

STANDARD 20-40/500D
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 ¹ <i>(3 individual maximum per family²)</i>	\$2,000/individual
PCP Office Visits	\$20 Copayment
Specialist/Nonphysician Health Care Practitioner Office Visits ³ <i>(Member required to obtain referral to specialist or nonphysician health care practitioner, except for OB/GYN Physician services and Emergency/Urgently Needed Services)</i>	\$40 Copayment
Hospital Benefits <i>(Only one hospital Copayment per day is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment for that day) (Autologous (self-donated) blood limited up to \$120.00 per unit)</i>	\$500 Copayment per day Copayment applies to a maximum of 3 days per stay
Emergency Services <i>(Copayment not waived if admitted)</i>	\$100 Copayment
Urgently Needed Services <i>(Medically Necessary services required outside geographic area served by your Participating Medical Group. Please consult your brochure for additional details. Copayment not waived if admitted)</i>	\$100 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	\$500 Copayment per day Copayment applies to a maximum of 3 days per stay
Bone Marrow Transplants <i>(Donor searches limited to \$15,000 per procedure)</i>	\$500 Copayment per day Copayment applies to a maximum of 3 days per stay
Cancer Clinical Trials ⁴	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Hospice Services <i>(Prognosis of life expectancy of one year or less)</i>	\$500 Copayment per day Copayment applies to a maximum of 3 days per stay
Hospital Benefits ⁵ <i>(Only one hospital Copayment per day is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment for that day) (Autologous (self-donated) blood limited up to \$120.00 per unit)</i>	\$500 Copayment per day Copayment applies to a maximum of 3 days per stay
Mastectomy/Breast Reconstruction <i>(After mastectomy and complications from mastectomy)</i>	\$500 Copayment per day Copayment applies to a maximum of 3 days per stay
Maternity Care	\$500 Copayment per day Copayment applies to a maximum of 3 days per stay

Benefits Available While Hospitalized as an Inpatient (Continued)

Mental Health Services <i>(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 PacifiCare Combined Evidence of Coverage and Disclosure Form for a description of this coverage.)</i>	\$250 Copayment per day Copayment applies to a maximum of 3 days per stay
Newborn Care ⁵	\$500 Copayment per day Copayment applies to a maximum of 3 days per stay
Physician Care	Paid in full
Reconstructive Surgery	\$500 Copayment per day Copayment applies to a maximum of 3 days per stay
Rehabilitation Care <i>(Including physical, occupational and speech therapy)</i>	\$500 Copayment per day Copayment applies to a maximum of 3 days per stay
Skilled Nursing Facility Care <i>(Up to 100 consecutive calendar days from the first treatment per disability)</i>	\$200 Copayment per day Copayment applies to a maximum of 3 days per stay
Voluntary Termination of Pregnancy <i>(Medical/medication and surgical)</i> 1 st trimester 2 nd trimester (12-20 weeks) – After 20 weeks, not covered unless mother's life is in jeopardy or fetus is not viable.	\$125 Copayment \$125 Copayment

Benefits Available on an Outpatient Basis

Alcohol, Drug or Other Substance Abuse Detoxification	\$40 Office Visit Copayment
Allergy Testing/Treatment <i>(Serum is covered)</i> PCP Office Visit Specialist/Nonphysician Health Care Practitioner Office Visit	\$20 Office Visit Copayment \$40 Office Visit Copayment
Ambulance <i>(Only one ambulance Copayment per trip may be applicable. If a subsequent ambulance transfer to another facility is necessary, you are not responsible for the additional ambulance Copayment)</i>	\$50 Copayment
Cancer Clinical Trials ⁴	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Cochlear Implant Devices <i>(Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply)</i>	\$40 Copayment ⁶
Crisis Intervention	Not covered
Dental Treatment Anesthesia <i>(Additional Copayment for outpatient surgery or inpatient hospital benefits may apply)</i>	\$40 Copayment
Dialysis <i>(Physician office visit Copayment may apply)</i>	\$40 Copayment per treatment
Durable Medical Equipment <i>(\$5,000 annual benefit maximum per calendar year)</i>	\$50 Copayment ⁶
Durable Medical Equipment for the Treatment of Pediatric Asthma <i>(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.)</i>	Paid in Full

Benefits Available on an Outpatient Basis (Continued)

