

PLAN 70-50/1000 (WITH MATERNITY)  
 PPO SCHEDULE OF BENEFITS

**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 Coinsurance Maximum. 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.

<b>Schedule of Benefits</b>	<b>Participating Providers</b>	<b>Non-Participating Providers<sup>1</sup></b>
<b>Limiting Age for Dependent Children</b>	Through age 18, or through age 23 if a full-time student	
<b>Preauthorization List</b>	Inpatient Hospital Services, Transplant Services, Outpatient Surgical Services in a Hospital or Free-standing Surgical Center, Home Health Care Services	
<b>Your Policy Maximum While Insured</b>	\$5,000,000	
<b>Calendar Year Deductible</b>		
Individual	\$1,000	
Family maximum <i>(2x individual)</i>	\$2,000	
Deductible must be satisfied before benefits are paid		
<b>Calendar Year Coinsurance Maximum</b>		
Individual	\$2,500	\$5,000
Family maximum <i>(2x individual)</i>	\$5,000	\$10,000
	plus Deductible(s), Copayments and penalties	plus Deductible(s), Copayments and penalties

**Hospital and Facility Services**

<b>Additional Deductibles <i>(per occurrence)</i></b>		
Inpatient services	Not applicable	Not applicable
Outpatient surgical services	Not applicable	Not applicable
Emergency room services <i>(Waived if admitted)</i>	\$100 per occurrence	
Failure to obtain Preauthorization of services <i>(Waived with Preauthorization of services)</i>	\$250	\$500

**Hospital and Facility Services  
(Continued)**

	<b>Participating Providers</b>	<b>Non-Participating Providers<sup>1</sup></b>
<b>Inpatient Hospital and Facility Services</b>	70% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible up to \$1000 maximum benefit per day <sup>1</sup>
<b>Organ Transplant and Transplant Services</b>	70% of Covered Expense after satisfying the Deductible	Not Covered
	\$5,000 donor maximum	
Maximum benefit while insured	\$5,000,000	
<b>Chemical Dependency</b>	70% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible up to \$200 maximum benefit per day <sup>1</sup>
	\$2,500 Inpatient maximum per Calendar Year	
<b>Mental Illness (other than SMI)</b>	70% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible up to \$200 maximum benefit per day <sup>1</sup>
	\$2,500 Inpatient maximum per Calendar Year	
<b>Skilled Nursing Facilities</b>	70% 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	
<b>Outpatient Surgical and Facility Services Same day services performed at a Hospital or free standing surgical center</b>	70% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible up to \$750 maximum benefit per day <sup>1</sup>
<b>Hospice Care</b>	70% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible up to \$750 maximum benefit per day <sup>1</sup>
	\$5,000 maximum benefit while insured	

**Outpatient Provider Services**

	<b>Participating Providers</b>	<b>Non-Participating Providers<sup>1</sup></b>
<b>Physician Office Visits</b>	70% of Covered Expense – Deductible Waived	50% of Limited Fee Schedule after satisfying the Deductible*
<b>Physician Services</b> Other than Physician Office Visits	70% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible*
<b>Maternity Care</b> Prenatal, postnatal and childbirth expenses	70% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible*
<b>Laboratory Services X-ray Services Diagnostic Testing</b>	70% of Covered Expense – Deductible Waived	50% of Limited Fee Schedule after satisfying the Deductible*

## Wellness and Preventive Care

Wellness and Preventive Care Preventive care for children with immunizations (through age 18) Mammogram screening Breast and pelvic exams Prostate cancer screening Detection of osteoporosis	70% including laboratory and X-ray services. Deductible Waived	50% of Limited Fee Schedule after satisfying the Deductible*
<b>Periodic Health Evaluations</b> ( <i>age 19 and over</i> )	70% including laboratory and X-ray services. Deductible Waived	50% of Limited Fee Schedule after satisfying the Deductible*
\$300 maximum benefit per Calendar Year		

## Other Outpatient Provider Services

	Participating Providers	Non-Participating Providers <sup>1</sup>
<b>Ambulance</b> ( <i>Emergency services and specified transfers</i> )	60% of Covered Expense after satisfying the Deductible	
<b>Chemical Dependency</b>	70% 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	
<b>Severe Mental Illness</b> Specified diagnosis only	70% of Covered Expense after satisfying the Deductible	Not Covered
<b>Mental Illness Services</b> ( <i>other than SMI and SED</i> ) Outpatient Services	70% 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	
<b>Durable Medical Equipment</b>	70% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible*
	\$2,000 combined per Calendar Year Maximum	
<b>Home Health Care</b>	70% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible*
	100 visits combined maximum per Calendar Year	
<b>Infusion Therapy</b> Infusion Therapy Drugs	70% 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
<b>Neuromuscular Skeletal Services</b>	70% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible*
	\$1,000 combined per Calendar Year Maximum	
<b>Prosthetics</b>	70% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible
	\$2,000 combined per Calendar Year Maximum	
<b>Rehabilitation Services</b> Speech, physical, occupational therapy	70% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible*
	\$1,000 combined per Calendar Year Maximum	
<b>Orthotic Devices</b>	70% 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	

**Other Outpatient Provider Services  
(Continued)**

**Participating  
Providers**

**Non-Participating  
Providers<sup>1</sup>**

<b>Specialized Footwear</b>	70% 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	
<b>Infertility Services</b>	Not Covered	
<b>Injectable Drugs</b> <i>(except insulin)</i>	70% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible*
<b>Prescriptions</b>	100% after Copayment of: \$10 Copayment generic \$35 Copayment brand	50% after Copayment of: \$10 Copayment generic \$35 Copayment brand
	<b>Prescription Drug Deductible</b> \$250 combined per Calendar Year for brand drugs and for retail and mail service	

<sup>1</sup> 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.

\*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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CM-704-PCA077711

GHC-SM-SOB-04-CA

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