

# Small Group Plans



Effective October 1, 2005

***PacifiCare***<sup>®</sup>  
Caring is good. Doing something is better.<sup>SM</sup>



# A health care company you can count on

PacifiCare has been recognized by industry experts and mainstream publications like *Fortune Magazine* as “one of the most respected names in the health care industry.” It’s easy to see why: We’re tireless in our pursuit to provide valuable products and superior service to the public we serve.

PacifiCare contracts with some of the most prestigious physicians and health care facilities in the medical industry. We negotiate the lowest rates with providers, pharmaceutical companies and manufacturers. We seek to expand the rights and privileges enjoyed by consumers – in short, we’re working to better our company, our offerings to customers, and the way health care is practiced across this country.

It’s a revolutionary approach, but we think our customers deserve nothing less. We are committed to excellence, in products and services, and passing that onto our consumer, our brokers, their clients and their end users.

Our efforts start with you.

## **We're behind you, every step of the way**

We won't compromise on the quality of support we offer our clients. In addition to furnishing a superior "product" – health care plans that combine benefits with quality – we work to achieve an exemplary level of service. For example, we provide each PacifiCare group with a dedicated Account Management Team. The team is always there to answer questions, provide assistance, and reassure our clients that we're still looking out for them.

## **PacifiCare is more than health care coverage**

We provide more than access to doctors: we educate, with powerful tools like our proprietary QUALITY INDEX®, a revolutionary ranking system that measures doctor and hospital performance and actually promotes higher degrees of accountability for providers. We enable people to make better decisions about their health, with value-added programs that teach and encourage healthy behavior. In short, we empower them to become stewards of their own well-being by helping to reduce their overall costs while sending their level of satisfaction skyrocketing.



## PacifiCare SignatureValue<sup>SM</sup> (HMO)

Our flagship HMO product put PacifiCare on the map more than 25 years ago — and every year, we believe in continuous improvement for our reputation as being a leader in quality, disease management, health care cost management and service.

The PacifiCare SignatureValue plans are anything but traditional. We're always looking for new ways to add value, give members better services and help them make the most of their benefits.

# PacifiCare SignatureValue (HMO)

	PacifiCare SignatureValue 10-30/100	PacifiCare SignatureValue 15-30/250a
<b>Annual Deductible</b>	None	None
<b>Lifetime Maximum</b>	None	None
<b>Annual Copayment Maximum<sup>1</sup></b>	\$1,500/3 max per family	\$1,500/3 max per family
<b>Professional Services</b>		
<b>Office Visits</b>	\$10/\$30 Copayment <sup>2</sup>	\$15/\$30 Copayment <sup>2</sup>
<b>Periodic Health Evaluations</b>	\$10 Copayment	\$15 Copayment
<b>Vision And Hearing Screening</b>	\$10/\$30 Copayment <sup>2</sup>	\$15/\$30 Copayment <sup>2</sup>
<b>Laboratory And Radiology</b> (Standard)	Paid in full	Paid in full
<b>Maternity Care</b>	Paid in full	Paid in full
<b>Well-Baby Care</b> (Up To Age 2)	Paid in full	Paid in full
<b>Well-Woman Care</b>	\$10 Copayment	\$15 Copayment
<b>Outpatient Services</b>		
<b>Outpatient Surgery</b>	Paid in full	\$250 per admission
<b>Hospitalization Services</b>		
<b>Inpatient Hospital Benefits</b>	Paid in full	\$250 per admission
<b>Inpatient Physician Care</b>	Paid in full	Paid in full
<b>Skilled Nursing Facility</b> (Up To 100 Consecutive Calendar Days From First Treatment Per Disability)	Paid in full	\$100 per day
<b>Emergency Health Coverage</b>		
<b>Emergency Services</b> (Copayment Waived If Admitted)	\$50 Copayment	\$50 Copayment
<b>Urgently Needed Services</b> (Copayment Waived If Admitted)	\$50 Copayment	\$50 Copayment
<b>Ambulance Services</b>	Paid in full	Paid in full
<b>Durable Medical Equipment</b>		
<b>Durable Medical Equipment</b> (\$2,000 Maximum Benefit Per Calendar Year) (The annual DME benefit maximum does not apply to nebulizers, masks, tubing and peak flow meters for the treatment of asthma for Dependent children under the age of 19)	\$50 Copayment per item <sup>5</sup>	\$50 Copayment per item <sup>5</sup>
<b>Mental Health Services</b>		
<b>Severe Mental Illness (SMI) and Serious Emotional Disturbances Of A Child (SED)<sup>4</sup></b>		
■ Inpatient	Paid in full	\$250 per admission
■ Outpatient	\$30 Copayment	\$30 Copayment
<b>Crisis Intervention</b> (Up To 20 Visits)	\$35 Copayment	\$35 Copayment
<b>Chemical Dependency Services</b>		
<b>Alcohol, Drug Or Other Substance Abuse</b> (Detoxification Only)		
■ Inpatient	Paid in full	\$250 per admission
■ Outpatient	\$30 Copayment	\$30 Copayment
<b>Home Health Services</b>		
<b>Home Health Care: Home Visits By A Licensed Professional</b> (Up To 100 Visits Per Calendar Year)	\$15 per visit	\$15 per visit
<b>Other Services</b>		
<b>Infertility Services</b>	50% of cost Copayment <sup>6</sup>	50% of cost Copayment <sup>6</sup>
<b>Injectable Drugs</b> (Copayment Not Applicable To Allergy Serum, Immunizations, Birth Control, Infertility And Insulin)	\$150 Copayment <sup>5</sup>	\$150 Copayment <sup>5</sup>
<b>Outpatient Prescription Drug Coverage<sup>3</sup></b>		
<b>Generic Formulary/Brand-Name Formulary/Non-Formulary</b>	\$10 Copayment/\$25 Copayment/ \$35 Copayment	\$10 Copayment/\$25 Copayment/ \$35 Copayment

<sup>1</sup> Copayments for Pharmacy, Durable Medical Equipment and supplemental benefits are not included in the cumulative Annual Copayment Maximum.

<sup>2</sup> PCP Copayment/Specialist Copayment. Refer to the *Schedule of Benefits* for coverage details.

<sup>3</sup> Copayment applies per Prescription Unit or up to a 30-day supply. Covered when obtained through a PacifiCare Participating Pharmacy. Discount mail order available.

<sup>4</sup> Refer to the Supplement to the Combined Evidence of Coverage and Disclosure Form for Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED) for coverage details.

<sup>5</sup> In instances where the negotiated rate is less than your Copayment, you will pay only the negotiated rate.

<sup>6</sup> Percentage Copayment amounts are based upon PacifiCare's negotiated rate.

