

PacifiCare SignatureValue® (HealthCare Partners Network) Offered by PacifiCare of California

25-75/500ded

HMO Deductible Schedule of Benefits

Effective 10/1/2010

These services are covered as indicated when authorized through your Primary Care Physician in the Healthcare Partners Narrow Network.

General Features

Calendar Year Deductible ¹ (2 individual maximum per family)	\$500 Individual
Maximum Benefits	Unlimited
Annual Out-of-Pocket Maximum ² (Combined total of Deductible and Annual Copayment Maximum)	\$1,500 Individual \$3,000 Family
PCP Office Visit Copayment Deductible Maximum Per Visit (Deductible Maximum Charged per office visit until Calendar Year Deductible Satisfied) ^{1a}	\$85 Deductible Maximum Per Visit
Specialist Office Visit Copayment Deductible Maximum Per Visit Deductible Maximum Charged per office visit until Calendar Year Deductible Satisfied) ^{1a}	\$200 Deductible Maximum Per Visit
PCP Office Visit	\$25 PCP Copayment after Deductible
Specialist/Nonphysician Health Care Practitioner Office Visits (You are required to obtain referrals to Specialists, except for OB/GYN Physician Services and Emergency/Urgently Needed Services) ³	\$75 Specialist Copayment after Deductible
Hospital Benefits ⁴	20% of Cost Copayment ⁴ after Deductible
Emergency Services (Copayment waived if admitted)	20% of Cost Copayment ⁴ after Deductible
Urgently Needed Services (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.)	20% of Cost Copayment ⁴ after Deductible
Pre-Existing Conditions	All conditions covered, provided they are covered benefits

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	20% of Cost Copayment ⁴ after Deductible
Cancer Clinical Trials ⁵	Paid at negotiated rate after Deductible (Balance if any is the responsibility of the Member)
Hospice Services (Prognosis of life expectancy of one year or less)	20% of Cost Copayment ⁴ after Deductible
Hospital Benefits (Autologous (self-donated) blood up to \$120.00 per unit)	20% of Cost Copayment ⁴ after Deductible

Benefits Available While Hospitalized as an Inpatient (Continued)

Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	20% of Cost Copayment ⁴ after Deductible
Maternity Care	20% of Cost Copayment ⁴ after Deductible
Mental Health Services Severe Mental Illness (SMI) and Serious Emotional Disturbance of Children (SED) (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.)	20% of Cost Copayment ⁴ (Deductible Waived)
Newborn Care (The newborn care Deductible and/or Copayment does not apply when the newborn is discharged with the mother within 48 hours of normal vaginal delivery or 96 hours of the cesarean delivery. Please see the Combined Evidence of Coverage and Disclosure Form for more details)	20% of Cost Copayment ⁴ after Deductible
Physician Care	Paid in full (Deductible Waived)
Reconstructive Surgery	20% of Cost Copayment ⁴ after Deductible
Rehabilitation Care (Including physical, occupational and speech therapy)	20% of Cost Copayment ⁴ after Deductible
Skilled Nursing Facility Care (Up to 100 consecutive calendar days from the first treatment per disability)	20% of Cost Copayment ⁴ after Deductible
Voluntary Termination of Pregnancy (Medical/medication and surgical) – 1 st trimester – 2 nd trimester – After 20 weeks Not covered unless Medically Necessary, such as the Mother's life is in jeopardy or fetus is not viable	\$125 Copayment after Deductible \$200 Copayment after Deductible

Benefits Available on an Outpatient Basis

Allergy Testing/Treatment PCP Office Visit Specialist/Nonphysician Health Care Practitioner Office Visit (Serum is covered)	\$25 PCP Office Visit Copayment after Deductible \$75 Specialist Office Visit Copayment after Deductible
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 additional ambulance Copayment)	\$50 Copayment (Deductible Waived)
Cancer Clinical Trials ⁵	Paid at negotiated rate after Deductible (Balance if any is the responsibility of the Member)
Cochlear Implant Devices ⁶ (Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply)	\$50 Copayment per item after Deductible
Dental Treatment Anesthesia (Additional Copayment for outpatient surgery or inpatient hospital benefits may apply)	\$50 Copayment per treatment after Deductible

Benefits Available on an Outpatient Basis (Continued)

Dialysis (Physician office visit Copayment may apply)	\$50 Copayment per treatment after Deductible
Durable Medical Equipment ^{2,6} (\$2,000 Annual Benefit Maximum) (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. Also, the DME benefit maximum does not apply to diabetic supplies.)	\$50 Copayment per item (Deductible Waived)
Durable Medical Equipment for the Treatment of Pediatric Asthma (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)	Paid in full (Deductible Waived)
Family Planning/Voluntary Termination of Pregnancy	
Vasectomy	\$50 Copayment after Deductible
Tubal Ligation (Additional Copayment for inpatient hospital benefits may apply if performed on an inpatient basis.)	\$100 Copayment after Deductible
Insertion/Removal of Intra-Uterine Device (IUD)	
PCP Office Visit	\$25 PCP Office Visit Copayment after Deductible
Specialist/Nonphysician Health Care Practitioner Office Visit	\$75 Specialist Office Visit Copayment after Deductible
Intra-Uterine Device (IUD)	\$50 Copayment after Deductible
Removal of Norplant	
PCP Office Visit	\$25 PCP Office Visit Copayment after Deductible
Specialist/Nonphysician Health Care Practitioner Office Visit	\$75 Specialist Office Visit Copayment after Deductible
Depo-Provera Injection	
PCP Office Visit	\$25 PCP Office Visit Copayment after Deductible
Specialist/Nonphysician Health Care Practitioner Office Visit	\$75 Specialist Office Visit Copayment after Deductible
Depo-Provera Medication (Limited to one Depo-Provera injection every 90 days)	\$35 Copayment after Deductible
Voluntary Termination of Pregnancy (Medical/medication and surgical)	
– 1 st trimester	\$125 Copayment after Deductible
– 2 nd trimester	\$200 Copayment after Deductible
– After 20 weeks	
Not covered unless Medically Necessary, such as the Mother's life is in jeopardy or fetus is not viable	
Health Education Services	Paid in full
Hearing Aid – Standard (\$2,500 Benefit Maximum every three years. Limited to a single hearing aid (including repair/replacement) every three years)	\$50 Copayment (Deductible Waived)
Hearing Aid – Bone Anchored ⁸ 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	
PCP Office Visit	\$25 PCP Office Visit Copayment after Deductible
Specialist/Nonphysician Health Care Practitioner Office Visit) ³	\$75 Specialist Office Visit Copayment after Deductible
Home Health Care Visits (Up to 100 visits per calendar year)	\$15 Copayment per visit (Deductible Waived)

