CALIFORNIA INDIVIDUAL

PacifiCare SignatureOptions℠
Health Savings Account Compatible Plans

PLAN 100-50/5000
PPO SCHEDULE OF BENEFITS

EFFECTIVE MAY 1, 2005

NOTE: 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 Out-of-Pocket. To avoid any penalty, please refer to "Preauthorization Requirements" in your Certificate.

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

Schedule of Benefits

	Participating Providers	Non-Participating Providers
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	$5,000,000	
Calendar Year Deductible		
Individual (Self Only)	$5,000	$10,000
Aggregate Family maximum	$10,000	$20,000
Out-of-Pocket Maximum		
Individual (Self Only)	$5,000	$20,000
Aggregate Family maximum	$10,000 plus Deductible(s), Copayments and penalties	$40,000 plus Deductible(s), Copayments and penalties

Hospital and Facility Services

Additional Deductibles *(per occurrence)*		
Inpatient services	Not applicable	Not applicable
Outpatient surgical services	Not applicable	Not applicable
Emergency room services *(Waived if admitted)*	Not Applicable	
Failure to obtain Preauthorization of services *(Waived with Preauthorization of services)*	$250	$500

Hospital and Facility Services (Continued)	**Participating Providers**	**Non-Participating Providers**
Inpatient Hospital and Facility Services	100% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible up to $1000 maximum benefit per day[1]
Organ Transplant and Transplant Services	100% of Covered Expense after satisfying the Deductible	Not Covered
	$5,000 donor maximum	
Maximum benefit while insured	$5,000,000	
Chemical Dependency	100% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible up to $200 maximum benefit per day
	$2,500 Inpatient maximum per Calendar Year	
Mental Illness (other than SMI)	100% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible up to $200maximum benefit per day
	$2,500 Inpatient maximum per Calendar Year	
Skilled Nursing Facilities	100% of Covered Expense after satisfying the Deductible	Covered Person responsible for all charges over $200 maximum benefit per day
	Up to 90 days Inpatient per Calendar Year	
Outpatient Surgical and Facility Services **Same day services performed at a Hospital or free standing surgical center**	100% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible up to $750 maximum benefit per day
Hospice Care	100% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible up to $1000 maximum benefit per day
	$10,000 maximum benefit while insured	

Outpatient Provider Services	**Participating Providers**	**Non-Participating Providers**
Physician Office Visits ***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.*** **Allergy Testing and Treatment** **Antibiotic Injections**	100% of Covered Expense after satisfying the deductible	50% of Limited Fee Schedule after satisfying the Deductible*
Physician Services Other than Physician Office Visits	100% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible*
Maternity Care Prenatal, postnatal and childbirth expenses	Not Covered	
Laboratory Services **X-ray Services** **Diagnostic Testing** ***Other than Physician Office Visits***	100% of Covered Expense after satisfying deductible	50% of Limited Fee Schedule after satisfying the Deductible*

Wellness and Preventive Care

Breast and pelvic cancer screening including mammogram screening Detection of osteoporosis Colorectal cancer screenings Prostate cancer screening Periodic health evaluations for children (through age 18) including age appropriate immunizations, laboratory tests, height and weight evaluation, vision screening	100% of Covered Expense – Deductible waived	50% of Limited Fee Schedule after satisfying the Deductible*
Periodic Health Evaluations *(age 19 and over)* Hearing screening Vision screening Immunizations and adult boosters Weight evaluation	100% of Covered Expense – Deductible waived	50% of Limited Fee Schedule after satisfying the Deductible*
	$400 maximum benefit per Calendar Year	

Other Outpatient Provider Services	**Participating Providers**	**Non-Participating Providers**
Ambulance *(Emergency services and specified transfers)*	60% of Covered Expense after satisfying the Deductible	
Chemical Dependency	100% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible*
	1 visit per day, 20 visits per Calendar Year maximum	
Severe Mental Illness Specified diagnosis only	100% of Covered Expense after satisfying the Deductible	Not Covered
Mental Illness Services *(other than SMI and SED)* Outpatient Services	100% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible*
	1 visit per day, 20 visits per Calendar Year	
Durable Medical Equipment	100% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible*
	$2,000 combined per Calendar Year Maximum	
Home Health Care	100% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible*
	100 visits combined maximum per Calendar Year	
Infusion Therapy Infusion Therapy Drugs	100% 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
Neuromuscular Skeletal Services	100% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible*
	$1,000 combined per Calendar Year Maximum	
Prosthetics	100% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
	$2,000 combined per Calendar Year Maximum	

Other Outpatient Provider Services (Continued)	**Participating Providers**	**Non-Participating Providers**
Rehabilitation Services Speech, physical, occupational therapy	100% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible*
	$5,000 combined per Calendar Year Maximum	
Orthotic Devices	100% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible*
	$500 combined per Calendar Year Maximum; $1,000 while insured	
Specialized Footwear	100% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible*
	$500 combined per Calendar Year Maximum; $1,000 while insured	
Infertility Services	Not Covered	
Injectable Drugs *(except insulin)*	100% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible*
Outpatient Prescription Drugs **Generic Drugs**	100% of Covered Expense after satisfying the deductible (per Prescription Unit or up to 30-day supply)	50% of Covered Expense after satisfying the deductible (per Prescription Unit or up to 30-day supply)
Brand Formulary	100% of Covered Expense after satisfying the deductible (per Prescription Unit or up to 30-day supply)	50% of Covered Expense after satisfying the deductible (per Prescription Unit or up to 30-day supply)
Mail Service	100% of Covered Expense after satisfying the deductible (per Prescription Unit or up to 90-day supply)	Not Covered

*Percentage of the Limited Fee Schedule, plus you are responsible for all charges above the Limited Fee Schedule.

Important PPO Information

PARTICIPATING PROVIDERS AND NON-PARTICIPATING PROVIDERS. The Policy provides benefits for Covered Services obtained from 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.

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, it is important that the Covered Person receives services from a Participating Provider.

	Participating Provider	Non-Participating Provider
Negotiated Fees for Covered Services	Yes	No
Balance Billing for Covered Services	No	Covered Person responsible for 100% of charges that exceed the Covered Expense Limited Fee Schedule
Inpatient Hospital Deductibles	Lower	Higher
Coinsurance Maximums	Lower	Higher

CHANGE IN PARTICIPATION. If while a Covered Person is confined in a Facility which is a Participating Provider Hospital, that Facility ceases to remain a Participating Provider Hospital, coverage will be provided throughout the period of confinement at the negotiated rate for that Facility before it ceased to be a Participating Provider Hospital.

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 Pre-authorized services at the negotiated rate for that Provider before the Provider ceased to be a Participating Provider.

EFFECT ON BENEFITS

Preauthorization is required prior to obtaining certain services. Failure to obtain Pre-Authorization 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.

LIMITED FEE SCHEDULE. The Company offers Covered Persons a wide range of health care options within its Preferred Provider Organization (PPO). Covered Persons have access to quality care through our network and enjoy maximum subscriber savings. Although Covered Persons may choose a Non-Participating Provider, the Company uses a Limited Fee Schedule to determine the Covered Expense for services or supplies outside our network which may result in a higher Coinsurance payment, reduced benefits and higher out-of-pocket expenses. Please refer to the Definitions list in Section 4 of the Certificate for further information on the Limited fee Schedule.

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