

PLAN 80-50/2000

SDHP SCHEDULE OF BENEFITS

Self Directed Account Maximum per Calendar Year	
Individual	\$250 per Calendar Quarter
Family maximum (2x individual)	\$500 per Calendar Quarter
Self Directed Account Rollover per Calendar Year	
Individual	\$1,000 per Calendar Year eligible for rollover
Family maximum (2x individual)	\$2,000 per Calendar Year eligible for rollover

Reimbursements under the Self Directed Account (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.

SDA Covered Services: The following is a summary of SDA covered services. Please note that this is not a completed list. Refer to the Certificate for additional plan information, including exclusions and limitations. Covered Expenses reimbursable under the SDA include the following: Physician Office Visits, Preventive Screenings – Breast Cancer Screening including Mammography screening, Pelvic Cancer Screening, Detection of Osteoporosis, Colorectal Cancer Screening, Prostate Cancer Screening, Covered diagnostic laboratory services, Radiology services limited to standard plain x-ray films, Periodic Health Evaluations. If a Covered Person has a question regarding a specific SDA service, he or she should contact Customer Service at the number located on their ID card.

Deductibles & Policy Maximums	Participating Providers	Non-Participating Providers*
Calendar Year Deductible		
Individual	\$2,000	\$4,000
Family maximum (2x individual)	\$4,000	\$8,000
Additional Deductibles (per occurrence)		
Inpatient services	Not applicable	Not applicable
Outpatient surgical services	Not applicable	Not applicable
Emergency room services	\$100 (waived if admitted) then 80% of Covered Expense after satisfying the Deductible	
Failure to obtain Preauthorization of services (waived with Preauthorization of services)	\$250	\$500
Coinsurance Maximum		
Individual	\$2,000	\$6,000
Family maximum (2x individual)	\$4,000	\$12,000
Your Policy Maximum While Insured	\$2,000,000	

Inpatient Benefits	Participating Providers	Non-Participating Providers*
Inpatient Hospital Services	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible; up to \$500 maximum benefit per day ¹
Inpatient Alcohol, Drug or Other Substance Abuse Detoxification	Not covered	Not covered
Inpatient Alcohol, Drug or Other Substance Abuse Rehabilitation	Not covered	Not covered
Organ Transplant Services² Bone marrow, stem cell and organ transplants Donor maximum National preferred transplant facility Company authorized transplant facility Maximum benefit while insured	80% of Covered Expense after satisfying the Deductible \$15,000 per occurrence \$15,000 per occurrence Up to policy maximum	Not covered
Inpatient Maternity and Newborn Care Labor, delivery and postnatal hospital services	80% of Covered Expense after satisfying the Deductible; coverage is limited to newborn care (Deductible waived) and complications of pregnancy	50% of Covered Expense after satisfying the Deductible; coverage is limited to newborn care (Deductible waived) and complications of pregnancy
Inpatient Skilled Nursing Facilities Maximum	80% of Covered Expense after satisfying the Deductible Up to 30 days per Calendar Year	50% of Covered Expense after satisfying the Deductible
Inpatient Hospice Care Maximum	80% of Covered Expense after satisfying the Deductible 30 day maximum while insured inpatient and outpatient combined	50% of Covered Expense after satisfying the Deductible
Inpatient Mental Illness Services (including Biologically Based Mental Illness)	Not covered	Not covered
Inpatient Rehabilitation Care Maximum	80% of Covered Expense after satisfying the Deductible 30 day maximum benefit while insured	50% of Covered Expense after satisfying the Deductible

