



## **PacifiCare Products**

# PacifiCare SignatureValue (HMO) Plans

	10-30/100	15-30/250a
<b>Annual Deductible</b>	None	None
<b>Lifetime Maximum</b>	None	None
<b>Annual Copayment Maximum<sup>1</sup></b>	\$1,500/3 max per family	\$1,500/3 max per family
<b>Annual Out-of-Pocket Maximum<sup>2</sup></b>	NA	NA
<b>Professional Services</b>		
<b>Office Visits</b>	\$10/\$30 Copayment <sup>3</sup>	\$15/\$30 Copayment <sup>3</sup>
<b>Periodic Health Evaluations</b>	\$10 Copayment	\$15 Copayment
<b>Vision And Hearing Screening</b>	\$10/\$30 Copayment <sup>3</sup>	\$15/\$30 Copayment <sup>3</sup>
<b>Laboratory And Radiology</b> (standard)	Paid in full	Paid in full
<b>Maternity Care</b>	Paid in full	Paid in full
<b>Well-Baby Care</b> (up to age 2)	Paid in full	Paid in full
<b>Well-Woman Care</b>	\$10 Copayment	\$15 Copayment
<b>Outpatient Services</b>		
<b>Outpatient Surgery</b>	Paid in full	\$250 per admission
<b>Hospitalization Services</b>		
<b>Inpatient Hospital Benefits</b>	Paid in full	\$250 per admission
<b>Inpatient Physician Care</b>	Paid in full	Paid in full
<b>Skilled Nursing Facility Care</b> (up to 100 consecutive calendar days from first treatment per disability)	Paid in full	\$100 per day
<b>Emergency Health Coverage</b>		
<b>Emergency Services</b> (Copayment waived if admitted)	\$50 Copayment	\$50 Copayment
<b>Urgently Needed Services</b> (Copayment waived if admitted)	\$50 Copayment	\$50 Copayment
<b>Ambulance Services</b>	Paid in full	Paid in full
<b>Durable Medical Equipment</b>		
<b>Durable Medical Equipment</b> (\$2,000 Maximum Benefit 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.)	\$50 Copayment per item <sup>4</sup>	\$50 Copayment per item <sup>4</sup>
<b>Mental Health Services</b>		
<b>Severe Mental Illness (SMI) and Serious Emotional Disturbances Of A Child (SED)<sup>5</sup></b>		
■ Inpatient	Paid in full	\$250 per admission
■ Outpatient	\$30 Copayment	\$30 Copayment
<b>Crisis Intervention</b> (up to 20 visits)	\$35 Copayment	\$35 Copayment
<b>Chemical Dependency Services</b>		
<b>Alcohol, Drug Or Other Substance Abuse</b> (Detoxification only)		
■ Inpatient	Paid in full	\$250 per admission
■ Outpatient	\$30 Copayment	\$30 Copayment
<b>Home Health Services</b>		
<b>Home Health Care:</b>		
<b>Home Visits By A Licensed Professional</b> (Up to 100 visits per Calendar Year)	\$15 per visit	\$15 per visit
<b>Other Services</b>		
<b>Infertility Services</b>	50% of cost Copayment <sup>6</sup>	50% of cost Copayment <sup>6</sup>
<b>Injectable Drugs</b> (Copayment not applicable to allergy serum, immunizations, birth control, infertility and insulin)	\$150 Copayment <sup>4</sup>	\$150 Copayment <sup>4</sup>
<b>Outpatient Prescription Drug Coverage<sup>7</sup></b>		
<b>Generic Formulary/Brand-Name Formulary/Non-Formulary</b>	\$10 Copayment/\$25 Copayment/ \$35 Copayment	\$10 Copayment/\$25 Copayment/ \$35 Copayment
<b>Optional Group Coverage</b>		
<b>Chiropractic/Acupuncture offered through ACN Group of California, Inc.</b> (maximum 30 visits per Calendar Year)	\$10 Copayment	\$10 Copayment

1 Annual Copayment Maximum does not include Copayments for durable medical equipment (except for diabetic supplies and nebulizers, peak flow meters, face masks and tubing Medically Necessary for the treatment of pediatric asthma), pharmacy and supplemental benefits.

2 Copayments for certain types of Covered Services do not apply toward the Out-of-Pocket Maximum. Please refer to the *Schedule of Benefits* to determine applicability to the plan.

The Out-of-Pocket Maximum does not include Copayments for pharmacy, durable medical equipment (except for diabetic supplies and nebulizers, peak flow meters, face masks and Medically Necessary treatment of pediatric asthma) and supplemental benefits.

