

**CALIFORNIA INDIVIDUAL PLAN**



**PACIFICARE SIGNATUREVALUE 35/50  
HMO SCHEDULE OF BENEFITS**

EFFECTIVE MAY 1, 2005

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 <sup>1</sup> <i>No family maximum</i>	\$5,000/individual
Office Visits	\$35 Copayment
Hospitalization <i>(Autologous (self-donated) blood limited up to \$120.00 per unit.)</i>	50% of cost Copayment <sup>2</sup>
Emergency Services <i>(Copayment not 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 not waived if admitted.)</i>	\$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	50% of cost Copayment <sup>2</sup>
Bone Marrow Transplants <i>(Donor searches limited to \$15,000 per procedure)</i>	50% of cost Copayment <sup>2</sup>
Cancer Clinical Trials <sup>3</sup>	Paid at contracting rate Balance (if any) is the responsibility of the Member.
Hospice Services <i>(Prognosis of life expectancy of one year or less.)</i>	50% of cost Copayment <sup>2</sup>
Hospital Benefits <i>(Autologous (self-donated) blood up to \$120.00 per unit.)</i>	50% of cost Copayment <sup>2</sup>
Mastectomy/Breast Reconstruction <i>(After mastectomy and complications from mastectomy)</i>	50% of cost Copayment <sup>2</sup>
Maternity Care	50% of cost Copayment <sup>2</sup>
Mental Health (SMI and SED) <i>Severe Mental illness (SMI) and Serious Emotional Disturbance of Children (SED) (As required by state law, coverage includes treatment for Severe Mental Illness (SMI) of adults and children and the treatment of Serious Emotional Disturbance of Children (SED). Please refer to your Supplement to the Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form (HMO) for a description of this coverage.)</i>	50% of cost Copayment <sup>2</sup>
Newborn Care	50% of cost Copayment <sup>2</sup>
Physician Care	Paid in full
Reconstructive Surgery	50% of cost Copayment <sup>2</sup>

Rehabilitation Care <i>(including physical, occupational and speech therapy)</i>	50% of cost Copayment <sup>2</sup>
Skilled Nursing Care <i>(Up to 100 consecutive calendar days from the first treatment per admission.)</i>	50% of cost Copayment <sup>2</sup>
Voluntary Termination of Pregnancy <i>(Medical/medication and surgical)</i>	
– 1st trimester	\$125 Copayment
– 2nd trimester (12–20 weeks)	\$200 Copayment
<i>After 20 weeks, not covered unless mother's life is in jeopardy or fetus is not viable.</i>	

### Benefits Available on an Outpatient Basis

Alcohol, Drug or Other Substance Abuse - Detoxification	\$35 Office Visit Copayment
Allergy Testing/Treatment <i>(Serum is covered)</i>	\$35 Office Visit 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>	\$50 Copayment
Cancer Clinical Trials <sup>3</sup>	Paid at contracting rate balance (if any) is the responsibility of the member
Cochlear Implant Device <i>(Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply.)</i>	\$100 Copayment <sup>4</sup>
Crisis Intervention	Not covered
Dental Treatment Anesthesia <i>(Additional Copayment for outpatient surgery or inpatient hospital benefits may apply.)</i>	\$35 Copayment
Dialysis <i>(Physician office visit Copayment may apply.)</i>	\$100 Copayment per treatment
Durable Medical Equipment, <i>(\$2,000 annual benefit maximum per calendar year.)</i>	\$50 Copayment <sup>4</sup>
Family Planning/Voluntary Interruption of Pregnancy	
Vasectomy	\$50 Copayment
Tubal Ligation	\$100 Copayment
<i>(Additional Copayment for inpatient hospital benefits may apply if performed on an inpatient basis.)</i>	
Insertion/Removal of Intra-Uterine Device (IUD)	\$35 Office Visit Copayment
Intra-Uterine Device (IUD)	\$50 Copayment
Removal of Norplant	\$35 Office Visit Copayment
Depo-Provera Injection	\$35 Office Visit Copayment
<b>Depo-Provera Medication</b> <i>(Limited to one Depo-Provera injection every 90 days)</i>	\$35 Copayment
<b>Voluntary Termination of Pregnancy</b> <i>(Medical/medication and surgical)</i>	
1st trimester	\$125 Copayment
2nd trimester (12–20 weeks)	\$200 Copayment
<i>After 20 weeks, not covered unless mother's life is in jeopardy or fetus is not viable.</i>	
Health Education Services	Paid in full
Hearing Screening	\$35 Office Visit Copayment

Home Health Care <i>(Up to 100 visits per calendar year)</i>	\$10 Copayment per visit
Hospice Care <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>	\$35 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>4</sup>
Injectable Drugs (Outpatient Injectable Medications and 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 Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form (HMO) for more information on these benefits, if any.)</i>	\$150 Copayment per visit <sup>4</sup>
Laboratory Services <i>(When available through or authorized by your Participating Medical Group.)</i>	Paid in full
Maternity Care, Tests and Procedures	\$35 Copayment per visit
Mental Health Services <i>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.)</i>	\$35 Office Visit Copayment
Oral Surgery Services	\$200 Copayment <sup>4</sup>
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility <i>(Including physical, occupational and speech therapy.)</i>	\$35 Office Visit Copayment
Outpatient Prescription Drug Benefits <sup>1</sup> <i>(Copayment applies per Prescription Unit or up to 30 days. Please refer to your Supplement to the Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form (HMO) for coverage details.)</i>	
<i>Generic Formulary</i>	\$20 Copayment
<i>Brand-Name Formulary</i>	\$35 Copayment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Center <i>(Services delivered on an outpatient basis without an overnight stay.)</i>	50% of cost Copayment <sup>4</sup>
Periodic Health Evaluations <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>	\$35 Office Visit Copayment
Physician Care <i>(For children under two years of age, refer to Well-Baby Care.)</i>	\$35 Copayment
Prosthetics and Corrective Appliances	\$50 Copayment per item <sup>4</sup>

<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; GammaKnife and stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Copayment amount, if any.)</i>	\$400 Copayment <sup>4</sup>
<b>Radiology Services</b>	
Standard: <i>Specialized scanning and imaging procedures: (Examples include but are not limited to, CT, SPECT, PET, MRA and MRI – with or without contrast media.)</i>	Paid in full \$200 Copayment per procedure <sup>4</sup>
<b>Vision Screening/Refractions</b>	\$35 Office Visit Copayment
<b>Well-Baby Care</b>	Paid in full
<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>	
<b>Well-Woman Care</b>	\$35 Office Visit Copayment
<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>	

<sup>1</sup> Annual Copayment Maximum does not include Copayments for durable medical equipment, pharmacy and supplemental benefits.

<sup>2</sup> Percentage Copayment amounts are based upon the PacifiCare negotiated rate.  
Each hospital admission requires a 50% of cost Copayment.

<sup>3</sup> 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 Providers billed charges and the rate negotiated by PacifiCare with Participating Providers, in addition to any applicable Copayments, coinsurance or deductibles.

<sup>4</sup> In instances where the negotiated rate is less than your Copayment, you will pay only the negotiated 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 *Individual Health Plan HMO Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form* and additional benefit materials must be consulted to determine the exact terms and conditions of coverage.