

PacifiCare SignaturePOS[®] Offered by PacifiCare of California

POS Schedule of Benefits

General Features	In-Network	Out-of-Network	
	Option 1 HMO	Option 2 Preferred Providers ¹	Option 3 Non-Preferred Providers ²
Your Policy Maximum While Insured	Unlimited	\$2,000,000	
Calendar Year Deductible (Maximum 3 individual Deductibles per family)	None	\$250 (Deductible is Combined for Options Two and Three)	
Annual Copayment Maximum ³ (3 individual maximum per family)	\$800/Individual	\$1,000/Individual ⁴	\$3,000/Individual ⁴
Office Visits	\$10 Copayment	\$20 Copayment ⁵	30% Copayment
Hospital Benefits (Only one Hospital Copayment per admit is applicable; if a subsequent transfer to another Facility is necessary, the Member is not responsible for additional Hospital admission Copayment.) (Autologous (self-donated) blood up to \$120 per unit)	\$100 per admit	10% Copayment ⁷	30% Copayment ⁷
Emergency Services	\$35 Copayment (Copayment is waived if admitted as an Inpatient)	Covered In-Network	
Urgently Needed Services (Medically Necessary services required outside your service area; please consult your Evidence of Coverage for additional details)	\$35 Copayment (Copayment is waived if admitted as an Inpatient)	Covered In-Network	
Pre-Existing Conditions	All conditions covered, provided they are covered benefits		

Benefits Available While Hospitalized as an Inpatient	In-Network	Out-of-Network	
	Option 1 HMO	Option 2 Preferred Providers ¹	Option 3 Non-Preferred Providers ²
Bone Marrow Transplants (Donor searches limited to \$15,000 per procedure)	\$100 per admit	10% Copayment ⁷	Not covered
Cancer Clinical Trials ⁷ (Services must be authorized by PacifiCare)	Paid at Negotiated rate; balance (if any) is the responsibility of the Member Copayments for routine patient care costs apply ⁸	Not covered	Not covered

Benefits Available While Hospitalized as an Inpatient (Continued)	In-Network	Out-of-Network	
	Option 1 HMO	Option 2 Preferred Providers ¹	Option 3 Non-Preferred Providers ²
Hospice Services (Prognosis of life expectancy of one year or less)	Paid in full	10% Copayment ⁷	30% Copayment ⁷
Hospital Benefits ⁹ (Only one Hospital Copayment per admit is applicable; if a subsequent transfer to another Facility is necessary, the Member is not responsible for additional Hospital admission Copayment.) (Autologous (self-donated) blood up to \$120.00 per unit)	\$100 per admit	10% Copayment ⁷	30% Copayment ⁷
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	\$100 per admit	10% Copayment ⁷	30% Copayment ⁷
Maternity Care	\$100 per admit	10% Copayment ⁷	30% Copayment ⁷
Mental Health Services (Severe Mental Illness (SMI) and Serious Emotional Disturbances of Children (SED) ¹⁰ (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.)	\$100 per admit	10% Copayment ⁷	30% Copayment ⁷
Newborn Care ⁹	\$100 per admit	10% Copayment ⁷	30% Copayment ⁷
Physician Care	Paid in full	10% Copayment ⁷	30% Copayment ⁷
Reconstructive Surgery	\$100 per admit	Not covered	Not covered
Rehabilitation Care (Including physical, occupational and speech therapy)	\$100 per admit	10% Copayment ⁷	30% Copayment ⁷
Skilled Nursing Facility Care	Paid in full	10% Copayment ⁷	30% Copayment ⁷
		(Up to Sixty (60) consecutive days from first treatment per disability) ¹²	
Substance Use Disorder Detoxification (Only one hospital Copayment per admit is applicable. If a transfer to another facility is necessary, the Member is not responsible for the additional Hospital admission Copayment.)	\$100 per admit	10% Copayment ⁷	30% Copayment ⁷
Voluntary Termination of Pregnancy (Medical/medication and surgical) – 1st Trimester – 2nd Trimester (12-20 weeks) After 20 weeks ¹³	\$10 Copayment	Not covered	Not covered
	\$10 Copayment	Not covered	Not covered
	Not covered	Not covered	Not covered

