PacifiCare®



CALIFORNIA

Individual Summary Matrix

Effective April 1, 2004

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Individual Plans
PacifiCare SignatureOptions℠ (PPO)

Effective April 1, 2004

Overview for the Individual PacifiCare SignatureOptions℠ (PPO) Plans

As a PacifiCare SignatureOptions (PPO) enrollee, you're free to see any licensed health care provider that you like, anywhere in the United States; however, you will generally find greater savings through fewer Deductibles and lower Coinsurance expenses if you receive your care from our wide selection of Participating Providers. That means to take the best advantage of your benefits, it's a good idea to use our network.

Introduction

With the PacifiCare SignatureOptions Plans, getting health care is simple; after all, you have the freedom to visit any certified health care Provider in the United States. You also have access to a network of Participating Providers.

As a rule, these Participating Providers have lowered their fees to offer their services to our enrollees. That means you generally spend less when you receive your care through these doctors. If you choose to receive care from a Non-Participating Provider, your coverage is limited to the Limited Fee Schedule. If a Non-Participating Provider charges you more than what PacifiCare has determined on the Limited Fee Schedule, you will be responsible for paying the difference.

How to Select a Doctor

You are free to visit any licensed health care Provider in the United States, and no referral is needed to see a specialist. You select who provides your care; however, if you wish to take full advantage of your PacifiCare SignatureOptions plan, select your doctor from our *Provider Directory.* Our list of Participating Providers includes everyone from family doctors to specialists in pediatrics and cardiology.

Once you select a Physician, call his or her office directly and identify yourself as a PacifiCare SignatureOptions enrollee. If the doctor is accepting new patients, an appointment will be scheduled.

To see an online PacifiCare SignatureOptions directory of our Participating Providers, visit our Web site at **www.pacificare.com**. You can also call our Customer Service Center at 1-866-316-9776. A member of our Customer Service team will do everything from checking a Physician's name to finding a Participating Provider who's close to your home.

How to Select a Hospital

These plans contain a hospital network that is comprised of Participating and Non-Participating hospitals. Obtaining covered services at a Participating Hospital may cost you less than obtaining covered services from a non-Participating Hospital.

Enrollees should confirm the availability and status of a hospital prior to receiving services by visiting our Web site at **www.pacificare.com** or calling the Customer Service department.

How to Select a Doctor

Before you choose a doctor, be sure to look at your *Schedule of Benefits*. As you'll see, your expenses are lower when you see a PacifiCare Participating Provider. You should also become familiar with the terms of your coverage. You can find these terms in your *Policy*. This book will introduce you to the *Policy*, as well as the *Schedule of Benefits*.

All of your medical benefits are detailed in your *Policy* and your *Schedule of Benefits*. Please read these publications to fully understand your coverage.

Summary Benefits and Coverages Comparison Chart
(Health Plan Benefits and Coverage Matrix)

Principal Benefits

PacifiCare SignatureOptions (PPO) Plans

80-50/750 (with maternity)

