

# PacifiCare SignatureValue®

## Offered by PacifiCare of Arizona, Inc.

\$20 - \$40/\$500 Plan 6

2009 HMO Summary of Benefits

### Physician Care

Office visit copayment includes coverage for immunizations, pneumonia and Hepatitis B. Flu shots are covered 100%.

Primary Care Physician Office Visit ( <i>Includes OB/GYN</i> )	You pay \$20 per visit
Specialist Office Visit	You pay \$40 per visit

### Outpatient Benefits

Allergy Testing	You pay \$20 or \$40 per visit, depending on provider type
Allergy Treatment ( <i>includes serum</i> )	You pay nothing per visit
Breast Cancer Screening and Diagnosis ( <i>Mammogram</i> )	You pay \$20 per visit
Cancer Clinical Trials	Copayment matches place of service
Chiropractic ( <i>Limited to 12 self-referred visits per Year</i> )	You pay \$10 per visit
Colorectal Screening	Copayment matches place of service
Diabetic Self Management Items ( <i>Equipment &amp; Supplies</i> )	You pay nothing per visit
Diabetic Management and Treatment	You pay \$20 or \$40 per visit, depending on provider type
Dialysis	You pay \$20 per visit
Eosinophilic Gastrointestinal Disorder ( <i>Limited to \$20,000 per Year for Medically Necessary amino acid-based formula</i> )	You pay 25%
Hearing Screening ( <i>Limited to one per Year</i> )	You pay \$40 per visit
Home Health Care ( <i>Limited to 100 days per Year</i> )	You pay \$40 per day
Infusion Therapy ( <i>including but not limited to home infusion and chemotherapy</i> )	You pay \$40 per visit
Inherited Metabolic Disorders ( <i>Limited to \$5,000 per Year for Medically Necessary special food products</i> )	You pay 50%
Injectable Drugs - Self-Injectable Medications – <i>30-day supply or prescribed course of treatment, whichever is shorter (Insulin is covered under your pharmacy plan copayments)</i>	You pay \$50
Laboratory Services ( <i>Includes cytologic screening</i> )	You pay nothing per visit
Outpatient Medical Rehabilitation Therapy - Physical, occupational and speech therapy ( <i>Limited to 40 visits per Year</i> )	You pay \$40 per visit
Outpatient Medical Rehabilitation Therapy - Cardiac Rehabilitation ( <i>Unlimited</i> )	You pay \$20 per visit
Outpatient Surgery ( <i>includes Anesthesia, Physician Services, Surgeon, Assistant Surgeon, Facility</i> )	You pay \$400 per outpatient visit
Periodic Health Evaluation	You pay \$20 per visit
Radiation Therapy	You pay \$40 per visit
Radiology Services - X-rays and other Tests	You pay \$20 per visit
Radiology Services - Specialized Scanning and Imaging ( <i>Including but not limited to MRIs, MRAs, CTs, PETs, IMRTs, SPECTs</i> )	You pay \$200 per visit
Temporomandibular (TMJ) ( <i>Limited to \$1,000 per lifetime</i> )	You pay 20%
Vision - Refractions ( <i>Limited to one per Year</i> )	You pay \$40 per visit
Well-Baby Care ( <i>Including routine immunizations</i> )	You pay \$20 per visit

## Inpatient Benefits

Inpatient Hospital Benefits/Acute Care <i>(includes Anesthesia, Physician Services, Surgeon, Assistant Surgeon)</i>	You pay \$500 per inpatient day, up to 3 days
Acute Inpatient Rehabilitation Care <i>(Limited to 30 days per Year; Inpatient Cardiac Rehabilitation unlimited)</i>	You pay \$500 per inpatient day, up to 3 days
Transplants	You pay \$500 per inpatient day, up to 3 days
Bariatric Surgery/Gastric Bypass	Not Covered
Hospice <i>(Terminally ill care)</i>	You pay nothing per inpatient admit
Skilled Nursing/Subacute and Transitional Care <i>(Limited to 30 days per Year)</i>	You pay nothing per inpatient admit

