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[1] **SDA Non-Covered Services:** Covered Expenses not eligible for reimbursement under the SDA include, but are not limited to the following:

Allergy Testing/Serum and Treatment, Ambulance, Colonoscopy or flexible sigmoidoscopy, except for qualified individuals as part of Colorectal Cancer Screening, Durable medical equipment, Emergency room, Family Planning Services, Genetic Testing and Counseling, Hearing Aids and Hearing Devices, Hospice Services, Infusion Therapy, Infertility Treatment, Injectable or Intravenous drugs (other than antibiotics and immunization injections, Inpatient and Outpatient Alcohol, Drug or Other Substance Abuse, Inpatient and Outpatient Hospital Services, Inpatient and Outpatient Maternity and Newborn Care (Labor, Delivery and Postnatal Hospital Services),Inpatient and outpatient Rehabilitation Care, Inpatient Hospice Care, Inpatient Skilled Nursing Facilities, Laboratory Services (other than those under Physician Office Visits), Mental Illness services, Neuromuscular Skeletal Services, Organ Transplantation Services (Bone Marrow, Stem Cell and Organ Transplants), Outpatient or Physician office based surgery Physician services (other than physician office visits), Prescription drugs, Prosthetic devices, Prosthetics and Corrective Appliances, Radiology Services (other than standard x-rays), Specialized scanning, imaging, and diagnostic procedures such as Computed Tomography (CT), Single Photon Emission Computerized Tomography radionuclide Scanning (SPECT), Positron Emission Tomography (PET), Magnetic Resonance Angiography (MRA) and Magnetic Resonance Imaging (MRI) (with or without oral, rectal, injected or infused contrast media), Electrocardiogram (EKG), Electro-encephalography (EEG), Electromyograph (EMG) and nuclear medicine studies, Sterilization, Therapeutic services, Transplants, Ultrasound, and Urgent Care facility services. Any service shown as not applicable or not covered, Nontraditional or non-Covered Services are also not eligible for reimbursement under the SDA . Please refer to the Certificate for additional plan information, including exclusions and imitations.

Reimbursements under the Self Directed Account (SDA) are limited to Covered Services indicated in this Comparison as SDA -eligible expenses and are subject to the conditions and limitations of the Policy. In all cases, reimbursements will be limited to substantiated qualified medical expenses. SDA Covered Services: The following is a summary of SDA covered services. Please note that this is not a complete list. Refer to the Certificate for additional plan information, including exclusions and limitations. Covered Expenses reimbursable under the SDA include the following: Physician Office Visits, Preventive Screenings -- Breast Cancer Screening including Mammography screening, Pelvic Cancer Screening, Detection of Osteoporosis, Colorectal Cancer Screening, Prostate Cancer Screening, Covered diagnostic laboratory services, Radiology services limited to standard plain x-ray films, Periodic Health Evaluations.

