Benefit Details

Proposed Effective Date: 8/1/2005

HMO $30/$40

HMO	IN-NETWORK BENEFITS	NON-NETWORK BENEFITS
Annual Deductible	*None*	*Not Applicable*
Maximum Annual Copay Limit	*Individual: $3,000 Family: $6,000*	*Not Applicable*
Maximum Lifetime Benefit	*Unlimited*	*Not Applicable*
PHYSICIAN SERVICES		
Office Visits	*$30; $40 Specialist*	*Not Applicable*
Lab and X-Rays	*$40*	*Not Applicable*
Physical Exams	*$30*	*Not Applicable*
Out-Patient Mental Health	*$40 (20 visits per year)*	*Not Applicable*
Chiropratic Care	*Discount Program Included, $30 per visit*	*Not Applicable*
Acupuncture	*Discount Program Included, $30 per visit*	*Not Applicable*
PRESCRIPTION DRUGS		
Out-Patient Prescriptions	*$15 Generic $35 Brand-Formulary $50 Non-Formulary ($1,000 maximum benefit per year)*	*Not Applicable*
HOSPITAL SERVICES		
Out-Patient Surgery	*$250 per visit*	*Not Applicable*
In-Patient Hospital and Maternity	*$300 per day for 7 days*	*Not Applicable*
In-Patient Chemical Dependency	*$300 per day up to 7 days per admission then no charge (Dextox only)*	*Not Applicable*
In-Patient Mental Services	*Not Covered*	*Not Applicable*
EMERGENCY SERVICES		
Emergency Room	*$100 (waived if admitted)*	*$100 (waived if admitted)*
Ambulance	*$100 per trip*	*$100 per trip*

Important Notice: Coinsurance amounts represented with a "%" are payable after the plan deductibles are reached; Copay amounts represented with a "$" are not subject to plan deductibles (except where noted). Refer to contract for a detailed explanation of plan benefits, features, exclusions and limitations. Benefits subject to change without notice.

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Benefit Details

Proposed Effective Date: 8/1/2005

HMO $20/$40

HMO	IN-NETWORK BENEFITS	NON-NETWORK BENEFITS
Annual Deductible	*None*	*Not Applicable*
Maximum Annual Copay Limit	*Individual: $2,000 Family: $4,000*	*Not Applicable*
Maximum Lifetime Benefit	*Unlimited*	*Not Applicable*
PHYSICIAN SERVICES		
Office Visits	*$20; $40 Specialist*	*Not Applicable*
Lab and X-Rays	*$40*	*Not Applicable*
Physical Exams	*$20*	*Not Applicable*
Out-Patient Mental Health	*$40 (20 visits per year)*	*Not Applicable*
Chiropratic Care	*Discount Program Included, $30 per visit*	*Not Applicable*
Acupuncture	*Discount Program Included, $30 per visit*	*Not Applicable*
PRESCRIPTION DRUGS		
Out-Patient Prescriptions	*$15 Generic $35 Brand-Formulary $50 Non-Formulary*	*Not Applicable*
HOSPITAL SERVICES		
Out-Patient Surgery	*$250 per visit*	*Not Applicable*
In-Patient Hospital and Maternity	*$300 per day for 5 days*	*Not Applicable*
In-Patient Chemical Dependency	*$300 per day up to 5 days per admission then no charge (Dextox only)*	*Not Applicable*
In-Patient Mental Services	*Not Covered*	*Not Applicable*
EMERGENCY SERVICES		
Emergency Room	*$100 (waived if admitted)*	*$100 (waived if admitted)*
Ambulance	*$100 per trip*	*$100 per trip*