Family Planning/Voluntary Termination of Pregnancy	
<i>Vasectomy</i>	\$50 Copayment
<i>Tubal Ligation</i>	\$100 Copayment
<i>(Additional Copayment for inpatient hospital benefits may apply if performed on an inpatient basis.)</i>	
<i>Insertion/Removal of Intra-Uterine Device (IUD)</i>	
<i>PCP Office Visit</i>	\$20 Office Visit Copayment
<i>Specialist/Nonphysician Health Care Practitioner Office Visit</i>	\$40 Office Visit Copayment
<i>Intra-Uterine Device (IUD)</i>	\$50 Copayment
<i>Removal of Norplant</i>	
<i>PCP Office Visit</i>	\$20 Office Visit Copayment
<i>Specialist/Nonphysician Health Care Practitioner Office Visit</i>	\$40 Office Visit Copayment
<i>Depo-Provera Injection</i>	
<i>PCP Office Visit</i>	\$20 Office Visit Copayment
<i>Specialist/Nonphysician Health Care Practitioner Office Visit</i>	\$40 Office Visit Copayment
<i>Depo-Provera Medication</i>	\$35 Copayment
<i>(Limited to one Depo-Provera injection every 90 days.)</i>	
<i>Voluntary Termination of Pregnancy</i>	
<i>(Medical/medication and surgical)</i>	
<i>1st trimester</i>	\$125 Copayment
<i>2nd trimester (12-20 weeks)</i>	\$125 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	
PCP Office Visit	\$20 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit ³	\$40 Office Visit Copayment
Home Health Care Visits	\$10 Copayment per visit
<i>(Up to 100 visits per calendar year)</i>	
Hospice Services	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 Office Visit	\$20 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	\$40 Office Visit Copayment
Infertility Services	Not covered
Infusion Therapy	\$50 Copayment ⁶
<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>	
Injectable Drugs (Outpatient Injectable Medications and Self-Injectable Medications)	\$50 Copayment per visit ⁶
<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 PacifiCare Combined Evidence of Coverage and Disclosure Form for more information on these benefits, if any. Office visit Copayment may also apply)</i>	
Laboratory Services	Paid in full
<i>(When available through or authorized by your Participating Medical Group)</i>	
Maternity Care, Tests and Procedures	Paid in full

Benefits Available on an Outpatient Basis (Continued)

<p>Mental Health Services <i>(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 PacifiCare Combined Evidence of Coverage and Disclosure Form for a description of this coverage.)</i></p>	\$40 Office Visit Copayment
<p>Oral Surgery Services</p>	\$50 Copayment ⁶
<p>Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility <i>(Including physical, occupational and speech therapy)</i> PCP Office Visit Specialist/Nonphysician Health Care Practitioner Office Visit</p>	\$40 Office Visit Copayment
<p>Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility</p>	\$250 Copayment
<p>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></p>	\$20 Office Visit Copayment
<p>Physician Care <i>(For children under two years of age, refer to Well-Baby Care)</i> PCP Office Visit Specialist/Nonphysician Health Care Practitioner Office Visit</p>	\$20 Office Visit Copayment \$40 Office Visit Copayment
<p>Prosthetics and Corrective Appliances</p>	\$50 Copayment per item ⁶
<p>Radiation Therapy Standard: <i>(Photon beam radiation therapy)</i> 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></p>	Paid in full \$50 Copayment ⁶
<p>Radiology Services Standard: Specialized scanning and imaging procedures: <i>(Examples include but are not limited to, CT, SPECT, PET, MRA and MRI – with or without contrast media)</i></p>	Paid in full \$50 Copayment per procedure ⁶
<p>Vision Screening/Refractions PCP Office Visit Specialist/Nonphysician Health Care Practitioner Office Visit</p>	\$20 Office Visit Copayment \$40 Office Visit Copayment

Benefits Available on an Outpatient Basis (Continued)

Well-Baby Care <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>	Paid in full
Well-Woman Care <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>	\$20 Office Visit Copayment

¹Annual Copayment Maximum does not include Copayments for pharmacy and supplemental benefits.

²When individual member meets annual copayment maximum, no further copayments are required for the year for that individual.

³Copayments for audiologist and podiatrist visits will be the same as for the PCP.

⁴Cancer 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.

⁵The 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.

⁶In 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 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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