

CALIFORNIA



**STANDARD 15/250A
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 <i>(3 individual maximum per family)</i>	\$2,000/individual
Office Visits	\$15 Copayment
Hospital Benefits <i>(Only one hospital Copayment per admit is applicable. If a subsequent transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment)</i>	\$250 Copayment per admit ²
Blood and Blood Products <i>(Autologous (self-donated) blood limited up to \$120.00 per unit)</i>	Paid in full
Emergency Services <i>(Copayment waived if admitted)</i>	\$100 Copayment
Urgently Needed Services <i>(Medically Necessary services required outside geographic area served by your Participating Medical Group. Please consult your brochure for additional details. Copayment waived if admitted)</i>	\$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	\$250 Copayment per admit ²
Bone Marrow Transplants <i>(Donor searches limited to \$15,000 per procedure)</i>	\$250 Copayment per admit ²
Cancer Clinical Trials ³	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Hospice Services <i>(Prognosis of life expectancy of one year or less)</i>	\$250 Copayment per admit ²
Hospital Benefits ⁴	\$250 Copayment per admit ²
Mastectomy/Breast Reconstruction <i>(After mastectomy and complications from mastectomy)</i>	\$250 Copayment per admit ²
Maternity Care	\$250 Copayment per admit ²
Mental Health Services <i>(As required by state law, coverage includes treatment for Severe Mental Illness (SMI) of adults and children and 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)</i>	\$250 Copayment per admit ²
Newborn Care ⁴	\$250 Copayment per admit ²
Physician Care	Paid in full
Reconstructive Surgery	\$250 Copayment per admit ²
Rehabilitation Care <i>(Including physical, occupational and speech therapy)</i>	\$250 Copayment per admit ²

Benefits Available While Hospitalized as an Inpatient (Continued)

Skilled Nursing Facility Care <i>(Up to 100 consecutive calendar days from the first treatment per disability)</i>	\$125 Copayment per admit
Voluntary Termination of Pregnancy <i>(Medical/medication and surgical)</i> 1 st trimester	\$125 Copayment
2 nd trimester – After 20 weeks, not covered unless mother’s life is in jeopardy or fetus is not viable.	\$125 Copayment

Benefits Available on an Outpatient Basis

Alcohol, Drug or Other Substance Abuse Detoxification	Paid in full
Allergy Testing/Treatment <i>(Serum is covered)</i>	\$15 Office Visit Copayment
Ambulance <i>(Only one ambulance Copayment per trip may be applicable. If a subsequent ambulance transfer to another facility is necessary, you are not responsible for an additional ambulance Copayment)</i>	\$50 Copayment
Cancer Clinical Trials ³	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Cochlear Implant Devices <i>(Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply)</i>	\$15 Office Visit Copayment
Crisis Intervention	Not covered
Dental Treatment Anesthesia <i>(Additional Copayment for outpatient surgery or inpatient hospital benefits may apply)</i>	\$15 Office Visit Copayment
Dialysis <i>(Physician office visit Copayment may apply)</i>	\$15 Copayment per treatment
Durable Medical Equipment <i>(\$5,000 annual benefit maximum per calendar year)</i>	\$50 Copayment per item ⁵
Durable Medical Equipment for the Treatment of Pediatric Asthma <i>(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.)</i>	Paid in full
Family Planning/Voluntary Termination of Pregnancy Vasectomy	\$50 Copayment
Tubal Ligation <i>(Additional Copayment for inpatient hospital benefits may apply if performed on an inpatient basis)</i>	\$100 Copayment
Insertion/Removal of Intra-Uterine Device (IUD)	\$15 Office Visit Copayment
Intra-Uterine Device (IUD)	\$50 Copayment
Removal of Norplant	\$15 Office Visit Copayment
Depo-Provera Injection	\$15 Office Visit Copayment
Depo-Provera Medication <i>(Limited to one Depo-Provera injection every 90 days)</i>	\$35 Copayment
Voluntary Termination of Pregnancy <i>(Medical/medication and surgical)</i> 1 st trimester	\$125 Copayment
2 nd trimester – After 20 weeks, not covered unless mother’s life is in jeopardy or fetus is not viable.	\$125 Copayment
Health Education Services	Paid in full

Benefits Available on an Outpatient Basis (Continued)

Hearing Screening	\$15 Office Visit Copayment
Home Health Care <i>(Up to 100 visits per calendar year)</i>	\$10 Copayment per visit
Hospice Services <i>(Prognosis of life expectancy of one year or less.)</i>	Paid in full
Immunizations <i>(For children under two years of age, refer to Well-Baby Care)</i>	\$15 Office Visit Copayment
Infertility Services	Not covered
Infusion Therapy <i>(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)</i>	\$50 Copayment ⁵
Injectable Drugs (Outpatient Injectable Medications and Self-Injectable Medications) <i>(Copayment not applicable to allergy serum, immunizations, birth control, Infertility and insulin. The Self-Injectable medications Copayment applies per 30 days or treatment plan, whichever is shorter. Please see the PacifiCare Combined Evidence of Coverage and Disclosure Form for more information on these benefits, if any. Office visit Copayment may also apply)</i>	\$50 Copayment ⁵
Laboratory Services <i>(When available through or authorized by your Participating Medical Group)</i>	Paid in full
Maternity Care, Tests and Procedures	Paid in full
Mental Health Services <i>(As required by state law, coverage includes treatment for Severe Mental Illnesses (SMI) of adults and children and 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)</i>	\$15 Office Visit Copayment
Oral Surgery Services	\$50 Copayment ⁵
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility <i>(Including physical, occupational and speech therapy)</i>	\$15 Office Visit Copayment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	\$125 Copayment
Periodic Health Evaluations <i>(Physician, laboratory, radiology and related services as recommended by the American Academy of Pediatrics (AAP), Advisory Committee on Immunization Practices (ACIP) 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)</i>	\$15 Office Visit Copayment
Physician Care <i>(For children under two years of age, refer to Well-Baby Care)</i>	\$15 Office Visit Copayment
Prosthetics and Corrective Appliances	\$50 Copayment per item ⁵

Benefits Available on an Outpatient Basis (Continued)

Radiation Therapy Standard: <i>(Photon beam radiation therapy)</i>	Paid in full
Complex: <i>(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)</i>	\$50 Copayment ⁵
Radiology Services Standard: Specialized scanning and imaging procedures: <i>(Examples include but are not limited to, CT, SPECT, PET, MRA and MRI – with or without contrast media)</i>	Paid in full \$50 Copayment per procedure ⁵
Vision Screening/Refractions	\$15 Office Visit Copayment
Well-Baby Care <i>(Preventive health service, including immunizations as recommended by the American Academy of Pediatrics (AAP), Advisory Committee on Immunization Practices (ACIP) 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)</i>	Paid in full
Well-Woman Care <i>(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)</i>	\$15 Office Visit Copayment

¹ Annual Copayment Maximum does not include Copayments for pharmacy and supplemental benefits.

² Each hospital admission requires a \$250 Copayment.

³ Cancer Clinical Trial services require preauthorization by PacifiCare. If you participate in a Cancer 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.

⁴ The inpatient hospital benefits Copayment does not apply to newborns 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.

⁵ In instances where the negotiated rate is less than your Copayment, you will pay only the negotiated rate.

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

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