CALIFORNIA

PacifiCare®
SignatureValue
A select group of physicians

10-30/250a
HMO Schedule of Benefits

Effective July 1, 2003

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

General Features

Benefit	Coverage
Calendar Year Deductible	-0-
Maximum Benefits	Unlimited
Annual Copayment Maximum[1] *2 individual maximum per family*	$2,500/individual
Office Visits *– PCP* *– Specialist/Other Licensed Health Care Practitioner[2]* *(Member required to obtain referral to a Specialist or Other Licensed Health Care Practitioner except for OB/GYN Physician Services and Emergency/Urgently Needed Services.)*	 $10 Copayment $30 Copayment
Hospitalization	$250 Copayment per Admit
Emergency Services *(Copayment waived if admitted)*	$100 Copayment
Urgently Needed Services *(Medically Necessary services required outside your Service Area. Please consult your brochure for additional details. Copayment waived if admitted.)*	$50 Copayment

Benefits Available While Hospitalized As an Inpatient

Benefit	Coverage
Alcohol, Drug, or Other Substance Abuse or Addiction *(Detoxification only. Up to 5 days per year, 30 days per lifetime)*	$250 Copayment per Admit
Bone Marrow Transplants *(donor searches limited to $15,000)*	$250 Copayment per Admit
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)*	$250 Copayment per Admit
Hospital Benefits *(autologous (self-donated) blood up to $120.00 per unit)*	$250 Copayment per Admit
Mastectomy/Breast Reconstruction *(after mastectomy and complications from mastectomy)*	$250 Copayment per Admit
Maternity Care	$250 Copayment per Admit
Newborn Care[5]	$250 Copayment per Admit
Physician Care	Paid in Full
Reconstructive Surgery	$250 Copayment per Admit
Rehabilitation Care/Subacute Care	$250 Copayment per Admit
Skilled Nursing Care *(up to one hundred (100) consecutive calendar days from the first treatment per disability)*	$50 Copayment per Day
Voluntary Interruption of Pregnancy *– 1st trimester* *– 2nd trimester (12 – 20 weeks)* *– After 20 weeks*	 $125 Copayment $200 Copayment Not Covered unless mother's life is in jeopardy or when fetus is not viable

Benefits Available on an Outpatient Basis

Benefit	Copayment
Alcohol, Drug, or Other Substance Abuse or Addiction *(Detoxification only. Up to 5 days per year, 30 days per lifetime.)*	$30 Copayment
Allergy Testing/Treatment *(Serum is not covered.)*	
– PCP	$10 Copayment
– Specialist	$30 Copayment
Ambulance	$50 Copayment
Attention Deficit Disorder *(Medical Management)*	
– PCP	$10 Copayment
– Specialist/Other Licensed Health Care Practitioner	$30 Copayment
Cancer Clinical Trials[3, 4]	Paid at contracting rate Balance (if any) is the responsibility of the Member
Cochlear Implants	$30 Copayment
Corrective Appliances and Prosthetics	$50 Copayment[6]
Durable Medical Equipment *($2,000 annual benefit maximum)*	$50 Copayment[1, 6]
Eligible Materials and Supplies	Paid in Full
Family Planning/Voluntary Interruption of Pregnancy	
– Vasectomy	$50 Copayment
– Tubal Ligation[7]	$100 Copayment
– Insertion/Removal of Intra-Uterine Device (IUD)	
– PCP	$10 Copayment
– Specialist	$30 Copayment
– Intra-Uterine Device (IUD)	$50 Copayment
– Removal of Norplant	
– PCP	$10 Copayment
– Specialist	$30 Copayment
– Depo-Provera injection	
– PCP	$10 Copayment
– Specialist	$30 Copayment
– Depo-Provera medication (limited to one Depo-Provera injection every 90 days)	$35 Copayment
– Voluntary interruption of pregnancy	
1st Trimester	$125 Copayment
2nd Trimester (12 – 20 weeks)	$200 Copayment
After 20 weeks	Not covered unless mother's life is in jeopardy or when fetus is not viable
Health Education Services	Paid in Full
Hearing Screening	
– PCP/Other Licensed Health Care Practitioner[2]	$10 Copayment
– Specialist	$30 Copayment
Hemodialysis	$30 Copayment
Home Care *(up to one hundred (100) visits per 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)*	
– PCP	$10 Copayment
– Specialist	$30 Copayment
Infusion Therapy *(Infusion Therapy is a separate Copayment in addition to Home Health or a Facility Copayment.)*	$100 Copayment[6]
Injectable Drugs *(Copayment not applicable to allergy serum, immunizations, birth control, infertility or insulin. Please see the PacifiCare Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form for more information on these benefits, if any.)*	$150 Copayment[6]
Laboratory	Paid in Full