PacifiCare SignatureValue 10/500d	PacifiCare SignatureValue 20-40/500d	PacifiCare SignatureValue 35/600d
None	None	None
None	None	None
\$2,000/3 max per family	\$3,000/\$5,000 per family	\$5,000/3 max per family
\$10 Copayment	\$20/\$40 Copayment <sup>2</sup>	\$35 Copayment
\$10 Copayment	\$20 Copayment	\$35 Copayment
\$10 Copayment	\$20/\$40 Copayment <sup>2</sup>	\$35 Copayment
Paid in full	Paid in full	Paid in full
Paid in full	Paid in full	Paid in full
Paid in full	Paid in full	Paid in full
\$10 Copayment	\$20 Copayment	\$35 Copayment
\$400 per admission	\$400 per admission	\$500 per admission
\$500 per day, up to 2 days per admission	\$500 per day	\$600 per day, up to 3 days per admission
Paid in full	Paid in full	Paid in full
\$200 per day	\$200 per day	\$200 per day
\$50 Copayment	\$50 Copayment	\$150
\$50 Copayment	\$50 Copayment	\$150
\$50 Copayment	\$50 Copayment	\$50 Copayment
\$50 Copayment per item <sup>5</sup>	\$50 Copayment per item <sup>5</sup>	\$50 Copayment per item <sup>5</sup>
\$250 per admission	\$250 per admission	\$250 per admission
\$10 Copayment	\$40 Copayment	\$35 Copayment
\$35 Copayment	\$35 Copayment	Not Covered
\$500 per day, up to 2 days per admission	\$500 per day	\$600 per day, up to 3 days per admission
\$10 Copayment	\$40 Copayment	\$35 Copayment
\$15 per visit	\$15 per visit	\$15 per visit
Not Covered	Not Covered	Not Covered
\$150 Copayment <sup>5</sup>	\$150 Copayment <sup>5</sup>	\$100 Copayment <sup>5</sup>
\$15 Copayment/\$35 Copayment/ \$50 Copayment	\$15 Copayment/\$35 Copayment/ \$50 Copayment	\$15 Copayment/\$35 Copayment/ \$50 Copayment



## PacifiCare SignatureValue<sup>SM</sup> Advantage (HMO Value)

The PacifiCare SignatureValue Advantage (HMO Value) is almost identical to our HMO plans, but is offered for a lower premium. The difference is in the provider network, a high-performing, cost-effective subset of participating medical groups and affiliated hospitals from the HMO network.

Providers in the PacifiCare SignatureValue Advantage (HMO Value) network are evaluated on many cost and quality factors, including, most importantly, member satisfaction. The plan's health care costs are generally lower than the standard HMO network, which can be a significant saving in health care costs for employers.

PacifiCare SignatureValue Advantage (HMO Value) participating medical groups are located in Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Francisco and Santa Clara counties.

# PacifiCare SignatureValue Advantage (HMO Value)

	PacifiCare SignatureValue Advantage (HMO Value) 10/500d	PacifiCare SignatureValue Advantage (HMO Value) 35/600d
<b>Annual Deductible</b>	None	None
<b>Lifetime Maximum</b>	None	None
<b>Annual Copayment Maximum<sup>1</sup></b>	\$2,000/3 max per family	\$5,000/3 max per family
<b>Professional Services</b>		
<b>Office Visits</b>	\$10 Copayment	\$35 Copayment
<b>Periodic Health Evaluations</b>	\$10 Copayment	\$35 Copayment
<b>Vision And Hearing Screening</b>	\$10 Copayment	\$35 Copayment
<b>Laboratory And Radiology (Standard)</b>	Paid in full	Paid in full
<b>Maternity Care</b>	Paid in full	Paid in full
<b>Well-Baby Care (Up To Age 2)</b>	Paid in full	Paid in full
<b>Well-Woman Care</b>	\$10 Copayment	\$35 Copayment
<b>Outpatient Services</b>		
<b>Outpatient Surgery</b>	\$400 per admission	\$500 per admission
<b>Hospitalization Services</b>		
<b>Inpatient Hospital Benefits</b>	\$500 per day, up to 2 days per admission	\$600 per day, up to 3 days per admission
<b>Inpatient Physician Care</b>	Paid in full	Paid in full
<b>Skilled Nursing Facility</b> (Up To 100 Consecutive Calendar Days From First Treatment Per Disability)	\$200 per day	\$200 per day
<b>Emergency Health Coverage</b>		
<b>Emergency Services</b> (Copayment Waived If Admitted)	\$50 Copayment	\$150
<b>Urgently Needed Services</b> (Copayment Waived If Admitted)	\$50 Copayment	\$150
<b>Ambulance Services</b>	\$50 Copayment	\$50 Copayment
<b>Durable Medical Equipment</b>		
<b>Durable Medical Equipment</b> (\$2,000 Maximum Benefit Per Calendar Year) (The annual DME benefit maximum does not apply to nebulizers, masks, tubing and peak flow meters for the treatment of asthma for Dependent children under the age of 19)	\$50 Copayment per item <sup>5</sup>	\$50 Copayment per item <sup>5</sup>
<b>Mental Health Services</b>		
<b>Severe Mental Illness (SMI) and Serious Emotional Disturbances Of A Child (SED)<sup>2</sup></b>		
■ Inpatient	\$250 per admission	\$250 per admission
■ Outpatient	\$10 Copayment	\$35 Copayment
<b>Crisis Intervention (Up To 20 Visits)</b>	\$35 Copayment	Not Covered
<b>Chemical Dependency Services</b>		
<b>Alcohol, Drug Or Other Substance Abuse</b> (Detoxification Only)		
■ Inpatient	\$500 per day, up to 2 days per admission	\$600 per day, up to 3 days per admission
■ Outpatient	\$10 Copayment	\$35 Copayment
<b>Home Health Services</b>		
<b>Home Health Care: Home Visits By A Licensed Professional</b> (Up To 100 Visits Per Calendar Year)	\$15 per visit	\$15 per visit
<b>Other Services</b>		
<b>Infertility Services</b>	Not Covered	Not Covered
<b>Injectable Drugs</b> (Copayment Not Applicable To Allergy Serum, Immunizations, Birth Control, Infertility And Insulin)	\$150 Copayment <sup>6</sup>	\$100 Copayment <sup>6</sup>
<b>Outpatient Prescription Drug Coverage<sup>3</sup></b>		
<b>Generic Formulary/Brand-Name Formulary/Non-Formulary</b>	\$15 Copayment/\$35 Copayment/\$50 Copayment	\$15 Copayment/\$35 Copayment/\$50 Copayment

1 Copayments for Pharmacy, Durable Medical Equipment and supplemental benefits are not included in the cumulative Annual Copayment Maximum.

2 PCP Copayment/Specialist Copayment. Refer to the *Schedule of Benefits* for coverage details.

3 Copayment applies per Prescription Unit or up to a 30-day supply. Covered when obtained through a PacifiCare Participating Pharmacy. Discount mail order available.

4 Refer to the Supplement to the Combined Evidence of Coverage and Disclosure Form for Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED) for coverage details.

5 In instances where the negotiated rate is less than your Copayment, you will pay only the negotiated rate.

6 Percentage Copayment amounts are based upon PacifiCare's negotiated rate.



## PacifiCare SignaturePOS<sup>SM</sup>

PacifiCare SignaturePOS plans provide the structure of an HMO/managed care plan with the flexibility of a PPO plan. Members enjoy lower copayments when they use providers within PacifiCare's extensive network but can access physicians and hospitals outside this network.

With PacifiCare SignaturePOS, employers receive all the advantages of a managed care plan, but they still have the freedom to see other providers outside of our contracted HMO network.

