CALIFORNIA

PacifiCare
SignatureValue®
A select group of physicians

Standard 25/70
HMO Schedule of Benefits

These services are covered as indicated when authorized through your Primary Care Physician in your Participating Medical Group.

General Features

Calendar Year Deductible	0
Maximum Benefits	Unlimited
Annual Copayment Maximum[1] *(3 individual maximum per family)*	$2,000/individual
Office Visits	$25 Copayment
Hospitalization *(autologous (self-donated) blood up to $120.00 per unit)*	30% Copayment[2]
Emergency Services *(Copayment not waived if admitted)*	$100 Copayment
Urgently Needed Services *(Medically Necessary services required outside geographic area served by your Participating Medical Group. Please consult your brochure for additional details. Copayment not waived if admitted)*	$100 Copayment
Pre-Existing Conditions	All conditions covered, provided they are covered benefits

Benefits Available While Hospitalized as an Inpatient

Alcohol, Drug or Other Substance Abuse - Detoxification	30% Copayment[2]
Bone Marrow Transplants *(donor searches limited to $15,000 per procedure)*	30% Copayment[2]
Cancer Clinical Trials[3,4]	Paid at contracting rate Balance (if any) is the responsibility of the Member
Hospice Care *(prognosis of life expectancy of one year or less)*	30% Copayment[2]
Hospital Benefits *(autologous (self-donated) blood up to $120.00 per unit)*	30% Copayment[2]
Mastectomy/Breast Reconstruction *(after mastectomy and complications from mastectomy)*	30% Copayment[2]
Maternity Care	30% Copayment[2]
Newborn Care[5]	30% Copayment[2]
Physician Care	Paid in full
Reconstructive Surgery	30% Copayment[2]
Rehabilitation Care *(including physical, occupational and speech therapy)*	30% Copayment[2]
Skilled Nursing Care *(up to 100 consecutive calendar days from the first treatment per disability)*	30% Copayment[2]
Voluntary Interruption of Pregnancy *(medical/medication and surgical)*	
–- 1st trimester	$125 Copayment
– 2nd trimester (12–20 weeks)	$125 Copayment
– After 20 weeks	Not covered unless Mother's life is in jeopardy or fetus is not viable

Benefits Available on an Outpatient Basis

Benefit	Cost
Alcohol, Drug or Other Substance Abuse - Detoxification	$25 Copayment
Allergy Testing/Treatment *(serum is covered)*	$25 Copayment
Ambulance *(only one ambulance Copayment per trip may be applicable; if subsequent ambulance transfer to another facility is necessary, the Member is not responsible for additional ambulance Copayment.)*	$50 Copayment
Cancer Clinical Trials[3,4]	Paid at contracting rate Balance (if any) is the responsibility of the Member
Cochlear Implants Devices *(outpatient surgery or inpatient hospitalization and outpatient rehabilitation therapy Copayments may apply)*	$25 Copayment
Corrective Appliances and Prosthetics	$50 Copayment per item[6]
Crisis Intervention	Not covered
Dental Treatment Anesthesia *(additional charges for outpatient and inpatient surgery may apply)*	$20 Copayment
Durable Medical Equipment *($5,000 annual benefit maximum)*	$50 Copayment per item[6]
Durable Medical Equipment for the Treatment of Pediatric Asthma *(Includes nebulizers, peak flow meters, face masks and tubing for the Medically Necessary treatment of pediatric asthma of Dependent children under the age of 19. Does not apply to the annual Durable Medical Equipment benefit maximum.)*	Paid in full
Family Planning/Voluntary Interruption of Pregnancy	
Vasectomy	$50 Copayment
Tubal Ligation	$100 Copayment[7]
Insertion/Removal of Intra-Uterine Device (IUD)	$25 Copayment
Intra-Uterine Device (IUD)	$50 Copayment
Removal of Norplant	$25 Copayment
Depo-Provera Injection	$25 Copayment
Depo-Provera Medication (limited to one Depo-Provera injection every 90 days)	$35 Copayment
Voluntary Interruption of Pregnancy (medical/medication and surgical)	
– 1st trimester	$125 Copayment
– 2nd trimester (12–20 weeks)	$125 Copayment
– After 20 weeks	Not covered unless Mother's life is in jeopardy or fetus is not viable
Health Education Services	Paid in full
Hearing Screening	$25 Copayment
Hemodialysis *(Physician office visit Copayment may apply)*	$25 per treatment
Home Health Care *(up to 100 visits per calendar year)*	$10 Copayment per visit
Hospice Care *(prognosis of life expectancy of one year or less)*	Paid in full
Immunizations *(for children under two years of age, refer to Well-Baby Care)*	$25 Copayment
Infertility Services	Not covered
Infusion Therapy *(Infusion Therapy is a separate Copayment in addition to a home health care or an office visit Copayment. Copayment applies per 30 days or treatment plan, whichever is shorter)*	$50 Copayment[6]

