

**PACIFICARE SIGNATUREVALUE 20-35/80
HMO SCHEDULE OF BENEFITS**

EFFECTIVE NOVEMBER 1, 2004

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 <i>(2 individual maximums per family)</i>	\$2,500/Individual
Office Visits - PCP - Specialist/Nonphysician Health Care Practitioner ² <i>(Member required to obtain referral to a specialist or Nonphysician HealthCare Practitioner, except for OB/GYN Physician Services and Emergency/Urgently Needed Services.)</i>	\$20 Copayment \$35 Copayment
Hospitalization <i>(Only one hospital Copayment per admit is applicable. If a subsequent transfer to another facility is necessary, the Member is not responsible for the addition hospital admission Copayment.)</i>	20% of Cost Copayment ³
Emergency Services <i>(Copayment waived if admitted)</i>	\$100 Copayment
Urgently Needed Services <i>(Medically Necessary services required outside the geographic area served by your Participating Medical Group. Please consult your brochure for additional details. Copayment waived if admitted.)</i>	\$50 Copayment

Benefits Available While Hospitalized as an Inpatient

Alcohol, Drug or Other Substance Abuse - Detoxification <i>(Up to five days per year, 30 days per lifetime)</i>	20% of Cost Copayment ³
Bone Marrow Transplants <i>(Donor searches limited to \$15,000)</i>	20% of Cost Copayment ³
Cancer Clinical Trials ^{4,5}	Paid at contracting rate Balance (if any) is the responsibility of the Member.
Hospice Care <i>(Prognosis of life expectancy of one year or less)</i>	20% of Cost Copayment ³
Hospital Benefits <i>(Autologous (self-donated) blood up to \$120.00 per unit. Only one hospital Copayment per day is applicable. If a subsequent transfer to another facility is necessary, the Member is not responsible for the additional hospital admission Copayment.)</i>	20% of Cost Copayment ³
Mastectomy/Breast Reconstruction <i>(After mastectomy and complications from mastectomy)</i>	20% of Cost Copayment ³
Maternity Care	20% of Cost Copayment ³
Newborn Care ⁶	20% of Cost Copayment ³
Physician Care	Paid in full
Reconstructive Surgery	20% of Cost Copayment ³

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

Rehabilitation Care <i>(Including physical, occupational and speech therapy)</i>	20% of Cost Copayment ³
Skilled Nursing Care <i>(Up to 100 consecutive calendar days from the first treatment per admission)</i>	20% of Cost Copayment ³
Voluntary Termination of Pregnancy <i>(Medical/medication and surgical)</i>	
– 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

Alcohol, Drug or Other Substance Abuse - Detoxification <i>(Up to five days per year, 30 days per lifetime)</i>	\$35 Copayment
Allergy Testing/Treatment	
- PCP	\$20 Copayment
- Specialist/Nonphysician Health Care Practitioner	\$35 Copayment
Ambulance <i>(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 the additional ambulance Copayment.)</i>	\$100 Copayment
Attention Deficit Disorder <i>(Medical management)</i>	
- PCP	\$20 Copayment
- Specialist/ Nonphysician Health Care Practitioner	\$35 Copayment
Cancer Clinical Trials ^{4,5}	Paid at contracting rate Balance (if any) is the responsibility of the Member
Cochlear Implants <i>(Outpatient surgery or inpatient hospitalization and outpatient rehabilitation therapy Copayments may apply.)</i>	\$35 Copayment ⁷
Corrective Appliances and Prosthetics	\$50 Copayment ⁷
Crisis Intervention	Not Covered
Dental Anesthesia <i>(Additional charges for outpatient and inpatient surgery may apply.)</i>	\$35 Copayment
Durable Medical Equipment <i>(\$2,000 annual benefit maximum)</i>	\$50 Copayment ^{1,7}
Eligible Materials and Supplies	Paid in full