# PacifiCare SignaturePOS (POS)

POS 15/80-60 Principal Benefits	In-Network	Out-of-Network Preferred Providers <sup>1</sup>	Out-of-Network Non-Preferred Providers <sup>1</sup>
<b>Deductible</b>	0	\$300/3 max per family <sup>5</sup>	\$300/3 max per family <sup>5</sup>
<b>Lifetime Maximum Benefits</b>	Unlimited	\$2,000,000 <sup>5</sup>	\$2,000,000 <sup>5</sup>
<b>Annual Copayment Maximum<sup>3</sup></b>	\$2,500/3 max per family	\$4,000/3 max per family	\$4,000/3 max per family
<b>Professional Services</b>			
<b>Physician Office Visits</b>	\$15 Copayment	\$35 Copayment*	40% Copayment
<b>Periodic Health Evaluations</b>			
■ Ages 2 to 17	\$15 Copayment	\$35 Copayment*	40% Copayment
■ Ages 18 and older	\$15 Copayment	Not covered	Not covered
<b>Immunizations</b> (0 to 2 years refer to Well-Baby Care)	\$15 Copayment	\$35 Copayment*	40% Copayment
<b>Vision/Hearing Screening</b>	\$15 Copayment	Not covered	Not covered
<b>Laboratory and Radiology</b>	Paid in full	\$35 Copayment*	40% Copayment
<b>Maternity Care</b>	Paid in full	\$35 Copayment*	40% Copayment
<b>Well-Baby Care</b> (up to Age 2)	\$15 Copayment	\$35 Copayment*	40% Copayment
<b>Well-Woman Care</b>	\$15 Copayment	\$35 Copayment*	40% Copayment
<b>Outpatient Services</b>			
<b>Outpatient Surgery</b>	\$250 per admission	20% Copayment	40% Copayment
<b>Hospitalization Services</b>			
<b>Inpatient Hospital Benefits</b>	\$250 per admission	20% Copayment	40% Copayment
<b>Inpatient Physician Care</b>	Paid in full	20% Copayment	40% Copayment
<b>Skilled Nursing Facility Care</b> (Up to 100 consecutive calendar days from the first treatment per disability for In-Network Services, up to 60 consecutive days for Out-of-Network Services)	\$100 per day	20% Copayment*	40% Copayment*
<b>Emergency Health Coverage</b>			
<b>Emergency Care Services</b> (waived if admitted as an inpatient)	\$50 Copayment	Covered as an in-network benefit	Covered as an in-network benefit
<b>Urgently Needed Services</b> (waived if admitted as an inpatient)	\$50 Copayment	Covered as an in-network benefit	Covered as an in-network benefit
<b>Ambulance Services</b>	Paid in full	30% Copayment	30% Copayment
<b>Durable Medical Equipment</b>			
<b>Durable Medical Equipment</b>	\$50 Copayment	20% Copayment \$2,000 annual maximum <sup>6</sup>	40% Copayment \$2,000 annual maximum <sup>6</sup>
<b>Mental Health Services</b>			
<b>Severe Mental Illness (SMI) and Serious Emotional Disturbances Of A Child (SED)<sup>8</sup></b>			
Inpatient	\$250 per admission	Not covered	Not covered
Outpatient	\$15 Copayment	Not covered	Not covered
<b>Crisis Intervention</b> (Up to 20 Visits, maximum benefit \$50 per visit for out-of-network <sup>4</sup> )	\$35 Copayment	20% Copayment	40% Copayment
<b>Chemical Dependency Services</b>			
<b>Alcohol, Drug or Other Substance Abuse</b> (Detoxification Only)			
Inpatient	\$250 per admission	20% Copayment	40% Copayment
Outpatient	\$15 Copayment	\$35 Copayment*	40% Copayment
<b>Home Health Services</b>			
<b>Home Health Care: Home visits by a Licensed Professional</b> (Up to 100 visits per for In-Network Services; up to 100 visits per year for Out-of-Network Services <sup>9</sup> )	\$15 per visit	\$35 Copayment*	40% Copayment
<b>Other Services</b>			
<b>Infertility Services</b>	50% of cost Copayment <sup>1</sup>	Not covered	Not covered
<b>Outpatient Prescription Drug Coverage<sup>4</sup></b>			
<b>Generic Formulary/Brand-Name Formulary/Non-Formulary</b>	\$10/\$25/\$50 Copayment	Covered as an in-network benefit	Covered as an in-network benefit
<b>Optional Group Coverage</b>			
<b>Chiropractic/Acupuncture offered through American Specialty Health Plans</b> (Maximum 30 visits per calendar year)	\$10 Copayment	Not Covered	Not Covered

<sup>1</sup> Percentage Copayment amounts are based upon PacifiCare's contracted rate. Excludes Ambulance Services.

<sup>2</sup> Percentage Copayment amounts are based upon PacifiCare's Limited Fee Schedule. Excludes Ambulance Services.

<sup>3</sup> Copayments for pharmacy and supplemental benefits are not included in the cumulative Annual Copayments maximum.

<sup>4</sup> Copayment applies per Prescription Unit or up to 30 days. Covered when obtained through a PacifiCare Participating Pharmacy. Discount mail order available.

<sup>5</sup> The dollar amounts are combined for Out-of-Network Preferred Providers and Non-Preferred Providers.

<sup>6</sup> Combined limitations. The benefits received under Out-of-Network Preferred Providers and Non-Preferred Providers will be counted toward the total benefit limit.

<sup>7</sup> Combined inpatient and outpatient benefit.

<sup>8</sup> Refer to your Supplemental Combined Evidence of Coverage and Disclosure Form for Severe Mental Illness (SMI) and Serious Emotional Disturbances of Children (SED) for coverage details.

<sup>9</sup> Services require Preauthorization by PacifiCare.

<sup>10</sup> 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.

\* Deductible amount is waived.





## PacifiCare SignatureOptions<sup>SM</sup> (PPO)

It's easy to understand why our PPO plans are among the most popular: enrollees have access to an expanded network of physicians and specialists, and both doctors and members enjoy the simplicity of not needing a referral to see a specialist. We provide an array of products with varying benefits and deductible levels.

