not covered	
Self-Injectables	Subject to medical Deductibles and Coinsurance	Subject to medical Deductibles and Coinsurance
Prescriptions	100% after Copayments of \$15 generic/\$40 brand/\$60 non-Formulary and a \$250 Deductible	Not covered

¹ 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 100% due to satisfaction of any Coinsurance Maximum.

² Services not covered under the SDA include Neuromuscular Skeletal Disorders; Outpatient rehabilitation services; Chemical Dependency services; mental illness services; EMG or EEG services; allergy testing, antigen therapy and immunotherapy services; colonoscopy; surgery performed in the Physician's office.

Important PPO Information

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 Policy 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
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
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

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.

Limited Fee Schedule. The Limited Fee Schedule is the allowable amount of Covered Expenses based on Medicare's Resource Based Relative Value System (RBRVS) and dollar amount conversion factor or comparable amount as determined by the Company. The Covered Person is responsible for any changes in excess of the allowable Covered Expenses.

PacifiCare Health Plan Administrators
P.O. Box 69312
Harrisburg, PA 17106

Customer Service:
866-867-0700
866-867-0701 (TDHI)
www.pacificare.com

©2004 by PacifiCare Health Systems, Inc.
CM-604-67095
PAZ0567

Underwritten by PacifiCare Life Assurance Company