PacifiCare
SignatureValue®
A select group of physicians

PacifiCare of California – HMO

Individual Summary Matrix

Effective February 1, 2008

Individual Plans
PacifiCare SignatureValue® (HMO)

Effective February 1, 2008

Overview for the Individual PacifiCare SignatureValue (HMO) plans

PacifiCare SignatureValue (HMO) Plans allow members to take advantage of low copayments with comprehensive coverage.

The PacifiCare SignatureValue (HMO) plans offer affordable, quality health-care benefits with minimal out-of-pocket expense. When you choose a PacifiCare SignatureValue plan, you receive comprehensive health-care benefits provided or coordinated by the Primary care physician of your choice. PacifiCare contracts with independent physicians, medical groups and Individual Practice Associations (IPAs) located throughout PacifiCare's service area, making it easy to find a doctor convenient to your home or workplace. The PacifiCare SignatureValue plans pay for covered health-care services, such as hospitals and surgery. In addition, preventive health care, including checkups, is covered.

There are four individual PacifiCare SignatureValue plan choices, and the information that follows, along with the Benefits Comparison Chart, summarizes the principal benefits and coverages under these plans.

PacifiCare SignatureValue (HMO) Plans

- Low copayment for doctor office visits.
- Extensive participating provider network.
- Choice of a different primary care physician for each family member.
- Ability to change your primary care physician monthly.
- Variety of preventive health-care programs.
- Well-woman and Well-baby benefits.
- Worldwide emergency coverage.
- No claim forms.
- Toll-free customer service.

PacifiCare SignatureValue (HMO) 10-35/250d Plan

- $10 copayment for doctor office visits.
- $35 copayment for specialists visits.
- $10 generic/$35 brand-name prescription drug benefit.

PacifiCare SignatureValue (HMO) 20-35/80 Plan

- $20 copayment for doctor office visits.
- $35 copayment for specialists visits.
- $20 generic/$35 brand-name prescription drug benefit.
  - $100 brand-name deductible.

PacifiCare SignatureValue (HMO) 35/70 Plan

- $35 copayment for doctor office visits.
- $20 generic/$35 brand-name prescription drug benefit.

PacifiCare SignatureValue (HMO) 35/50 Plan

- $35 copayment for doctor office visits.
- $20 generic/$35 brand-name prescription drug benefit.

Summary Benefits and Coverages Comparison Chart
(Health Plan Benefits and Coverage Matrix)

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The PacifiCare individual plan subscriber agreement should be consulted for a detailed description of coverage benefits, exclusions and limitations.