# PacifiCare SignatureOptions (PPO)

	PacifiCare SignatureOptions 15/90-50/250		PacifiCare SignatureOptions 20/80-60/250	
	Participating Provider	Non-Participating Provider Limited Fee Schedule <sup>1</sup>	Participating Provider	Non-Participating Provider Limited Fee Schedule <sup>1</sup>
<b>Calendar Year Deductible<sup>2</sup> Individual/Family</b>	\$250/\$500		\$250/\$500	
<b>Additional Deductibles</b> (per occurrence) Services are subject to applicable Calendar Year Deductible, coinsurance, and any benefit maximums				
■ Inpatient services	NA	\$500	NA	NA
■ Emergency room services Waived if admitted	\$100		\$100	
■ Failure to obtain Preauthorization of services Waived with Preauthorization of services	\$250	\$500	\$250	\$500
<b>Coinsurance Maximum Individual/Family</b>	\$3,000/\$6,000	\$6,000/\$12,000	\$3,000/\$6,000	\$6,000/\$12,000
<b>Policy Maximum</b>	\$5,000,000		\$5,000,000	
<b>Professional Services</b>				
<b>Physician Office Visits</b>				
<b>Periodic Health Evaluations for children</b> (through age 18)	\$15 Copayment; 90% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	50% <sup>4</sup>	\$20 Copayment; 80% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	60% <sup>5</sup>
<b>Periodic Health Evaluations</b> (age 19 and over) Maximum \$400 per Calendar Year				
<b>Laboratory Services</b>	90% <sup>4</sup>	50% <sup>4</sup>	80% <sup>4</sup>	60% <sup>5</sup>
<b>Maternity Care, Tests or Procedures</b>	\$15 Copayment for initial visit, then 90% <sup>4</sup>	50% <sup>4</sup>	\$20 Copayment for initial visit, then 80% <sup>4</sup>	60% <sup>5</sup>
<b>Outpatient Services</b>				
<b>Outpatient Surgery</b>	90% <sup>4</sup>	50% <sup>4</sup> up to \$750 maximum benefit per day	80% <sup>4</sup>	60% <sup>5</sup> up to \$750 maximum benefit per day <sup>3</sup>
<b>Hospitalization Services</b>				
<b>Inpatient Hospice Services</b> (\$5,000 combined maximum for Inpatient and Outpatient benefits while insured)	90% <sup>4</sup>	50% <sup>4</sup>	80% <sup>4</sup>	60% <sup>5</sup> up to \$1,000 maximum benefit per day
<b>Inpatient Physician Services</b>	90% <sup>4</sup>	50% <sup>4</sup>	80% <sup>4</sup>	60% <sup>5</sup> up to \$1,000 maximum benefit per day
<b>Inpatient Skilled Nursing Facility Care</b> (Up to 90 days Inpatient per Calendar Year)	90% <sup>4</sup>	50% <sup>4</sup>	80% <sup>4</sup>	Covered Person responsible for all charges over \$200 maximum benefit per day
<b>Emergency Health Coverage</b>				
<b>Emergency Room Services</b>	90% <sup>4</sup>		80% <sup>4</sup>	
<b>Urgent Care Services</b>	\$50 Copayment; 90% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	50% <sup>4</sup>	\$50 Copayment; 80% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	60% <sup>5</sup>
<b>Ambulance Services</b>	70% <sup>4</sup>		70% <sup>4</sup>	
<b>Durable Medical Equipment</b>				
<b>Durable Medical Equipment</b> (\$2,000 per Calendar Year)	90% <sup>4</sup>	50% <sup>4</sup>	80% <sup>4</sup>	60% <sup>5</sup>
<b>Mental Health Services</b>				
<b>Severe Mental Illness Services</b> Specified diagnosis only	90% <sup>4</sup>	Not Covered	80% <sup>4</sup>	Not Covered
<b>Mental Illness Services<sup>2</sup></b>				
<b>Inpatient Mental Illness Services<sup>2</sup></b> (\$2,500 per Calendar Year)	90% <sup>4</sup>	50% <sup>4</sup>	80% <sup>4</sup>	60% <sup>5</sup> up to \$200 maximum benefit per day
<b>Outpatient Mental Illness Services<sup>2</sup></b> (One visit per day; 20 visits per Calendar Year)	90% <sup>4</sup>	50% <sup>4</sup>	80% <sup>4</sup>	60% <sup>5</sup>
<b>Chemical Dependency Services</b>				
<b>Alcohol, Drug or Other Substance Abuse<sup>2</sup></b> (Detoxification only)	90% <sup>4</sup>	50% <sup>4</sup>	80% <sup>4</sup>	60% <sup>5</sup> up to \$200 maximum benefit per day
<b>Inpatient</b> (up to \$2,500 per Calendar Year)				
<b>Outpatient</b> (One visit per day; 20 visits per Calendar Year)	90% <sup>4</sup>	50% <sup>4</sup>	80% <sup>4</sup>	60% <sup>5</sup>
■ <b>Benefit Maximum</b>	One visit per day; 20 visits per Calendar Year		One visit per day; 20 visits per Calendar Year	
<b>Home Health Services</b>				
<b>Home Health Care</b> (100 visits per Calendar Year)	90% <sup>4</sup>	50% <sup>4</sup>	80% <sup>4</sup>	60% <sup>5</sup>
<b>Other Services</b>				
<b>Infertility Services</b> (up to \$2,000 while insured)	90% <sup>4</sup>	50% <sup>4</sup>	80% <sup>4</sup>	60% <sup>5</sup>
<b>Injectable Drugs</b>	90% <sup>4</sup>	50% <sup>4</sup>	80% <sup>4</sup>	60% <sup>5</sup>
<b>Outpatient Prescription Drugs<sup>3</sup></b>	Participating Pharmacy 100% after Copayment of	Non-Participating Pharmacy 80% after Copayment of	Participating Pharmacy 100% after Copayment of	Non-Participating Pharmacy 80% after Copayment of
■ <b>Generic Formulary/Brand-Name Formulary/Non-Formulary</b>	\$10/\$25/\$50		\$10/\$25/\$50	

1 The Covered Person is responsible for any charges in excess of the allowable Covered Expense.

2 Copayments or additional deductibles for Covered Expenses do not apply toward the Calendar Year Deductible.

3 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.

4 Coinsurance level of Coverage Expense after satisfying the Deductible

5 Coinsurance level of Limited Fee Schedule after satisfying the Deductible

PacifiCare SignatureOptions 30/70-50/250		PacifiCare SignatureOptions 35/80-60/500	
Participating Provider	Non-Participating Provider Limited Fee Schedule <sup>1</sup>	Participating Provider	Non-Participating Provider Limited Fee Schedule <sup>1</sup>
	\$250/\$500		\$500/\$1,000
NA	NA	NA	NA
	\$100		\$100
\$250	\$500	\$250	\$500
\$3,000/\$6,000	\$6,000/\$12,000	\$5,000/\$10,000	\$10,000/\$20,000
	\$5,000,000		\$5,000,000
\$30 Copayment; 70% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	50% <sup>5</sup>	\$35 Copayment; 80% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	60% <sup>5</sup>
70% <sup>4</sup>	50% <sup>5</sup>	80% <sup>4</sup>	60% <sup>5</sup>
\$30 Copayment for initial visit, then 70% <sup>4</sup>	50% <sup>5</sup>	\$35 Copayment for initial visit, then 80% <sup>4</sup>	60% <sup>5</sup>
70% <sup>4</sup>	50% <sup>5</sup> up to \$750 maximum benefit per day <sup>2</sup>	80% <sup>4</sup>	60% <sup>5</sup> up to \$750 maximum benefit per day <sup>2</sup>
70% <sup>4</sup>	50% <sup>4</sup> up to \$1,000 maximum benefit per day	80% <sup>4</sup>	60% <sup>4</sup> up to \$1,000 maximum benefit per day
70% <sup>4</sup>	50% <sup>4</sup> up to \$1,000 maximum benefit per day	80% <sup>4</sup>	60% <sup>4</sup> up to \$1,000 maximum benefit per day
70% <sup>4</sup>	Covered Person responsible for all charges over \$200 maximum benefit per day	80% <sup>4</sup>	Covered Person responsible for all charges over \$200 maximum benefit per day
70% <sup>4</sup>		80% <sup>4</sup>	
\$50 Copayment; 70% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	50% <sup>5</sup>	\$50 Copayment; 80% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	60% <sup>5</sup>
60% <sup>4</sup>		70% <sup>4</sup>	
70% <sup>4</sup>	50% <sup>5</sup>	80% <sup>4</sup>	60% <sup>5</sup>
70% <sup>4</sup>	Not Covered	80% <sup>4</sup>	Not Covered
70% <sup>4</sup>	50% <sup>5</sup> up to \$200 maximum benefit per day	80% <sup>4</sup>	60% <sup>5</sup> up to \$200 maximum benefit per day
70% <sup>4</sup>	50% <sup>5</sup>	80% <sup>4</sup>	60% <sup>5</sup>
70% <sup>4</sup>	50% <sup>5</sup> up to \$200 maximum benefit per day	80% <sup>4</sup>	60% <sup>5</sup> up to \$200 maximum benefit per day
70% <sup>4</sup>	50% <sup>5</sup>	80% <sup>4</sup>	60% <sup>5</sup>
	One visit per day; 20 visits per Calendar Year		One visit per day; 20 visits per Calendar Year
70% <sup>4</sup>	50% <sup>5</sup>	80% <sup>4</sup>	60% <sup>5</sup>
70% <sup>4</sup>	50% <sup>5</sup>	80% <sup>4</sup>	60% <sup>5</sup>
70% <sup>4</sup>	50% <sup>5</sup>	80% <sup>4</sup>	60% <sup>5</sup>
Participating Pharmacy 100% after Copayment of	Non-Participating Pharmacy 80% after Copayment of	Participating Pharmacy 100% after Copayment of	Non-Participating Pharmacy 80% after Copayment of
	\$10/\$35/\$50		\$10/\$35/\$50