Benefits Available on an Outpatient Basis (Continued)

Hospice Services (Prognosis of life expectancy of one year or less)	Paid in full after Deductible
Immunizations (Children under 2 years of age refer to Well-Baby Care)	Paid in full (Deductible Waived)
Infertility Treatment ⁷	Not covered
Infusion Therapy ⁶ (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)	\$100 Copayment after Deductible
Injectable Drugs Outpatient Injectable Medications ⁶ Self-Injectable Medications ⁶ (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.)	\$100 Copayment after Deductible \$100 Copayment (Deductible Waived)
Laboratory Services (When available through or authorized by your Participating Medical Group)	Paid in full
Maternity Care, Tests and Procedures	\$25 PCP Office Visit Copayment (Deductible Waived)
Mental Health Services Severe Mental Illness (SMI) and Serious Emotional Disturbance of Children (SED)	\$40 Office Visit Copayment (Deductible Waived)
Oral Surgery Services ⁶	\$100 Copayment after Deductible
Outpatient Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility	\$25 PCP Office Visit Copayment after Deductible \$75 Specialist Office Visit Copayment after Deductible
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery facility	20% of Cost of Copayment after Deductible
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)	Paid in full (Deductible Waived)
Prosthetics and Corrective Appliances ⁶	\$50 Copayment per item (Deductible Waived)
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 Gamma Knife and Stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for copayment amount, if any.) ^{1a, 6}	Paid in Full (Deductible Waived) \$50 Deductible Maximum Per Visit (Paid in full after Deductible has been met)
Radiology Services Standard Specialized Scanning and Imaging Procedures: (Examples include, but are not limited to, CT, SPECT, PET, MRA and MRI - with or without contrast media) ^{1a, 6}	Paid in full (Deductible Waived) \$50 Deductible Maximum Per Visit (Paid in full after Deductible has been met)
Specialized Footwear for Foot Disfigurement ⁶	\$50 Copayment per item (Deductible Waived)

Benefits Available on an Outpatient Basis (Continued)

Vision Screening/Refractions	
PCP Office Visit	\$25 PCP Office Visit Copayment after Deductible
Specialist/Nonphysician Health Care Practitioner Office Visit	\$75 Specialist Office Visit Copayment after Deductible
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 (Deductible Waived)
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)	Paid in full (Deductible Waived)

¹ Calendar Year Deductible – You are responsible for 100% of the cost of certain covered services until the Calendar Year Deductible is met. Only amounts incurred for Covered Services that are subject to the Deductible will count toward the Deductible. When an individual member of a 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. When enrolled members of the family meet the Family Calendar Year Deductible, no further Calendar Year Deductible is required for members 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.

^{1a}When a member has not met the Calendar Year Deductible, the member has to pay the applicable PCP Office Visit Copayment Deductible Maximum Per Visit, Specialist/Nonphysician Health Care Practitioner Office Visit Deductible Maximum Per Visit, Complex Radiation Therapy and Specialized Scanning and Imaging Procedures Radiology Services Deductible Maximum Per Visit. Once the Calendar Year Deductible is met, the member will pay the applicable Copayment.

If the actual cost of the services the member receives from his Primary Care Physician or Specialist is below the Primary Care and Specialist Office Visit Deductible Maximum, the member will be charged the lower amount.

² Annual Out-of-Pocket Maximum – means the Out-of-Pocket Maximum shown on the Schedule of Benefits. When a Member has paid an amount of deductibles and/or Copayments during the Calendar Year equal to the Out-of-Pocket Maximums. Copayments for certain types of Covered Services do not apply toward the Out-of-Pocket Maximum.

When enrolled members of the family meet the Family Annual Out-of-Pocket Maximum, no further copayments are required for members of the same family. When an individual member of a family meets the Individual Out-of-Pocket Maximum, no further copayments are required for the year for that individual.

Out-of-Pocket Maximum does not include Copayments for Durable Medical Equipment (except for nebulizers, peak flow meters, face masks and Medically Necessary treatment of pediatric asthma and diabetic supplies), Infertility Services, Pharmacy. The Out-of-Pocket Maximum includes the SMI/SED mental health services and Behavioral Health Supplemental Benefits, if any.

³ Copayments for Audiologist and Podiatrist visits will be the same as for the PCP.

⁴ Percentage of Contracted rate is based on PacifiCare's Contracted Rate.

⁵ 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.

⁶ In instances where the contracted rate is less than your copayment, you will pay only the contracted rate

⁷ Infertility treatment is not covered except for Groups that elect the Infertility Rider. The infertility treatment is covered at 50% of Cost Copayment.

⁸ 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 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.

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.

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