CALIFORNIA SMALL GROUP

PacifiCare SignatureValue℠
A select group of physicians

PacifiCare SignatureValue 10/500d HMO Schedule of Benefits

Effective February 1, 2006

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

General Features

Calendar Year Deductible	None
Maximum Benefits	Unlimited
Annual Copayment Maximum[1] *(3 individual maximum per family)*	$2,000/individual
Office Visits	$10 Copayment
Hospital Benefits *(Only one hospital Copayment per day is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment for that day. Autologous (self-donated) blood up to $120.00 per unit.)*	$500 Copayment per day Copayment applies to a maximum of 2 days per stay
Emergency Services *(Copayment waived if admitted)*	$50 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.)*	$50 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	$500 Copayment per day Copayment applies to a maximum of 2 days per stay
Bone Marrow Transplants *(Donor searches limited to $15,000 per procedure)*	$500 Copayment per day Copayment applies to a maximum of 2 days per stay
Cancer Clinical Trials[2]	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Hospice Services *(Prognosis of life expectancy of one year or less)*	$500 Copayment per day Copayment applies to a maximum of 2 days per stay
Hospital Benefits *(Only one hospital Copayment per day is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment for that day. Autologous (self-donated) blood up to $120.00 per unit.)*	$500 Copayment per day Copayment applies to a maximum of 2 days per stay
Mastectomy/Breast Reconstruction *(After mastectomy and complications from mastectomy)*	$500 Copayment per day Copayment applies to a maximum of 2 days per stay
Maternity Care	$500 Copayment per day Copayment applies to a maximum of 2 days per stay

Benefits Available While Hospitalized as an Inpatient (Continued)

Benefit	Copayment
Mental Health Services	
Severe Mental Illness (SMI) and Serious Emotional Disturbance of Children (SED)[3] *(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.)*	$250 Copayment per admit
Newborn Care[4]	$500 Copayment per day Copayment applies to a maximum of 2 days per stay
Physician Care	Paid in full
Reconstructive Surgery	$500 Copayment per day Copayment applies to a maximum of 2 days per stay
Rehabilitation Care *(Including physical, occupational and speech therapy)*	$500 Copayment per day Copayment applies to a maximum of 2 days per stay
Skilled Nursing Facility Care *(Up to 100 consecutive calendar days from the first treatment per disability)*	$200 Copayment per day
Voluntary Termination of Pregnancy *(Medical/medication and surgical)*	
1st trimester	$125 Copayment
2nd trimester (12-20 weeks)	$200 Copayment
After 20 weeks	Not covered unless Mother's life is in jeopardy or fetus is not viable

Benefits Available on an Outpatient Basis

Benefit	Copayment
Alcohol, Drug or Other Substance Abuse - Detoxification	$10 Office Visit Copayment
Allergy Testing/Treatment *(Serum is covered)*	$10 Office Visit Copayment
Ambulance *(Only one ambulance Copayment per trip may be applicable. If a subsequent ambulance transfer to another facility is necessary, you are not responsible for the additional ambulance Copayment.)*	$50 Copayment
Cancer Clinical Trials[2]	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Cochlear Implant Device *(Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply)*	$40 Copayment[6] per item
Dental Treatment Anesthesia *(Additional Copayment for outpatient surgery and inpatient hospital benefits may apply)*	$40 Copayment
Dialysis *(Physician office visit Copayment may apply)*	$40 Copayment per treatment
Durable Medical Equipment *($2,000 annual benefit maximum)*	$50 Copayment[6] per item
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. Does not apply to the annual Durable Medical Equipment benefit maximum.)*	50% of cost Copayment[7]

Benefits Available on an Outpatient Basis (Continued)

Benefit	Copayment
Family Planning/Voluntary Termination of Pregnancy	
Vasectomy	$50 Copayment
Tubal Ligation	$100 Copayment
(Additional Copayment for inpatient hospital benefits may apply if performed on an inpatient basis)	
Insertion/Removal of Intra-Uterine Device (IUD)	$10 Office Visit Copayment
Intra-Uterine Device (IUD)	$50 Copayment
Removal of Norplant	$10 Office Visit Copayment
Depo-Provera Injection	$10 Office Visit Copayment
Depo-Provera Medication *(Limited to one Depo-Provera injection every 90 days)*	$35 Copayment
Voluntary Termination of Pregnancy *(Medical/medication and surgical)*	
- 1st trimester	$125 Copayment
- 2nd trimester (12-20 weeks)	$200 Copayment
- After 20 weeks	Not covered unless Mother's life is in jeopardy or fetus is not viable
Health Education Services	Paid in full
Hearing Screening	$10 Office Visit Copayment
Home Health Care *(Up to 100 visits per calendar year)*	$15 Copayment per visit
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)*	$10 Office Visit Copayment
Infertility Services	Not covered
Infusion Therapy *(Infusion therapy is a separate Copayment in addition to a home health or a facility Copayment. Copayment applies per 30 days or treatment plan, whichever is shorter.)*	$100 Copayment[6]
Injectable Drugs	
Outpatient Injectable Medications and Self-Injectable Medications *(Copayment not applicable to allergy serum, immunizations, birth control, infertility and insulin. For 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 or the Group Subscriber Agreement for more information on these benefits, if any.)*	$150 Copayment[6] per visit
Laboratory Services *(When available through and authorized by the Member's Participating Medical Group)*	Paid in full
Maternity Care, Tests and Procedures	Paid in full
Mental Health Services	
Crisis Intervention *(Up to twenty (20) visits per Calendar Year)*	$35 Copayment
Severe Mental Illness (SMI) and Serious Emotional Disturbance of Children (SED)[3] *(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.)*	$10 Office Visit Copayment
Oral Surgery Services	$300 Copayment[6]

Benefits Available on an Outpatient Basis (Continued)

Benefit	Copayment
Outpatient Prescription Drug Benefit[5]	
(Copayment applies per Prescription Unit or up to 30 days)	
Generic Formulary	$15 Copayment
Brand-Name Formulary	$35 Copayment
Non-Formulary	$50 Copayment
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility *(Including physical, occupational and speech therapy)*	$10 Office Visit Copayment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	$400 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.)*	$10 Office Visit Copayment
Physician Care *(For children under two years of age, refer to Well-Baby Care)*	$10 Office Visit Copayment
Prosthetics and Corrective Appliances	$50 Copayment[6] per item
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. Gamma knife and stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Copayment amount, if any.)*	$200 Copayment[6]
Radiology Services	
Standard	Paid in full
Specialized scanning and imaging procedures *(Examples include, but are not limited to, CT, SPECT, PET, MRA and MRI – with or without contrast media)*	$100 Copayment[6] per procedure
Specialized Footwear for Foot Disfigurement	$50 Copayment[6] per item
Vision Screening/Refractions	$10 Office Visit Copayment
Well-Baby Care *(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.)*	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 U.S. Preventive Services Task Force)*	$10 Office Visit Copayment

[1]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), pharmacy and supplemental benefits.

[2]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.

[3]Refer to your *Supplement to the Combined Evidence of Coverage and Disclosure Form* for Severe Mental Illness (SMI) and Serious Emotional Disturbance of Children (SED) for coverage details.

[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. Refer to your *Combined Evidence of Coverage and Disclosure Form* for more details.

[5] Refer to your *Supplement to the Combined Evidence of Coverage and Disclosure Form* and *Pharmacy Schedule of Benefits* for Outpatient Prescription Drug Benefits for coverage details.

[6]In instances where the contracted rate is less than your Copayment, you will pay only the contracted rate.

[7]Percentage Copayment amounts are based upon PacifiCare's contracted 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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