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Benefit Details

Proposed Effective Date: 8/1/2005

Classic HMO

HMO	IN-NETWORK BENEFITS	NON-NETWORK BENEFITS
Annual Deductible	*None*	*Not Applicable*
Maximum Annual Copay Limit	*$1,750 per member, $3,500 per family*	*Not applicable*
Maximum Lifetime Benefit	*Unlimited*	*Not applicable*
PHYSICIAN SERVICES		
Office Visits	*$20 copay*	*Not applicable*
Lab and X-Rays	*No charge*	*Not applicable*
Physical Exams	*$20 copay per office visit*	*Not applicable*
Out-Patient Mental Health	*$20 copay (20 visits per year)*	*Not applicable*
Chiropratic Care	*Not Covered*	*Not applicable*
Acupuncture	*Not Covered*	*Not applicable*
PRESCRIPTION DRUGS		
Out-Patient Prescriptions	*$10 Generic $25 Brand-Formulary ($150 Brand Ded.)*	*50% (Limited*) ($150 Brand Ded.)*
HOSPITAL SERVICES		
Out-Patient Surgery	*20% copay*	*Not Covered, except for certain emergency services*
In-Patient Hospital and Maternity	*$250 copay per admission*	*Not Covered, except for certain emergency services*
In-Patient Chemical Dependency	*$250 copay per admission*	*Not applicable*
In-Patient Mental Services	*See Benefit Contract*	*Not applicable*
EMERGENCY SERVICES		
Emergency Room	*$100 (waived if admitted)*	*$100 (waived if admitted)*
Ambulance	*No charge*	*Not Covered, except for medical emergency services or authorized referral*

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Benefit Details

Proposed Effective Date: 8/1/2005

HMO 100%

HMO	IN-NETWORK BENEFITS	NON-NETWORK BENEFITS
Annual Deductible	*None*	*Not Applicable*
Maximum Annual Copay Limit	*$1,750 per member, $3,500 per family*	*Not applicable*
Maximum Lifetime Benefit	*Unlimited*	*Not applicable*
PHYSICIAN SERVICES		
Office Visits	*$10 copay*	*Not applicable*
Lab and X-Rays	*No charge*	*Not applicable*
Physical Exams	*$10 copay per office visit*	*Not applicable*
Out-Patient Mental Health	*$20 copay (20 visits per year)*	*Not applicable*
Chiropratic Care	*Not Covered*	*Not applicable*
Acupuncture	*Not Covered*	*Not applicable*
PRESCRIPTION DRUGS		
Out-Patient Prescriptions	*$10 Generic $20 Brand-Formulary ($150 Brand Ded.)*	*50% (Limited*) ($150 Brand Ded.)*
HOSPITAL SERVICES		
Out-Patient Surgery	*No Charge*	*Not Covered, except for certain emergency services*
In-Patient Hospital and Maternity	*No Charge*	*Not Covered, except for certain emergency services*
In-Patient Chemical Dependency	*No charge*	*Not applicable*
In-Patient Mental Services	*See Benefit Contract*	*Not applicable*
EMERGENCY SERVICES		
Emergency Room	*$100 (waived if admitted)*	*$100 (waived if admitted)*
Ambulance	*No charge*	*Not Covered, except for medical emergency services*

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Benefit Details

Proposed Effective Date: 8/1/2005

Saver PPO

PPO	IN-NETWORK BENEFITS	NON-NETWORK BENEFITS
Annual Deductible	*$500 Hospital $5,000 Other Covered Services*	*$500 Hospital $5,000 Other Covered Services*
Maximum Annual Copay Limit	*$5,000 per member, two-member maximum*	*$5,000 per member, two-member maximum*
Maximum Lifetime Benefit	*$5,000,000*	*$5,000,000*

PHYSICIAN SERVICES		
Office Visits	*$20 copay (2 visits/adult, 4 visits/child) ($5,000 Ded. After office visit max is met)*	*50% Not subject to ded. (2 visits/adult, 4 visits/child)($5,000 Ded. After office visit max is met)*
Lab and X-Rays	*20% of the negotiated fee ($500 Max benefit per year)*	*50% of the negotiated fee ($500 Max benefit per year)*
Physical Exams	*$25 or $75 copay options*	*Not Covered*
Out-Patient Mental Health	*Not Covered*	*Not Covered*
Chiropratic Care	*Not Covered*	*Not Covered*
Acupuncture	*All charges except $25 per visit after deductible (24 visits per year)*	*All charges except $25 per visit after deductible (24 visits per year)*

