

35/70

HMO SCHEDULE OF BENEFITS

Effective April 1, 2004

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>(no family maximum)</i>	\$5,000/individual
Office Visits	\$35 Copayment
Hospitalization <i>(only one hospital Copayment per admit is applicable. If a subsequent transfer to another facility is necessary, the Member is not responsible for the additional hospital admission Copayment)</i>	30% of cost Copayment ²
Emergency Services <i>(Copayment not waived if admitted)</i>	\$100 Copayment
Urgently Needed Services <i>(Medically Necessary Services required outside your Service Area. 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 or Addiction <i>(detoxification only)</i>	30% of cost Copayment ²
Bone Marrow Transplants <i>(donor searches limited to \$15,000)</i>	30% of cost Copayment ²
Cancer Clinical Trials ^{3,4}	Paid at contracting rate Balance (if any) is the responsibility of the Member
Hospice Care <i>(prognosis of life expectancy of one year or less)</i>	30% of cost Copayment ²
Hospital Benefits <i>(autologous (self-donated) blood up to \$120.00 per unit. Only one hospital Copayment per day is applicable. If a subsequent transfer to another facility is necessary, the Member is not responsible for the additional hospital admission Copayment)</i>	30% of cost Copayment ²
Mastectomy/Breast Reconstruction <i>(after mastectomy and complications from mastectomy)</i>	30% of cost Copayment ²
Maternity Care	30% of cost Copayment ²
Newborn Care ⁵	30% of cost Copayment ²
Physician Care	Paid in full
Reconstructive Surgery	30% of cost Copayment ²
Rehabilitation Care <i>(physical, occupational and speech therapy)</i>	30% of cost Copayment ²
Skilled Nursing Care <i>(up to one hundred (100) consecutive calendar days from the first treatment per disability)</i>	30% of cost Copayment ²
Voluntary Interruption of Pregnancy – 1st trimester – 2nd trimester (12–20 weeks) – After 20 weeks	\$125 Copayment \$200 Copayment Not covered unless mother's life is in jeopardy or fetus not viable

Benefits Available on an Outpatient Basis

Alcohol, Drug or Other Substance Abuse or Addiction <i>(detoxification only)</i>	\$35 Copayment
Allergy Testing/Treatment	\$35 Copayment
Ambulance <i>(only one ambulance Copayment per trip may be applicable. If a subsequent ambulance transfer to another facility is necessary, the Member is not responsible for the additional ambulance Copayment)</i>	\$50 Copayment
Attention Deficit Disorder <i>(Medical Management)</i>	\$35 Copayment
Cancer Clinical Trials ^{3,4}	Paid at contracting rate Balance (if any) is the responsibility of the Member
Cochlear Implants <i>(outpatient surgery or inpatient hospitalization and outpatient rehabilitation therapy Copayments may apply)</i>	\$35 Copayment ⁶
Corrective Appliances and Prosthetics	\$50 Copayment ⁶
Crisis Intervention	Not covered
Dental Anesthesia <i>(additional charges for outpatient and inpatient surgery may apply)</i>	\$35 Copayment
Durable Medical Equipment <i>(unlimited)</i>	\$50 Copayment ^{1,6}
Eligible Materials and Supplies	Paid in full
Family Planning/Voluntary Interruption of Pregnancy	
– Vasectomy	\$50 Copayment
– Tubal ligation ⁷	\$100 Copayment
– Insertion/removal of Intra-Uterine Device (IUD)	\$35 Copayment
– Intra-Uterine Device (IUD)	\$50 Copayment
– Removal of Norplant	\$35 Copayment
– Depo-Provera injection	\$35 Copayment
– Depo-Provera medication <i>(limited to one Depo-Provera injection every 90 days)</i>	\$35 Copayment
– Voluntary interruption of pregnancy (medical/medication and surgical)	
– 1st trimester	\$125 Copayment
– 2nd trimester (12–20 weeks)	\$200 Copayment
– After 20 weeks	Not Covered unless mother's life is in jeopardy or fetus not viable
Health Education Services	Paid in full
Hearing Screening	\$35 Copayment
Hemodialysis <i>(Physician office visit Copayment may apply)</i>	\$35 per treatment
Home Care <i>(up to one hundred (100) visits per calendar year)</i>	\$10 per visit
Hospice Care <i>(prognosis of life of one year or less)</i>	Paid in full
Immunizations <i>(for children under two years of age, refer to Well-Baby Care)</i>	\$35 Copayment
Infertility Services	Not covered
Infusion Therapy <i>(infusion therapy is a separate Copayment in addition to a home health or a facility Copayment)</i>	\$100 Copayment ⁶
Injectable Drugs <i>(Copayment not applicable to allergy serum, immunizations, birth control, infertility and insulin. Please see the PacifiCare Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form for more information on these benefits, if any.)</i>	\$100 Copayment ⁶
Laboratory	Paid in full
Maternity Care, Tests and Procedures	\$35 Copayment
Medical Social Services	Paid in full

