

# PacifiCare SignatureValue® Advantage (VEBA Value Network) Offered by PacifiCare of California

20/250A

## HMO Schedule of Benefits

These services are covered as indicated when authorized through your Primary Care Physician in your PacifiCare SignatureValue-Advantage (VEBA Value Network) Participating Medical Group.

### General Features

|  |  |
|--|--|
| Calendar Year Deductible   | None   |
| Maximum Benefits   | Unlimited  |
| Annual Copayment Maximum <sup>1</sup><br>(2 individual maximum per family <sup>2</sup> )   | \$5,000/individual   |
| Office Visits  | \$20 Copayment   |
| Hospital Benefits<br>(Only one hospital Copayment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment.) (Autologous (self-donated) blood limited up to \$120.00 per unit) | \$250 Copayment per admit <sup>3</sup>                     |
| Emergency Services<br>(Copayment waived if admitted)   | \$100 Copayment  |
| Urgently Needed Services<br>(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<br>(Donor searches limited to \$15,000 per procedure)   | \$250 Copayment per admit <sup>3</sup>  |
| Cancer Clinical Trials <sup>4</sup>   | Paid at negotiated rate<br>Balance (if any) is the responsibility of the Member |
| Hospice Services<br>(Prognosis of life expectancy of one year or less)  | \$250 Copayment per admit <sup>3</sup>  |
| Hospital Benefits <sup>5</sup><br>(Only one hospital Copayment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment.) (Autologous (self-donated) blood limited up to \$120.00 per unit) | \$250 Copayment per admit <sup>3</sup>  |
| Mastectomy/Breast Reconstruction<br>(After mastectomy and complications from mastectomy)  | \$250 Copayment per admit <sup>3</sup>  |
| Maternity Care  | \$250 Copayment per admit <sup>3</sup>  |

## Benefits Available While Hospitalized as an Inpatient (Continued)

|   |  |
|---|--|
| Mental Health Services<br>(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).<br><b>Please refer to your Supplement to the PacifiCare Combined Evidence of Coverage and Disclosure Form for a description of this coverage.)</b><br>(Only one hospital Copayment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment.) | \$250 Copayment per admit <sup>3</sup> |
| Newborn Care <sup>5</sup>   | \$250 Copayment per admit <sup>3</sup> |
| Physician Care  | Paid in full                           |
| Reconstructive Surgery  | \$250 Copayment per admit <sup>3</sup> |
| Rehabilitation Care<br>(Including physical, occupational and speech therapy)  | \$250 Copayment per admit <sup>3</sup> |
| Skilled Nursing Care  | \$250 Copayment per admit <sup>3</sup> |
| Substance Use Disorder Detoxification<br>(Only one hospital Copayment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment.)  | \$250 Copayment per admit <sup>3</sup> |
| Voluntary Termination of Pregnancy<br>(Medical/medication and surgical)   |  |
| 1st trimester   | \$20 Copayment                         |
| 2nd trimester (12-20 weeks)   | \$20 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<br>(Serum is covered)  | \$20 Office Visit Copayment   |
| Ambulance  | Paid in full  |
| Cancer Clinical Trials <sup>4</sup>  | Paid at negotiated rate<br>Balance (if any) is the responsibility of the Member |
| Cochlear Implants Devices<br>(Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply)  | Paid in full  |
| Dental Treatment Anesthesia<br>(Additional charges for outpatient surgery or inpatient hospital benefits may apply)  | \$20 Copayment  |
| Dialysis<br>(Physician office visit Copayment may apply)   | \$20 Copayment per treatment  |
| Durable Medical Equipment  | Paid in full  |
| Durable Medical Equipment for the Treatment of Pediatric Asthma<br>(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<br>Vasectomy & Tubal Ligation   | Copayment will be the applicable Physician office visit, Outpatient Surgery or Inpatient Surgery Copayment   |
| Insertion/Removal of Intra-Uterine Device (IUD)  | \$20 Office Visit Copayment  |
| Intra-Uterine Device (IUD)   | 50% of cost Copayment <sup>6</sup>   |
| Removal of Norplant  | \$20 Office Visit Copayment  |
| Depo-Provera Injection   | \$20 Office Visit Copayment  |
| Depo-Provera medication<br>(Limited to one Depo-Provera injection every 90 days.)  | \$35 Copayment   |
| Voluntary Termination of Pregnancy<br>(Medical/medication and surgical)  |  |
| 1st trimester  | \$20 Copayment   |
| 2nd trimester (12-20 weeks)<br>– After 20 weeks, not covered unless Medically Necessary, such as the mother's life is in jeopardy or fetus is not viable.  | \$20 Copayment   |
| Health Education Services  | Paid in full   |
| Hearing Aid – Standard<br>\$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 <sup>8</sup><br>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<br>(Prognosis of life expectancy of one year or less)   | Paid in full   |
| Immunizations<br>(For children under two years of age, refer to Well-Baby Care)  | Paid in full   |
| Infertility Services   | Not covered  |
| Infusion Therapy<br>(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)<br>(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<br>(When available through and authorized by your <b>PacifiCare SignatureValue-Advantage (VEBA Value Network)</b> Participating Medical Group.)  | Paid in full   |
| Maternity Care, Tests and Procedures   | Paid in full   |