PRESCRIPTION DRUGS		
Out-Patient Prescriptions	*$10 Generic $25 Brand-Formulary ($500 Max benefit per year)*	*50% (Limited*) Not subject to deductible ($500 Max benefit per year)*

HOSPITAL SERVICES		
Out-Patient Surgery	*20% of the negotiated fee.*	*Member pays all charges except $380 per day after deductible*
In-Patient Hospital and Maternity	*20% of the negotiated fee.*	*All charges except $650 per day after deductible*
In-Patient Chemical Dependency	*All of the negotiated fees except $175 per day after deductible (30 days max)*	*All charges except $175 per day after deductible (30 days max)*
In-Patient Mental Services	*All of the negotiated fees except $175 per day after deductible (30 days max)*	*All charges except $175 per day after deductible (30 days max)*

EMERGENCY SERVICES		
Emergency Room	*$100 (waived if admitted) 20% of negotiated fee*	*$100 (waived if admitted) 20% (first 48 hrs) then 100% over $650/day*
Ambulance	*20% of the negotiated fee ($750 max per trip)*	*50% of customary and reasonable charges ($750 max per trip)*

Important Notice: Coinsurance amounts represented with a "%" are payable after the plan deductibles are reached; Copay amounts represented with a "$" are not subject to plan deductibles (except where noted). Refer to contract for a detailed explanation of plan benefits, features, exclusions and limitations. Benefits subject to change without notice.

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Benefit Details

Proposed Effective Date: 8/1/2005

Power HealthFund 500 Plan

PPO	IN-NETWORK BENEFITS	NON-NETWORK BENEFITS
Annual Deductible	*$1,000 single / $2,000 Family*	*$1,000 single / $2,000 family contract*
Maximum Annual Copay Limit	*$5,000 single, $10,000 family contract*	*Once Blue Cross payments reach $10,000 single, $20,000 family contract*
Maximum Lifetime Benefit	*$5,000,000*	*$5,000,000*
Additional Benefits	*$500 Allowance Ind. $1,000 Family for eligible services*	*$500 Allowance Ind. $1,000 Family for eligible services*
PHYSICIAN SERVICES		
Office Visits	*$40 copay*	*50% of the negotiated fee.*
Lab and X-Rays	*40% of the negotiated fee*	*50% of the negotiated fee*
Physical Exams	*$40 copay per office visit plus 40% of the negotiated fee for all other services*	*50% of the negotiated fee*
Out-Patient Mental Health	*All of the negotiated fees except $25 per day after deductible (20 visits per year)*	*All charges except $25 per visit after annual deductible after deductible (20 visits per year)*
Chiropratic Care	*40% of the negotiated fee (12 visits per year)*	*All charges except $25 per visit after deductible (12 visits per year)*
Acupuncture	*All charges except $25 per visit after deductible (12 visits per year)*	*All charges except $25 per visit after deductible (12 visits per year)*
PRESCRIPTION DRUGS		
Out-Patient Prescriptions	*$10 Generic $35 Brand-Formulary ($350 Brand Ded.)*	*50% of Drug Limited Fee Schedule if filled within California ($350 Brand Ded.)*
HOSPITAL SERVICES		
Out-Patient Surgery	*40% of the negotiated fee*	*Members pay all charges except $380 per day*
In-Patient Hospital and Maternity	*40% of the negotiated fee*	*All charges except $650 per day after Deductible*
In-Patient Chemical Dependency	*All charges except $175 per day after deductible (30 days max)*	*All charges except $175 per day after deductible (30 days max)*
In-Patient Mental Services	*All charges except $175 per day after deductible (30 days max)*	*All charges except $175 per day after deductible (30 days max)*
EMERGENCY SERVICES		
Emergency Room	*$100 (waived if admitted) 40% of negotiated fee*	*$100 (waived if admitted) 40% (first 48 hrs) then 100% over $650/day*
Ambulance	*40% of the negotiated fee*	*50% of the negotiated fee*