# PacifiCare SignatureOptions (PPO)

PacifiCare SignatureOptions 35/70-50/1000		PacifiCare SignatureOptions 35/50-50/1000		
	Participating Provider	Non-Participating Provider Limited Fee Schedule <sup>1</sup>	Participating Provider	Non-Participating Provider Limited Fee Schedule <sup>1</sup>
<b>Calendar Year Deductible<sup>2</sup> Individual/Family</b>	\$1,000/\$2,000		\$1,000/\$2,000	
<b>Additional Deductibles</b> (per occurrence) <b>Services are subject to applicable Calendar Year Deductible, coinsurance, and any benefit maximums</b>				
■ Inpatient services	NA	NA	NA	NA
■ Emergency room services Waived if admitted	\$100		\$100	
■ Failure to obtain Preauthorization of services Waived with Preauthorization of services	\$250	\$500	\$250	\$500
<b>Coinsurance Maximum Individual/Family</b>	\$5,000/\$10,000	\$10,000/\$20,000	\$3,000/\$6,000	\$6,000/\$12,000
<b>Policy Maximum</b>	\$5,000,000		\$5,000,000	
<b>Professional Services</b>				
<b>Physician Office Visits</b>				
<b>Periodic Health Evaluations for children</b> (through age 18)	\$35 Copayment; 70% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	50% <sup>5</sup>	\$35 Copayment; 50% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	50% <sup>5</sup>
<b>Periodic Health Evaluations</b> (age 19 and over) <b>Maximum \$400 per Calendar Year</b>				
<b>Laboratory Services</b>	70% <sup>4</sup>	50% <sup>5</sup>	50% <sup>4</sup>	50% <sup>5</sup>
<b>Maternity Care, Tests or Procedures</b>	\$35 Copayment for initial visit, then 70% <sup>4</sup>	50% <sup>5</sup>	\$35 Copayment for initial visit, then 50% <sup>4</sup>	50% <sup>5</sup>
<b>Outpatient Services</b>				
<b>Outpatient Surgery</b>	70% <sup>4</sup>	50% <sup>5</sup> up to \$750 maximum benefit per day <sup>3</sup>	50% <sup>4</sup>	50% <sup>5</sup> up to \$750 maximum benefit per day <sup>3</sup>
<b>Hospitalization Services</b>				
<b>Inpatient Hospice Services</b> (\$5,000 combined maximum for Inpatient and Outpatient benefits while insured)	70% <sup>4</sup>	50% <sup>5</sup> up to \$1,000 maximum benefit per day	50% <sup>4</sup>	50% <sup>5</sup> up to \$1,000 maximum benefit per day
<b>Inpatient Physician Services</b>	70% <sup>4</sup>	50% <sup>5</sup> up to \$1,000 maximum benefit per day	50% <sup>4</sup>	50% <sup>5</sup> up to \$1,000 maximum benefit per day
<b>Inpatient Skilled Nursing Facility Care</b> (Up to 90 days Inpatient per Calendar Year)	70% <sup>4</sup>	Covered Person responsible for all charges over \$200 maximum benefit per day	50% <sup>4</sup>	Covered Person responsible for all charges over \$200 maximum benefit per day
<b>Emergency Health Coverage</b>				
<b>Emergency Room Services</b>	70% <sup>4</sup>		50% <sup>4</sup>	
<b>Urgent Care Services</b>	\$50 Copayment; 70% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	50% <sup>5</sup>	\$50 Copayment; 50% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	50% <sup>5</sup>
<b>Ambulance Services</b>	60% <sup>4</sup>		50% <sup>4</sup>	
<b>Durable Medical Equipment</b>				
<b>Durable Medical Equipment</b> (\$2,000 per Calendar Year)	70% <sup>4</sup>	50% <sup>5</sup>	50% <sup>4</sup>	50% <sup>5</sup>
<b>Mental Health Services</b>				
<b>Severe Mental Illness Services</b> <b>Specified diagnosis only</b>	70% <sup>4</sup>	Not Covered	50% <sup>4</sup>	Not Covered
<b>Mental Illness Services<sup>3</sup></b>				
<b>Inpatient Mental Illness Services<sup>3</sup></b> (\$2,500 per Calendar Year)	70% <sup>4</sup>	50% <sup>5</sup> up to \$200 maximum benefit per day	50% <sup>4</sup>	50% <sup>5</sup> up to \$200 maximum benefit per day
<b>Outpatient Mental Illness Services<sup>3</sup></b> (One visit per day; 20 visits per Calendar Year)	70% <sup>4</sup>	50% <sup>5</sup>	50% <sup>4</sup>	50% <sup>5</sup>
<b>Chemical Dependency Services</b>				
<b>Alcohol, Drug or Other Substance Abuse<sup>3</sup></b> (Detoxification only)	70% <sup>4</sup>	50% <sup>5</sup> up to \$200 maximum benefit per day	50% <sup>4</sup>	50% <sup>5</sup> up to \$200 maximum benefit per day
<b>Inpatient</b> (up to \$2,500 per Calendar Year)				
<b>Outpatient</b> (One visit per day; 20 visits per Calendar Year)	70% <sup>4</sup>	50% <sup>5</sup>	50% <sup>4</sup>	50% <sup>5</sup>
■ <b>Benefit Maximum</b>	One visit per day; 20 visits per Calendar Year		One visit per day; 20 visits per Calendar Year	
<b>Home Health Services</b>				
<b>Home Health Care</b> (100 visits per Calendar Year)	70% <sup>4</sup>	50% <sup>5</sup>	50% <sup>4</sup>	50% <sup>5</sup>
<b>Other Services</b>				
<b>Infertility Services</b> (up to \$2,000 while insured)	70% <sup>4</sup>	50% <sup>5</sup>	50% <sup>4</sup>	50% <sup>5</sup>
<b>Injectable Drugs</b>	70% <sup>4</sup>	50% <sup>5</sup>	50% <sup>4</sup>	50% <sup>5</sup>
<b>Outpatient Prescription Drugs<sup>3</sup></b>	Participating Pharmacy 100% after Copayment of	Non-Participating Pharmacy 80% after Copayment of	Participating Pharmacy 100% after Copayment of	Non-Participating Pharmacy 80% after Copayment of
■ <b>Generic Formulary/Brand-Name Formulary/Non-Formulary</b>	\$10/\$35/\$50		\$10/\$35/\$50	

1 The Covered Person is responsible for any charges in excess of the allowable Covered Expense.

2 Copayments or additional deductibles for Covered Expenses do not apply toward the Calendar Year Deductible.

3 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.

