

PLAN 70-50/3000

SDHP 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.

Reimbursements under the SDA are limited to the following Covered Services 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 Quarter Individual Family	\$250 per Calendar Quarter benefit
	\$500 per Calendar Quarter benefit
Self Directed Account Rollover per Calendar Quarter Individual Family	\$250 per Calendar Quarter eligible for Rollover
	\$500 per Calendar Quarter eligible for Rollover

Schedule of Benefits	Participating Providers	Non-Participating Providers ¹
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 Family maximum (2x individual) Deductible must be satisfied before benefits are paid	\$3,000	
	\$6,000	
Calendar Year Coinsurance Maximum Individual Family maximum (2x individual)	\$4,000	\$8,000
	\$8,000 plus Deductible(s), Copayments and penalties	\$16,000 plus Deductible(s), Copayments, penalties and all amounts above the Limited Fee Schedule

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)	\$200 per occurrence	
Failure to obtain Preauthorization of services (Waived with Preauthorization of services)	\$250	\$500
Inpatient Hospital and Facility Services	70% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible up to \$500 maximum benefit per day ¹
Organ Transplant and Transplant Services	70% of Covered Expense after satisfying the Deductible	Not Covered
	\$5,000 donor maximum	
Maximum benefit while insured	\$5,000,000	
Chemical Dependency	70% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible up to \$200 maximum benefit per day ¹
	\$2,500 Inpatient maximum per Calendar Year	
Mental Illness (other than SMI)	70% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible up to \$200 maximum benefit per day ¹
	\$2,500 Inpatient maximum per Calendar Year	
Skilled Nursing Facilities	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	
Outpatient Surgical and Facility Services Same day services performed at a Hospital or free standing surgical center	70% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible up to \$500 maximum benefit per day ¹
Hospice Care	70% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible up to \$500 maximum benefit per day ¹
	\$5,000 maximum benefit while insured	

Outpatient Provider Services

	Participating Providers	Non-Participating Providers ¹
Physician Office Visits ²	70% of Covered Expense after satisfying the Deductible to SDA maximum	50% of Limited Fee Schedule after satisfying the Deductible* to SDA maximum
Physician Services Other than Physician Office Visits	70% 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	Not Covered
Laboratory Services ² X-ray Services ² Diagnostic Testing ²	70% of Covered Expense after satisfying the Deductible to SDA maximum	50% of Limited Fee Schedule after satisfying the Deductible* to SDA maximum

Wellness and Preventive Care

Wellness and Preventive Care ² Preventive care for children with immunizations (through age 18) Mammogram screening Breast and pelvic exams Prostate cancer screening Detection of osteoporosis	70% of Covered Expense after satisfying the Deductible to SDA maximum (including laboratory and X-ray services)	50% of Limited Fee Schedule after satisfying the Deductible* to SDA maximum
Periodic Health Evaluations (age 19 and over)	70% of Covered Expense after satisfying the Deductible to SDA maximum (including laboratory and X-ray services)	50% of Limited Fee Schedule after satisfying the Deductible* to SDA maximum

Other Outpatient Provider Services	Participating Providers	Non-Participating Providers ¹
Ambulance (Emergency services and specified transfers)	60% of Covered Expense after satisfying the Deductible	
Chemical Dependency	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	
Severe Mental Illness Specified diagnosis only	70% of Covered Expense after satisfying the Deductible	Not Covered
Mental Illness Services (other than SMI and SED) 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	
Durable Medical Equipment	70% 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	70% 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	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
	70% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible*
Neuromuscular Skeletal Services	70% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible*
	\$1,000 combined per Calendar Year Maximum	
Prosthetics	70% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible*
	\$2,000 combined per Calendar Year Maximum	
Rehabilitation Services 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	

**Other Outpatient Provider Services
(Continued)**

Orthotic Devices	70% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible*
	\$500 maximum benefit per Calendar Year; \$1,000 maximum benefit while insured	
Specialized Footwear	70% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible*
	\$500 maximum benefit per Calendar Year; \$1,000 maximum benefit while insured	
Infertility Services	Not Covered	
Injectable Drugs (except insulin)	70% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule after satisfying the Deductible*
Prescriptions	100% after Copayment of: \$20 Copayment generic \$35 Copayment brand	50% after Copayment of: \$20 Copayment generic \$35 Copayment brand
	\$1,000 maximum on brand only	
Prescription Drug Deductible	\$250 combined per Calendar Year for retail and mail service brand drugs	

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 to 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 and surgery performed in the Physician's office.

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

NOTE: This *Schedule of Benefits* is only valid with the Self Directed Account (SDA) *Certificate of Insurance*. Please refer to your SDA Certificate for an explanation of account coverage.

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 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.

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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