

PacifiCare SignatureValue®

Offered by PacifiCare of California

15/100%, \$1500DED

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* (100% of Covered Inpatient Hospital Services after satisfying the Deductible.)	\$1,500 Inpatient Hospital Only (3 individual maximum per family)
Maximum Benefits	Unlimited
Annual Copayment Maximum ^{Δ,1} (3 individual maximum per family ²)	\$3,000/individual
Office Visits	\$15 Copayment
Hospital Benefits (Autologous (self-donated) blood limited up to \$120.00 per unit)	100% of Covered Inpatient Hospital Benefits after satisfying the Deductible. \$1,500 Deductible
Emergency Services (Copayment 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 waived if admitted)	\$100 Copayment
Pre-Existing Conditions	All conditions covered, provided they are covered benefits

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants (Donor searches limited to \$15,000 per procedure)	100% of Covered Inpatient Hospital Benefits after satisfying the Deductible.
Cancer Clinical Trials ³	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Hospice Services (Prognosis of life expectancy of one year or less)	100% of Covered Inpatient Hospital Benefits after satisfying the Deductible.
Hospital Benefits ⁴ (Autologous (self-donated) blood limited up to \$120.00 per unit)	100% of Covered Inpatient Hospital Benefits after satisfying the Deductible.
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	100% of Covered Inpatient Hospital Benefits after satisfying the Deductible.
Maternity Care	100% of Covered Inpatient Hospital Benefits after satisfying the Deductible.

Benefits Available While Hospitalized as an Inpatient (Continued)

Mental Health Services (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.)	Paid in full
Newborn Care ⁴	100% of Covered Inpatient Hospital Benefits after satisfying the Deductible.
Physician Care	Paid in full
Reconstructive Surgery	100% of Covered Inpatient Hospital Benefits after satisfying the Deductible.
Rehabilitation Care (Including physical, occupational and speech therapy)	100% of Covered Inpatient Hospital Benefits after satisfying the Deductible.
Skilled Nursing Care (Up to 100 consecutive calendar days from the first treatment per disability)	100% of Covered Inpatient Hospital Benefits after satisfying the Deductible.
Substance Use Disorder Detoxification	100% of Covered Inpatient Hospital Benefits after satisfying the Deductible.
Voluntary Termination of Pregnancy (Medical/medication and surgical)	
1st trimester	\$15 Copayment
2nd trimester (12-20 weeks)	\$15 Copayment
– After 20 weeks, not covered unless Medically Necessary, such as the mother's life is in jeopardy or fetus is not viable.	

Benefits Available on an Outpatient Basis

Allergy Testing/Treatment (Serum is covered)	\$15 Office Visit Copayment
Ambulance	Paid in full
Cancer Clinical Trials	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Cochlear Implants Devices (Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply)	Paid in full
Dental Treatment Anesthesia (Additional Copayment for outpatient surgery or inpatient hospital benefits may apply)	\$15 Copayment
Dialysis (Physician office visit Copayment may apply)	\$15 Copayment per treatment
Durable Medical Equipment	Paid in full
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.	Paid in full

Benefits Available on an Outpatient Basis (Continued)