4 Coinsurance level of Coverage Expense after satisfying the Deductible

5 Coinsurance level of Limited Fee Schedule after satisfying the Deductible

PacifiCare SignatureOptions 70-50/2000		PacifiCare SignatureOptions 70-50/3500	
Participating Provider	Non-Participating Provider Limited Fee Schedule <sup>1</sup>	Participating Provider	Non-Participating Provider Limited Fee Schedule <sup>1</sup>
\$2,000/\$4,000		\$3,500/\$7,000	
NA	NA	NA	NA
\$100		\$100	
\$250	\$500	\$250	\$500
\$3,000/\$6,000	\$10,000/\$20,000	\$2,000/\$4,000	\$10,000/\$20,000
\$5,000,000		\$5,000,000	
70% <sup>4</sup>	50% <sup>5</sup>	70% <sup>4</sup>	50% <sup>5</sup>
70% <sup>4</sup>	50% <sup>5</sup>	70% <sup>4</sup>	50% <sup>5</sup>
70% <sup>4</sup>	50% <sup>5</sup>	70% <sup>4</sup>	50% <sup>5</sup>
70% <sup>4</sup>	50% <sup>5</sup> up to \$750 maximum benefit per day <sup>2</sup>	70% <sup>4</sup>	50% <sup>5</sup> up to \$750 maximum benefit per day <sup>2</sup>
70% <sup>4</sup>	50% <sup>4</sup> up to \$1,000 maximum benefit per day	70% <sup>4</sup>	50% <sup>4</sup> up to \$1,000 maximum benefit per day
70% <sup>4</sup>	50% <sup>4</sup> up to \$1,000 maximum benefit per day	70% <sup>4</sup>	50% <sup>4</sup> up to \$1,000 maximum benefit per day
70% <sup>4</sup>	Covered Person responsible for all charges over \$200 maximum benefit per day	70% <sup>4</sup>	Covered Person responsible for all charges over \$200 maximum benefit per day
70% <sup>4</sup>	70% <sup>4</sup>	70% <sup>4</sup>	70% <sup>4</sup>
70% <sup>4</sup>	50% <sup>5</sup>	70% <sup>4</sup>	50% <sup>5</sup>
60% <sup>4</sup>		60% <sup>4</sup>	
70% <sup>4</sup>	50% <sup>5</sup>	70% <sup>4</sup>	50% <sup>5</sup>
70% <sup>4</sup>	Not Covered	70% <sup>4</sup>	Not Covered
70% <sup>4</sup>	50% <sup>5</sup> up to \$200 maximum benefit per day	70% <sup>4</sup>	50% <sup>5</sup> up to \$200 maximum benefit per day
70% <sup>4</sup>	50% <sup>5</sup>	70% <sup>4</sup>	50% <sup>5</sup>
70% <sup>4</sup>	50% <sup>5</sup> up to \$200 maximum benefit per day	70% <sup>4</sup>	50% <sup>5</sup> up to \$200 maximum benefit per day
70% <sup>4</sup>	50% <sup>5</sup>	70% <sup>4</sup>	50% <sup>5</sup>
One visit per day; 20 visits per Calendar Year		One visit per day; 20 visits per Calendar Year	
70% <sup>4</sup>	50% <sup>5</sup>	70% <sup>4</sup>	50% <sup>5</sup>
70% <sup>4</sup>	50% <sup>5</sup>	70% <sup>4</sup>	50% <sup>5</sup>
70% <sup>4</sup>	50% <sup>5</sup>	70% <sup>4</sup>	50% <sup>5</sup>
Participating Pharmacy 100% after Copayment of	Non-Participating Pharmacy 80% after Copayment of	Participating Pharmacy 100% after Copayment of	Non-Participating Pharmacy 80% after Copayment of
\$10/\$35/\$50 \$250 Combined Deductible for Formulary and Non-Formulary Drugs		\$10/\$35/\$50 \$250 Combined Deductible for Formulary and Non-Formulary Drugs	





## PacifiCare SignatureOptions<sup>SM</sup> (HSA-Compatible)

Our high-deductible Health Savings Account (HSA)-Compatible PPO plans offer coverage for outpatient services, doctor visits, hospitalization and more, once the deductible is met. These plans offer enrollees the opportunity to take advantage of income tax benefits associated with an HSA, which allows individuals the option to pay for qualified medical and health expenses using tax-free dollars.\*

\*This High Deductible Health Plan is designed to allow eligible Covered persons to take advantage of the income tax benefits associated with the Health Savings Account (HSA); this plan is not an HSA, and does not establish an HSA. To establish an HSA, an individual must be eligible under IRS regulations and must open an HSA that meets IRS requirements at a qualifying bank or financial institution. For additional information regarding an HSA, please contact a tax advisor or qualified financial institution.

# PacifiCare SignatureOptions (HSA-Compatible)

PacifiCare SignatureOptions 80-50/2700 (HSA Compatible)		
	Participating Provider	Non-Participating Provider
<b>Covered Expense</b>	Limited Fee Schedule <sup>1</sup>	
<b>Calendar Year Deductible<sup>2</sup></b>		
■ Individual/Family	\$2,700/\$5,400	\$5,000/\$10,000
■ Emergency room services (waived if admitted)		\$100
■ Failure to obtain Preauthorization of services (waived with Preauthorization of services)	\$250	\$500
<b>Out-of-Pocket Maximum</b>		
■ Individual/Family	\$5000/\$10,000	\$15,000/\$30,000
<b>Coinsurance Maximum</b>		
■ Individual/Family	NA	NA
<b>Policy Maximum</b>	\$5,000,000	
<b>Professional Services</b>		
<b>Physician Office Visits</b>	80% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
<b>Periodic Health Evaluations for children</b> (through age 18)	80% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
<b>Periodic Health Evaluations</b> (age 19 and over)	80% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
■ Benefit Maximum	\$400 per Calendar Year	
<b>Laboratory and Radiology Services</b>	80% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
<b>Maternity Care</b>	80% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
<b>Outpatient Services</b>		
<b>Outpatient Surgery</b>	80% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible up to \$750 maximum benefit per day
<b>Hospitalization Services</b>		
<b>Inpatient Hospital Services</b>	80% of Covered Expense after Deductible	50% of Covered Expense after Deductible up to \$1,000 maximum benefit per day
<b>Inpatient Physician Services</b>	80% of Covered Expense after Deductible	50% of Covered Expense after Deductible up to \$1,000 maximum benefit per day
<b>Inpatient Skilled Nursing Facility Care</b>	80% of Covered Expense after Deductible	Covered Person responsible for all charges over \$200 maximum benefit per day
■ Benefit Maximum	Up to 90 days Inpatient per Calendar Year	
<b>Emergency Health Coverage</b>		
<b>Emergency Room Services</b>	80% of Covered Expense after Deductible	
<b>Urgent Care Services</b>	80% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
<b>Ambulance Services</b>	70% of Covered Expense after Deductible	
<b>Durable Medical Equipment</b>		
<b>Durable Medical Equipment</b> (up to \$2,000 per Calendar Year)	80% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
<b>Mental Health Services</b>		
<b>Severe Mental Illness Services</b> (Specified diagnosis only)	80% of Covered Expense after Deductible	Not Covered
<b>Inpatient Mental Illness Services</b> (\$2,500 per Calendar Year)	80% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible up to \$200 maximum benefit per day
<b>Outpatient Mental Illness Services</b> (One visit per day; 20 visits per Calendar Year)	80% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
<b>Chemical Dependency Services</b>		
<b>Alcohol, Drug or Other Substance Abuse</b> (Detoxification only)		
<b>Inpatient</b> (up to \$2,500 per Plan Year)	80% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
<b>Outpatient</b> (up to one visit per day; 20 visits per Calendar Year)	80% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
<b>Home Health Services</b>		
<b>Home Health Care: Home Visits By A Licensed Professional</b> (up to 100 visits per Plan Year)	80% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
<b>Other Services</b>		
<b>Infertility Services</b> (Up to \$2,000 while insured)	80% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
<b>Injectable Drugs</b>	80% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
<b>Outpatient Prescription Drugs</b>		
<b>Generic Formulary/Brand-Name Formulary/Non-Formulary</b>	80% after Deductible	50% after Deductible
<b>Mail Order</b>	90% after Deductible	

<sup>1</sup> The Covered Person is responsible for any charges in excess of the allowable Covered Expense.

<sup>2</sup> Copayments or additional deductibles for Covered Expenses do not apply toward the Calendar Year Deductible.