Important Notice: Coinsurance amounts represented with a "%" are payable after the plan deductibles are reached; Copay amounts represented with a "$" are not subject to plan deductibles (except where noted). Refer to contract for a detailed explanation of plan benefits, features, exclusions and limitations. Benefits subject to change without notice.

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Benefit Details

Proposed Effective Date: 8/1/2005

PPO $40 Copay

PPO	IN-NETWORK BENEFITS	NON-NETWORK BENEFITS
Annual Deductible	*$500 per member, two-member maximum*	*$500 per member, two-member maximum*
Maximum Annual Copay Limit	*$4,500 per member, two-member maximum*	*Once Blue Cross payments reach $10,000, member pays nothing*
Maximum Lifetime Benefit	*$5,000,000*	*$5,000,000*
PHYSICIAN SERVICES		
Office Visits	*$40 inital 12 visits per member. Additional visits: 45%, not subject to deductible.*	*50% of the negotiated fee. Not subject to deductible.*
Lab and X-Rays	*40% of the negotiated fee*	*50% of the negotiated fee*
Physical Exams	*$25 or $75 copay options*	*Not Covered*
Out-Patient Mental Health	*All of the negotiated fees except $25 per day after deductible (20 visits per year)*	*All charges except $25 per visit after annual deductible after deductible (20 visits per year)*
Chiropratic Care	*40% of the negotiated fees (12 visits per year)*	*All charges except $25 per visit after deductible (12 visits per year)*
Acupuncture	*All charges except $25 per visit after deductible (24 visits per year)*	*All charges except $25 per visit after deductible (24 visits per year)*
PRESCRIPTION DRUGS		
Out-Patient Prescriptions	*$15 Generic $25 Brand-Formulary ($150 Brand Ded.)*	*50% (Limited*) ($150 Brand Ded.)*
HOSPITAL SERVICES		
Out-Patient Surgery	*40% of the negotiated fee.*	*Member pays all charges except $380 per day after deductible*
In-Patient Hospital and Maternity	*40% of the negotiated fee.*	*All charges except $650 per day after Deductible*
In-Patient Chemical Dependency	*All of the negotiated fees except $175 per day after deductible (30 days max)*	*All charges except $175 per day after deductible (30 days max)*
In-Patient Mental Services	*All of the negotiated fees except $175 per day after deductible (30 days max)*	*All charges except $175 per day after deductible (30 days max)*
EMERGENCY SERVICES		
Emergency Room	*$100 (waived if admitted) 40% of negotiated fee*	*$100 (waived if admitted) 40% (first 48 hrs) then 100% over $650/day*
Ambulance	*40% of the negotiated fee*	*50% of customary and reasonable charges*

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PacifiCare® of CALIFORNIA

Benefit Details

Proposed Effective Date: 8/1/2005

SignatureValue HMO 35

HMO	IN-NETWORK BENEFITS	NON-NETWORK BENEFITS
Annual Deductible	*None*	*Not Applicable*
Maximum Annual Copay Limit	*Individual: $5,000 Family: $15,000*	*Not Applicable*
Maximum Lifetime Benefit	*Unlimited*	*Not Applicable*
PHYSICIAN SERVICES		
Office Visits	*$35*	*Not Applicable*
Lab and X-Rays	*No charge*	*Not Applicable*
Physical Exams	*$35*	*Not Applicable*
Out-Patient Mental Health	*See Benefit Contract*	*Not Applicable*
Chiropratic Care	*Available as Rider*	*Not Applicable*
Acupuncture	*Available as Rider*	*Not Applicable*
PRESCRIPTION DRUGS		
Out-Patient Prescriptions	*$15 Generic $35 Brand-Formulary $50 Non-Formulary*	*Not Applicable*
HOSPITAL SERVICES		
Out-Patient Surgery	*$500 per admission*	*Not Applicable*
In-Patient Hospital and Maternity	*$600 per day (3 day maximum per stay)*	*Not Applicable*
In-Patient Chemical Dependency	*30% (Detox Only)*	*Not Applicable*
In-Patient Mental Services	*See Benefit Contract*	*Not Applicable*
EMERGENCY SERVICES		
Emergency Room	*$150 (waived if admitted)*	*$150 (waived if admitted)*
Ambulance	*$50*	*Not Applicable*