## Emergency Services

Ambulance <i>(Medically Necessary)</i>	You pay nothing per trip
Emergency Room <i>(Not waived if admitted)</i> <i>Inpatient hospitalization benefits apply if admitted</i>	You pay \$125 per visit
Urgent Care	You pay \$40 per visit

## Maternity Care

Maternity Care Outpatient Tests, Procedures and Genetic Testing office visits	You pay \$20 per visit
Maternity Care Inpatient Care and Delivery	You pay \$500 per inpatient day, up to 3 days

## Family Planning

Infertility Services Outpatient (Basic) – Diagnosis	Not Covered
Infertility Services and Treatment	Not Covered
Tubal Ligation	Copayment matches place of service
Vasectomy	Copayment matches place of service

## Alcohol, Drug, or Other Substance Abuse Detoxification

Outpatient office visits	You pay \$40 per visit
Inpatient <i>(short-term only)</i>	You pay \$500 per inpatient day, up to 3 days

## Mental Health Services

Outpatient office visits <i>(Limited to 20 visits per Year)</i>	You pay \$40 per visit
Inpatient <i>(Limited to 7 days per Year)</i>	You pay \$500 per inpatient day, up to 3 days

## Durable Medical Equipment

Standard <i>(Limited to \$5,000 per Year combined with Specialty/Custom DME)</i>	You pay nothing per item
Specialty/Custom <i>(i.e. wheelchairs, bed lifts, ventilators) (Limited to \$5,000 per Year combined with Standard DME)</i>	You pay nothing per item
Prosthetics <i>(i.e. arm, eye, leg) (Limited to \$5,000 per Year)</i>	You pay 50% per item
Corrective Appliances	You pay nothing per item

## Plan Maximums

Individual Copayment & Coinsurance Maximum	\$4,000 per Year
Family Copayment & Coinsurance Maximum	\$12,000 per Year
Maximum While Insured	Unlimited

**Year** -The twelve month period that begins on the first day of the month the Group Service Agreement between your employer and PacifiCare becomes effective.

## Exclusions & Limitations

This is a brief summary only. Please refer to the *Combined Evidence of Coverage (EOC) and Disclosure Form* for a full description of benefits, limitations and exclusions.