Outpatient Benefits	Participating Providers	Non-Participating Providers*
Physician Office Visits <i>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</i> Allergy testing and treatment	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible
Physician Office Visits <i>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</i> Breast and pelvic cancer screening including mammography screening Pelvic Cancer Screening Detection of osteoporosis Colorectal cancer screenings Prostate cancer screening Preventive care for children including immunizations (birth through 12 years of age): <i>Age 0 through 12 months: 1 newborn home visit, 5 well-child visits and 1 PKU test</i> <i>Age 1 through 2 years: 2 well-child visits</i> <i>Age 3 through 6 years: 3 well-child visits</i> <i>Age 7 through 12 years: 3 well-child visits</i> Preventive care for children 13 through 18 years: 1 age appropriate health service per Plan Year.	100% of physician office visit services to SDA maximum then 80% of Covered Expense after satisfying the Deductible	100% of physician office visit services to SDA maximum then 50% of Limited Fee Schedule of Covered Expense after satisfying the Deductible
Mammography screening is not subject to any Deductibles. Prostate cancer screening is not subject to any Deductibles. Preventive care for children (birth through 12 years of age) are not subject to any Deductibles.		
Periodic Health Evaluations (age 19 and over) Hearing screening Vision screening Immunizations and adult boosters Routine laboratory tests age and gender appropriate Weight evaluation	100% of periodic health evaluation services to SDA maximum then 80% of Covered Expense after satisfying the Deductible	100% of periodic health evaluation services to SDA maximum then 50% of Limited Fee Schedule of Covered Expense after satisfying the Deductible
Outpatient Maternity Care Physician office visits, lab and radiology services Prenatal, post-partum, maternity care	Not covered	Not covered
Urgent Care Services (per occurrence)	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible
Outpatient Alcohol, Drug or Other Substance Abuse	Not covered	Not covered
Ambulance <i>(Emergency services and specified transfers)</i>	70% of Covered Expense after satisfying the Deductible	

Outpatient Benefits (continued)	Participating Providers	Non-Participating Providers*
Durable Medical Equipment Rental, purchase or repair Maximum benefit	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule of Covered Expense after satisfying the Deductible
	\$2000 combined per Calendar Year Maximum	
Home Health Care Maximum benefit	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule of Covered Expense after satisfying the Deductible
	60 visits combined maximum per Calendar Year	
Outpatient Hospice Services Home care for crisis period and acute care management Maximum benefit	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible
	30 day maximum while insured combined with inpatient	
Outpatient Mental Illness Services (including Biologically Based Mental Illness)	Not covered	Not covered
Laboratory Services <i>(other than physician office visits)</i>	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule of Covered Expense after satisfying the Deductible
Radiology Services <i>(other than physician office visits)</i>	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule of Covered Expense after satisfying the Deductible
Specialized Scanning, Imaging and Laboratory Services (other than Physician Office Visits) CT, SPECT, PET, MRA, MRI, ultrasounds, EKG, EEG, AMG and nuclear medicine studies	80% of Covered Expense after satisfying the Deductible	50% of Limited Fee Schedule of Covered Expense after satisfying the Deductible
Outpatient Medical Rehabilitative Therapy¹ Speech, physical, occupational therapy Maximum benefit	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible
	\$2000 combined per Calendar Year maximum For children born with congenital defects and birth abnormalities, from birth to age 5 years, 20 visits each for physical, speech and occupational therapy per Calendar Year. For children with autism, from birth to age 5 years, 20 visits each for physical, speech and occupational therapy per Calendar Year.	
Prosthetics and Corrective Appliances (other than prosthetic arms and legs)	80% of Covered Expense after satisfying the Deductible up to the durable medical equipment maximum.	50% of Covered Expense after satisfying the Deductible up to the durable medical equipment maximum.
Prosthetic Arms and Legs	Prosthetic arms and legs will not be limited to the durable medical equipment maximum; 80% of Covered Expense after satisfying the Deductible.	
Biologically Based Mental Illness Specified diagnosis only	Not covered	Not covered
Neuromuscular Skeletal Services	Not covered	Not covered
Outpatient Surgery Same day services performed at a Hospital or free standing surgical center	80% of Covered Expense after satisfying the Deductible	50% of Covered Expense after satisfying the Deductible

Important PPO Information

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 Preauthorize 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 Preauthorizing services will not apply toward your Calendar Year Deductible or Coinsurance Maximum. To avoid any penalty, please refer to "Preauthorization Requirements."

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.

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.

Application of Additional Deductibles. Additional Deductibles are separate Deductibles applied per occurrence for services specified on the Schedule. Additional Deductibles are in addition to, and do not apply toward satisfaction of any Calendar Year Deductibles under the Policy. The Covered Person is responsible for any additional Deductibles applied per occurrence.

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 *Certificate 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

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.

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

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

©2005 by PacifiCare Health Systems, Inc.
PC0135359-003

Underwritten by PacifiCare Life Assurance Company