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

10/500d	20-40/500d	35/600d	20/1500ded
None	None	None	\$1,500/2 max per family
None	None	None	None
\$2,000/3 max per family	\$3,000/\$5,000 per family	\$5,000/3 max per family	NA
NA	NA	NA	\$4,000/2 max per family
\$10 Copayment	\$20/\$40 Copayment <sup>3</sup>	\$35 Copayment	\$20 Copayment
\$10 Copayment	\$20 Copayment	\$35 Copayment	\$20 Copayment
\$10 Copayment	\$20/\$40 Copayment <sup>3</sup>	\$35 Copayment	\$20 Copayment
Paid in full	Paid in full	Paid in full	Paid in full
Paid in full	Paid in full	Paid in full	Paid in full
Paid in full	Paid in full	Paid in full	Paid in full
\$10 Copayment	\$20 Copayment	\$35 Copayment	\$20 Copayment
\$400 per admission	\$400 per admission	\$500 per admission	\$300 per admission after Deductible
\$500 per day, up to 2 days per admission	\$500 per day	\$600 per day, up to 3 days per admission	\$500 per day after Deductible
Paid in full	Paid in full	Paid in full	Paid in full
\$200 per day	\$200 per day	\$200 per day	\$200 per day
\$50 Copayment	\$50 Copayment	\$100 Copayment	\$100 Copayment
\$50 Copayment	\$50 Copayment	\$100 Copayment	\$100 Copayment
\$50 Copayment	\$50 Copayment	\$50 Copayment	\$50 Copayment
\$50 Copayment per item <sup>4</sup>	\$50 Copayment per item <sup>4</sup>	\$50 Copayment per item <sup>4</sup>	\$50 Copayment per item <sup>4</sup>
\$250 per admission	\$250 per admission	\$250 per admission	\$250 per admission
\$10 Copayment	\$40 Copayment	\$35 Copayment	\$20 Copayment
\$35 Copayment	\$35 Copayment	Not covered	Not covered
\$500 per day, up to 2 days per admission	\$500 per day	\$600 per day, up to 3 days per admission	\$500 per day after Deductible
\$10 Copayment	\$40 Copayment	\$35 Copayment	\$20 Copayment
\$15 per visit	\$15 per visit	\$10 per visit	\$15 per visit
Not covered	Not covered	Not covered	Not covered
\$150 Copayment <sup>4</sup>	\$150 Copayment <sup>4</sup>	\$100 Copayment <sup>4</sup>	\$150 Copayment <sup>4</sup> after Deductible
\$15 Copayment/\$35 Copayment/ \$50 Copayment	\$15 Copayment/\$35 Copayment/ \$50 Copayment	\$15 Copayment/\$35 Copayment/ \$50 Copayment	\$20 Copayment/\$35 Copayment/ \$50 Copayment
\$10 Copayment	\$10 Copayment	\$10 Copayment	\$10 Copayment

4 In instances where the contracted rate is less than your Copayment, you will pay only the contracted rate.

5 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.

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

7 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.