PacifiCare SignatureOptions 70-50/3500 (HSA Compatible)		PacifiCare SignatureOptions 100-50/5000 (HSA Compatible)	
Participating Provider	Non-Participating Provider	Participating Provider	Non-Participating Provider
Limited Fee Schedule <sup>1</sup>		Limited Fee Schedule <sup>1</sup>	
\$3,500/\$7,000	\$7,000/\$14,000	\$5,000/\$10,000	\$10,000/\$20,000
\$100		\$100	
\$250	\$500	\$250	\$500
\$5000/\$10,000	\$15,000/\$30,000	\$5000/\$10,000	\$20,000/\$40,000
NA	NA	NA	NA
\$5,000,000		\$5,000,000	
70% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible	100% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
70% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible	100% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
70% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible	100% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
\$400 per Calendar Year		\$400 per Calendar Year	
70% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible	100% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
70% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible	100% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
70% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible up to \$750 maximum benefit per day	100% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible up to \$750 maximum benefit per day
70% of Covered Expense after Deductible	50% of Covered Expense after Deductible up to \$1,000 maximum benefit per day	100% of Covered Expense after Deductible	50% of Covered Expense after Deductible up to \$1,000 maximum benefit per day
70% of Covered Expense after Deductible	50% of Covered Expense after Deductible up to \$1,000 maximum benefit per day	100% of Covered Expense after Deductible	50% of Covered Expense after Deductible up to \$1,000 maximum benefit per day
70% of Covered Expense after Deductible	Covered Person responsible for all charges over \$200 maximum benefit per day	100% of Covered Expense after Deductible	Covered Person responsible for all charges over \$200 maximum benefit per day
Up to 90 days Inpatient per Calendar Year		Up to 90 days Inpatient per Calendar Year	
70% of Covered Expense after Deductible		100% of Covered Expense after Deductible	
70% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible	100% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
60% of Covered Expense after Deductible		80% of Covered Expense after Deductible	
70% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible	100% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
70% of Covered Expense after Deductible	Not Covered	100% of Covered Expense after Deductible	Not Covered
70% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible up to \$200 maximum benefit per day	100% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible up to \$200 maximum benefit per day
70% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible	100% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
70% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible	100% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
70% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible	100% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
70% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible	100% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
70% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible	100% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
70% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible	100% of Covered Expense after Deductible	50% of Limited Fee Schedule after Deductible
70% after Deductible	50% after Deductible	100% after Deductible	50% after Deductible
90% after Deductible		100% after Deductible	





## PacifiCare SignatureFreedom<sup>SM</sup> (SDHP)

Introducing a health plan that doesn't tell members what to do or place restrictions on their independence. It's called PacifiCare SignatureFreedom, a self-directed health plan (SDHP) that allows enrollees to visit any licensed or certified provider. Enrollees get a Self Directed Account (SDA), an "allowance" of \$1,000 for first-dollar coverage on certain types of services including routine office visits and preventive services.\*

Another benefit is that any unused Self Directed Account (SDA) balance is "rolled over" to the next year – year after year.

But in the reverse case – once the SDA is depleted, enrollees satisfy the rest of their annual deductible, and traditional PPO benefits begin.

A self-directed health plan is an excellent choice for cost-conscious consumers who want to know they'll be covered in case of a catastrophic illness but don't want high premiums or to feel like they're paying for a service they just won't use.

Plus, by giving enrollees more control with respect to their health care spending, this type of plan has been proven to drive down health expenses for their employers as well.

\*Please refer to the *Certificate of Coverage* for a list of the covered services.

# PacifiCare SignatureFreedom (SDHP)

PacifiCare SignatureFreedom 80-50/2000 or PacifiCare SignatureFreedom 80-50/2000 with Dental		
Self Directed Account (SDA) <sup>1</sup>	Participating Provider	Non-Participating Provider
<b>Applies toward Plan Year Deductible</b> Individual/Family		\$1,000/\$2,000
<b>Additional SDA Payable toward Medical and/or Dental</b> <sup>2</sup> Individual/Family (This option only available for SignatureFreedom with Dental plans)		\$200/\$400
Deductibles and Policy Maximums	Participating Provider	Non-Participating Provider Limited Fee Schedule <sup>3</sup>
<b>Plan Year Deductible</b> <sup>4</sup> Individual/Family		\$2,000/\$4,000
<b>Additional Deductibles</b> (per occurrence) Services are subject to applicable Calendar Year Deductible, coinsurance, and any benefit maximums		
■ Emergency room services (waived if admitted)		\$100
■ Failure to obtain Preauthorization of services (waived with Preauthorization of services)	\$250	\$500
<b>Coinsurance Maximum</b> Individual/Family	\$3,000/\$6,000	\$6,000/\$12,000
<b>Policy Maximum</b>		\$5,000,000
Professional Services		
Physician Office Visits		
<b>Periodic Health Evaluations for children</b> (through age 18)	100% to SDA maximum, then 80% after Deductible	100% to SDA maximum, then 50% after Deductible
<b>Periodic Health Evaluations</b> (age 19 and over)		
<b>Laboratory and Radiology Services</b>	80% after Deductible	50% after Deductible
<b>Maternity Care</b>	80% after Deductible	50% after Deductible
Outpatient Services		
<b>Outpatient Surgery</b>	80% after Deductible	50% after Deductible up to \$750 maximum benefit per day <sup>5</sup>
Hospitalization Services		
<b>Inpatient Hospital Services</b>	80% after Deductible	50% after Deductible up to \$1,000 maximum benefit per day
<b>Inpatient Physician Services</b>	80% after Deductible	50% after Deductible
<b>Inpatient Skilled Nursing Facility</b> (up to 90 days as an Inpatient per Plan Year)	80% after Deductible	Covered Person responsible for all charges over \$200 maximum benefit per day
Emergency Health Coverage		
<b>Emergency Room Services</b>	80% after Deductible	
<b>Urgent Care Services</b>	80% after Deductible	50% after Deductible
<b>Ambulance Services</b>	70% after Deductible	
<b>Deductible per Plan Year</b>	None	
Durable Medical Equipment		
<b>Durable Medical Equipment</b> (up to \$2,000 per Plan Year)	80% after Deductible	50% after Deductible
Mental Health Services		
<b>Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED)</b> Specified diagnosis only	80% after Deductible	Not Covered
<b>Mental Illness Services</b> <sup>5</sup>		
■ Inpatient (up to \$2,500 per Plan Year)	80% after Deductible	50% after Deductible up to \$200 maximum benefit per day
■ Outpatient (up to one visit per day; 20 visits per Plan Year)	80% after Deductible	50% after Deductible
Chemical Dependency Services		
<b>Alcohol, Drug or Other Substance Abuse</b> <sup>5</sup> (Detoxification only)		
■ Inpatient (up to \$2,500 per Plan Year)	80% after Deductible	50% after Deductible up to \$200 maximum benefit per day
■ Outpatient (up to one visit per day; 20 visits per Plan Year)	80% after Deductible	50% after Deductible
Home Health Services		
<b>Home Health Care: Home Visits By A Licensed Professional</b> (up to 100 visits per Plan Year)	80% after Deductible	50% after Deductible
Other Services		
<b>Infertility Services</b> (up to \$2,000 while insured)	80% after Deductible	50% after Deductible
<b>Injectable Drugs</b>	80% after Deductible	50% after Deductible
Outpatient Prescription Drugs <sup>5</sup>		
	Participating Pharmacy 100% after Copayment of	Non-Participating Pharmacy 80% after Copayment of
<b>Generic Formulary/Brand-Name Formulary/Non-Formulary</b>		\$10/\$25/\$50

<sup>1</sup> Services covered under the Policy may not be eligible for reimbursement under the Self-Directed Account. Refer to the SignatureFreedom Certificate and Schedule of Benefits for coverage details.

<sup>2</sup> Covered Expenses under the Additional SDA payable toward covered diagnostic and preventive dental services do not apply toward the Plan Year Deductible.

<sup>3</sup> The Covered Person is responsible for any charges in excess of the allowable Covered Expense.

<sup>4</sup> Copayments or additional deductibles for Covered Expenses do not apply toward the Plan Year Deductible.

<sup>5</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.

