

SIGNATUREPOS 15/80-60
POS PLAN MATRIX

Effective July 1, 2006

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. This Health Plan Benefits and Coverage Matrix is being provided pursuant to Section 1363(b)(1) of the Health and Safety Code, and supersedes any other matrix describing benefits of these plans.

**PacifiCare SignaturePOS (POS)
Principal Benefits**

	IN-NETWORK	OUT-OF-NETWORK Preferred Providers ¹	OUT-OF-NETWORK Non-Preferred ²
Calendar Year Deductible	None	\$300/3 Max per Family	
Lifetime Maximum Benefit	Unlimited	\$2,000,000	
Annual Copayment Maximum ³	\$2,500/3 Max per Family	\$4,000/3 Max per Family	

Professional Services

	IN-NETWORK	OUT-OF-NETWORK Preferred Providers ¹	OUT-OF-NETWORK Non-Preferred ²
Office Visits	\$15 Copayment	\$35 Copayment ⁴	40% Copayment
Periodic Health Evaluations			
Age 2 through 17	\$15 Copayment	\$35 Copayment ⁴	40% Copayment
Age 18 and older	\$15 Copayment	Not Covered	Not Covered
Vision and Hearing Screening	\$15 Copayment	Not Covered	
Laboratory and Radiology (<i>Standard</i>)	Paid in Full	\$35 Copayment ⁴	40% Copayment
Maternity Care	Paid in Full	\$35 Copayment ⁴	40% Copayment
Well-Baby Care (<i>up to age 2</i>)	\$15 Copayment	\$35 Copayment ⁴	40% Copayment
Well-Woman Care	\$15 Copayment	\$35 Copayment ⁴	40% Copayment

Outpatient Services

	IN-NETWORK	OUT-OF-NETWORK Preferred Providers ¹	OUT-OF-NETWORK Non-Preferred ²
Outpatient Surgery	\$250 per Admission	20% Copayment	40% Copayment

Hospitalization Services

	IN-NETWORK	OUT-OF-NETWORK Preferred Providers ¹	OUT-OF-NETWORK Non-Preferred ²
Inpatient Hospital Benefits	\$250 per Admission	20% Copayment ⁵	40% Copayment ⁵
Inpatient Physician Care	Paid in Full	20% Copayment ⁵	40% Copayment ⁵
Skilled Nursing Facility Care (<i>Up to 100 consecutive calendar days from first treatment per disability for In-Network Services; Up to 60 consecutive calendar days for Out-of-Network Services</i>)	\$100 per Day	20% Copayment ⁵	40% Copayment ⁵

Other Services

	IN-NETWORK	OUT-OF-NETWORK Preferred Providers ¹	OUT-OF-NETWORK Non-Preferred ²
Emergency Health Coverage			
Emergency Services (Copayment waived if admitted)	\$50 Copayment	Covered as an in-network benefit	
Urgently Needed Services (Copayment waived if admitted)	\$50 Copayment	Covered as an in-network benefit	

Other Services (continued)	IN-NETWORK	OUT-OF-NETWORK Preferred Providers¹	OUT-OF-NETWORK Non-Preferred²
Ambulance Services	Paid in Full	30% Copayment	30% Copayment
Outpatient Prescription Drug Coverage⁶ Generic Formulary Brand-Name Formulary Non-Formulary	\$10 Copayment \$25 Copayment \$50 Copayment	Covered as an in-network benefit	
Durable Medical Equipment Durable Medical Equipment <i>(\$2,000 maximum benefit per Calendar Year for Out-of-Network. 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.)</i>	\$50 Copayment	20% Copayment	40% Copayment
Mental Health Services Severe Mental Illness (SMI) and Serious Emotional Disturbance of Children (SED) only ⁷ Inpatient Outpatient Crisis Intervention <i>(Up to 20 Visits; maximum benefit \$50 per visit for Out-of-Network)</i>	\$250 per Admission \$15 Copayment \$35 Copayment	20% Copayment	Not Covered Not Covered 40% Copayment
Chemical Dependency Services Alcohol, Drug, or Other Substance Abuse <i>(Detoxification only)</i> Inpatient Outpatient	\$250 per Admission \$15 Copayment	20% Copayment ⁵ \$35 Copayment ⁴	40% Copayment ⁵ 40% Copayment
Home Health Services Home Health Care – Home Visits by a Licensed Professional <i>(Up to 100 visits per calendar year for In-Network services; Up to 100 visits per Calendar year for Out-of-Network services)</i>	\$15 Copayment per Visit	\$35 Copayment ^{4,5}	40% Copayment ⁵
Infertility Services	50% of Cost Copayment ¹	Not Covered	

¹ Percentage Copayment amounts are based on PacifiCare's negotiated rate. Excludes Ambulance Services.

² Percentage Copayment amounts are based on PacifiCare's Limited Fee Schedule (excludes Ambulance Services). Covered expenses subject to the Limited Fee Schedule. Non-Preferred Providers may charge more than the Limited Fee Schedule amount.

³ Copayment for Durable Medical Equipment (except for nebulizers, peak flow meters, face masks and tubing for the Medically Necessary treatment of pediatric asthma and diabetic supplies), Pharmacy and supplemental benefits are not included in the cumulative Annual Copayment Maximum.

⁴ The Deductible amount is waived.

⁵ Services require preauthorization by PacifiCare.

⁶ Copayment applies per Prescription unit or up to 30 days. Covered when obtained through a PacifiCare Participating Pharmacy. Discount mail order available. Refer to your Supplement to the *Combined Evidence of Coverage and Disclosure Form* and *Pharmacy Schedule of Benefits* for Outpatient Prescription Drug Benefits for coverage details.

⁷ Refer to your Supplement to the *Combined Evidence of Coverage and Disclosure Form* for Severe Mental Illness (SMI) and Serious Emotional Disturbance of Children (SED) for coverage details.

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