

**CALIFORNIA'S VALUED TRUST
PACIFICARE HEALTH PLANS
2009 / 2010**

BENEFIT	PacifiCare 1	PacifiCare 2	PacifiCare 3	PacifiCare 4	PacifiCare 5	PacifiCare 6
MAJOR MEDICAL*	No Deductible Copay Out-of-Pocket Max: \$800 individual / \$2400 family	No Deductible Copay Out-of-Pocket Max: \$1,000 individual / \$3,000 family			No Deductible Copay Out-of-Pocket Max: \$3,000 individual / \$9,000 family	No Deductible Copay Out-of-Pocket Max: \$4,500 individual / \$9,000 family (2 in Family)
DOCTOR VISITS	Covered, No Charge	\$5 Copay, Then 100%	\$10 Copay, Then 100%	\$20 Copay, Then 100%	\$15 Copay, Then 100%	\$20 Copay, Then 100%
ANNUAL PHYSICAL	Covered, No Charge	\$5 Copay, Then 100%	\$10 Copay, Then 100%	\$20 Copay, Then 100%	\$15 Copay – PCP \$30 Copay - Specialist	\$20 Copay – PCP \$40 Copay - Specialist
IMMUNIZATIONS	Covered, No Charge	\$5 Copay, Then 100%	\$10 Copay, Then 100%	\$20 Copay, Then 100%	Covered, No Charge – Under 2 \$15 Copay – PCP \$30 Copay – Specialist	Covered, No Charge – Under 2 \$20 Copay – PCP \$40 Copay – Specialist
PREVENTIVE CARE FOR CHILDREN	Covered, No Charge	Covered, No Charge – Under 2 \$5 Copay Over 2	Covered, No Charge – Under 2 \$10 Copay Over 2	Covered, No Charge – Under 2 \$20 Copay Over 2	Covered, No Charge – Under 2 \$15 Copay Over 2	Covered, No Charge – Under 2 \$20 Copay Over 2
WELL WOMAN: PAP SMEAR/ MAMMOGRAM	Covered, No Charge	\$5 Copay, Then 100%	\$10 Copay, Then 100%	\$20 Copay, Then 100%	\$15 Copay, Then 100%	\$20 Copay, Then 100%
OUTPATIENT X-RAY & LAB	Covered, No Charge				Lab - Covered, No Charge Std. X-Ray - Covered, No Charge Specialized - \$200	
PHYSICAL THERAPY	Covered, No Charge	\$5 Copay, Then 100%	\$10 Copay, Then 100%	\$20 Copay, Then 100%	\$30 Copay, Then 100%	\$40 Copay, Then 100%
CHIROPRACTIC	Not Covered					
ACUPUNCTURE	Not Covered					
HOSPITAL INPATIENT	Covered, No Charge				\$400 Copay	\$250 / Daily

<i>Page Two</i>	PacifiCare 1	PacifiCare 2	PacifiCare 3	PacifiCare 4	PacifiCare 5	PacifiCare 6
HOSPITAL OUTPATIENT	Covered, No Charge / \$35 Copay ER	Covered, No Charge / \$50 Copay ER			\$200 Copay Outpatient \$100 Copay ER	\$125 Copay Outpatient \$100 Copay ER
RADIATION THERAPY, CHEMOTHERAPY & SURGERY	Covered, No Charge					
HOME HEALTH CARE	Covered, No Charge				Covered, No Charge 100 Visits Per Year	
HOSPICE	Covered, No Charge (prognosis of life expectancy of one year or less)					
DURABLE MEDICAL EQUIPMENT	Covered, No Charge				Covered, No Charge \$5,000 Annual Max	
AMBULANCE- GROUND/AIR	No charge, if medically necessary					
MENTAL HEALTH INPATIENT	30 days per calendar year; substance abuse limited to hospital detox plus residential treatment (limits)					\$250/Daily 30 visits per calendar year
MENTAL HEALTH- PROFESSIONAL CHARGES (INPATIENT & OUTPATIENT)	30 visits per calendar year	\$5 Copay 30 visits per calendar year	\$10 Copay 30 visits per calendar year	\$20 Copay 30 visits per calendar year	\$30 Copay 30 visits per calendar year	\$40 Copay 30 visits per calendar year
LIFETIME MAX PER PERSON	N/A					

THIS SUMMARY IS FOR COMPARISON PURPOSES ONLY. PLEASE REFER TO THE ACTUAL SUMMARY PLAN DESCRIPTION FOR COMPLETE BENEFITS.