# PacifiCare SignatureValue Advantage (HMO) Plans

	10-30/100	15-30/250a	10/500d
<b>Annual Deductible</b>	None	None	None
<b>Lifetime Maximum</b>	None	None	None
<b>Annual Copayment Maximum<sup>1</sup></b>	\$1,500/3 max per family	\$1,500/3 max per family	\$2,000/3 max per family
<b>Annual Out-of-Pocket Maximum<sup>2</sup></b>	NA	NA	NA
<b>Professional Services</b>			
<b>Office Visits</b>	\$10/\$30 Copayment <sup>3</sup>	\$15/\$30 Copayment <sup>3</sup>	\$10 Copayment
<b>Periodic Health Evaluations</b>	\$10 Copayment	\$15 Copayment	\$10 Copayment
<b>Vision And Hearing Screening</b>	\$10/\$30 Copayment <sup>3</sup>	\$15/\$30 Copayment <sup>3</sup>	\$10 Copayment
<b>Laboratory And Radiology (standard)</b>	Paid in full	Paid in full	Paid in full
<b>Maternity Care</b>	Paid in full	Paid in full	Paid in full
<b>Well-Baby Care (up to age 2)</b>	Paid in full	Paid in full	Paid in full
<b>Well-Woman Care</b>	\$10 Copayment	\$15 Copayment	\$10 Copayment
<b>Outpatient Services</b>			
<b>Outpatient Surgery</b>	Paid in full	\$250 per admission	\$400 per admission
<b>Hospitalization Services</b>			
<b>Inpatient Hospital Benefits</b>	Paid in full	\$250 per admission	\$500 per day, up to 2 days per admission
<b>Inpatient Physician Care</b>	Paid in full	Paid in full	Paid in full
<b>Skilled Nursing Facility Care</b> (up to 100 consecutive calendar days from first treatment per disability)	Paid in full	\$100 per day	\$200 per day
<b>Emergency Health Coverage</b>			
<b>Emergency Services (Copayment waived if admitted)</b>	\$50 Copayment	\$50 Copayment	\$50 Copayment
<b>Urgently Needed Services (Copayment waived if admitted)</b>	\$50 Copayment	\$50 Copayment	\$50 Copayment
<b>Ambulance Services</b>	Paid in full	Paid in full	\$50 Copayment
<b>Durable Medical Equipment</b>			
<b>Durable Medical Equipment</b> (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.)	\$50 Copayment per item <sup>4</sup> (\$2,000 maximum benefit per Calendar Year)	\$50 Copayment per item <sup>4</sup> (\$2,000 maximum benefit per Calendar Year)	\$50 Copayment per item <sup>4</sup> (\$2,000 maximum benefit per Calendar Year)
<b>Mental Health Services</b>			
<b>Severe Mental Illness (SMI) and Serious Emotional Disturbances Of A Child (SED)<sup>5</sup></b>			
■ Inpatient	Paid in full	\$250 per admission	\$250 per admission
■ Outpatient	\$30 Copayment	\$30 Copayment	\$10 Copayment
<b>Crisis Intervention (up to 20 visits)</b>	\$35 Copayment	\$35 Copayment	\$35 Copayment
<b>Chemical Dependency Services</b>			
<b>Alcohol, Drug Or Other Substance Abuse (Detoxification Only)</b>			
■ Inpatient	Paid in full	\$250 per admission	\$500 per day, up to 2 days per admission
■ Outpatient	\$30 Copayment	\$30 Copayment	\$10 Copayment
<b>Home Health Services</b>			
<b>Home Health Care: Home Visits By A Licensed Professional</b> (up to 100 visits per Calendar Year)	\$15 per visit	\$15 per visit	\$15 per visit
<b>Other Services</b>			
<b>Infertility Services</b>	50% of cost Copayment <sup>6</sup>	50% of cost Copayment <sup>6</sup>	Not covered
<b>Injectable Drugs (Copayment not applicable to allergy serum, immunizations, birth control, infertility and insulin)</b>	\$150 Copayment <sup>4</sup>	\$150 Copayment <sup>4</sup>	\$150 Copayment <sup>4</sup>
<b>Outpatient Prescription Drug Coverage<sup>7</sup></b>			
<b>Generic Formulary/Brand-Name Formulary/Non-Formulary</b>	\$10 Copayment/\$25 Copayment/\$35 Copayment	\$10 Copayment/\$25 Copayment/\$35 Copayment	\$15 Copayment/\$35 Copayment/\$50 Copayment
