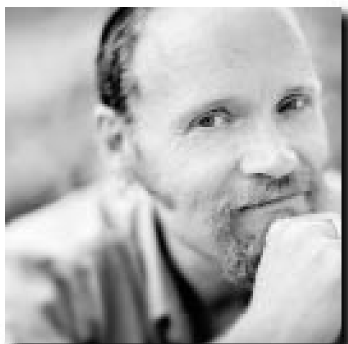
PacifiCare
SignatureOptions℠
A choice of physicians and price



NEVADA

2004 Individual Plan
PPO Benefits At-A-Glance

Nevada PPO I Plan

Nevada PPO I Plan	Plan 1	Plan 2	**Plan 3**
Outpatient Provider Services			
Physician's Office Visit [2]	100% after $30 Copayment, up to 4 visits per Calendar Year maximum/50% after Deductible	100% after $20 Copayment/50% after Deductible	100% after $30 Copayment, up to 4 visits per Calendar Year maximum/50% after Deductible
Wellness and Preventive Services			
Breast and Pelvic Exams [2]	80%/50% after Deductible	80%/50% after Deductible	100% after $30 Copayment/50% after Deductible
Mammogram Screening [2]			70%/50% after Deductible
Osteoporosis Screening [2]			Not covered
Prostate Cancer Screening [2]			
Children With Immunizations [2]			
Periodic Health Evaluations *(age 19 and over)*	$300 per Calendar Year maximum	$300 per Calendar Year maximum	
Physician Services			
Laboratory Services	80%/50% after Deductible	80%/50% after Deductible	70%/50% after Deductible
X-Ray Services			
Diagnostic Testing			
Hospital Services			
Inpatient Care	80%/50% after Deductible *($500 per day maximum at Non-Participating Providers)*	80%/50% after Deductible *($500 per day maximum at Non-Participating Providers)*	70%/50% after Deductible *($500 per day maximum at Non-Participating Providers)*
Outpatient Surgery			
Emergency Services			
Ambulance *(Medically Necessary transport)*	60% after Deductible	60% after Deductible	60% after Deductible
Emergency room services *(waived if admitted)*	$100 additional Deductible	$100 additional Deductible	$100 additional Deductible
Urgent Care	80%/50% after Deductible	80%/50% after Deductible	70%/50% after Deductible
Behavioral Health - Inpatient			
Chemical Dependency Inpatient [1] *($9,000 per Calendar Year maximum)*	80%/50% after Deductible *($500 per day maximum at Non-Participating Providers)*	80%/50% after Deductible *($200 per day maximum at Non-Participating Providers)*	70%/50% after Deductible *($500 per day maximum at Non-Participating Providers)*
Chemical Dependency Inpatient Detoxification [1] *($1,500 per Calendar Year maximum)*			
Severe Mental Illness Inpatient *(up to 40 days per Calendar Year maximum)*		80%/50% after Deductible *($500 per day maximum at Non-Participating Providers)*	
Mental Illness *(other than Severe Mental Illness)*	Not covered	Not covered	Not covered
Behavioral Health - Outpatient			
Chemical Dependency Outpatient [1] *($2,500 per Calendar Year maximum)*	80%/50% after Deductible	80%/50% after Deductible	70%/50% after Deductible
Severe Mental Illness Outpatient *(up to 40 visits per Calendar Year maximum)*			
Mental Illness *(other than Severe Mental Illness)*	Not covered	Not covered	Not covered

Nevada PPO I Plan	Plan 1	Plan 2	Plan 3
Other Services			
Maternity Care: Prenatal, Postnatal and Childbirth Expenses	Not covered	Not covered	Not covered
Neuromuscular Skeletal Disorders			
Rehabilitation Services *(physical, speech and occupational therapy) ($1,000 per Calendar Year maximum)*	80%/50% after Deductible	80%/50% after Deductible	70%/50% after Deductible
Durable Medical Equipment *($2000 per Calendar Year maximum)*			
Prosthetic Devices *($2000 per Calendar Year maximum)*			
Hospice Care or Outpatient Hospice *($10,000 per Calendar Year maximum)*			
Home Health Care *(100 visits per Calendar Year maximum)*			
Skilled Nursing Facilities *(90 days per Calendar Year maximum)*	80% after Deductible/$200 per day maximum	80% after Deductible/$200 per day maximum	70% after Deductible/$200 per day maximum
Prescription Drug Coverage			
Generic *(retail)*	$10	$10	$20
Brand *(retail)*	$35; $100 Deductible, $1,000 Calendar Year maximum	$30	$35; $100 Deductible, $1,000 Calendar Year maximum
Non-Formulary *(retail)*	N/A	$50	N/A
Mail Order Service	2 retail Copayments for a 90-day supply	2 retail Copayments for a 90-day supply	2 retail Copayments for a 90-day supply
Calendar Year Deductible			
Individual	$1,500	$500	$2,000
Family	$3,000	$1,500	$4,000
Copayment/Coinsurance Maximum per year			
Individual	$4,000/$8,000	$2,000/$4,000	$4,000/$8,000
Family	$8,000/$16,000	$4,000/$8,000	$8,000/$16,000
Policy Maximum while insured			
	$2,000,000	$2,000,000	$2,000,000

1. Coinsurance for this 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. Copayment-based services do not apply to services for Neuromuscular Skeletal Disorders, rehabilitation services, mental illness, Chemical Dependency services, or surgery performed in the Physician's office.

Exclusions and Limitations

- Cosmetic or reconstructive procedure, unless it is specifically included in the "Cosmetic and Reconstructive Surgery" provision in Section 9, "Comprehensive Major Medical Coverage," in your *Certificate of Coverage*.
- Eye examinations, routine eye refractions, frames and lenses for eyeglasses and contact lenses unless it is specifically included in the "Cosmetic and Reconstructive Surgery" provision in Section 9, "Comprehensive Major Medical Coverage," in your *Certificate of Coverage*.
- Obesity treatment or weight reduction, even if the Covered Person has other health conditions which might be helped by a reduction of obesity or weight.
- Visual therapy, including eye exercises, orthoptics, radial keratotomy (LASIK), keratimileusis and keratophakai.
- Diagnosis or treatment of infertility.
- Treatment for hearing disorders, including hearing aids and cochlear implants.

Please refer to your *Certificate of Coverage* for a complete list of exclusions and limitations.

PPO products are underwritten by PacifiCare Life Assurance Company

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PNV223483-000