PLAN SUMMARY	Participating Provider	Non-Participating Provider
Calendar Year Deductible - Individual - Family (2x individual)		$750 $1,500
Calendar Year Coinsurance Maximum - Individual - Family (2x individual) Deductible must be satisfied before benefits are paid.	$2,000 $4,000	$4,000 $8,000
Policy Maximum		$2,000,000
Limiting Age for Dependent Children - Age if full-time student		Through age 18 Through age 23
OUTPATIENT PROVIDER SERVICES		
Physician Office Visits[1]	$30 Copayment	50% after Deductible
Other Physician Services	80% after Deductible	50% after Deductible
Maternity Care (prenatal, postnatal and childbirth expenses)	80% after Deductible	50% after Deductible
Laboratory Services, X-ray Services, Diagnostic Testing	80% after Deductible	50% after Deductible
WELLNESS AND PREVENTIVE CARE[1]		
Preventive Care for children (through age 18)	$30 Copayment	50% after Deductible
Periodic Health Evaluations (age 19 and over)	$30 Copayment	50% after Deductible
	$300 maximum benefit per Calendar Year	
OTHER OUTPATIENT PROVIDER SERVICES		
Ambulance (Medically Necessary transport)	60% after Deductible	
Chemical Dependency[2]	80% after Deductible	50% after Deductible
	One visit per day, 20 visits per Calendar Year	
Severe Mental Illness (specified diagnosis only)	80% after Deductible	Not covered
Mental Illness (other than SMI)[2]	80% after Deductible	50% after Deductible
	One visit per day, 20 visits per Calendar Year	
Rehabilitation Services (speech, physical, occupational therapy)	80% after Deductible	50% after Deductible
	$1,000 maximum benefit Per Year	
Durable Medical Equipment	80% after Deductible	50% after Deductible
	$2,000 maximum benefit per Calendar Year	
Home Health Care	80% after Deductible	50% after Deductible
	100 visits per Calendar Year maximum	
Neuromuscular Skeletal Disorders	80% after Deductible	50% after Deductible
	$1,000 maximum benefit per Calendar Year	
Infertility Services	Not covered	
HOSPITAL AND FACILITY SERVICES	**Participating Hospitals**	**Non-Participating Hospitals**
Inpatient Hospital and Facility Services	80% after Deductible	50% after Deductible up to $1,000 maximum benefit per day[2]
Skilled Nursing Facilities	80% after Deductible	Covered Person responsible for all charges over $200 Maximum Benefit per day
	Up to 90 days per Calendar Year maximum	
Outpatient Surgical and Facility Services	80% after Deductible	50% after Deductible up to $750 maximum benefit per day[2]
Hospice Care	80% after Deductible	50% after Deductible up to $750 maximum benefit per day[2]
	$5,000 maximum benefit while insured	
Chemical Dependency[2]	80% after Deductible	50% after Deductible up to $200 maximum benefit per day
	$2,500 maximum benefit per Calendar Year	
Mental Illness (other than SMI)	80% after Deductible	50% after Deductible up to $200 maximum benefit per day
	$2,500 maximum benefit per Calendar Year	
PRESCRIPTION DRUG COVERAGE	**Participating Pharmacy**	**Non-Participating Pharmacy**
	100% after Copayment of	50% after Copayment of
- Generic Formulary	$10	
- Brand-Name Formulary	$35	
Deductible per Calendar Year	None	

* Underwritten by PacifiCare Life and Health Insurance Company

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE PACIFICARE INDIVIDUAL PLAN POLICY AND SCHEDULE OF BENEFITS SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS, EXCLUSIONS AND LIMITATIONS.

PacifiCare SignatureOptions℠ (PPO) Plans

70-50/1000 (with maternity)		70-50/1500 (with maternity)	
Participating Provider	**Non-Participating Provider**	**Participating Provider**	**Non-Participating Provider**
$1,000 $2,000		$1,500 $3,000	
$2,500 $5,000	$5,000 $10,000	$3,000 $6,000	$6,000 $12,000
$2,000,000		$2,000,000	
Through age 18 Through age 23		Through age 18 Through age 23	
70% Deductible waived	50% after Deductible	70% after Deductible	50% after Deductible
70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
70% Deductible waived	50% after Deductible	70% after Deductible	50% after Deductible
70% Deductible waived	50% after Deductible	70% after Deductible	50% after Deductible
$300 maximum benefit per Calendar Year		$300 maximum benefit per Calendar Year	
60% after Deductible		60% after Deductible	
70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
One visit per day, 20 visits per Calendar Year		One visit per day, 20 visits per Calendar Year	
70% after Deductible	Not covered	70% after Deductible	Not covered
70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
One visit per day, 20 visits per Calendar Year		One visit per day, 20 visits per Calendar Year	
70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
$1,000 maximum benefit Per Year		$1,000 maximum benefit Per Year	
70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
$2,000 maximum benefit per Calendar Year		$2,000 maximum benefit per Calendar Year	
70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
100 visits per Calendar Year maximum		100 visits per Calendar Year maximum	
70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
$1,000 maximum benefit per Calendar Year		$1,000 maximum benefit per Calendar Year	
Not covered		Not covered	
Participating Hospitals	**Non-Participating Hospitals**	**Participating Hospitals**	**Non-Participating Hospitals**
70% after Deductible	50% after Deductible up to $1,000 maximum benefit per day[2]	70% after Deductible	50% after Deductible up to $1,000 maximum benefit per day[2]
70% after Deductible	Covered Person responsible for all charges over $200 Maximum Benefit per day	70% after Deductible	Covered Person responsible for all charges over $200 Maximum Benefit per day
Up to 90 days per Calendar Year maximum		Up to 90 days per Calendar Year maximum	
70% after Deductible	50% after Deductible up to $750 maximum benefit per day[2]	70% after Deductible	50% after Deductible up to $750maximum benefit per day[2]
70% after Deductible	50% after Deductible up to $750 maximum benefit per day[2]	70% after Deductible	50% after Deductible up to $750 maximum benefit per day[2]
$5,000 maximum benefit while insured		$5,000 maximum benefit while insured	
70% after Deductible	50% after Deductible up to $200 maximum benefit per day	70% after Deductible	50% after Deductible up to $200 maximum benefit per day
$2,500 maximum benefit per Calendar Year		$2,500 maximum benefit per Calendar Year	
70% after Deductible	50% after Deductible up to $200 maximum benefit per day	70% after Deductible	50% after Deductible up to $200 maximum benefit per day
$2,500 maximum benefit per Calendar Year		$2,500 maximum benefit per Calendar Year	
Participating Pharmacy	**Non-Participating Pharmacy**	**Participating Pharmacy**	**Non-Participating Pharmacy**
100% after Copayment of	50% after Copayment of	100% after Copayment of	50% after Copayment of
$10		$20	
$35		$35	
$100 (Brand)		$250 (Brand)	