- Services that are not Medically Necessary, as defined in the Combined EOC and Disclosure Form are not covered
- Services not specifically included in Section Five, Medical Benefits of the Combined EOC and Disclosure Form or any supplemental benefit rider purchased by the Member's Employer, are not covered
- Services that are rendered without Pre-authorization from both the Member's Contracted Medical Group and PacifiCare (except for Emergency Services or Urgently Needed Services) described in the Combined EOC and Disclosure Form are not covered
- Services obtained from Non-Contracted Providers or Contracted Providers who are not affiliated with the Member's Contracted Medical Group without authorization from PacifiCare of the Contracted Medical Group are not covered
- Services rendered prior to the Member's effective date of enrollment or after the effective date of termination are not covered
- Services obtained outside the Geographic Service Area are not covered except for Emergency Services or Urgently Needed Services
- PacifiCare does not cover the services or costs associated with a service that is not a Covered Service under the Member's PacifiCare Health Plan including but not limited to cosmetic surgery, bariatric surgery, Infertility, and Experimental and Investigational procedures. PacifiCare will not cover follow-up care or complications associated with or arising from a non-Covered Service
- Acupuncture/Acupressure - Not covered
- Air Conditioners/Air Purifiers and Other Environmental Equipment - Not covered
- Alcoholism, Drug and Other Substance Abuse Rehabilitation - Not covered unless provided by a supplemental benefit
- Ambulance - Ambulance service is covered only when Medically Necessary. Ambulance service is not covered when used only for the Member's convenience or when another available form of transportation would be more appropriate.
- Artificial Hearts - Artificial hearts are not covered
- Behavior Modification and Non-Crisis Health Counseling and Treatment - Counseling and treatment for behavior modification and non-crisis mental health are not covered
- Biofeedback - not covered except for urinary incontinence, fecal incontinence or constipation for Members with organic neuromuscular impairment when part of an authorized treatment plan
- Bloodless Surgery Services - Bloodless surgery services are only covered to the extent available within the Member's Contracted Medical Group
- Bone Marrow and Stem Cell Transplants - Not covered when they are Experimental or Investigational
- Communication Devices - Computers, personal digital assistants and any speech-generating devices (except artificial larynxes) are not covered
- Complementary/Alternative Medicine - Not covered
- Cosmetic Surgery/Services - Not covered
- Cranial Banding - Not covered
- Custodial Care - Not covered except for services provided by an appropriately licensed Hospice agency or Hospice Facility incident to a Member's terminal illness as described in the Combined EOC and Disclosure Form
- Dental Care, Services, Appliances and Orthodontics - Not covered, except as otherwise provided in the Outpatient benefit section in the Combined EOC and Disclosure Form
- Dental Treatment Anesthesia - Dental treatment anesthesia in a dentist's office is not covered
- Dialysis - Chronic dialysis (peritoneal or hemodialysis) is not covered outside of the Member's Contracted Medical Group
- Disabilities Connected to Military Services - Treatment in a government Facility for services related to military service is not covered
- Drugs/Prescription Medication (Outpatient) - Outpatient medications are not covered, except for controlling blood sugar, unless provided by supplemental benefit
- Durable Medical Equipment (DME) - Replacement of lost or stolen DME is not covered
- Educational Services for Developmental Delays and Learning Disabilities - Educational services to treat developmental delays or learning disabilities are not covered
- Elective Enhancements - Not covered
- Emergency Services or Urgently Needed Services (Follow Up Care) - Services following discharge after receipt of Emergency Services or Urgently Needed Services, including but not limited to treatments, procedures, X-rays, lab work, Physician visits, rehabilitation and Skilled Nursing Services are not covered without the Contracted Medical Group's or PacifiCare's authorization