PacifiCare®

Individual Plan Comparison Guide

February 1, 2005 - January 31, 2006

PACIFICARE LIFE ASSURANCE COMPANY: OREGON INDIVIDUAL PLANS

	SignatureFreedom 80-60/1500		SignatureFreedom 80-60/3000		SignatureFreedom Elect 70/3000		SignatureOptions 80-60/5000	
Self Directed Account Maximum per Calendar Year *								
Individual	$250 per Calendar Quarter Benefit		$250 per Calendar Quarter Benefit		$250 per Calendar Quarter Benefit		**Not Applicable**	
Family	$500 per Calendar Quarter Benefit		$500 per Calendar Quarter Benefit		$500 per Calendar Quarter Benefit		**Not Applicable**	
Self Directed Account Rollover per Calendar Year *								
Individual	$1,000 per Calendar Year Benefit		$1,000 per Calendar Year Benefit		$1,000 per Calendar Year Benefit		**Not Applicable**	
Family	$2,000 per Calendar Year Benefit		$2,000 per Calendar Year Benefit		$2,000 per Calendar Year Benefit		**Not Applicable**	
Deductible & Policy Maximums	**Participating Provider**	**Non-Participating Provider**	**Participating Provider**	**Non-Participating Provider**	**Participating Provider**		**Participating Provider**	**Non-Participating Provider**
Calendar year Deductible								
Individual	$1,500		$3,000		$3,000		$5,000	
Family Maximum (2x Individual)	$3,000		$6,000		$6,000		$10,000	
Additional Deductible (per occurrence)								
Inpatient Hospital Services	Not Applicable	$500	Not Applicable	$500	Not Applicable		Not Applicable	$500
Outpatient Surgical Services	Not Applicable	$250	Not Applicable	$250	Not Applicable		Not Applicable	$250
Emergency Room Services (waived if admitted)	$100		$100		$100		$100	
Failure to obtain Pre-Authorization of Services	Not Applicable	$500	Not Applicable	$500	Not Applicable		Not Applicable	$500
Coinsurance Maximum								
Individual	$2,500	$7,500	$3,000	$9,000	$3,000		$5,000	$10,000
Family (2x Individual)	$5,000	$15,000	$6,000	$18,000	$6,000		$10,000	$20,000
Policy Maximum While Insured (per individual)	$2,000,000		$2,000,000		$2,000,000		$2,000,000	
Inpatient Benefits	**Participating Provider** **Services subject to the Deductible**	**Non-Participating Provider** **Services subject to the Deductible**	**Participating Provider** **Services subject to the Deductible**	**Non-Participating Provider** **Services subject to the Deductible**	**Tier One Facility Select Hospital** **Services subject to the Deductible**	**Tier Two Facility Standard Hospital** **Services subject to the Deductible**	**Participating Provider** **Services subject to the Deductible**	**Non-Participating Provider** **Services subject to the Deductible**
Inpatient Hospital Services	80%	60%	80%	60%	70%	50%	80%	60%
Organ Transplantation Services[(1)]	80%	Not Covered	80%	Not Covered	70%	50%	80%	Not Covered
-Maximum benefit while Insured (24 month waiting period)	Covered under Policy Maximum up to $2,000,000		Covered under Policy Maximum up to $2,000,000		Covered under Policy Maximum up to $2,000,000		Covered under Policy Maximum up to $2,000,000	
Inpatient Maternity and Newborn Care[(1)] Labor, Delivery and Postnatal Hospital Services	80%	60%	80%	60%	70%	50%	80%	60%
Inpatient Skilled Nursing Facilities *-Maximum Benefit Up to 90 days per Calendar Year*	80%	60%	80%	60%	70%		80%	60%
Inpatient Hospice Care *-Maximum Benefit $10,000 combined for Inpatient / Outpatient benefits per Calendar Year*	80%	60%	80%	60%	70%		80%	60%
Inpatient Rehabilitation Care	80%	60%	80%	60%	70%	50%	80%	60%
Mental Illness and Mental Health Inpatient Treatment *-Maximum Benefit $2,000 combined for Inpatient / Outpatient benefits per Calendar Year*	80%	60%	80%	60%	70%		80%	60%
Outpatient Benefits	**Participating Provider** **Services subject to the Deductible**	**Non-Participating Provider** **Services subject to the Deductible**	**Participating Provider** **Services subject to the Deductible**	**Non-Participating Provider** **Services subject to the Deductible**	**Participating Provider** **Services subject to the Deductible**		**Participating Provider** **Services subject to the Deductible**	**Non-Participating Provider** **Services subject to the Deductible**
Physician Office Visits [(1)] Services include the detection and treatment of an injury or sickness during a Physician Office Visit including associated Covered diagnostic X-ray and laboratory services; Breast, Pelvic Cancer and Mammography screening; Detection of Osteoporosis; Prostate Cancer Screening; Periodic health evaluations for children (through age 18); Diabetic Education	100% to Physician's Office Visit Services to SDA maximum then 80% after deductible.	100% to Physician's Office Visit Services to SDA maximum then 60% after deductible.	100% to Physician's Office Visit Services to SDA maximum then 80% after deductible.	100% to Physician's Office Visit Services to SDA maximum then 60% after deductible.	100% to Physician's Office Visit Services to SDA maximum then 70% after deductible.		80%	60%