Benefits Available on an Outpatient Basis	In-Network	Out-of-Network	
	Option 1 HMO	Option 2 Preferred Providers¹	Option 3 Non-Preferred Providers²
Allergy Testing/Treatment (Serum is covered)	\$10 Copayment	\$20 Copayment ⁵	30% Copayment
Ambulance (Only one ambulance Copayment per trip may be applicable; if a subsequent ambulance transfer to another facility is necessary, the member is not responsible for additional ambulance Copayment)	Paid in full	Paid in full	Paid in full
Attention Deficit Disorder (Medical management)	\$10 Copayment	\$20 Copayment ⁵	30% Copayment
Cancer Clinical Trials ⁷ Balance (if any) is the responsibility of the Member	Paid at negotiated rate ⁸	Not covered	Not covered
Cochlear Implant Devices (Additional Copayment for Outpatient Surgery or Inpatient Hospital Benefits and Outpatient Rehabilitation Therapy may apply)	Paid in full	10% Copayment	30% Copayment
Dental Treatment Anesthesia (Additional Copayment for Outpatient Surgery and Inpatient Hospital Benefits may apply)	\$10 Copayment	Not covered	Not covered
Dialysis (Physician office visit Copayment may apply)	\$10 per treatment	\$20 Copayment ⁵	30% Copayment
Durable Medical Equipment	Paid in full	10% Copayment	30% Copayment
		(\$2,000 Annual Benefit Maximum) ¹²	
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	10% Copayment	30% Copayment
		(Does not apply to the annual Durable Medical Equipment benefit maximum)	
Family Planning/Voluntary Interruption of Pregnancy			
Vasectomy	\$10 Copayment	Not covered	Not covered
Tubal Ligation ¹⁵	\$10 Copayment	Not covered	Not covered
Insertion/Removal of Intra-Uterine Device (IUD)	\$10 Copayment	\$20 Copayment ⁵	30% Copayment
Intra-Uterine Device (IUD)	50% of Cost Copayment ⁵	Not covered	Not covered
Removal of Norplant	\$10 Copayment	\$20 Copayment ⁵	30% Copayment
Depo-Provera Injection	\$10 Copayment	\$20 Copayment ⁵	30% Copayment
Depo-Provera Medication (Limited to one Depo-Provera injection every 90 days)	\$35 Copayment	Not covered	Not covered
Voluntary Termination of Pregnancy			
– 1st Trimester	\$10 Copayment	Not covered	Not covered
– 2nd Trimester (12-20 weeks)	\$10 Copayment	Not covered	Not covered
After 20 weeks ¹³	Not covered	Not covered	Not covered

Benefits Available on an Outpatient Basis (Continued)	In-Network	Out-of-Network	
	Option 1 HMO	Option 2 Preferred Providers¹	Option 3 Non-Preferred Providers²
Health Education Services	Paid in full	Not covered	Not covered
Hearing Aid – Standard Benefit Maximum applies every three years. Limited to a single hearing aid (including repair/replacement) every three years)	Paid in full (\$5,000 Benefit Maximum)	10% Copayment (\$2,500 Benefit Maximum) ¹²	30% Copayment
Hearing Aid – Bone Anchored ¹⁶ 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	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	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	\$10 Copayment	Not covered	Not covered
Home Health Care Visits	Paid in full	\$20 Copayment ⁵ (Up to one-hundred (100) visits per year) ¹²	20% Copayment ⁷
Hospice Services (Prognosis of life expectancy of one year or less)	Paid in full	\$20 Copayment ^{5,7}	30% Copayment ⁷
Immunizations (For children under two years of age, refer to Well-Baby Care)	\$10 Copayment	\$20 Copayment ⁵	30% Copayment
Infertility Services	Not covered	Not covered	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	10% Copayment ⁷	30% Copayment ⁷
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	10% Copayment ⁷	30% Copayment ⁷

Benefits Available on an Outpatient Basis (Continued)	In-Network	Out-of-Network	
	Option 1 HMO	Option 2 Preferred Providers ¹	Option 3 Non-Preferred Providers ²
Laboratory Services	Paid in full (When available through and authorized by the Member's Participating Medical Group)	\$20 Copayment ⁵	30% Copayment
Maternity Care, Test and Procedures	Paid in full	\$20 Copayment ⁵	30% Copayment
Mental Health Services (Severe Mental Illness (SMI) and Serious Emotional Disturbances of Children (SED) ¹⁰) (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.)	\$10 Copayment	\$20 Copayment ⁵	30% Copayment
Oral Surgery Services	Paid in full	10% Copayment ⁷	30% Copayment ⁷
Outpatient Medical Rehabilitation Therapy (Including physical, occupational and speech therapy)	\$10 Copayment	\$20 Copayment ⁵ (Up to Sixty (60) consecutive days from first treatment per condition) ¹¹	30% Copayment
Outpatient Surgery	Paid in full	10% Copayment	30% Copayment
Periodic Health Evaluations Children 2–17 years Adults 18 years and over 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 year of age, refer to Well-Baby Care	\$10 Copayment \$10 Copayment	\$20 Copayment ⁵ Not covered	30% Copayment Not covered
Physician Care (For Children under two years of age, refer to Well-Baby Care)	\$10 Copayment	\$20 Copayment ⁵	30% Copayment
Prosthetics and Corrective Appliances	Paid in full	10% Copayment	30% Copayment