1. Copayment-based services do not apply to Neuromuscular Skeletal Disorders, rehabilitation services, mental illness, and Chemical Dependency services or surgery performed in the Physician's office.
2. 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.

Summary Benefits and Coverages Comparison Chart
(Health Plan Benefits and Coverage Matrix)

Principal Benefits

PacifiCare SignatureOptions (PPO) Plans

PLAN SUMMARY	70-50/500 Participating Provider	70-50/500 Non-Participating Provider	70-50/1000 Participating Provider	70-50/1000 Non-Participating Provider
Calendar Year Deductible - Individual - Family (2x individual)		$500 $1,000		$1,000 $2,000
Calendar Year Coinsurance Maximum - Individual - Family (2x individual) Deductible must be satisfied before benefits are paid.	$2,500 $5,000	$5,000 $10,000	$4,000 $8,000	$8,000 $16,000
Policy Maximum		$2,000,000		$2,000,000
Limiting Age for Dependent Children - Age if full-time student		Through age 18 Through age 23		Through age 18 Through age 23
OUTPATIENT PROVIDER SERVICES				
Physician Office Visits[1]	70% Deductible waived	50% after Deductible	70% Deductible waived	50% after Deductible
Other Physician Services	70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
Maternity Care (prenatal, postnatal and childbirth expenses)		Not covered		Not covered
Laboratory Services, X-ray Services, Diagnostic Testing	70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
WELLNESS AND PREVENTIVE CARE[1]				
Preventive Care for children (through age 18)	70% Deductible waived	50% after Deductible	70% Deductible waived	50% after Deductible
Periodic Health Evaluations	70% Deductible waived	50% after Deductible	70% Deductible waived	50% after Deductible
(age 19 and over)	$300 maximum benefit per Calendar Year		$300 maximum benefit per Calendar Year	
OTHER OUTPATIENT PROVIDER SERVICES				
Ambulance (Medically Necessary transport)	60% after Deductible		60% after Deductible	
Chemical Dependency[2]	70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
	One visit per day, 20 visits per Calendar Year		One visit per day, 20 visits per Calendar Year	
Severe Mental Illness (specified diagnosis only)	70% after Deductible	Not covered	70% after Deductible	Not covered
Mental Illness (other than SMI)[2]	70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
	One visit per day, 20 visits per Calendar Year		One visit per day, 20 visits per Calendar Year	
Prosthetic Devices	70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
	$2,000 maximum benefit per Calendar Year		$2,000 maximum benefit per Calendar Year	
Durable Medical Equipment	70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
	$2,000 maximum benefit per Calendar Year		$2,000 maximum benefit per Calendar Year	
Home Health Care	70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
	100 visits per Calendar Year maximum		100 visits per Calendar Year maximum	
Neuromuscular Skeletal Disorders	70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
	$1,000 maximum benefit per Calendar Year		$1,000 maximum benefit per Calendar Year	
Infertility Services	Not covered		Not covered	
HOSPITAL AND FACILITY SERVICES	**Participating Hospitals**	**Non-Participating Hospitals**	**Participating Hospitals**	**Non-Participating Hospitals**
Inpatient Hospital and Facility Services	70% after Deductible	50% after Deductible up to $1,000 Maximum Benefit per day[2]	70% after Deductible	50% after Deductible up to $1,000 Maximum Benefit per day[2]
Skilled Nursing Facilities	70% after Deductible	Covered Person responsible for all charges over $200 Maximum Benefit per day	70% after Deductible	Covered Person responsible for all charges over $200 Maximum Benefit per day
	Up to 90 days per Calendar Year maximum		Up to 90 days per Calendar Year maximum	
Outpatient Surgical and Facility Services	70% after Deductible	50% after Deductible up to $750 Maximum Benefit per day[2]	70% after Deductible	50% after Deductible up to $750 Maximum Benefit per day[2]
Hospice Care	70% after Deductible	50% after Deductible up to $750 Maximum Benefit per day[2]	70% after Deductible	50% after Deductible up to $750 Maximum Benefit per day[2]
	$5,000 maximum benefit while insured		$5,000 maximum benefit while insured	
Chemical Dependency[2]	70% after Deductible	50% after Deductible up to $200 Maximum Benefit per day	70% after Deductible	50% after Deductible up to $200 Maximum Benefit per day
	$2,500 maximum benefit per Calendar Year		$2,500 maximum benefit per Calendar Year	
Mental Illness (other than SMI)	70% after Deductible	50% after Deductible up to $200 Maximum Benefit per day	70% after Deductible	50% after Deductible up to $200 Maximum Benefit per day
	$2,500 maximum benefit per Calendar Year		$2,500 maximum benefit per Calendar Year	
PRESCRIPTION DRUG COVERAGE	**Participating Pharmacy**	**Non-Participating Pharmacy**	**Participating Pharmacy**	**Non-Participating Pharmacy**
	100% after Copayment of	50% after Copayment of	100% after Copayment of	50% after Copayment of
- Generic Formulary	$15		$20	
- Brand-Name Formulary	$35		$35	
Deductible per Calendar Year	None		$250 (Brand)	

