

# PacifiCare SignatureValue<sup>®</sup> Offered by PacifiCare of California

Standard 20/250a  
HMO Schedule of Benefits

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

## General Features

Calendar Year Deductible	0
Maximum Benefits	Unlimited
Annual Copayment Maximum <sup>1</sup> (3 individual maximum per family)	\$2,000/individual
Office Visits	\$20 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) (Autologous (self-donated) blood limited up to \$120.00 per unit)	\$250 Copayment <sup>2</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 (Donor searches limited to \$15,000 per procedure)	\$250 Copayment <sup>2</sup>
Cancer Clinical Trials <sup>3</sup>	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Hospice Services (Prognosis of life expectancy of one year or less)	\$250 Copayment <sup>2</sup>
Hospital Benefits <sup>4</sup> (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)	\$250 Copayment <sup>2</sup>
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	\$250 Copayment <sup>2</sup>
Maternity Care	\$250 Copayment <sup>2</sup>
Mental Health Services (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). <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.)	\$250 Copayment <sup>2</sup>

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

Newborn Care <sup>4</sup>	\$250 Copayment <sup>2</sup>
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Physician Care	Paid in full
Reconstructive Surgery	\$250 Copayment <sup>2</sup>
Rehabilitation Care (Including physical, occupational and speech therapy)	\$250 Copayment <sup>2</sup>
Skilled Nursing Facility Care (Up to 100 consecutive calendar days from the first treatment per disability)	\$200 Copayment
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.)	\$250 Copayment <sup>2</sup>
Voluntary Termination of Pregnancy (Medical/medication and surgical)	
1 <sup>st</sup> trimester	\$125 Copayment
2 <sup>nd</sup> trimester (12-20 weeks) – After 20 weeks, not covered unless Medically Necessary, such as the mother's life is in jeopardy or fetus is not viable.	\$125 Copayment

### Benefits Available on an Outpatient Basis

Allergy Testing/Treatment (Serum is covered)	\$20 Office Visit Copayment
Ambulance	Paid in full
Cancer Clinical Trials <sup>3</sup>	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Cochlear Implant Devices (Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply)	Paid in full
Dental Treatment Anesthesia (Additional Copayment for outpatient surgery or inpatient hospital benefits may apply)	\$20 Office Visit Copayment
Dialysis (Physician office visit Copayment may apply)	\$20 Copayment per treatment
Durable Medical Equipment (\$5,000 annual benefit maximum per calendar year)	Paid in full
Durable Medical Equipment for the Treatment of Pediatric Asthma (Includes nebulizers, peak flow meters, face masks and tubing for the Medically Necessary treatment of pediatric asthma of Dependent children under the age of 19. Does not apply to the annual Durable Medical Equipment benefit maximum.)	Paid in full
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)	\$20 Office Visit Copayment
Intra-Uterine Device (IUD)	\$50 Copayment
Removal of Norplant	\$20 Office Visit Copayment
Depo-Provera Injection	\$20 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)	
1 <sup>st</sup> trimester	\$125 Copayment
2 <sup>nd</sup> trimester (12-20 weeks) – After 20 weeks, not covered unless Medically Necessary, such as the mother's life is in jeopardy or fetus is not viable.	\$125 Copayment

## Benefits Available on an Outpatient Basis (Continued)

Health Education Services	Paid in full
Hearing Aid – Standard \$5,000 Benefit Maximum every three years. Limited to a single hearing aid (including repair/replacement) every three years.	Paid in full
Hearing Aid – Bone Anchored <sup>6</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	\$20 Office Visit Copayment
Home Health Care Visits (Up to 100 visits per calendar year)	Paid in full
Hospice Services (Prognosis of life expectancy of one year or less)	Paid in full
Immunizations (For children under two years of age, refer to Well-Baby Care)	\$20 Office Visit Copayment
Infertility Services	Not covered
Infusion Therapy (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)	Paid in full
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 <sup>5</sup>
Laboratory Services (When available through or authorized by your Participating Medical Group)	Paid in full
Maternity Care, Tests and Procedures	Paid in full
Mental Health Services (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). <b>Please refer to your Supplement to the PacifiCare Combined Evidence of Coverage and Disclosure Form for a description of this coverage.</b> )	\$20 Office Visit Copayment
Oral Surgery Services	Paid in full
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy)	\$20 Office Visit Copayment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	\$50 Copayment
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)	\$20 Office Visit Copayment
Physician Care (For children under two years of age, refer to Well-Baby Care)	\$20 Office Visit Copayment
Prosthetics and Corrective Appliances	Paid in full

## Benefits Available on an Outpatient Basis (Continued)

Radiation Therapy Standard: (Photon beam radiation therapy)	Paid in full
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; GammaKnife and stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Copayment amount if any)	Paid in full
Radiology Services Standard:	Paid in full
Specialized scanning and imaging procedures: (Examples include but are not limited to, CT, SPECT, PET, MRA and MRI – with or without contrast media)	Paid in full
Substance Use Disorder Detoxification	Paid in full
Vision Screening/Refractions	\$20 Office Visit Copayment
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
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)	\$20 Office Visit Copayment

<sup>1</sup> Annual Copayment Maximum does not include Copayments for pharmacy and supplemental benefits, except Behavioral Health Supplemental Benefits.

<sup>2</sup> Each hospital admission requires a \$250 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> 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>5</sup> In instances where the negotiated rate is less than your Copayment, you will pay only the negotiated rate.

<sup>6</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 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.



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