<b>Optional Group Coverage</b>			
<b>Chiropractic/Acupuncture offered through ACN Group of California, Inc. (maximum 30 visits per Calendar Year)</b>	\$10 Copayment	\$10 Copayment	\$10 Copayment

1 Annual Copayment Maximum does not include Copayments for durable medical equipment (except for diabetic supplies and nebulizers, peak flow meters, face masks and tubing Medically Necessary for the treatment of pediatric asthma), pharmacy and supplemental benefits.

2 Copayments for certain types of Covered Services do not apply toward the Out-of-Pocket Maximum. Please refer to the *Schedule of Benefits* to determine applicability to the plan. The Out-of-Pocket Maximum does not include Copayments for pharmacy, durable medical equipment (except for diabetic supplies and nebulizers, peak flow meters, face masks and Medically Necessary treatment of pediatric asthma) and supplemental benefits.

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

20-40/500d	35/600d	20/1500ded	40-60/2000ded
None	None	\$1500/2 max per family	\$2,000 Inpatient Hospital Only (3 max per Family)
None	None	None	None
\$3,000/\$5,000 per family	\$5,000/3 max per family	NA	NA
NA	NA	\$4000/2 max per family	\$5,000/3 max per family
\$20/\$40 Copayment <sup>a</sup>	\$35 Copayment	\$20 Copayment	\$40/\$60 Copayment <sup>a</sup>
\$20 Copayment	\$35 Copayment	\$20 Copayment	\$40 Copayment
\$20/\$40 Copayment <sup>a</sup>	\$35 Copayment	\$20 Copayment	\$40/\$60 Copayment <sup>a</sup>
Paid in full	Paid in full	Paid in full	Paid in full
Paid in full	Paid in full	Paid in full	\$40 Copayment
Paid in full	Paid in full	Paid in full	Paid in full
\$20 Copayment	\$35 Copayment	\$20 Copayment	\$40 Copayment
\$400 per admission	\$500 per admission	\$300 per admission after Deductible	\$1,000 per admission
\$500 per day	\$600 per day, up to 3 days per admission	\$500 per day after Deductible	Paid in full after satisfying the Deductible
Paid in full	Paid in full	Paid in full	Paid in full
\$200 per day	\$200 per day	\$200 per day	\$300 per day
\$50 Copayment	\$100 Copayment	\$100 Copayment	\$100 Copayment
\$50 Copayment	\$100 Copayment	\$100 Copayment	\$100 Copayment
\$50 Copayment	\$50 Copayment	\$50 Copayment	\$50 Copayment
\$50 Copayment per item <sup>d</sup> (\$2,000 maximum benefit per Calendar Year)	\$50 Copayment per item <sup>d</sup> (\$2,000 maximum benefit per Calendar Year)	\$50 Copayment per item <sup>d</sup> (\$2,000 maximum benefit per Calendar Year)	\$70 Copayment per item <sup>d</sup> (\$5,000 maximum benefit per Calendar Year)
\$250 per admission	\$250 per admission	\$250 per admission	\$250 per admission
\$40 Copayment	\$35 Copayment	\$20 Copayment	\$60 Copayment
\$35 Copayment	Not covered	Not covered	Not covered
\$500 per day	\$600 per day, up to 3 days per admission	\$500 per day after Deductible	Paid in full after Deductible
\$40 Copayment	\$35 Copayment	\$20 Copayment	\$60 Copayment
\$15 per visit	\$10 per visit	\$15 per visit	\$15 per visit
Not covered	Not covered	Not covered	Not covered
\$150 Copayment <sup>d</sup>	\$100 Copayment <sup>d</sup>	\$150 Copayment <sup>d</sup> after Deductible	\$100 Copayment <sup>d</sup>
\$15 Copayment/\$35 Copayment/\$50 Copayment	\$15 Copayment/\$35 Copayment/\$50 Copayment	\$20 Copayment/\$35 Copayment/\$50 Copayment	\$15 Copayment/\$35 Copayment/\$50 Copayment
\$10 Copayment	\$10 Copayment	\$10 Copayment	\$10 Copayment