* Underwritten by PacifiCare Life and Health Insurance Company

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE PACIFICARE INDIVIDUAL PLAN POLICY AND SCHEDULE OF BENEFITS SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS, EXCLUSIONS AND LIMITATIONS.

PacifiCare SignatureOptions℠ (PPO) Plans

70-50/2000		70-50/3000	
Participating Provider	**Non-Participating Provider**	**Participating Provider**	**Non-Participating Provider**
$2,000 $4,000		$3,000 $6,000	
$4,000 $8,000	$8,000 $16,000	$4,000 $8,000	$8,000 $16,000
$2,000,000		$2,000,000	
Through age 18 Through age 23		Through age 18 Through age 23	
70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
Not covered		Not covered	
70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
$300 maximum benefit per Calendar Year		$300 maximum benefit per Calendar Year	
60% after Deductible		60% after Deductible	
70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
One visit per day, 20 visits per Calendar Year		One visit per day, 20 visits per Calendar Year	
70% after Deductible	Not covered	70% after Deductible	Not covered
70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
One visit per day, 20 visits per Calendar Year		One visit per day, 20 visits per Calendar Year	
70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
$2,000 maximum benefit per Calendar Year		$2,000 maximum benefit per Calendar Year	
70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
$2,000 maximum benefit per Calendar Year		$2,000 maximum benefit per Calendar Year	
70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
100 visits per Calendar Year maximum		100 visits per Calendar Year maximum	
70% after Deductible	50% after Deductible	70% after Deductible	50% after Deductible
$1,000 maximum benefit per Calendar Year		$1,000 maximum benefit per Calendar Year	
Not covered		Not covered	
Participating Hospitals	**Non-Participating Hospitals**	**Participating Hospitals**	**Non-Participating Hospitals**
70% after Deductible	50% after Deductible up to $1,000 Maximum Benefit per day[2]	70% after Deductible	50% after Deductible up to $1,000 Maximum Benefit per day[2]
70% after Deductible	Covered Person responsible for all charges over $200 maximum benefit per day	70% after Deductible	Covered Person responsible for all charges over $200 maximum benefit per day
Up to 90 days per Calendar Year maximum		Up to 90 days per Calendar Year maximum	
70% after Deductible	50% after Deductible up to $750 maximum benefit per day[2]	70% after Deductible	50% after Deductible up to $750 maximum benefit per day[2]
70% after Deductible	50% after Deductible up to $750 Maximum Benefit per day[2]	70% after Deductible	50% after Deductible up to $750 Maximum Benefit per day[2]
$5,000 maximum benefit while insured		$5,000 maximum benefit while insured	
70% after Deductible	50% after Deductible up to $200 Maximum Benefit per day	70% after Deductible	50% after Deductible up to $200 Maximum Benefit per day
$2,500 maximum benefit per Calendar Year		$2,500 maximum benefit per Calendar Year	
70% after Deductible	50% after Deductible up to $200 Maximum Benefit per day	70% after Deductible	50% after Deductible up to $200 Maximum Benefit per day
$2,500 maximum benefit per Calendar Year		$2,500 maximum benefit per Calendar Year	
Participating Pharmacy	**Non-Participating Pharmacy**	**Participating Pharmacy**	**Non-Participating Pharmacy**
100% after Copayment of	50% after Copayment of	100% after Copayment of	50% after Copayment of
$20		Not covered	
$35		Not covered	
$250 (Brand)		Not covered	

1. Copayment-based services do not apply to Neuromuscular Skeletal Disorders, rehabilitation services, mental illness, and Chemical Dependency services or surgery performed in the Physician's office.
2. 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.