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

Family Planning/Voluntary Interruption of Pregnancy	
Vasectomy	\$50 Copayment
Tubal Ligation ⁸	\$100 Copayment
Insertion/Removal of Intra-Uterine Device (IUD)	
- PCP	\$20 Copayment
- Specialist	\$35 Copayment
Intra-Uterine Device (IUD)	\$50 Copayment
Removal of Norplant	
- PCP	\$25 Copayment
- Specialist	\$35 Copayment
Depo-Provera Injection	
- PCP	\$20 Copayment
- Specialist	\$35 Copayment
Depo-Provera Medication (<i>Limited to one Depo-Provera injection every 90 days</i>)	\$35 Copayment
Voluntary Termination of Pregnancy (<i>Medical/medication and surgical</i>)	
— 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	
- PCP/Nonphysician Health Care Practitioner ²	\$20 Copayment
- Specialist	\$35 Copayment
Hemodialysis	\$35 Copayment
(<i>Physician office visit Copayment may apply.</i>)	per treatment
Home Health Care	\$10 Copayment per visit
(<i>Up to 100 visits per calendar year</i>)	
Hospice Care	Paid in full
(<i>Prognosis of life expectancy of one year or less</i>)	
Immunizations (<i>For children under two years of age, refer to Well-Baby Care</i>)	
- PCP	\$20 Copayment
- Specialist	\$35 Copayment
Infertility Services	Not Covered
Infusion Therapy	\$100 Copayment ⁷
(<i>Infusion therapy is a separate Copayment in addition to a home health or a facility Copayment.</i>)	
Injectable Drugs	\$150 Copayment ⁷
(<i>Copayment not applicable to immunizations, birth control, infertility and insulin. Please see the PacifiCare Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form for more information on these benefits, if any.</i>)	
Laboratory	Paid in full
Maternity Care, Tests and Procedures	\$20 Copayment

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

<p>Mental Health Services</p> <ul style="list-style-type: none"> - Inpatient – Severe Mental Illness (SMI) and Serious Emotional Disturbances of children (SED) only - Outpatient – SMI and SED - Outpatient – Crisis Intervention (up to 20 visits per calendar year) <p><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 Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form for a description of this coverage.)</i></p>	<p>20% of Cost Copayment³</p> <p>\$35 Copayment per visit</p> <p>Not covered</p>
Oral Surgery Services	\$100 Copayment ⁷
Outpatient Rehabilitation Therapy	\$35 Copayment
Outpatient Surgery	20% of Cost Copayment ³
<p>Periodic Health Evaluations</p> <p><i>(For children under two years of age, refer to Well-Baby Care.)</i></p>	\$20 Copayment
<p>Physician Care</p> <p><i>(For children under two years of age, refer to Well-Baby Care.)</i></p> <ul style="list-style-type: none"> - PCP/Nonphysician Health Care Practitioner² - Specialist/Nonphysician Health Care Practitioner² 	<p>\$20 Copayment</p> <p>\$35 Copayment</p>
<p>Radiation Therapy</p> <ul style="list-style-type: none"> - Standard <i>(photon beam radiation therapy)</i> - Complex <i>(Examples include but are not limited to brachytherapy, radioactive implants and conformal photon beam. Gamma knife stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Copayment amount, if any.)</i> 	<p>Paid in full</p> <p>\$100 Copayment⁷</p>
<p>Radiological Procedures</p> <ul style="list-style-type: none"> - Standard - Specialized scanning and imaging procedures <i>(CT, SPECT, PET and MRI with or without contrast media)</i> 	<p>Paid in full</p> <p>\$150 Copayment⁷</p>
Vision Refractions	\$35 Copayment
<p>Vision Screening</p> <ul style="list-style-type: none"> - PCP - Specialist/Nonphysician Health Care Practitioner 	<p>\$20 Copayment</p> <p>\$35 Copayment</p>
<p>Well-Baby Care</p> <p><i>(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. The applicable office visit Copayment applies to infants who are ill at the time of service.)</i></p>	Paid in full
<p>Well-Woman Care</p> <p><i>(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.)</i></p>	\$20 Copayment

Supplemental Outpatient Prescription Drug Benefits

Prescription Benefits ^{1,9} <i>(Copayment applies per prescription up to a one-month supply for Formulary and prior-authorized non-Formulary drugs)</i>	Retail: \$20 Copayment for Generic Drugs ^{1,9} \$35 Copayment for Brand-Name Drugs ^{1,9} (\$100 Brand Deductible)
<i>Mail Order (up to three Prescription Units or a 90-day supply)</i>	
- Generic	\$40 Copayment ^{1,9}
- Brand Name	\$70 Copayment ^{1,9} (\$100 Brand Deductible)

¹Annual Copayment Maximum does not include Copayments for supplemental outpatient prescription drug benefits or durable medical equipment.

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

³Percentage Copayment amounts are based upon PacifiCare's contracted rate.

⁴Services require preauthorization by PacifiCare.

⁵If 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 Providers' billed charges and the rate negotiated by PacifiCare with Participating Providers, in addition to any applicable Copayments, Coinsurance or Deductibles.

⁶The newborn care Copayment does not apply when the newborn is discharged with the mother within 48 hours of the baby's normal vaginal delivery or 96 hours of the baby's cesarean delivery. Please see the Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form for more details.

⁷In instances where the contracted rate is less than your Copayment, you will pay only the contracted rate.

⁸This 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.

⁹Refer 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 is 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/Combined Evidence of Coverage and Disclosure Form 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/Combined Evidence of Coverage and Disclosure Form*. Please keep this *Schedule of Benefits* with your Agreement.

- NOTES -

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**P.O. Box 6006
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**Customer Service:
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