Benefits Available on an Outpatient Basis (Continued)

Mental Health Services	
Inpatient – Severe Mental Illness (SMI) and Serious Emotional Disturbances of Children (SED) only	30% of Cost Copayment ²
Outpatient – SMI and SED	\$35 Copayment
Outpatient – Crisis Intervention	Not covered
<i>(as required by state law, coverage includes treatment for Severe Mental Illness (SMI) of adults and children and treatment of Serious Emotional Disturbances of Children (SED). Please refer to your Supplement to the PacifiCare Subscriber Agreement/ Combined Evidence of Coverage and Disclosure Form for a description of this coverage)</i>	
Oral Surgery Services	\$200 Copayment ⁶
Outpatient Rehabilitation Therapy	\$35 Copayment
Outpatient Surgery	30% of cost Copayment ²
Periodic Health Evaluations <i>(for children under two years of age, refer to Well-Baby Care)</i>	\$35 Copayment
Physician Care <i>(for children under two years of age, refer to Well-Baby Care)</i>	\$35 Copayment
Radiation Therapy	
– Standard (photon beam radiation therapy)	Paid in full
– Complex (examples include, but are not limited to, brachytherapy, radioactive implants, proton beam and conformal photon beam. Gamma knife and stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Copayment amount, if any)	\$400 Copayment ⁶
Radiological Procedures	
– Standard	Paid in full
– Specialized scanning and imaging procedures <i>(CT, SPECT, PET and MRI with or without contrast media)</i>	\$200 Copayment ⁶
Vision Refractions	\$35 Copayment
Vision Screening	\$35 Copayment
Well-Baby Care	Paid in full
<i>Preventive health services, including immunizations, as recommended by the American Academy of Pediatrics (AAP) 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 the time of of services.</i>	
Well-Woman Care	\$35 Copayment
<i>Includes Pap smear (by your Primary Care Physician, 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>	

Supplemental Outpatient Prescription Drug Benefits

Retail <i>(Copayment applies per prescription up to a one-month supply for Formulary and prior authorized non-Formulary Drugs)</i>	
– Generic	\$20 Copayment ^{1,8}
– Brand name	\$35 Copayment ^{1,8}
Mail Order <i>(up to 3 Prescription Units or a 90-day supply)</i>	
– Generic	\$40 Copayment ¹
– Brand name	\$70 Copayment ¹

¹ Annual Copayment Maximum does not include Copayments for supplemental outpatient prescription drug benefits or durable medical equipment.

² Percentage Copayment amounts are based upon PacifiCare's contracted rate.

³ Services require preauthorization by PacifiCare.

- ⁴ 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.
- ⁵ The newborn care Copayment does not apply when the newborn is discharged with the mother within 48 hours of the baby's normal vaginal delivery or 96 hours of the baby's cesarean delivery. Please see the *Combined Evidence of Coverage and Disclosure Form* for more details.
- ⁶ In instances where the contracted rate is less than your Copayment, you will pay only the contracted rate.
- ⁷ This Copayment applies regardless of whether this service is performed on an inpatient or outpatient basis. If the service is performed on an inpatient basis, you will also be required to pay the applicable inpatient Copayment for your benefit plan, if any.
- ⁸ Refer to your *Supplement to the Combined Evidence of Coverage and Disclosure Form* and *Pharmacy Schedule of Benefits* for prescription drugs coverage details.

Except in the case of a Medically Necessary Emergency or an Urgently Needed Service (outside the Geographic Area served by your Participating Medical Group), each of the above-noted benefits are covered when authorized by your Participating Medical Group or PacifiCare. A Utilization Review Committee may review the request for services.

The *Individual Health Plan HMO Subscriber Agreement* must be consulted to determine the exact terms and conditions of coverage.

NOTE: This *Schedule of Benefits* constitutes an integral part of your *Individual Health Plan HMO Subscriber Agreement*. Please keep this *Schedule of Benefits* with your Agreement.