PacifiCare SignatureFreedom℠ (Self Directed Health Plan)

PRINCIPAL BENEFITS	PacifiCare SignatureFreedom 70-50/3000	
Self Directed Account (SDA)	**Participating Provider**	**Non-Participating Provider**
Applies Toward Annual Deductible		
– Individual	$250 per Calendar Quarter	
– Family	$500 per Calendar Quarter	
PPO Principal Benefits	**Participating Provider**	**Non-Participating Provider** Limited Fee Schedule[3]
Covered Expense		
Calendar Year Deductible *– Individual* *– Family (2x Individual)*	 $3,000 $6,000	
Coinsurance Maximum *– Individual* *– Family (2x Individual)*	 $4,000 $8,000	 $8,000 $16,000
Policy Maximum	$2,000,000	
Limiting Age for Dependent Children *– Age if full-time student*	Through age 18 Through age 23	
Outpatient Provider Services		
Physician Office Visits[1]	70% after Deductible	50% after Deductible
Other Physician Services	70% after Deductible	50% after Deductible
Maternity Care *(prenatal, postnatal and childbirth expenses)*	Not covered	
Laboratory Services	70% after Deductible	50% after Deductible
X-ray Services	70% after Deductible	50% after Deductible
Diagnostic Testing	70% after Deductible	50% after Deductible
Wellness and Preventive Care[1]		
Preventive Care for Children *(through age 18)*	70% after Deductible	50% after Deductible
Periodic Health Evaluations *(age 19 and over)*	70% after Deductible	50% after Deductible
Other Outpatient Provider Services		
Ambulance *(Medically Necessary transport)*	60% after Deductible	
Chemical Dependency[2]	70% after Deductible One visit per day, 20 visits per calendar year	50% after Deductible
Severe Mental Illness *(specified diagnosis only)*	70% after Deductible	Not covered
Mental Illness (Other than SMI)[2]	70% after Deductible One visit per day, 20 visits per Calendar Year	50% after Deductible
Infertility Services	Not covered	
Hospital and Facility Services	**Participating Hospitals**	**Non-Participating Hospitals**
Additional Deductibles *(per occurrence)*		
– Inpatient Services	N/A	N/A
– Outpatient Hospital and free-standing surgical services	N/A	N/A
– Emergency room services (waived if admitted)	$200	
– Failure to obtain Preauthorization of services	$250	$500
Inpatient Hospital and Facility Services	70% after Deductible(s)	50% after Deductible up to $1,000 Maximum Benefit per day[2]
Skilled Nursing Facilities	70% after Deductible(s) Up to 90 days per Calendar Year Maximum	Covered Person responsible for all charges over $200 Maximum Benefit per day
Outpatient Surgical and Facility Services	70% after Deductible(s)	50% after Deductible up to $750 Maximum Benefit per day[2]

PRINCIPAL BENEFITS	PacifiCare SignatureFreedom 70-50/3000	
Hospital and Facility Services (Continued)	**Participating Hospitals**	**Non-Participating Hospitals**
Hospice Care	70% after Deductible(s)	50% after Deductible up to $750 Maximum Benefit per day[2] $5,000 Maximum Benefit while insured
Chemical Dependency[2]	70% after Deductible(s)	50% after Deductible up to $200 Maximum Benefit per day $2,500 Maximum Benefit per Calendar Year
Mental Illness *(other than SMI)*[1]	70% after Deductible(s)	50% after Deductible up to $200 Maximum Benefit per day $2,500 Maximum Benefit per Calendar Year
Prescription Drug Coverage	**Participating Pharmacy** 100% after Copayment of:	**Non-Participating Pharmacy** 50% after Copayment of:
– Generic Formulary	$20	
– Brand-Name Formulary	$35 ($1,000 Annual Brand Maximum)	
Deductible per Calendar Year	None	

1 Copayment-based services do not apply to Neuromuscular Skeletal Disorders, rehabilitation services, mental illness, and Chemical Dependency services or surgery performed in the Physician's office.

