CALIFORNIA SMALL GROUP

UnitedHealthcare®
PacifiCare®

PacifiCare SignatureValue®
Offered by PacifiCare of California

20-40/1500ded

HMO Deductible Schedule of Benefits

Effective November 1, 2009

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

General Features

Calendar Year Deductible[1]	Individual $1,500 Family $3,000
Maximum Benefits	Unlimited
Out-of-Pocket Maximum[2,3] *(Combined total of Deductible and Annual Copayment Maximum)*	Individual $4,000 Family[4] $8,000
PCP Office Visits	$20 Copayment
Specialist/Nonphysician Health Care Practitioner Office Visits *(Member required to obtain referral to specialist or other licensed health care practitioner, except for OB/GYN Physician services and Emergency/Urgently Needed Services)*	$40 Copayment[5]
Hospital Benefits *(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 up to $120.00 per unit.)*	$500 Copayment per day after Deductible
Emergency Services *(Copayment waived if admitted)*	$150 Copayment
Urgently Needed Services *(Medically Necessary services required outside geographic area served by your Participating Medical Group. Please consult your Combined Evidence of Coverage and Disclosure Form for additional details. Copayment waived if admitted.)*	$75 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)*	$500 Copayment per day after Deductible
Cancer Clinical Trials[6]	Paid at negotiated rate after Deductible Balance (if any) is the responsibility of the Member
Hospice Services *(Prognosis of life expectancy of one year or less)*	$500 Copayment per day after Deductible
Hospital Benefits *(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 up to $120.00 per unit.)*	$500 Copayment per day after Deductible
Mastectomy/Breast Reconstruction *(After mastectomy and complications from mastectomy)*	$500 Copayment per day after Deductible
Maternity Care	$500 Copayment per day after Deductible

Benefits Available While Hospitalized as an Inpatient (Continued)

Mental Health Services 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.****)*	$250 Copayment per admit
Newborn Care *(The newborn care Deductible and Copayment does not apply 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.)*	$500 Copayment per day after Deductible
Physician Care	Paid in Full
Reconstructive Surgery	$500 Copayment per day after Deductible
Rehabilitation Care *(Including physical, occupational and speech therapy)*	$500 Copayment per day after Deductible
Skilled Nursing Facility Care *(Up to 100 consecutive calendar days from the first treatment per disability)*	$200 Copayment per day
Substance Use Disorder – Detoxification *(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.)*	$500 Copayment per day after Deductible
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	$20 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	$40 Office Visit Copayment
Ambulance *(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.)*	$50 Copayment
Cancer Clinical Trials[6]	Paid at negotiated rate after Deductible 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)*	$40 Copayment[7] per item after Deductible
Dental Treatment Anesthesia *(Additional Copayment for outpatient surgery and inpatient hospital benefits may apply)*	$40 Copayment after Deductible
Dialysis *(Physician office visit Copayment may apply)*	$40 Copayment per treatment after Deductible
Durable Medical Equipment[3] *($2,000 annual benefit maximum)*	$50 Copayment[7] per item

Benefits Available on an Outpatient Basis (Continued)

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.)*	30% of Cost Copayment[8]
Family Planning/Voluntary Termination of Pregnancy	
Vasectomy	$50 Copayment
Tubal Ligation	$100 Copayment
(Additional Copayment for inpatient hospital benefits may apply if performed on an inpatient basis)	
Insertion/Removal of Intra-Uterine Device (IUD)	
- PCP Office Visit	$20 Office Visit Copayment
- Specialist/Nonphysician Health Care Practitioner Office Visit	$40 Office Visit Copayment
Intra-Uterine Device (IUD)	$50 Copayment
Removal of Norplant	
- PCP Office Visit	$20 Office Visit Copayment
- Specialist/ Nonphysician Health Care Practitioner Office Visit	$40 Office Visit Copayment
Depo-Provera Injection	
- PCP Office Visit	$20 Office Visit Copayment
- Specialist/ Nonphysician Health Care Practitioner Office Visit	$40 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)*	$50 Copayment
Hearing Aid – Bone Anchored[11] *(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	$20 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	$40 Office Visit Copayment[5]
Home Health Care *(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
Immunizations *(For children under two years of age, refer to Well-Baby Care)*	
PCP Office Visit	$20 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	$40 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.)*	$100 Copayment[7] after Deductible

Benefits Available on an Outpatient Basis (Continued)

Injectable Drugs	
Outpatient Injectable Medications	$150 Copayment[7] per visit after Deductible
Self-Injectable Medications	$150 Copayment[7]
(Copayment not applicable to allergy serum, immunizations, birth control, infertility and insulin. For 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 or the Group Subscriber Agreement for more information on these benefits, if any.)	
Laboratory Services *(When available through and authorized by the Member's Participating Medical Group)*	Paid in Full
Maternity Care, Tests and Procedures	Paid in Full
Mental Health Services	
Severe Mental Illness (SMI) and Serious Emotional Disturbance of Children (SED)[9] *(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.****)*	$40 Office Visit Copayment
Oral Surgery Services	$300 Copayment[7] after Deductible
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility *(Including physical, occupational and speech therapy)*	$40 Office Visit Copayment
Outpatient Prescription Drug Benefit[3,10] *(Copayment applies per Prescription Unit or up to 30 days)*	
Generic Formulary	$20 Copayment
Brand-Name Formulary	$35 Copayment
Non-Formulary	$50 Copayment
Prescription Drug Deductible (*Per member per Calendar Year)*	$150 for Brand-Name drugs Applies to retail and mail service
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	$300 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 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)*	
PCP Office Visit	$20 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	$40 Office Visit Copayment[5]
Prosthetics and Corrective Appliances	$50 Copayment[7] per item after Deductible
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. Gamma knife and stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Copayment amount, if any.)*	$200 Copayment[7] after Deductible

Benefits Available on an Outpatient Basis (Continued)

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)* A separate Copayment will be charged for each part of the body scanned as part of an imaging procedure.	$100 Copayment[7] after Deductible
Specialized Footwear for Foot Disfigurement	$50 Copayment[7] per item after Deductible
Substance Use Disorder - Detoxification	$40 Office Visit Copayment
Vision Screening/Refractions	
PCP Office Visit	$20 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	$40 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

[1] 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.

[2] 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.

[3] The Out-of-Pocket Maximum does not include Copayments for Durable Medical Equipment (except for diabetic supplies and nebulizers, peak flow meters, face masks and tubing for the medically necessary treatment of pediatric asthma), Pharmacy and Supplemental Benefits

[4] When individual member meets the Individual Out-of-Pocket Maximum, no further copayments are required for the year for that individual.

[5] Copayments for Audiologist and Podiatrist visits will be the same as for the PCP.

[6] Cancer Clinical Trial Services require pre-authorization by PacifiCare. If you participate in a 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.

[7] In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.

[8] Percentage Copayment amounts are based upon PacifiCare's contracted rate.

[9] Refer to your *Supplement to the Combined Evidence of Coverage and Disclosure Form* for Severe Mental Illness (SMI) and serious Emotional Disturbance of Children (SED) for coverage details.

[10] Refer to your *Supplement to the Combined Evidence of Coverage and Disclosure Form* and *Pharmacy Schedule of Benefits* for Outpatient Prescription Drug Benefits for coverage details.

[11] 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.

P.O. Box 30968
Salt Lake City, UT 84130-0968

Customer Service:
800-624-8822
800-442-8833 (TDHI)
www.pacificare.com

©2009 United HealthCare Services, Inc.
PCA463413-000
UAB