

# PacifiCare SignatureValue<sup>®</sup>

## Offered by PacifiCare of California

15-30/100D/150a

### HMO Deductible Schedule of Benefits

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

#### General Features

Calendar Year Deductible <sup>1</sup>	Individual \$100 Family \$200
Maximum Benefits	Unlimited
Annual Out-of-Pocket Maximum <sup>2,3</sup>	Individual \$1,000 Family <sup>4</sup> \$3,000
PCP Office Visits	\$15 Copayment
Specialist/Nonphysician Health Care Practitioner Office Visits <sup>5</sup> (Member required to obtain referral to specialist or nonphysician health care practitioner, except for OB/GYN Physician services and Emergency/Urgently Needed Services)	\$30 Copayment
Hospital Benefits (Only one hospital Copayment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment.)	\$150 Copayment per admit, after Deductible <sup>6</sup>
Emergency Services (Copayment waived if admitted)	\$100 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

Bone Marrow Transplants	\$150 Copayment per admit, after Deductible <sup>6</sup>
Cancer Clinical Trials <sup>7</sup>	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Hospice Care (Prognosis of life expectancy of one year or less)	\$150 Copayment per admit, after Deductible <sup>6</sup>
Hospital Benefits (Only one hospital Copayment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment)	\$150 Copayment per admit, after Deductible <sup>6</sup>
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	\$150 Copayment per admit, after Deductible <sup>6</sup>
Maternity Care	\$150 Copayment per admit, after Deductible <sup>6</sup>

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

Mental Health Services (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). <b>Please refer to your Supplement to the PacifiCare Combined Evidence of Coverage and Disclosure Form for a description of this coverage.</b> ) (Only one hospital Copayment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment.)	\$150 Copayment per admit, after Deductible <sup>6</sup>
Newborn Care <sup>8</sup>	\$150 Copayment per admit, after Deductible <sup>6</sup>
Physician Care	Paid in full
Reconstructive Surgery	\$150 Copayment per admit, after Deductible <sup>6</sup>
Rehabilitation Care (Including physical, occupational and speech therapy)	\$150 Copayment per admit, after Deductible <sup>6</sup>
Skilled Nursing Care (Up to one hundred (100) consecutive calendar days from the first treatment per disability)	Paid in full, after Deductible <sup>6</sup>
Substance Use Disorder Detoxification (Only one hospital Copayment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment.)	\$150 Copayment per admit, after Deductible <sup>6</sup>
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 Medically Necessary, such as the mother's life is in jeopardy or fetus is not viable	

## Benefits Available on an Outpatient Basis

Allergy Testing/Treatment (Serum is covered)	
PCP Office Visit	\$15 Office Visit Copayment, after Deductible
Specialist/Nonphysician Health Care Practitioner Office Visit	\$30 Office Visit Copayment, after Deductible
Ambulance	\$50 per trip, after Deductible
Cancer Clinical Trials <sup>7</sup>	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Cochlear Implants Devices (Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply)	\$30 Copayment <sup>9</sup>
Dental Treatment Anesthesia (Additional charges for outpatient surgery and inpatient hospital benefits may apply)	\$30 Copayment, after Deductible
Dialysis (Physician office visit Copayment may apply)	Paid in full
Durable Medical Equipment <sup>3</sup> (\$2,500 annual benefit maximum per calendar year)	Paid in full, after Deductible
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.)	Paid in full, after Deductible