PacifiCare SignatureFreedom 70-50/2000 or PacifiCare SignatureFreedom 70-50/2000 with Dental		PacifiCare SignatureFreedom 50-50/3000 or PacifiCare SignatureFreedom 50-50/3000 with Dental	
Participating Provider	Non-Participating Provider	Participating Provider	Non-Participating Provider
	\$1,000 /\$2,000		\$1,000 /\$2,000
	\$200/\$400		\$200/\$400
Participating Provider	Non-Participating Provider	Participating Provider	Non-Participating Provider
Limited Fee Schedule <sup>3</sup>		Limited Fee Schedule <sup>3</sup>	
	\$2,000/\$4,000		\$3,000/\$6,000
	\$100		\$100
\$250	\$500	\$250	\$500
\$5,000/\$10,000	\$10,000/\$20,000	\$5,000/\$10,000	\$10,000/\$20,000
	\$5,000,000		\$5,000,000
100% to SDA maximum, then 70% after Deductible	100% to SDA maximum, then 50% after Deductible	100% to SDA maximum, then 50% after Deductible	100% to SDA maximum, then 50% after Deductible
70% after Deductible	50% after Deductible	50% after Deductible	50% after Deductible
70% after Deductible	50% after Deductible	50% after Deductible	50% after Deductible
70% after Deductible	50% after Deductible up to \$750 maximum benefit per day <sup>5</sup>	50% after Deductible	50% after Deductible up to \$750 maximum benefit per day <sup>5</sup>
70% after Deductible	50% after Deductible up to \$1,000 maximum benefit per day	50% after Deductible	50% after Deductible up to \$1,000 maximum benefit per day
70% after Deductible	50% after Deductible	50% after Deductible	50% after Deductible
70% after Deductible	Covered Person responsible for all charges over \$200 maximum benefit per day	50% after Deductible	Covered Person responsible for all charges over \$200 maximum benefit per day
70% after Deductible	50% after Deductible	50% after Deductible	50% after Deductible
70% after Deductible	50% after Deductible	50% after Deductible	50% after Deductible
60% after Deductible	50% after Deductible	50% after Deductible	50% after Deductible
None	50% after Deductible	50% after Deductible	50% after Deductible
70% after Deductible	50% after Deductible	50% after Deductible	50% after Deductible
70% after Deductible	Not Covered	50% after Deductible	Not Covered
70% after Deductible	50% after Deductible up to \$200 maximum benefit per day	50% after Deductible	50% after Deductible up to \$200 maximum benefit per day
70% after Deductible	50% after Deductible	50% after Deductible	50% after Deductible
70% after Deductible	50% after Deductible up to \$200 maximum benefit per day	50% after Deductible	50% after Deductible up to \$200 maximum benefit per day
70% after Deductible	50% after Deductible	50% after Deductible	50% after Deductible
70% after Deductible	50% after Deductible	50% after Deductible	50% after Deductible
70% after Deductible	50% after Deductible	50% after Deductible	50% after Deductible
70% after Deductible	50% after Deductible	50% after Deductible	50% after Deductible
Participating Pharmacy 100% after Copayment of	Non-Participating Pharmacy 80% after Copayment of	Participating Pharmacy 100% after Copayment of	Non-Participating Pharmacy 80% after Copayment of
	\$10/\$35/\$50		\$10/\$35/\$50



## PacifiCare SignatureIndependence<sup>SM</sup>

The PacifiCare SignatureIndependence is an indemnity plan that offers members unlimited provider choice: they have the freedom to see any licensed health care provider in the United States.

Through these plans, all benefits are based on a fee schedule. This type of insurance carries higher out-of-pocket expenses and premium rates; deductibles still apply.

# PacifiCare SignatureIndependence (Indemnity)

PacifiCare SignatureIndependence 80/1000		
Usual & Customary <sup>1</sup>		
<b>Calendar Year Deductible<sup>2</sup></b> <b>Individual/Family</b>	\$250/\$500	
<b>Additional Deductibles</b> (per occurrence) <b>Services are subject to applicable Calendar Year Deductible, coinsurance, and any benefit maximums</b>		
■ Inpatient services	\$500	
■ Emergency room services Waived if admitted	\$100	
■ Failure to obtain Preauthorization of services – Waived with Preauthorization of services	\$500	
<b>Coinsurance Maximum Individual/Family</b>	\$5,000/\$10,000	
<b>Policy Maximum</b>	\$5,000,000	
<b>Professional Services</b>		
<b>Physician Office Visits</b>		
<b>Periodic Health Evaluations for children</b> (through age 18)		
<b>Periodic Health Evaluations</b> (age 19 and over) <b>Maximum \$400 per Calendar Year</b>	80% <sup>4</sup>	
<b>Laboratory Services</b>	80% <sup>4</sup>	
<b>Maternity Care, Tests or Procedures</b>	80% <sup>4</sup>	
<b>Outpatient Services</b>		
<b>Outpatient Surgery</b>	80% <sup>4</sup> up to \$750 maximum benefit per day	80% <sup>4</sup> up to \$750 maximum benefit per day
<b>Hospitalization Services</b>		
<b>Inpatient Hospice Services</b> (\$5,000 combined maximum for Inpatient and Outpatient benefits while insured)	80% <sup>4</sup>	
<b>Inpatient Physician Services</b>	80% <sup>4</sup>	
<b>Inpatient Skilled Nursing Facility Care</b> (Up to 90 days Inpatient per Calendar Year)	80% <sup>4</sup>	
<b>Emergency Health Coverage</b>		
<b>Emergency Room Services</b>	80% <sup>4</sup>	
<b>Urgent Care Services</b>	80% <sup>4</sup>	
<b>Ambulance Services</b>	80% <sup>4</sup>	
<b>Durable Medical Equipment</b>		
<b>Durable Medical Equipment</b> (\$2,000 per Calendar Year)	80% <sup>4</sup>	
<b>Mental Health Services</b>		
<b>Severe Mental Illness Services</b> <b>Specified diagnosis only</b>	80% <sup>4</sup>	
<b>Mental Illness Services<sup>5</sup></b>		
<b>Inpatient Mental Illness Services<sup>5</sup></b> (\$2,500 per Calendar Year)	80% <sup>4</sup>	
<b>Outpatient Mental Illness Services<sup>5</sup></b> (one visit per day; 20 visits per Calendar Year)	80% <sup>4</sup>	
<b>Chemical Dependency Services</b>		
<b>Alcohol, Drug or Other Substance Abuse<sup>3</sup></b> (Detoxification only)	80% <sup>4</sup>	
<b>Inpatient</b> (up to \$2,500 per Calendar Year)		
<b>Outpatient</b> (one visit per day; 20 visits per Calendar Year)	80% <sup>4</sup>	
■ <b>Benefit Maximum</b>	One visit per day; 20 visits per Calendar Year	
<b>Home Health Services</b>		
<b>Home Health Care</b> (100 visits per Calendar Year)	80% <sup>4</sup>	
<b>Other Services</b>		
<b>Infertility Services</b> (up to \$2,000 while insured)	80% <sup>4</sup>	
<b>Injectable Drugs</b>	80% <sup>4</sup>	
<b>Outpatient Prescription Drugs<sup>3</sup></b>	Participating Pharmacy 100% after Copayment of	Non-Participating Pharmacy 80% after Copayment of
■ <b>Generic Formulary/Brand-Name Formulary/Non-Formulary</b>	\$10/\$35/\$50	

1 The Covered Person is responsible for any charges in excess of the allowable Covered Expense.

2 Copayments or additional deductibles for Covered Expenses do not apply toward the Calendar Year Deductible.

3 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.

4 Coinsurance level of Coverage Expense after satisfying the Deductible

5 Coinsurance level of Limited Fee Schedule after satisfying the Deductible