2 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.

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

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Individual Plans
PacifiCare SignatureValue℠ (HMO)

Effective April 1, 2004

Overview for the Individual PacifiCare SignatureValue℠ (HMO) Plans

PacifiCare SignatureValue (HMO) Plans allow Members to take advantage of low Copayments with comprehensive coverage.

The PacifiCare SignatureValue (HMO) Plans offer affordable, quality health care benefits with minimal out-of-pocket expense. When you choose a PacifiCare SignatureValue Plan, you receive comprehensive health care benefits provided or coordinated by the Primary Care Physician of your choice. PacifiCare contracts with independent Physicians, medical groups and Individual Practice Associations (IPAs) located throughout PacifiCare's Service Area, making it easy to find a doctor convenient to your home or workplace. The PacifiCare SignatureValue Plans pay for covered health care services, such as hospitals and surgery. In addition, preventive health care, including checkups, is covered.

There are three Individual PacifiCare SignatureValue Plan choices, and the information that follows, along with the Benefits Comparison Chart, summarizes the principal benefits and coverages under these plans.

PacifiCare SignatureValue℠ (HMO) Plans At-a-Glance

- Low Copayment for doctor office visits
- Extensive Participating Provider network
- Choice of different Primary Care Physician for each family Member
- Ability to change your Primary Care Physician monthly
- Variety of preventive health care programs
- Well-Woman and Well-Baby benefits
- Worldwide emergency coverage
- No claim forms
- Toll-free Customer Service

PacifiCare SignatureValue℠ (HMO) 10-30/250a Plan At-a-Glance

- $10 Copayment for doctor office visits
- $30 Copayment for specialists visits
- $10 Generic/$30 brand-name prescription drug benefit

PacifiCare SignatureValue℠ (HMO) 15-30/80 Plan At-a-Glance

- $15 Copayment for doctor office visits
- $30 Copayment for specialists visits
- $20 Generic/$35 brand-name prescription drug benefit

PacifiCare SignatureValue℠ (HMO) 35/70 Plan At-a-Glance

- $35 Copayment for doctor office visits
- $20 Generic/$35 brand-name prescription drug benefit

Summary Benefits and Coverages Comparison Chart

(Health Plan Benefits and Coverage Matrix)

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE PACIFICARE INDIVIDUAL PLAN SUBSCRIBER AGREEMENT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS, EXCLUSIONS AND LIMITATIONS.