Family Planning/Voluntary Termination of Pregnancy Vasectomy & Tubal Ligation	Copayment will be the applicable Physician office visit, Outpatient Surgery or Inpatient Surgery Copayment
Insertion/Removal of Intra-Uterine Device (IUD)	\$15 Office Visit Copayment
Intra-Uterine Device (IUD)	50% of cost Copayment ⁶
Removal of Norplant	\$15 Office Visit Copayment
Depo-Provera Injection, including Depo-Provera medication (Limited to one Depo-Provera injection every 90 days)	\$15 Office Visit Copayment
Voluntary Termination of Pregnancy (Medical/medication and surgical)	
1st trimester	\$15 Copayment
2 nd trimester (12-20 weeks)	\$15 Copayment
– After 20 weeks, not covered unless Medically Necessary, such as the mother's life is in jeopardy or fetus is not viable.	
Health Education Services	Paid in full
Hearing Aid – Standard \$5,000 Benefit Maximum every three years. Limited to a single hearing aid (including repair/replacement) every three years.	Paid in full
Hearing Aid – Bone Anchored ⁷ Limited to a single hearing aid during the entire period of time the member is enrolled in the Health Plan (per lifetime). Repairs and/or replacements are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.	Depending upon where the covered health service is provided, benefits for bone anchored hearing aid will be the same as those stated under each covered health service category in this Schedule of Benefits
Hearing Screening	Paid in full
Home Health Care Visits	Paid in full
Hospice Services (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)	Paid in full
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)	Paid in full
Injectable Drugs (Outpatient Injectable Medications and Self-Injectable Medications) (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)	Paid in full
Laboratory Services (When available through and authorized by your Participating Medical Group)	Paid in full
Maternity Care, Tests 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 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)	\$15 Office Visit Copayment
Oral Surgery Services	\$15 Copayment ⁵

Benefits Available on an Outpatient Basis (Continued)

Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy)	\$15 Office Visit Copayment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Center	\$100 Copayment per admit
Periodic Health Evaluations (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)	Paid in full
Physician Care (for children under two years of age, refer to Well-Baby Care)	\$15 Office Visit Copayment
Prosthetics and Corrective Appliances	Paid in full
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)	Paid in full
Radiology Services Standard: Specialized scanning and imaging procedures: (Examples include but are not limited to, CT, SPECT, PET, MRA and MRI - with or without contrast media) A separate Copayment will be charged for each part of the body scanned as part of an imaging procedure.	Paid in full \$100 Copayment per procedure
Substance Use Disorder Detoxification	Paid in full
Vision Screening/Refractions	Paid in full
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 US Preventive Services Task Force)	Paid in full

*Calendar Year Deductible – Certain Covered Services will not be covered until you meet the Calendar Year Deductible. Only amounts incurred for Covered Services that are subject to the Deductible will count toward the Deductible. When an individual member of a family unit satisfies the individual Deductible for the Calendar Year, no further Calendar Year Deductible will be required for that individual member of the family. The Calendar Year Deductible is separate from, and is in addition to, any Copayment responsibility. The Calendar Year Deductible applies to the Annual Out-of-Pocket Maximum. The amounts that apply to the Calendar Year Deductible and based upon the PacifiCare's contracted rates.

⁴Annual Out-of-Pocket Maximum – means the Out-of-Pocket Maximum shown on the Schedule of Benefits. When a Member has paid an amount of deductibles and/or Copayments during the Calendar Year equal to one of the Out-of-Pocket Maximums. Copayments for certain types of Covered Services do not apply toward the Out-of-Pocket Maximum. Please refer to the Schedule of Benefits to determine applicability to the plan. When an individual member has paid an amount of deductible and copayments for the Calendar Year equal to the individual Out-of-Pocket Maximum, no further payments will be due the plan for covered services.

¹Out-of-Pocket Maximum does not include Copayments for durable medical equipment (except for nebulizers, peak flow meters, face masks and tubing for the Medically Necessary treatment of pediatric asthma and diabetic supplies), pharmacy and supplemental benefits, except Behavioral Health Supplemental Benefits.

²When the individual member meets the individual Out-of-Pocket maximum, no further copayments are required for the year for that individual.

³Cancer 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.

⁴The 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.

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

⁶Percentage Copayments amounts are based upon the PacifiCare negotiated rate.

⁷Bone anchored hearing aid will be subject to applicable medical/surgical categories (e.g. inpatient hospital, physician fees) only for members who meet the medical criteria specified in the Combined Evidence of Coverage and Disclosure Form. Limited to one (1) bone anchored hearing aid during the period of time the member is enrolled in the Health Plan (per lifetime). Repairs and/or replacement for a bone anchored hearing aid are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.

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 PacifiCare 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 30968
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**Customer Service:
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