4 In instances where the contracted rate is less than your Copayment, you will pay only the contracted rate.

5 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.

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

7 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.

# PacifiCare SignaturePOS (POS) Plan

POS 15/80-60 Principal Benefits	In-Network	Out-of-Network Preferred Providers <sup>1</sup>	Out-of-Network Non-Preferred Providers <sup>2</sup>
<b>Deductible</b>	0	\$300/3 max per family	
<b>Lifetime Maximum Benefits</b>	Unlimited	\$2,000,000	
<b>Annual Copayment Maximum<sup>3</sup></b>	\$2,500/3 max per family	\$4,000/3 max per family	
<b>Professional Services</b>			
<b>Physician Office Visits</b>	\$15 Copayment	\$35 Copayment*	40% Copayment
<b>Periodic Health Evaluations</b>			
■ Ages 2 to 17	\$15 Copayment	\$35 Copayment*	40% Copayment
■ Ages 18 and older	\$15 Copayment	Not covered	Not covered
<b>Vision/Hearing Screening</b>	\$15 Copayment	Not covered	Not covered
<b>Laboratory and Radiology</b>	Paid in full	\$35 Copayment*	40% Copayment
<b>Maternity Care</b>	Paid in full	\$35 Copayment*	40% Copayment
<b>Well-Baby Care</b> (up to age 2)	\$15 Copayment	\$35 Copayment*	40% Copayment
<b>Well-Woman Care</b>	\$15 Copayment	\$35 Copayment*	40% Copayment
<b>Outpatient Services</b>			
<b>Outpatient Surgery</b>	\$250 per admission	20% Copayment	40% Copayment
<b>Hospitalization Services</b>			
<b>Inpatient Hospital Benefits</b>	\$250 per admission	20% Copayment <sup>4</sup>	40% Copayment <sup>4</sup>
<b>Inpatient Physician Care</b>	Paid in full	20% Copayment <sup>4</sup>	40% Copayment <sup>4</sup>
<b>Skilled Nursing Facility Care</b> (up to 100 consecutive calendar days from the first treatment per disability for In-Network Services, up to 60 consecutive days for Out-of-Network Services <sup>9</sup> )	\$100 per day	20% Copayment <sup>4</sup>	40% Copayment <sup>4</sup>
<b>Emergency Health Coverage</b>			
<b>Emergency Care Services</b> (waived if admitted as an inpatient)	\$50 Copayment	Covered as an in-network benefit	Covered as an in-network benefit
<b>Urgently Needed Services</b> (waived if admitted as an inpatient)	\$50 Copayment	Covered as an in-network benefit	Covered as an in-network benefit
<b>Ambulance Services<sup>5</sup></b>	Paid in full	30% Copayment	30% Copayment
<b>Durable Medical Equipment</b>			
<b>Durable Medical Equipment</b> (\$2,000 Maximum Benefit Per Calendar Year for Out-of-Network Services <sup>6</sup> )	\$50 Copayment	20% Copayment	40% Copayment
<b>Mental Health Services</b>			
<b>Severe Mental Illness (SMI) and Serious Emotional Disturbances Of A Child (SED)<sup>7</sup></b>			
■ Inpatient	\$250 per admission	Not covered	Not covered
■ Outpatient	\$15 Copayment	Not covered	Not covered
<b>Crisis Intervention</b> (Up to 20 Visits, maximum benefit \$50 per visit for Out-of-Network Services <sup>6</sup> )	\$35 Copayment	20% Copayment	40% Copayment
<b>Chemical Dependency Services</b>			
<b>Alcohol, Drug or Other Substance Abuse</b> (Detoxification Only)			
■ Inpatient	\$250 per admission	20% Copayment <sup>4</sup>	40% Copayment <sup>4</sup>
■ Outpatient	\$15 Copayment	\$35 Copayment*	40% Copayment
<b>Home Health Services</b>			
<b>Home Health Care: Home visits by a Licensed Professional</b> (up to 100 visits per year for In-Network Services; up to 100 visits per year for Out-of-Network Services <sup>6</sup> )	\$15 per visit	\$35 Copayment <sup>4*</sup>	40% Copayment <sup>4</sup>
<b>Other Services</b>			
<b>Infertility Services</b>	50% of cost Copayment <sup>8</sup>	Not covered	Not covered
<b>Injectable Drugs</b> (Copayment not applicable to allergy serum, immunizations, birth control, infertility and insulin)	\$50 Copayment	20% Copayment <sup>4</sup>	40% Copayment <sup>4</sup>
<b>Outpatient Prescription Drug Coverage<sup>9</sup></b>			
<b>Generic Formulary/Brand-Name Formulary/Non-Formulary</b>	\$10/\$25/\$50 Copayment	Covered as an in-network benefit	Covered as an in-network benefit
<b>Optional Group Coverage</b>			
<b>Chiropractic/Acupuncture offered through ACN Group of California, Inc.</b> (maximum 30 visits per Calendar Year)	\$10 Copayment	Not covered	Not covered