Principal Benefits	PacifiCare SignatureValue℠ (HMO) Plans		
	10-30/250a[1]	15-30/80[1]	35/70[1]
DEDUCTIBLES			
CALENDAR YEAR DEDUCTIBLE Per Individual	None	None	None
LIFETIME MAXIMUM BENEFITS			
ANNUAL COPAYMENT MAXIMUM Per Individual	$2,500 2 per family	$2,500 2 per family	$5,000 No per family limit
MAXIMUM BENEFIT WHILE COVERED Per Individual	Unlimited	Unlimited	Unlimited
PROFESSIONAL SERVICES			
PHYSICIAN OFFICE VISITS	$10/$30 Copayment[2]	$15/$30 Copayment[2]	$35 Copayment
ALLERGY TESTING/TREATMENT	$10/$30 Copayment[2]	$15/$30 Copayment[2]	$35 Copayment
ATTENTION DEFICIT DISORDER	$10/$30 Copayment[2]	$15/$30 Copayment[2]	$35 Copayment
HEARING SCREENING	$10/$30 Copayment[2]	$15/$30 Copayment[2]	$35 Copayment
IMMUNIZATIONS (0 to 2 refer to Well-Baby Care)	$10/$30 Copayment[2]	$15/$30 Copayment[2]	$35 Copayment
MATERNITY CARE, TESTS & PROCEDURES Prenatal and postnatal care office visits	$10 Copayment	$15 Copayment	$35 Copayment
PERIODIC HEALTH EVALUATIONS – Ages 2 and above – Children under 2 years old	$10 Copayment Refer to Well-Baby Care	$15 Copayment Refer to Well-Baby Care	$35 Copayment Refer to Well-Baby Care
VISION REFRACTIONS & SCREENING	$10/$30 Copayment[2]	$15/$30 Copayment[2]	$35 Copayment
WELL-BABY CARE	Paid in full	Paid in full	Paid in full
WELL-WOMAN CARE Annual Pap test, breast and pelvic exam	$10 Copayment	$15 Copayment	$35 Copayment
OUTPATIENT SERVICES			
CANCER CLINICAL TRIALS[3,4]	Paid at Contracting Rate. Balance (if any) is the responsibility of the Member.	Paid at Contracting Rate. Balance (if any) is the responsibility of the Member.	Paid at Contracting Rate. Balance (if any) is the responsibility of the Member.
FAMILY PLANNING/VOLUNTARY INTERRUPTION OF PREGNANCY			
■ Tubal ligation[5]	$100 Copayment	$100 Copayment	$100 Copayment
■ Vasectomy	$50 Copayment	$50 Copayment	$50 Copayment
■ Insertion/removal of Intra-Uterine Device (IUD)	$10/$30 Copayment[2]	$15/$30 Copayment[2]	$35 Copayment
■ Intra-Uterine Device (IUD)	$50 Copayment	$50 Copayment	$50 Copayment
■ Removal of Norplant	$10/$30 Copayment[2]	$15/$30 Copayment[2]	$35 Copayment
■ Depo-Provera Injection	$10/$30 Copayment[2]	$15/$30 Copayment[2]	$35 Copayment
■ Depo-Provera Medication (Limited to one Depo-Provera injection every 90 days)	$35 Copayment	$35 Copayment	$35 Copayment
■ Voluntary Interruption of Pregnancy – 1st Trimester – 2nd Trimester – After 20 weeks	$125 Copayment $200 Copayment Not covered[6]	$125 Copayment $200 Copayment Not covered[6]	$125 Copayment $200 Copayment Not covered[6]
HEALTH EDUCATION SERVICES	Paid in full	Paid in full	Paid in full
HEMODIALYSIS	$30 Copayment	$30 Copayment	$35 Copayment
INFERTILITY SERVICES	Not covered	Not covered	Not covered
LABORATORY	Paid in full	Paid in full	Paid in full
ORAL SURGERY SERVICES	Paid in full	$100 Copayment	$200 Copayment
OUTPATIENT REHABILITATION THERAPY	$30 Copayment	$30 Copayment	$35 Copayment
OUTPATIENT SURGERY	$250 Copayment per admit	20% of cost Copayment[7]	30% of cost Copayment[7]
HOSPITALIZATION SERVICES			
BONE MARROW TRANSPLANTS	$250 Copayment per admit	20% of cost Copayment[7]	30% of cost Copayment[7]