Periodic Health Evaluations (age 19 and over)[(1)] Hearing and Vision Screening; Immunizations; Routine Laboratory tests; Weight Evaluations; *- Maximum Benefit $400 per Calendar Year*	100% to Physician's Office Visit Services to SDA maximum then 80% after deductible.	100% to Physician's Office Visit Services to SDA maximum then 60% after deductible.	100% to Physician's Office Visit Services to SDA maximum then 80% after deductible.	100% to Physician's Office Visit Services to SDA maximum then 60% after deductible.	100% to Physician's Office Visit Services to SDA maximum then 70% after deductible.		80%	60%
Allergy Testing and Treatment	80%	60%	80%	60%	70%		80%	60%
Outpatient Maternity Care[(1)]	80%	60%	80%	60%	70%		80%	60%
Urgent Care Services	100% of Physician's Office Visit Services to SDA maximum then 80% after Deductible	100% of Physician's Office Visit Services to SDA maximum then 60% after Deductible	100% of Physician's Office Visit Services to SDA maximum then 80% after Deductible	100% of Physician's Office Visit Services to SDA maximum then 60% after Deductible	100% of Physician's Office Visit Services to SDA maximum then 70% after Deductible		80%	60%
Ambulance *(emergency services and specified transfers)* *- Maximum Benefit $3000 per Calendar Year*	80%		80%		70%		80%	
Durable Medical Equipment (DME), Prosthetics, and Corrective Appliances *- Maximum Benefit $5000 combined for DME, Prosthetics and Corrective Appliances per Calendar Year*	80%	60%	80%	60%	70%		80%	60%
Home Health Care *- Maximum Benefit 130 visits combined per Calendar Year*	80%	60%	80%	60%	70%		80%	60%
Outpatient Hospice Services *- Maximum Benefit $10,000 combined for Inpatient and Outpatient benefits per Calendar Year*	80%	60%	80%	60%	70%		80%	60%
Radiology & Laboratory Services (other than Physician Office visit)[(1)]	80%	60%	80%	60%	70%		80%	60%
Specialized Scanning, Imaging and Laboratory Services[(1)]	80%	60%	80%	60%	70%		80%	60%
Outpatient Medical Rehabilitative Therapy[(1)] Speech, Physical, Occupational therapy *- Maximum Benefit $2,000 per Calendar Year*	80%	60%	80%	60%	70%		80%	60%
Mental Illness and Mental Health [(1)] *- Maximum Benefit $2,000 combined for Inpatient and Outpatient benefits per Calendar Year*	80%	60%	80%	60%	70%		80%	60%
Complementary and Alternative Medicine[(1)] **Chiropractor and Acupuncture Services** *- Maximum Benefit $500 combined per Calendar Year*	80%	60%	80%	60%	70%		80%	60%
Outpatient Surgery [(1)]	80%	60%	80%	60%	70%		80%	60%
Outpatient Prescription Benefits	**Participating Pharmacy**	**Non-Participating Pharmacy**	**Participating Pharmacy**	**Non-Participating Pharmacy**	**Participating Pharmacy**	**Non-Participating Pharmacy**	**Participating Pharmacy**	**Non-Participating Pharmacy**
3-Tier Retail Pharmacy Generic / Brand Name / Non-Formulary (per one Prescription Unit or up to 30 days supply)	$250 Deductible then 100% after Co-Payment of $15 / $40 / $70	$250 Deductible then 80% after Co-Payment of $15 / $40 / $70	$500 Deductible then 100% after Co-Payment of $15 / $40 / $70	$500 Deductible then 80% after Co-Payment of $15 / $40 / $70	$500 Deductible then 100% after Co-Payment of $15 / $40 / $70	$500 Deductible then 80% after Co-Payment of $15 / $40 / $70	Not Covered	Not Covered
3-Tier Mail-Service Pharmacy Generic / Brand Name / Non-Formulary (per three Prescription Units or up to 90 days supply)	$0 Deductible then 100% after Co-Payment of $30 / $80 / $140	Not Covered	$0 Deductible then 100% after Co-Payment of $30 / $80 / $140	Not Covered	$0 Deductible then 100% after Co-Payment of $30 / $80 / $140	Not Covered	Not Covered	Not Covered
- Maximum Benefit	$5000 combined maximum for Retail and Mail-Service per Calendar Year		$5000 combined maximum for Retail and Mail-Service per Calendar Year		$5000 combined maximum for Retail and Mail-Service per Calendar Year		Not Covered	
Supplemental Benefit Rider	**Participating Provider**	**Non-Participating Provider**	**Participating Provider**	**Non-Participating Provider**	**Participating Provider**		**Participating Provider**	**Non-Participating Provider**
ALCOHOLISM TREATMENT Inpatient and Outpatient Treatment *- Maximum Benefit: Combined maximum of $4,500 in any 24-consecutive months.*	80%		80%		80%		80%	

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