1 Preferred Providers include PacifiCare SignatureOptions (PPO) network providers and PacifiCare SignatureValue (HMO) network providers seen without referral from your Participating Medical Group. Preferred Providers accept their contractual fees as payment in full. Percentage Copayment amounts are based upon the PacifiCare contracted Rate.

2 Non-Preferred Providers can charge you more than the Limited Fee Schedule. You will be responsible for amounts above the Limited Fee Schedule and these amounts do not accumulate toward the Annual Copayment Maximum. Percentage amounts are based on the Limited Fee Schedule.

3 Annual Copayment Maximum does not include Copayments for durable medical equipment (except for diabetic supplies and nebulizers, peak flow meters, face masks and tubing Medically Necessary for the treatment of pediatric asthma), pharmacy and supplemental benefits.

4 Services require Preauthorization by PacifiCare.

5 Non-Emergency ambulance services Copayment is based on actual charges.

6 Limitations are combined for Options Two and Three.

7 Please refer to your Supplemental *Combined Evidence of Coverage and Disclosure Form* for Severe Mental Illness (SMI) and Serious Emotional Disturbances of Children (SED) for coverage details.

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* and *Pharmacy Schedule of Benefits* for prescription of drug coverage details.

\* Deductible amount is waived

# PacifiCare SignatureOptions (PPO) Plans

	15/90-50/250		20/80-60/250	
	Participating Provider	Non-Participating Provider Limited Fee Schedule <sup>1</sup>	Participating Provider	Non-Participating Provider Limited Fee Schedule <sup>1</sup>
<b>Calendar Year Deductible<sup>2</sup> Individual/Family</b>	\$250/\$500		\$250/\$500	
<b>Additional Deductibles Per Occurrence</b> (Services are subject to applicable Calendar Year Deductible, coinsurance, and any benefit maximums)				
■ Inpatient services	NA	\$500	NA	NA
■ Emergency room services Waived if admitted	\$100		\$100	
■ Failure to obtain Preauthorization of services Waived with Preauthorization of services	\$250	\$500	\$250	\$500
<b>Coinsurance Maximum Individual/Family Policy Maximum</b>	\$3,000/\$6,000	\$6,000/\$12,000	\$3,000/\$6,000	\$6,000/\$12,000
<b>Professional Services</b>	\$5,000,000			
<b>Physician Office Visits</b>				
<b>Periodic Health Evaluations for children</b> (through age 18)	\$15 Copayment; 10% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	50% <sup>5</sup>	\$20 Copayment; 20% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	40% <sup>5</sup>
<b>Periodic Health Evaluations</b> (age 19 and over) Maximum \$400 per Calendar Year				
<b>Laboratory Services</b>	10% <sup>4</sup>	50% <sup>5</sup>	20% <sup>4</sup>	40% <sup>5</sup>
<b>Maternity Care, Tests or Procedures</b>	\$15 Copayment for initial visit, then 10% <sup>4</sup>	50% <sup>5</sup>	\$20 Copayment for initial visit, then 20% <sup>4</sup>	40% <sup>5</sup>
<b>Outpatient Services</b>				
<b>Outpatient Surgery</b>	10% <sup>4</sup>	50% <sup>5</sup>	20% <sup>4</sup>	40% <sup>5</sup>
<b>Hospitalization Services</b>		\$750 maximum benefit per day		\$750 maximum benefit per day <sup>3</sup>
<b>Inpatient Hospital Services</b>	10% <sup>4</sup>	50% <sup>5</sup>	20% <sup>4</sup>	40% <sup>5</sup> \$1,000 maximum benefit per day <sup>3</sup>
<b>Inpatient Physician Services</b>	10% <sup>4</sup>	50% <sup>5</sup>	20% <sup>4</sup>	40% <sup>5</sup> \$1,000 maximum benefit per day <sup>3</sup>
<b>Inpatient Skilled Nursing Facility Care</b> (Up to 90 days Inpatient per Calendar Year)	10% <sup>4</sup>	50% <sup>5</sup>	20% <sup>4</sup>	Covered Person responsible for all charges over \$200 maximum benefit per day <sup>3</sup>
<b>Emergency Health Coverage</b>				
<b>Emergency Room Services</b>	10% <sup>4</sup>		20% <sup>4</sup>	
<b>Urgent Care Services</b>	\$50 Copayment; 10% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	50% <sup>5</sup>	\$50 Copayment; 20% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	40% <sup>5</sup>
<b>Ambulance Services</b>	30% <sup>4</sup>		30% <sup>4</sup>	
<b>Durable Medical Equipment</b>				
<b>Durable Medical Equipment</b> (\$2,000 per Calendar Year)	10% <sup>4</sup>	50% <sup>5</sup>	20% <sup>4</sup>	40% <sup>5</sup>
<b>Mental Health Services</b>				
<b>Severe Mental Illness (SMI) Services</b> Specified diagnosis only	10% <sup>4</sup>	Not covered	20% <sup>4</sup>	Not covered
<b>Mental Illness Services (non-SMI)<sup>3</sup></b>				
■ <b>Inpatient<sup>3</sup></b> (\$2,500 per Calendar Year)	10% <sup>4</sup>	50% <sup>5</sup>	20% <sup>4</sup>	40% <sup>5</sup> \$200 maximum benefit per day
■ <b>Outpatient<sup>3</sup></b> (One visit per day; 20 visits per Calendar Year)	10% <sup>4</sup>	50% <sup>5</sup>	20% <sup>4</sup>	40% <sup>5</sup>
<b>Chemical Dependency Services</b>				
<b>Alcohol, Drug or Other Substance Abuse<sup>3</sup></b> (Detoxification only)				
■ <b>Inpatient</b> (\$2,500 per Calendar Year)	10% <sup>4</sup>	50% <sup>5</sup>	20% <sup>4</sup>	40% <sup>5</sup> \$200 maximum benefit per day
■ <b>Outpatient</b> (One visit per day; 20 visits per Calendar Year)	10% <sup>4</sup>	50% <sup>5</sup>	20% <sup>4</sup>	40% <sup>5</sup>
<b>Home Health Services</b>				
<b>Home Health Care</b> (100 visits per Calendar Year)	10% <sup>4</sup>	50% <sup>5</sup>	20% <sup>4</sup>	40% <sup>5</sup>
<b>Other Services</b>				
<b>Infertility Services</b> (\$2,000 while insured)	10% <sup>4</sup>	50% <sup>5</sup>	20% <sup>4</sup>	40% <sup>5</sup>
<b>Injectable Drugs</b>	10% <sup>4</sup>	50% <sup>5</sup>	20% <sup>4</sup>	40% <sup>5</sup>
<b>Outpatient Prescription Drugs<sup>3</sup></b>	<b>Participating Pharmacy</b> 0% after Copayment of:	<b>Non-Participating Pharmacy</b> 20% after Copayment of:	<b>Participating Pharmacy</b> 0% after Copayment of:	<b>Non-Participating Pharmacy</b> 20% after Copayment of:
<b>Generic Formulary/Brand-Name Formulary/ Non-Formulary</b>	\$10/\$25/\$50		\$10/\$25/\$50	

1 The Covered Person is responsible for any charges in excess of the allowable Covered Expense.

2 Copayments or additional deductibles for Covered Expenses do not apply toward the Calendar Year Deductible.

3 Coinsurance for this type of Covered Expense does not apply toward the Coinsurance Maximum, and the percentage payable for this type of Covered Expense does not increase to 100% due to satisfaction of any Coinsurance Maximum.