Benefit	Copayment
Maternity Care, Test and Procedures	$10 Copayment
Medical Social Services	Paid in Full
Mental Health Services	
– Inpatient – Severe Mental Illness (SMI) and Serious Emotional Disturbances of children (SED) only	$250 Copayment
– Outpatient – SMI and SED	$30 Copayment per Visit
– Outpatient – Crisis Intervention (Up to 20 Visits per Calendar Year)	$35 Copayment per Visit
(As required by state law, coverage includes treatment for Severe Mental Illness (SMI) of adults and children and treatment of Serious Emotional Disturbances of Children (SED). Please refer to your Supplement to the PacifiCare Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form for a description of this coverage.)	
Oral Surgery Services	Paid in Full
Outpatient Rehabilitation Therapy	$30 Copayment
Outpatient Surgery	$250 Copayment per Admit
Periodic Health Evaluations *(for children under two years of age, refer to Well-Baby Care)*	$10 Copayment
Physician Care *(for children under two years of age, refer to Well-Baby Care)*	
– PCP/Other Licensed Health Care Practitioner[2]	$10 Copayment
– Specialist/Other Licensed Health Care Practitioner[2]	$30 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. Gamma knife sterotactic procedures are covered as Outpatient surgery. Please refer to outpatient surgery for Copayment amount, if any.)	$100 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[6]
Vision Refractions	$30 Copayment
Vision Screening	
– PCP	$10 Copayment
– Specialist/Other Licensed Health Care Practitioner	$30 Copayment
Well-Baby Care *Preventive Health Service, including immunizations 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 for children under two years of age.*	Paid in Full
Well-Woman Care *(Includes Pap smear (by your Primary Care Physician or an OB/GYN in your Participating Medical Group or Family Practice Physician) and referral by the Participating Medical Group for screening mammography as recommended by the U.S. Preventive Services Task Force.)*	$10 Copayment

Supplemental Outpatient Prescription Drug Benefits

Benefit	Copayment
Prescription Benefits[8] *(Copayment applies per prescription up to a one-month supply for Formulary and prior authorized Non-Formulary drugs)*	RETAIL: $10 Copayment for Generic Drugs[1] $30 Copayment for Brand-Name Drugs[1]
Mail Order (up to 3 Prescription Units or a 90-day supply)	
– Generic	$20 Copayment[1]
– Brand Name	$60 Copayment[1]

[1] Annual Copayment Maximum does not include Copayments for Supplemental Outpatient Prescription Drug Benefits or Durable Medical Equipment.

[2] Copayments for Audiologist and Podiatrist visits will be the same as for the PCP.

[3] 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 Provider's 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 ours of the baby's normal vaginal delivery or 96 hours of the baby's 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] This Copayment applies regardless of whether this service 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.

[8] Refer to your *Supplement to the Combined Evidence of Coverage and Disclosure Form* and Pharmacy *Schedule of Benefits* for prescription drug coverage details.

Except in the case of a Medically Necessary Emergency or an Urgently Needed Service (outside the Geographic Area served 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.

The Individual Health Plan *HMO Subscriber Agreement* must be consulted to determine the exact terms and conditions of coverage.

Note: This *Schedule of Benefits* constitutes an integral part of your *Individual Health Plan HMO Subscriber Agreement*. Please keep this *Schedule of Benefits* with your agreement.

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