## Benefits Available on an Outpatient Basis (continued)

Family Planning/Voluntary Termination of Pregnancy	
Vasectomy	\$50 Copayment
Tubal Ligation (Additional Copayment for inpatient hospital benefits may apply if performed on an inpatient basis)	\$100 Copayment
Insertion/Removal of Intra-Uterine Device (IUD)	
PCP Office Visit	\$15 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	\$30 Office Visit Copayment
Intra-Uterine Device (IUD)	\$50 Copayment
Removal of Norplant	
PCP Office Visit	\$15 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	\$30 Office Visit Copayment
Depo-Provera Injection	
PCP Office Visit	\$15 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	\$30 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 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.	Paid in full, after Deductible
Hearing Aid – Bone Anchored <sup>10</sup> 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	\$15 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit <sup>5</sup>	\$30 Office Visit Copayment
Home Health Care Visits (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, after Deductible
Immunizations (For children under two years of age, refer to Well-Baby Care)	
PCP Office Visit	\$15 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	\$30 Office Visit Copayment
Infertility Services	Not covered
Infusion Therapy (Infusion therapy is a separate Copayment in addition to a home health or an office visit Copayment. Copayment applies per 30 days or treatment plan, whichever is shorter)	\$50 Copayment, after Deductible <sup>9</sup>

## Benefits Available on an Outpatient Basis (continued)

Injectable Drugs (Outpatient Injectable Medications and Self-Injectable Medications) (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. Office visit Copayment may also apply)	\$50 Copayment per visit, after Deductible <sup>9</sup>
Laboratory Services (When available through and authorized by your PacifiCare SignatureValue Participating Medical Group)	Paid in full
Maternity Care, Tests and Procedures	\$15 Office Visit Copayment
Mental Health Services (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). <b>Please refer to your Supplement to the PacifiCare Combined Evidence of Coverage and Disclosure Form for a description of this coverage.</b> )	\$30 Office Visit Copayment, after Deductible
Oral Surgery Services	\$150 Copayment, after Deductible <sup>9</sup>
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy) PCP Office Visit Specialist/Nonphysician Health Care Practitioner Office Visit	\$15 Office Visit Copayment, after Deductible \$30 Office Visit Copayment, after Deductible
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	\$30 Copayment per admit, 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 PacifiCare SignatureValue Participating Medical Group to determine your health status. For children under two years of age, refer to Well-Baby Care)	\$15 Office Visit Copayment
Physician Care (For children under two years of age, refer to Well-Baby Care) PCP Office Visit Specialist/Nonphysician Health Care Practitioner Office Visit	\$15 Office Visit Copayment \$30 Office Visit Copayment
Prosthetics and Corrective Appliances	Paid in full, after Deductible
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)	Paid in full, after Deductible \$100 Copayment, after Deductible <sup>9</sup>
Radiological Procedures Standard: Specialized scanning and imaging procedures: (Examples include but are not limited to CT, SPECT, PET, MRA and MRI – with or without contrast media) A separate Copayment will be charged for each part of the body scanned as part of an imaging procedure.	Paid in full \$100 Copayment, after Deductible <sup>9</sup>

## Benefits Available on an Outpatient Basis (continued)

Substance Use Disorder Detoxification	
PCP Office Visit	\$15 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	\$30 Office Visit Copayment
Vision Screening/Refractions	
PCP Office Visit	\$15 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	\$30 Office Visit Copayment
Well-Baby Care	Paid in full
(Preventive health service, including immunizations 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 PacifiCare SignatureValue 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)	
Well-Woman Care	\$15 Office Visit Copayment
(Includes Pap smear (by your Primary Care Physician or an OB/GYN in your PacifiCare SignatureValue Participating Medical Group) and referral by your Participating Medical Group for screening mammography as recommended by the U.S. Preventive Services Task Force)	

<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.

<sup>3</sup> The Out-of-Pocket 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 and diabetic supplies), Pharmacy and Supplemental Benefits, except Behavioral Health 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> Copayments for Audiologist and Podiatrist visits will be the same as for the PCP.

<sup>6</sup> Each hospital admission requires a \$150 Copayment, after the Deductible has been satisfied.

<sup>7</sup> Cancer 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.

<sup>8</sup> 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. Please see the Combined Evidence of Coverage and Disclosure Form for more details.

<sup>9</sup> In instances where the negotiated rate is less than your Copayment, you will pay only the negotiated rate.

<sup>10</sup> 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 PacifiCare SignatureValue Participating Medical Group), each of the above-noted benefits is covered when authorized by your PacifiCare SignatureValue 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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