Principal Benefits	PacifiCare SignatureValue (HMO) Plans			
	10-35/250d[1]	20-35/80[1]	35/70[1]	35/50[1]
DEDUCTIBLES				
Calendar-year Deductible Per Individual	None	None	None	None
LIFETIME MAXIMUM BENEFITS				
Annual Copayment Maximum Per Individual	$2,500 2 per family	$2,500 2 per family	$5,000 No Family Maximum	$5,000 No Family Maximum
Maximum Benefit While Covered Per Individual	Unlimited	Unlimited	Unlimited	Unlimited
PROFESSIONAL SERVICES				
Physician Office Visits	$10/$35 copayment[2]	$20/$35 copayment[2]	$35 copayment	$35 copayment
Allergy Testing/Treatment	$10/$35 copayment[2]	$20/$35 copayment[2]	$35 copayment	$35 copayment
Attention Deficit Disorder	$10/$35 copayment[2]	$20/$35 copayment[2]	$35 copayment	$35 copayment
Hearing Screening	$10/$35 copayment[2]	$20/$35 copayment[2]	$35 copayment	$35 copayment
Immunizations (0 to 2 refer to Well-Baby Care)	$10/$35 copayment[2]	$20/$35 copayment[2]	$35 copayment	$35 copayment
Maternity Care, Tests & Procedures Prenatal and postnatal care office visits	$10 copayment	$20 copayment	$35 copayment	$35 copayment
Periodic Health Evaluations – Ages 2 and above – Children under 2 years old	$10 copayment Refer to Well-baby care	$20 copayment Refer to Well-baby care	$35 copayment Refer to Well-baby care	$35 copayment Refer to Well-baby care
Vision Refractions & Screening	$10/$35 copayment[2]	$20/$35 copayment[2]	$35 copayment	$35 copayment
Well-baby Care	Paid in full	Paid in full	Paid in full	Paid in full
Well-woman Care Annual Pap test, breast and pelvic exam	$10 copayment	$20 copayment	$35 copayment	$35 copayment
OUTPATIENT SERVICES				
Cancer Clinical Trials[3, 4]	Paid at contracting rate. Balance (if any) is the responsibility of the member.	Paid at contracting rate. Balance (if any) is the responsibility of the member.	Paid at contracting rate. Balance (if any) is the responsibility of the member.	Paid at contracting rate. Balance (if any) is the responsibility of the member.
Family Planning/Voluntary Interruption of Pregnancy				
■ Tubal ligation[5]	$100 copayment	$100 copayment	$100 copayment	$100 copayment
■ Vasectomy	$50 copayment	$50 copayment	$50 copayment	$50 copayment
■ Insertion/removal of Intra-Uterine Device (IUD)	$10/$35 copayment[2]	$20/$35 copayment[2]	$35 copayment	$35 copayment
■ Intra-Uterine Device (IUD)	$50 copayment	$50 copayment	$50 copayment	$50 copayment
■ Removal of Norplant	$10/$35 copayment[2]	$20/$35 copayment[2]	$35 copayment	$35 copayment
■ Depo-Provera Injection	$10/$35 copayment[2]	$20/$35 copayment[2]	$35 copayment	$35 copayment
■ Depo-Provera Medication (Limited to one Depo-Provera injection every 90 days)	$35 copayment	$35 copayment	$35 copayment	$35 copayment
■ Voluntary Interruption of Pregnancy – 1st Trimester – 2nd Trimester – After 20 weeks	 $125 copayment $200 copayment Not covered[6]	 $125 copayment $200 copayment Not covered[6]	 $125 copayment $200 copayment Not covered[6]	 $125 copayment $200 copayment Not covered[6]
Health Education Services	Paid in full	Paid in full	Paid in full	Paid in full
Dialysis	$35 copayment	$35 copayment	$35 copayment	$100 copayment
Infertility Services	Not covered	Not covered	Not covered	Not covered
Laboratory	Paid in full	Paid in full	Paid in full	Paid in full
Oral Surgery Services	Paid in full	$100 copayment	$200 copayment	$200 copayment
Outpatient Rehabilitation Therapy	$35 copayment	$35 copayment	$35 copayment	$35 copayment
Outpatient Surgery	$250 copayment per day	20% of cost copayment[7]	30% of cost copayment[7]	50% of cost copayment[7]
HOSPITALIZATION SERVICES				
Bone Marrow Transplants	$250 copayment per day (4-day maximum copayment per stay)	20% of cost copayment[7]	30% of cost copayment[7]	50% of cost copayment[7]

