

PACIFICARE SIGNATUREVALUE ADVANTAGE 20/1500DED  
HMO DEDUCTIBLE SCHEDULE OF BENEFITS

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

**General Features**

Calendar Year Deductible <sup>1</sup>	Individual \$1,500 Family \$3,000
Maximum Benefits	Unlimited
Annual Out-of-Pocket Maximum <sup>2,3</sup> <i>(Combined total of Deductible and Annual Copayment Maximum)</i>	Individual \$4,000 Family <sup>4</sup> \$8,000
Office Visits	\$20 Copayment
Hospital Benefits <i>(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 per unit.)</i>	\$500 Copayment per day after Deductible
Emergency Services <i>(Copayment waived if admitted)</i>	\$100 Copayment
Urgently Needed Services <i>(Medically Necessary Services required outside geographic area served by your Participating Medical Group. Please consult your Combined Evidence of Coverage and Disclosure Form for additional details. Copayment waived if admitted.)</i>	\$100 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 after Deductible
Bone Marrow Transplants <i>(Donor searches limited to \$15,000 per procedure)</i>	\$500 Copayment per day after Deductible
Cancer Clinical Trials <sup>6</sup>	Paid at negotiated rate after Deductible Balance (if any) is the responsibility of the Member
Hospice Services <i>(Prognosis of life expectancy of one year or less)</i>	\$500 Copayment per day after Deductible
Hospital Benefits <i>(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.)</i>	\$500 Copayment per day after Deductible
Mastectomy/Breast Reconstruction <i>(After mastectomy and complications from mastectomy)</i>	\$500 Copayment per day after Deductible
Maternity Care	\$500 Copayment per day after Deductible

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

Mental Health Services <i>Severe Mental Illness (SMI) and Serious Emotional Disturbance of Children (SED)</i> <i>(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.)</i>	\$250 Copayment per admit
Newborn Care <i>(The newborn care Deductible and Copayment does not apply 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.)</i>	\$500 Copayment per day after Deductible
Physician Care	Paid in Full
Reconstructive Surgery	\$500 Copayment per day after Deductible
Rehabilitation Care <i>(Including physical, occupational and speech therapy)</i>	\$500 Copayment per day after Deductible
Skilled Nursing Facility Care <i>(Up to 100 consecutive calendar days from the first treatment per disability)</i>	\$200 Copayment per day
Voluntary Termination of Pregnancy <i>(Medical/medication and surgical)</i> - 1st Trimester - 2nd Trimester (12-20 weeks) - After 20 weeks	\$125 Copayment after Deductible \$200 Copayment after Deductible Not covered unless Mother's life is in jeopardy or fetus is not viable.

## Benefits Available on an Outpatient Basis

Alcohol, Drug, or Other Substance Abuse Detoxification	\$20 Office Visit Copayment
Allergy Testing/Treatment <i>(Serum is covered)</i>	\$20 Office Visit Copayment
Ambulance <i>(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.)</i>	\$50 Copayment
Cancer Clinical Trials <sup>6</sup>	Paid at negotiated rate after Deductible Balance (if any) is the responsibility of the Member
Cochlear Implant Devices <i>(Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply.)</i>	\$40 Copayment <sup>7</sup> per item after Deductible
Dental Treatment Anesthesia <i>(Additional Copayment for outpatient surgery or inpatient hospital benefits may apply)</i>	\$40 Copayment after Deductible
Dialysis <i>(Physician office visit copayment may apply)</i>	\$40 Copayment per treatment after Deductible
Durable Medical Equipment <sup>3</sup> <i>(\$2,000 Annual Benefit Maximum)</i>	\$50 Copayment <sup>7</sup> per item