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- Enteral Feeding - Enteral Feedings (food and formula) and the accessories and supplies are not covered except as required by State law
- Exercise Equipment and Services - Not covered
- Experimental and/or Investigational Procedures, Items and Treatments - Not covered
- Eye Wear and Corrective Refractive Procedures - Not covered unless provided by an attached supplemental benefit
- Family Planning - Family planning benefits, other than those specifically listed in the *Summary of Benefits*, are not covered
- Foot Care - Except as Medically Necessary, routine foot care is not covered
- Foot Orthotics/Footwear - Specialized footwear are not covered except for Members with diabetic foot disease or when an orthopedic shoe is permanently attached to a Medically Necessary orthopedic brace
- Genetic Testing, Treatment, or Counseling - Genetic testing, treatment or counseling are not covered for all of the following: a) solely to determine the gender of a fetus; b) non-medical reasons; c) screening for inheritable disorders; d) Members who have no clinical evidence or family history of a genetic abnormality; e) Members who do not meet Medical Necessity criteria for genetic testing and counseling
- Government Services and Treatment - Any services received from a local, state or federal governmental agency are not covered unless the Member is legally obligated to pay for such services
- Hearing Aids/Hearing Devices - Not covered unless provided by a supplemental benefit
- Hospice Services - Hospice services are not covered if Members do not meet the definition of terminally ill or if the services are not reasonable and necessary for treatment of a terminal illness
- Implants - Implants and services for removal and/or replacement of breast implants for non-medical reason and replacement of breast prosthesis and prosthesis itself following cosmetic surgery or after cosmetic breast reduction mammoplasty are not covered
- Infertility Reversal - Not covered
- Institutional Service and Supplies - Any services or supplies furnished by a Facility that is primarily a place of rest, a place for the aged, a nursing home or any similar institution are not covered, except for Skilled Nursing Services provided in a Skilled Nursing Facility
- Maternity Care, Tests, and Procedures - Educational courses on lactation, childcare and/or prepared childbirth classes are not covered
- Medical Foods - not covered except for Inherited Metabolic Disorders and Eosinophilic Gastrointestinal Disorder.
- Non-Physician Health Care Practitioners - Not covered unless provided by a supplemental benefit
- Nursing Services, Private Duty - Not covered
- Nutritional Supplement Formulas - Formulas, food, vitamins, herbs and dietary supplements are not covered except for Inherited Metabolic Disorders and Eosinophilic Gastrointestinal Disorder as listed in the Outpatient section of the Combined EOC and Disclosure Form
- Off Label Drug Use - Off Label Drug Use is only covered when criteria is met
- Oral Surgery and Dental Services - Not covered
- Oral Surgery and Dental Services: Dental Treatment Anesthesia - Dental anesthesia in a dental office or dental clinic is not covered
- Organ Donor Services - Medical and Hospital Services are only covered when the recipient is a Member
- Organ Transplants - All organ transplants must be Pre-authorized by PacifiCare and performed in a Designated Facility
- Orthognathic surgery - Not covered
- Pain Management - Pain management is only covered if pre-authorized. Multi-disciplinary pain programs are not covered
- Physical or Psychological Exams - Physical or psychological exams for non-preventive health reasons are not covered
- Private Rooms and Comfort Items - Personal or comfort items and non-Medically Necessary private rooms are not covered
- Prosthetics/Corrective Appliances/Non-Foot Orthotics - Replacements due to loss or damage by abuse are not covered. Bionic, myoelectric, microprocessor-controlled and computerized Prosthetics are not covered
- Pulmonary Rehabilitation Program - Not covered
- Reconstructive Surgery - Reconstructive surgery is not covered when another more appropriate surgical procedure has been offered and the surgery does not restore body function
- Recreational, Lifestyle, Educational or Hypnotic Therapy - Not covered
- Rehabilitation Services and Therapy - The following conditions are not covered: a) learning disability, b) mental retardation and related conditions, c) biofeedback (except for urinary incontinence, fecal incontinence or constipation for Members with organic neuromuscular impairment when part of an authorized treatment plan), d) Cognitive Behavioral Therapy, e) developmental and neuroeducational treatment and testing beyond initial diagnosis, f) hypnotherapy, g) psychological testing and h) vocational rehabilitation

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- Respite Care - Respite Care is not covered, unless part of a Hospice plan to relieve the caregiver in a Member's residence. Limited to 5 consecutive days at a time
- Routine Laboratory Testing Out-of-Area – Not covered while the Member is outside of the Geographic Service Area
- Services Provided at No Charge to Member – Services and supplies that are provided free of charge if the Member did not have coverage under the Health Plan or for which the Member will not be held financially responsible are not covered
- Services While Incarcerated or Confined - Not covered, unless required by state law
- Sex Transformations - All services related to sex transformations are not covered
- Sexual Dysfunction or Inadequacy Medications - Not covered
- Surrogacy - Infertility and maternity services for non-Members are not covered
- Telehealth and Telemedicine - Telehealth and Telemedicine services are not covered, unless determined Medically Necessary
- Transportation - Transportation is not covered except for Ambulance transportation as defined in the *Combined Evidence of Coverage and Disclosure Form*
- Veterans' Administration (VA) Services - Not covered, except for Emergency Services in a VA Facility
- Vision Training - Vision therapy rehabilitation and ocular training programs are not covered
- Visual Aids - Not covered, except as specified under the outpatient benefit for Diabetic Self-Management Items
- Weight Alteration Programs - Weight loss or weight gain programs are not covered

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