Principal Benefits	PacifiCare SignatureValue (HMO) Plans (Continued)			
	10-35/250d[1]	20-35/80[1]	35/70[1]	35/50[1]
HOSPITALIZATION SERVICES (Continued)				
Cancer Clinical Trials[3, 4]	Paid at contracting rate. Balance (if any) is the responsibility of the member.	Paid at contracting rate. Balance (if any) is the responsibility of the member.	Paid at contracting rate. Balance (if any) is the responsibility of the member.	Paid at contracting rate. Balance (if any) is the responsibility of the member.
Hospice Care Prognosis of life expectancy of one year or less	$250 copayment per day (4-day maximum copayment per stay)	20% of cost copayment[7]	30% of cost copayment[7]	50% of cost copayment[7]
Inpatient Hospital Benefits Semi-private room, Intensive Care	$250 copayment per day (4-day maximum copayment per stay)	20% of cost copayment[7]	30% of cost copayment[7]	50% of cost copayment[7]
Inpatient Physician Care	Paid in full	Paid in full	Paid in full	Paid in full
Inpatient Rehabilitation Care/ Subacute Care	$250 copayment per day (4-day maximum copayment per stay)	20% of cost copayment[7]	30% of cost copayment[7]	50% of cost copayment[7]
Maternity Care Normal delivery, cesarean section	$250 copayment per day (4-day maximum copayment per stay)	20% of cost copayment[7]	30% of cost copayment[7]	50% of cost copayment[7]
Newborn Care[12]	$250 copayment per day (4-day maximum copayment per stay)	20% of cost copayment[7]	30% of cost copayment[7]	50% of cost copayment[7]
Skilled Nursing Care Up to 100 consecutive days from first treatment per admission	$50 copayment per day	20% of cost copayment[7]	30% of cost copayment[7]	50% of cost copayment[7]
Voluntary Interruption of Pregnancy ■ 1st Trimester ■ 2nd Trimester ■ After 20 weeks* (*Covered only when mother's life is in jeopardy or when fetus is not viable.)	$125 copayment $200 copayment Not covered[6]	$125 copayment $200 copayment Not covered[6]	$125 copayment $200 copayment Not covered[6]	$125 copayment $200 copayment Not covered[6]
EMERGENCY HEALTH COVERAGE				
Emergency Services	$100 copayment[8]	$100 copayment[8]	$100 copayment	$100 copayment
Urgently Needed Services	$50 copayment[8]	$50 copayment[8]	$100 copayment	$50 copayment
AMBULANCE SERVICES				
Ambulance	$50 copayment	$50 copayment	$50 copayment	$50 copayment
PRESCRIPTION DRUG COVERAGE				
Outpatient Prescription Drugs[9, 10] Retail (per prescription unit or up to a 30-day supply)		$100 Brand Deductible		
■ Generic	$10 copayment[9]	$20 copayment[9]	$20 copayment[9]	$20 copayment[9]
■ Brand Name	$35 copayment[9]	$35 copayment[9]	$35 copayment[9]	$35 copayment[9]
Mail Order (up to 3 prescription units or a 90-day supply)				
■ Generic	$20 copayment[9]	$40 copayment[9]	$40 copayment[9]	$40 copayment[9]
■ Brand Name	$70 copayment[9]	$70 copayment[9]	$70 copayment[9]	$70 copayment[9]
DURABLE MEDICAL EQUIPMENT				
Corrective Appliances & Prosthetics[13]	$50 copayment	$50 copayment	$50 copayment	$50 copayment
Durable Medical Equipment (DME)[13, 14]	$50 copayment[9]	$50 copayment[9]	$50 copayment[9]	$50 copayment[9]
MENTAL HEALTH SERVICES				
■ Inpatient – severe mental illness (SMI) and serious emotional disturbances of children (SED) Only[11]	$250 copayment per day (4-day maximum copayment per stay)	20% of cost copayment[7]	30% of cost copayment[7]	50% of cost copayment[7]
■ Outpatient – SMI and SED[11]	$35 copayment	$35 copayment	$35 copayment	$35 copayment
■ Outpatient – Crisis Intervention	Not covered	Not covered	Not covered	Not covered
CHEMICAL DEPENDENCY SERVICES				
Inpatient Alcohol, Drug or Other Substance Abuse or Addiction (detoxification only)	$250 copayment per day (4-day maximum copayment per stay)	20% of cost copayment[7]	30% of cost copayment[7]	50% of cost copayment[7]
Outpatient Alcohol, Drug or Other Substance Abuse or Addiction (detoxification only)	$35 copayment	$35 copayment	$35 copayment	$35 copayment
HOME HEALTH SERVICES				
Home Care Home visits by a licensed professional (up to 100 visits per calendar year)	$10 copayment per visit	$10 copayment per visit	$10 copayment per visit	$10 copayment per visit
Hospice Care Outpatient Basis & In-Home Visits (prognosis of life expectancy of one year or less)	Paid in full	Paid in full	Paid in full	Paid in full

1 All services must be provided or arranged by your primary care physician, except for OB/GYN physician services and emergency/urgently needed services.
2 PCP Copayment/Specialist and non physician Health-care practitioner copayment. Refer to *Schedule of Benefits* for coverage details.
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 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.
6 Covered only when mother's life is in jeopardy or when fetus is not viable.
7 Percentage copayment amounts are based upon PacifiCare's contracted rates.
8 Copayment waived if admitted.
9 Annual copayment maximum does not include copayments for supplemental outpatient prescription drug benefits or durable medical equipment.
10 Refer to your *Supplement to the Combined Evidence of Coverage and Disclosure Form* and Pharmacy *Schedule of Benefits* for prescription drug coverage details.
11 Refer to your *Supplement to the Combined Evidence of Coverage and Disclosure Form* for severe mental illness (SMI) and serious emotional disturbances of children (SED) for coverage details.
12 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.
13 In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
14 $2,000 annual benefit maximum per calendar year. The annual DME benefit maximum does not apply to nebulizers, masks, tubing, and peak flow meters for the treatment of asthma for dependent children under the age of 19. Also, the DME benefit maximum does not apply to diabetic supplies.

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Visit our Web site @ www.pacificare.com

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