4 Coinsurance level of Covered Expense after satisfying the Deductible.

5 Coinsurance level of Limited Fee Schedule after satisfying the Deductible.

# PacifiCare SignatureOptions (PPO) Plans

	30/70-50/250		35/80-60/500	
	Participating Provider	Non-Participating Provider Limited Fee Schedule <sup>1</sup>	Participating Provider	Non-Participating Provider Limited Fee Schedule <sup>1</sup>
<b>Calendar Year Deductible<sup>2</sup></b> <b>Individual/Family</b>	\$250/\$500		\$500/\$1,000	
<b>Additional Deductibles Per Occurrence</b> (Services are subject to applicable Calendar Year Deductible, coinsurance, and any benefit maximums)				
■ Inpatient services	NA	NA	NA	NA
■ Emergency room services – Waived if admitted	\$100		\$100	
■ Failure to obtain Preauthorization of services Waived with Preauthorization of services	\$250	\$500	\$250	\$500
<b>Coinsurance Maximum Individual/Family</b>	\$3,000/\$6,000	\$6,000/\$12,000	\$5,000/\$10,000	\$10,000/\$20,000
<b>Policy Maximum</b>	\$5,000,000		\$5,000,000	
<b>Professional Services</b>				
<b>Physician Office Visits</b>	\$30 Copayment; 30% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	50% <sup>5</sup>	\$35 Copayment; 20% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	40% <sup>5</sup>
<b>Periodic Health Evaluations for children</b> (through age 18)				
<b>Periodic Health Evaluations</b> (age 19 and over) Maximum \$400 per Calendar Year				
<b>Laboratory Services</b>	30% <sup>4</sup>	50% <sup>5</sup>	20% <sup>4</sup>	40% <sup>5</sup>
<b>Maternity Care, Tests or Procedures</b>	\$30 Copayment for initial visit, then 30% <sup>4</sup>	50% <sup>5</sup>	\$35 Copayment for initial visit, then 20% <sup>4</sup>	40% <sup>5</sup>
<b>Outpatient Services</b>				
<b>Outpatient Surgery</b>	30% <sup>4</sup>	50% <sup>5</sup> \$750 maximum benefit per day <sup>3</sup>	20% <sup>4</sup>	40% <sup>5</sup> \$750 maximum benefit per day <sup>3</sup>
<b>Hospitalization Services</b>				
<b>Inpatient Hospital Services</b>	30% <sup>4</sup>	50% <sup>5</sup> \$1,000 maximum benefit per day <sup>3</sup>	20% <sup>4</sup>	40% <sup>5</sup> \$1,000 maximum benefit per day <sup>3</sup>
<b>Inpatient Physician Services</b>	30% <sup>4</sup>	50% <sup>5</sup> \$1,000 maximum benefit per day <sup>3</sup>	20% <sup>4</sup>	40% <sup>5</sup> \$1,000 maximum benefit per day <sup>3</sup>
<b>Inpatient Skilled Nursing Facility Care</b> (Up to 90 days Inpatient per Calendar Year)	30% <sup>4</sup>	Covered Person responsible for all charges over \$200 maximum benefit per day <sup>3</sup>	20% <sup>4</sup>	Covered Person responsible for all charges over \$200 maximum benefit per day <sup>3</sup>
<b>Emergency Health Coverage</b>				
<b>Emergency Room Services</b>	30% <sup>4</sup>		20% <sup>4</sup>	
<b>Urgent Care Services</b>	\$50 Copayment; 30% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	50% <sup>5</sup>	\$50 Copayment; 20% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	40% <sup>5</sup>
<b>Ambulance Services</b>	40% <sup>4</sup>		30% <sup>4</sup>	
<b>Durable Medical Equipment</b>				
<b>Durable Medical Equipment</b> (\$2,000 per Calendar Year)	30% <sup>4</sup>	50% <sup>5</sup>	20% <sup>4</sup>	40% <sup>5</sup>
<b>Mental Health Services</b>				
<b>Severe Mental Illness (SMI) Services</b> Specified diagnosis only	30% <sup>4</sup>	Not covered	20% <sup>4</sup>	Not covered
<b>Mental Illness Services (non-SMI)<sup>2</sup></b>				
■ <b>Inpatient<sup>3</sup></b> (\$2,500 per Calendar Year)	30% <sup>4</sup>	50% <sup>5</sup> \$200 maximum benefit per day	20% <sup>4</sup>	40% <sup>5</sup> \$200 maximum benefit per day
■ <b>Outpatient<sup>3</sup></b> (One visit per day; 20 visits per Calendar Year)	30% <sup>4</sup>	50% <sup>5</sup>	20% <sup>4</sup>	40% <sup>5</sup>
<b>Chemical Dependency Services</b>				
<b>Alcohol, Drug or Other Substance Abuse<sup>3</sup></b> (Detoxification only)				
■ <b>Inpatient</b> (\$2,500 per Calendar Year)	30% <sup>4</sup>	50% <sup>5</sup> \$200 maximum benefit per day	20% <sup>4</sup>	40% <sup>5</sup> \$200 maximum benefit per day
■ <b>Outpatient</b> (One visit per day; 20 visits per Calendar Year)	30% <sup>4</sup>	50% <sup>5</sup>	20% <sup>4</sup>	40% <sup>5</sup>
<b>Home Health Services</b>				
<b>Home Health Care</b> (100 visits per Calendar Year)	30% <sup>4</sup>	50% <sup>5</sup>	20% <sup>4</sup>	40% <sup>5</sup>
<b>Other Services</b>				
<b>Infertility Services</b> (\$2,000 while insured)	30% <sup>4</sup>	50% <sup>5</sup>	20% <sup>4</sup>	40% <sup>5</sup>
<b>Injectable Drugs</b>	30% <sup>4</sup>	50% <sup>5</sup>	20% <sup>4</sup>	40% <sup>5</sup>
<b>Outpatient Prescription Drugs<sup>3</sup></b>	<b>Participating Pharmacy</b> 0% after Copayment of:	<b>Non-Participating Pharmacy</b> 20% after Copayment of:	<b>Participating Pharmacy</b> 0% after Copayment of:	<b>Non-Participating Pharmacy</b> 20% after Copayment of:
<b>Generic Formulary/Brand-Name Formulary/ Non-Formulary</b>	\$10/\$35/\$50		\$10/\$35/\$50	