Benefits Available on an Outpatient Basis (Continued)

Benefit	Copayment
Injectable Drugs *(Copayment not applicable to allergy serum, immunizations, birth control, Infertility and insulin. Please see the PacifiCare Combined Evidence of Coverage and Disclosure Form or the Group Subscriber Agreement for more information on these benefits, if any. Copayment applies per 30 days or treatment plan, whichever is shorter)*	$50 Copayment[6]
Laboratory Services *(when available through and authorized by the Member's Participating Medical Group)*	Paid in full
Maternity Care, Test and Procedures	Paid in full
Mental Health Services *(as required by state law, coverage includes treatment for Severe Mental Illnesses (SMI) of adults and children and for children the treatment of Serious Emotional Disturbance of Children (SED). Please refer to your Supplement to the PacifiCare Combined Evidence of Coverage and Disclosure Form for a description of this coverage)*	$25 Copayment
Oral Surgery Services	$50 Copayment[6]
Outpatient Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility *(including physical, occupational and speech therapy)*	$25 Copayment
Outpatient Surgery	30% Copayment[2]
Periodic Health Evaluations *(Physician, laboratory, radiology and related services as recommended by the American Academy of Pediatrics (AAP) and U.S. Preventive Services Task Force and authorized through your Primary Care Physician in your Participating Medical Group to determine your health status. For children under two years of age, refer to Well-Baby Care)*	$25 Copayment
Physician Care *(for children under two years of age, refer to Well-Baby Care)*	$25 Copayment
Radiation Therapy	
Standard: *(photon beam radiation therapy)*	Paid in full
Complex: *(examples include, but are not limited to, brachytherapy, radioactive implants and conformal photon beam; Copayment applies per 30 days or treatment plan, whichever is shorter; GammaKnife and stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Copayment amount if any)*	$50 Copayment[6]
Radiological Procedures	
Standard:	Paid in full
Specialized scanning and imaging procedures: *(CT, SPECT, PET and MRI – with or without contrast media)*	$50 Copayment per procedure[6]
Vision Refractions	$25 Copayment
Vision Screening	$25 Copayment

Benefits Available on an Outpatient Basis (Continued)

Well-Baby Care *(preventive health service, including immunizations recommended by the American Academy of Pediatrics (AAP) and U.S. Preventive Services Task Force and authorized through your Primary Care Physician in your Participating Medical Group for children under two years of age. The applicable office visit Copayment applies to infants that are ill at time of services)*	Paid in full
Well-Woman Care *(Includes Pap smear (by your Primary Care Physician or an OB/GYN in your Participating Medical Group) and referral by the Participating Medical Group for screening mammography as recommended by the U.S. Preventive Services Task Force)*	$25 Copayment

[1] Annual Copayment Maximum does not include Copayments for pharmacy and supplemental benefits.
[2] Each hospital admission requires a 30% Copayment.
[3] Cancer Trial Services require preauthorization by PacifiCare.
[4] If you participate in a clinical trial provided by a Non-Participating Provider that does not agree to perform these services at the rate PacifiCare negotiates with Participating Providers, you will be responsible for payment of the difference between the Non-Participating Providers billed charges and the rate negotiated by PacifiCare with Participating Providers, in addition to any applicable Copayments, coinsurance or deductibles.
[5] The newborn care Copayment does not apply when the newborn is discharged with the mother within 48 hours of the normal vaginal delivery or 96 hours of the cesarean delivery. Please see the *Combined Evidence of Coverage and Disclosure Form* for more details.
[6] In instances where the contracted rate is less than your Copayment, you will pay only the contracted rate.
[7] Copayment applies regardless of whether this benefit is performed on an inpatient or outpatient basis. If performed on an inpatient basis, additional Inpatient Copayment, if any, will apply.

Except in the case of a Medically Necessary Emergency or an Urgently Needed Service (outside geographic area served by your Participating Medical Group), each of the above-noted benefits is covered when authorized by your Participating Medical Group or PacifiCare. A Utilization Review Committee may review the request for services.

Note: This is not a contract. This is a *Schedule of Benefits* and its enclosures constitute only a summary of the Health Plan.

The Medical and Hospital Group Subscriber Agreement and the PacifiCare of California *Combined Evidence of Coverage and Disclosure Form* and additional benefit materials must be consulted to determine the exact terms and conditions of coverage. A specimen copy of the contract will be furnished upon request and is available at the PacifiCare office and your employer's personnel office. PacifiCare's most recent audited financial information is also available upon request.

P.O. Box 6006
Cypress, CA 90630

Customer Service:
800-624-8822
800-442-8833 (TDHI)
www.pacificare.com

©2006 by PacifiCare Health Systems, Inc.
PCA133646-001
UA4/UA5/UAJ