Principal Benefits	10-30/250a[1]	15-30/80[1]	35/70[1]
HOSPITALIZATION SERVICES (Continued)			
CANCER CLINICAL TRIALS[3, 4]	Paid at Contracting Rate. Balance (if any) is the responsibility of the Member.	Paid at Contracting Rate. Balance (if any) is the responsibility of the Member.	Paid at Contracting Rate. Balance (if any) is the responsibility of the Member.
HOSPICE CARE Prognosis of life expectancy of one year or less	$250 Copayment per admit	20% of cost Copayment[7]	30% of cost Copayment[7]
INPATIENT HOSPITAL BENEFITS Semi-private room, Intensive Care	$250 Copayment per admit	20% of cost Copayment[7]	30% of cost Copayment[7]
INPATIENT PHYSICIAN CARE	Paid in full	Paid in full	Paid in full
INPATIENT REHABILITATION CARE/ SUBACUTE CARE	$250 Copayment per admit	20% of cost Copayment[7]	30% of cost Copayment[7]
MATERNITY CARE Normal delivery, cesarean section	$250 Copayment per admit	20% of cost Copayment[7]	30% of cost Copayment[7]
NEWBORN CARE[12]	$250 Copayment per admit	20% of cost Copayment[7]	30% of cost Copayment[7]
SKILLED NURSING CARE Up to 100 consecutive days from first treatment per admission	$50 Copayment per day	20% of cost Copayment[7]	30% of cost Copayment[7]
VOLUNTARY INTERRUPTION OF PREGNANCY ■ 1st Trimester ■ 2nd Trimester ■ After 20 weeks* (*Covered only when mother's life is in jeopardy or when fetus is not viable)	$125 Copayment $200 Copayment Not covered[6]	$125 Copayment $200 Copayment Not covered[6]	$125 Copayment $200 Copayment Not covered[6]
EMERGENCY HEALTH COVERAGE			
EMERGENCY SERVICES	$100 Copayment[8]	$100 Copayment[8]	$100 Copayment
URGENTLY NEEDED SERVICES	$50 Copayment[8]	$50 Copayment[8]	$100 Copayment
AMBULANCE SERVICES			
AMBULANCE	$50 Copayment	$50 Copayment	$50 Copayment
PRESCRIPTION DRUG COVERAGE			
OUTPATIENT PRESCRIPTION DRUGS[9, 10] Retail (per Prescription Unit or up to a 30-day supply) ■ Generic ■ Brand Name Mail Order (up to 3 Prescription Units or a 90-day supply) ■ Generic ■ Brand Name	 $10 Copayment[9] $30 Copayment[9] $20 Copayment[9] $60 Copayment[9]	 $20 Copayment[9] $35 Copayment[9] $40 Copayment[9] $70 Copayment[9]	 $20 Copayment[9] $35 Copayment[9] $40 Copayment[9] $70 Copayment[9]
DURABLE MEDICAL EQUIPMENT			
CORRECTIVE APPLIANCES & PROSTHETICS[13]	$50 Copayment	$50 Copayment	$50 Copayment
DURABLE MEDICAL EQUIPMENT[13]	$50 Copayment[9]	$50 Copayment[9]	$50 Copayment[9]
MENTAL HEALTH SERVICES			
■ Inpatient – Severe Mental Illness (SMI) and Serious Emotional Disturbances of Children (SED) Only[11] ■ Outpatient – SMI and SED[11] ■ Outpatient – Crisis Intervention (maximum 20 visits per Calendar Year)	$250 Copayment per admit $30 Copayment $35 Copayment	20% of cost Copayment[7] $30 Copayment $35 Copayment	30% of cost Copayment[7] $35 Copayment Not covered
CHEMICAL DEPENDENCY SERVICES			
INPATIENT ALCOHOL, DRUG OR OTHER SUBSTANCE ABUSE OR ADDICTION (detoxification only)	$250 Copayment per admit limit 5 days per year, 30 days lifetime maximum	20% of cost Copayment[7] limit 5 days per year, 30 days lifetime maximum	30% of cost Copayment[7] limit 5 days per year, 30 days lifetime maximum
OUTPATIENT ALCOHOL, DRUG OR OTHER SUBSTANCE ABUSE OR ADDICTION (detoxification only)	$30 Copayment 5 days per year, 30 days per lifetime	$30 Copayment 5 days per year, 30 days per lifetime	$35 Copayment 5 days per year, 30 days per lifetime
HOME HEALTH SERVICES			
HOME CARE Home visits by a licensed professional	$10 Copayment per visit	$10 Copayment per visit	$10 per visit
HOSPICE CARE Outpatient Basis & In-Home Visits (prognosis of life expectancy of one year or less)	Paid in full	Paid in full	Paid in full

1 All services must be provided or arranged by your Primary Care Physician, except for OB/GYN Physician Services and Emergency/Urgently Needed Services.
2 PCP Copayment/Specialist and Non Physician Health Care Practitioner Copayment. Refer to *Schedule of Benefits* for coverage details.
3 Services require Preauthorization by PacifiCare.
4 If you participate in a clinical trial provided by a Non-Participating Provider that does not agree to perform these services at the rate PacifiCare negotiates with Participating Providers, you will be responsible for payment of the difference between the Non-Participating Provider's billed charges and the rate negotiated by PacifiCare with Participating Providers, in addition to any applicable Copayments, Coinsurance or Deductibles.
5 This Copayment applies regardless of whether this service is performed on an inpatient or outpatient basis. If the service is performed on an inpatient basis, you will also be required to pay the applicable inpatient Copayment for your benefit plan, if any.
6 Covered only when mother's life is in jeopardy or when fetus is not viable.
7 Percentage Copayment amounts are based upon PacifiCare's contracted rates.
8 Copayment waived if admitted.
9 Annual Copayment Maximum does not include Copayments for supplemental outpatient prescription drug benefits or durable medical equipment.
10 Refer to your *Supplement to the Combined Evidence of Coverage and Disclosure Form* and Pharmacy *Schedule of Benefits* for Prescription drug coverage details.
11 Refer to your *Supplement to the Combined Evidence of Coverage and Disclosure Form* for Severe Mental illness (SMI) and Serious Emotional Disturbances of Children (SED) for coverage details.
12 The newborn care Copayment does not apply when the newborn is discharged with the mother within 48 hours of the baby's normal vaginal delivery or 96 hours of the baby's cesarean delivery. Please see the *Combined Evidence of Coverage and Disclosure Form* for more details.
13 In instances where the contracted rate is less than your Copayment, you will pay only the contracted rate.

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INSIDE BACK COVER

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Visit our Web site @ www.pacificare.com

CM-1103-56443
PC9012B-010 Rev. 11/03

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