Benefits Available on an Outpatient Basis (Continued)	In-Network	Out-of-Network	
	Option 1 HMO	Option 2 Preferred Providers¹	Option 3 Non-Preferred Providers²
Radiation Therapy Standard: (Photon beam radiation therapy) 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 Paid in full	10% Copayment 10% Copayment	30% Copayment 30% Copayment
Radiology Services Standard: Specialized scanning and imaging procedures: (Examples include but are not limited to, CT, SPECT, PET ⁷ 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 Paid in full	\$20 Copayment ⁵ 10% Copayment	30% Copayment 30% Copayment
Substance Use Disorder Detoxification	Paid in full	\$20 Copayment ⁵	30% Copayment ⁷
Vision Refractions	\$10 Copayment	Not covered	Not covered
Vision Screening	\$10 Copayment	Not covered	Not covered
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) (Office visit Copayment applies to infants that are ill at time of service)	Paid in full	\$20 Copayment ⁵	30% Copayment
Well-Women 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)	\$10 Copayment	\$20 Copayment ⁵	30% Copayment

¹ Preferred Providers include PacifiCare PPO network Providers and HMO network Providers seen without referral from your Participating Medical Group. Preferred Providers accept their contractual fees as payment in full.

² Non-Preferred Providers can charge you more than what is Usual, Customary and Reasonable (UCR). You will be responsible for amounts above UCR and these amounts do not accumulate toward the Annual Copayment Maximum.

³ 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.

⁴ The Annual Copayment Maximum is combined for Options Two and Three. Once the Option Three Annual Copayment Maximum has been met, no additional Copayments will be required under Option Two.

⁵ The Deductible amount is waived.

⁶ Percentage Copayment amounts are based upon PacifiCare's negotiated rate.

- 7 Services require Preauthorization by PacifiCare.
- 8 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 Provider, 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, minus any applicable Copayment, Coinsurance or Deductibles.
- 9 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.
- 10 Refer to your Supplement to the Combined Evidence of Coverage and Disclosure Form for Severe Mental Illness (SMI) and Serious Emotional Disturbances of Children (SED) for additional coverage details.
- 11 Limitations are combined for Options Two and Three and for Inpatient and Outpatient services.
- 12 Limitations are combined for Options Two and Three.
- 13 Voluntary termination of pregnancy after the 20th week will be covered only when the mother's life is in jeopardy or fetus is not viable.
- 14 In Instances where the negotiated rate is less than your Copayment, you will pay only the negotiated rate.
- 15 This Copayment applies regardless of whether this benefit is performed on an Inpatient or Outpatient basis. If the service is performed on an Inpatient basis, you will also be required to pay the applicable Inpatient Copayment for your benefit plan, if any.
- 16 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.

Use of Emergency Services

Emergency Services are covered In-Network worldwide with a Copayment (waived if admitted as an inpatient). If In-Network procedures are not followed, and/or if services are not considered to be Emergency Services as defined in your Evidence of Coverage and Disclosure Form, but are Medically Necessary, then services will be covered as Out-of-Network Services for the applicable percentage Copayment after the deductible is satisfied.

In-Network Services

Option One/HMO – Except in the case of Medically Necessary Emergency or an Urgently Needed Service (Outside the geographic area service by your Participating Medical Group.) Each of the above noted benefits are covered when authorized by your Participating Medical Group or PacifiCare. A Utilization Review Committee may review the request for services.

Out-of-Network Services - Options Two and Three

The PacifiCare Point-of Service Plan requires that certain services be Pre-Authorized. Please refer to the Combined Evidence of Coverage and Disclosure Form for the list of services. The percentage payable shall be reduced to fifty percent (50%) for Medically Necessary covered Out-of-Network Services received for which Pre-Authorization was not obtained. The additional amount a Member is required to pay because Pre-Authorization was not obtained will not be applied to the Annual Copayment Maximum.

Note: This is not a contract. This is a Schedule of Benefits and its enclosures constitutes only a summary of copayments and benefits.

The Medical and Hospital Group Subscriber Agreement, 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 30969
Salt Lake City, UT 84130-0969**

**Customer Service:
800-913-9133
800-422-8833 (TDHI)
www.pacificare.com**

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