## Benefits Available on an Outpatient Basis (Continued)

Durable Medical Equipment for the Treatment of Pediatric Asthma <i>(The annual DME benefit maximum does not apply to nebulizers, masks, tubing and peak flow meters for the treatment of asthma for Dependent children under the age of 19.[Does not apply to the annual Durable Medical Equipment benefit maximum.]</i>	30% of Cost Copayment <sup>5</sup>
Family Planning/Voluntary Termination of Pregnancy Vasectomy Tubal Ligation <i>(Additional Copayment for inpatient hospital benefits may apply if performed on an inpatient basis.)</i> Insertion/Removal of Intra-Uterine Device (IUD) Intra-Uterine Device (IUD) Removal of Norplant Depo-Provera Injection Depo-Provera Medication <i>(Limited to one Depo-Provera injection every 90 days.)</i> Voluntary Termination of Pregnancy <i>(Medical/medication and surgical)</i> - 1st Trimester - 2nd Trimester (12-20 weeks) - After 20 weeks	\$50 Copayment \$100 Copayment \$20 Office Visit Copayment \$50 Copayment \$20 Office Visit Copayment \$20 Office Visit Copayment \$35 Copayment \$125 Copayment after Deductible \$200 Copayment after Deductible Not covered unless Mother's life is in jeopardy or fetus is not viable.
Health Education Services	Paid in Full
Hearing Screening	\$20 Office Visit Copayment
Home Health Care Visits <i>(Up to 100 visits per calendar year)</i>	\$15 per visit
Hospice Services <i>(Prognosis of life expectancy of one year or less)</i>	Paid in Full
Immunizations <i>(For children under two years of age, refer to Well-Baby Care)</i>	\$20 Office Visit Copayment
Infertility Services	Not Covered
Infusion Therapy <i>(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.)</i>	\$100 Copayment <sup>7</sup> after Deductible
Injectable Drugs Outpatient Injectable Medications Self-Injectable Medications <i>(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.)</i>	\$150 Copayment <sup>7</sup> per visit after Deductible \$150 Copayment <sup>7</sup>
Laboratory Services <i>(When available through and authorized by your Participating Medical Group)</i>	Paid in Full
Maternity Care, Tests and Procedures	Paid in Full

## Benefits Available on an Outpatient Basis (Continued)

<b>Mental Health Services</b>	
Crisis Intervention	Not Covered
Severe Mental Illness (SMI) and Serious Emotional Disturbance of Children (SED) <i>(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.)</i>	\$20 Office Visit Copayment
<b>Oral Surgery Services</b>	\$300 Copayment <sup>7</sup> after Deductible
<b>Outpatient Prescription Drug Benefit<sup>3</sup></b> <i>(Copayment applies per Prescription Unit or up to 30 days)</i>	
Generic Formulary	\$20 Copayment
Brand-Name Formulary	\$35 Copayment
Non-Formulary	\$50 Copayment
<b>Outpatient Rehabilitation Therapy at a participating free-standing or outpatient facility</b> <i>(Including physical, occupational and speech therapy)</i>	\$20 Office Visit Copayment
<b>Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility</b>	\$300 Copayment per admit after Deductible
<b>Periodic Health Evaluations</b> <i>(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.)</i>	\$20 Office Visit Copayment
<b>Physician Care</b> <i>(For children under two years of age, refer to Well-Baby Care)</i>	\$20 Office Visit Copayment
<b>Prosthetics and Corrective Appliances</b>	\$50 Copayment <sup>7</sup> per item after Deductible
<b>Radiation Therapy</b>	
Standard: <i>(Photon beam radiation therapy)</i>	Paid in Full
Complex: <i>(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.)</i>	\$200 Copayment <sup>7</sup> after Deductible
<b>Radiology Services</b>	
Standard:	Paid in Full
Specialized Scanning and Imaging Procedures: <i>(Examples include, but are not limited to, CT, SPECT, PET, MRA and MRI - with or without contrast media)</i>	\$100 Copayment <sup>7</sup> after Deductible
<b>Specialized Footwear for Foot Disfigurement</b>	\$50 Copayment <sup>7</sup> per item after Deductible
<b>Vision Refractions</b>	\$20 Office Visit Copayment
<b>Vision Screening</b>	\$20 Office Visit Copayment

**Benefits Available on an Outpatient Basis (Continued)**

<b>Well-Baby Care</b> <i>(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.)</i>	Paid in Full
<b>Well-Woman Care</b> <i>(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)</i>	\$20 Office Visit Copayment

<sup>1</sup>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 the 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 applied to the Calendar Year Deductible are based upon PacifiCare's contracted rates.

<sup>2</sup>Out-of-Pocket Maximum - Copayments for certain types of Covered Services do not apply toward the Out-of-Pocket Maximum. Please refer to this 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 to the plan for covered services.

<sup>3</sup>The Out-of-Pocket Maximum does not include Copayments for Durable Medical Equipment (except for diabetic supplies and nebulizers, peak flow meters, face masks and Medically Necessary treatment of pediatric asthma), Pharmacy and Supplemental Benefits.

<sup>4</sup>When individual member meets the Individual Out-of-Pocket Maximum, no further copayments are required for the year for that individual.

<sup>5</sup>Percentage Copayment amounts are based upon PacifiCare's contracted rate.

<sup>6</sup>Cancer Clinical Trial Services require pre-authorization by PacifiCare. 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.

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