## Benefits Available On an Outpatient Basis (Continued)

|   |                             |
|---|-----------------------------|
| Mental Health Services<br>(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). <b>Please refer to your Supplement to the PacifiCare Combined Evidence of Coverage and Disclosure Form for a description of this coverage.</b> )  | \$20 Office Visit Copayment |
| Oral Surgery Services   | \$20 Copayment <sup>1</sup> |
| Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility<br>(Including physical, occupational and speech therapy)  | \$20 Office Visit Copayment |
| Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Center  | Paid in full                |
| Periodic Health Evaluations<br>(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 <b>PacifiCare SignatureValue-Advantage (VEBA Value Network)</b> 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<br>(For children under two years of age, refer to Well-Baby Care)  | \$20 Office Visit Copayment |
| Prosthetics and Corrective Appliances   | Paid in full                |
| Radiation Therapy<br>Standard:<br>(Photon beam radiation therapy)   | Paid in full                |
| Complex:<br>(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; Gamma knife and stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Copayment amount, if any)   | Paid in full                |
| Radiology Services<br>Standard:   | Paid in full                |
| Specialized scanning and imaging procedures:<br>(Examples include but are not limited to, CT, SPECT, PET, MRA and MRI - with or without contrast media)<br>A separate Copayment will be charged for each part of the body scanned as part of an imaging procedure.  | Paid in full                |
| Substance Use Disorder Detoxification   | \$20 Office Visit Copayment |
| Vision Screening/Refractions  | Paid in full                |
| Well-Baby Care<br>(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 <b>PacifiCare SignatureValue-Advantage (VEBA Value Network)</b> 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                |

## Benefits Available On an Outpatient Basis (Continued)

|   |              |
|---|--------------|
| Well-Woman Care<br>(Includes Pap smear (by your Primary Care Physician or an OB/GYN in your <b>PacifiCare SignatureValue-Advantage (VEBA Value Network)</b> Participating Medical Group) and referral by the <b>PacifiCare SignatureValue-Advantage (VEBA Value Network)</b> Participating Medical Group for screening mammography as recommended by the US Preventive Services Task Force) | Paid in full |
|---|--------------|

<sup>1</sup> Annual Copayment 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.

<sup>2</sup> When individual member meets annual copayment maximum, no further copayments are required for the year for that individual.

<sup>3</sup> Each hospital admission requires a \$250 Copayment.

<sup>4</sup> 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 Provider's billed charges and the rate negotiated by PacifiCare with Participating Providers, in addition to any applicable Copayments, Coinsurance or Deductibles.

<sup>5</sup> 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.

<sup>6</sup> Percentage Copayment amounts are based upon the PacifiCare negotiated rate.

<sup>7</sup> In instances where the negotiated rate is less than your Copayment, you will pay only the negotiated rate.

<sup>8</sup> Bone 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 PacifiCare SignatureValue-Advantage (VEBA Value Network) Participating Medical Group), each of the above-noted benefits is covered when authorized by your PacifiCare SignatureValue-Advantage (VEBA Value Network) 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  
Salt Lake City, UT 84130-0968**

**Customer Service:  
800-624-8822  
800-442-8833 (TDHI)  
[www.pacificare.com](http://www.pacificare.com)**

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