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PacifiCare® of CALIFORNIA

Benefit Details

Proposed Effective Date: 8/1/2005

SignatureValue HMO 20

HMO	IN-NETWORK BENEFITS	NON-NETWORK BENEFITS
Annual Deductible	*None*	*Not Applicable*
Maximum Annual Copay Limit	*Individual: $3,000 Family: $5,000*	*Not Applicable*
Maximum Lifetime Benefit	*Unlimited*	*Not Applicable*
PHYSICIAN SERVICES		
Office Visits	*$20/$40*	*Not Applicable*
Lab and X-Rays	*No charge*	*Not Applicable*
Physical Exams	*$20*	*Not Applicable*
Out-Patient Mental Health	*See Benefit Contract*	*Not Applicable*
Chiropratic Care	*Available as Rider*	*Not Applicable*
Acupuncture	*Available as Rider*	*Not Applicable*
PRESCRIPTION DRUGS		
Out-Patient Prescriptions	*$15 Generic $35 Brand-Formulary $50 Non-Formulary*	*Not Applicable*
HOSPITAL SERVICES		
Out-Patient Surgery	*$400 per admission*	*Not Applicable*
In-Patient Hospital and Maternity	*$500 per day*	*Not Applicable*
In-Patient Chemical Dependency	*$500 per day (Detox Only)*	*Not Applicable*
In-Patient Mental Services	*See Benefit Contract*	*Not Applicable*
EMERGENCY SERVICES		
Emergency Room	*$50 (waived if admitted)*	*$50 (waived if admitted)*
Ambulance	*$50*	*Not Applicable*

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PacifiCare® of CALIFORNIA

Benefit Details

Proposed Effective Date: 8/1/2005

SignatureValue HMO 10/500d

HMO	IN-NETWORK BENEFITS	NON-NETWORK BENEFITS
Annual Deductible	*None*	*Not Applicable*
Maximum Annual Copay Limit	*Individual: $2,000 Family: $6,000*	*Not Applicable*
Maximum Lifetime Benefit	*Unlimited*	*Not Applicable*
PHYSICIAN SERVICES		
Office Visits	*$10*	*Not Applicable*
Lab and X-Rays	*No charge*	*Not Applicable*
Physical Exams	*$10*	*Not Applicable*
Out-Patient Mental Health	*See Benefit Contract*	*Not Applicable*
Chiropratic Care	*Available as Rider*	*Not Applicable*
Acupuncture	*Available as Rider*	*Not Applicable*
PRESCRIPTION DRUGS		
Out-Patient Prescriptions	*$15 Generic $35 Brand-Formulary $50 Non-Formulary*	*Not Applicable*
HOSPITAL SERVICES		
Out-Patient Surgery	*$400 per admission*	*Not Applicable*
In-Patient Hospital and Maternity	*$500 per day (2 day maximum per stay)*	*Not Applicable*
In-Patient Chemical Dependency	*$500 per day (Detox Only)*	*Not Applicable*
In-Patient Mental Services	*See Benefit Contract*	*Not Applicable*
EMERGENCY SERVICES		
Emergency Room	*$50 (waived if admitted)*	*$50 (waived if admitted)*
Ambulance	*$50*	*Not Applicable*

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