1 The Covered Person is responsible for any charges in excess of the allowable Covered Expense.

2 Copayments or additional deductibles for Covered Expenses do not apply toward the Calendar Year Deductible.

3 Coinsurance for this type of Covered Expense does not apply toward the Coinsurance Maximum, and the percentage payable for this type of Covered Expense does not increase to 100% due to satisfaction of any Coinsurance Maximum.

35/70-50/1000		35/50-50/1000	
Participating Provider	Non-Participating Provider Limited Fee Schedule <sup>1</sup>	Participating Provider	Non-Participating Provider Limited Fee Schedule <sup>1</sup>
\$1,000/\$2,000		\$1,000/\$2,000	
NA	NA	NA	NA
\$100		\$100	
\$250	\$500	\$250	\$500
\$5,000/\$10,000	\$10,000/\$20,000	\$3,000/\$6,000	\$6,000/\$12,000
\$5,000,000		\$5,000,000	
\$35 Copayment; 30% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	50% <sup>5</sup>	\$35 Copayment; 50% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	50% <sup>5</sup>
30% <sup>4</sup>	50% <sup>5</sup>	50% <sup>4</sup>	50% <sup>5</sup>
\$35 Copayment for initial visit, then 30% <sup>4</sup>	50% <sup>5</sup>	\$35 Copayment for initial visit, then 50% <sup>4</sup>	50% <sup>5</sup>
30% <sup>4</sup>	50% <sup>5</sup> \$750 maximum benefit per day <sup>3</sup>	50% <sup>4</sup>	50% <sup>5</sup> \$750 maximum benefit per day <sup>3</sup>
30% <sup>4</sup>	50% <sup>5</sup> \$1,000 maximum benefit per day <sup>3</sup>	50% <sup>4</sup>	50% <sup>5</sup> \$1,000 maximum benefit per day <sup>3</sup>
30% <sup>4</sup>	50% <sup>5</sup> \$1,000 maximum benefit per day <sup>3</sup>	50% <sup>4</sup>	50% <sup>5</sup> \$1,000 maximum benefit per day <sup>3</sup>
30% <sup>4</sup>	Covered Person responsible for all charges over \$200 maximum benefit per day <sup>3</sup>	50% <sup>4</sup>	Covered Person responsible for all charges over \$200 maximum benefit per day <sup>3</sup>
30% <sup>4</sup>		50% <sup>4</sup>	
\$50 Copayment; 30% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	50% <sup>5</sup>	\$50 Copayment; 50% <sup>4</sup> for Participating Outpatient Laboratory and Radiology Services	50% <sup>5</sup>
40% <sup>4</sup>		50% <sup>4</sup>	
30% <sup>4</sup>	50% <sup>5</sup>	50% <sup>4</sup>	50% <sup>5</sup>
30% <sup>4</sup>	Not covered	50% <sup>4</sup>	Not covered
30% <sup>4</sup>	50% <sup>5</sup> \$200 maximum benefit per day	50% <sup>4</sup>	50% <sup>5</sup> \$200 maximum benefit per day
30% <sup>4</sup>	50% <sup>5</sup>	50% <sup>4</sup>	50% <sup>5</sup>
30% <sup>4</sup>	50% <sup>5</sup> \$200 maximum benefit per day	50% <sup>4</sup>	50% <sup>5</sup> \$200 maximum benefit per day
30% <sup>4</sup>	50% <sup>5</sup>	50% <sup>4</sup>	50% <sup>5</sup>
30% <sup>4</sup>	50% <sup>5</sup>	50% <sup>4</sup>	50% <sup>5</sup>
30% <sup>4</sup>	50% <sup>5</sup>	50% <sup>4</sup>	50% <sup>5</sup>
<b>Participating Pharmacy 0% after Copayment of:</b>	<b>Non-Participating Pharmacy 20% after Copayment of:</b>	<b>Participating Pharmacy 0% after Copayment of:</b>	<b>Non-Participating Pharmacy 20% after Copayment of:</b>
\$10/\$35/\$50		\$10/\$35/\$50	

4 Coinsurance level of Covered Expense after satisfying the Deductible.

5 Coinsurance level of Limited Fee Schedule after satisfying the Deductible.

# PacifiCare SignatureOptions (PPO) Plans

	70-50/2000		70-50/3500	
	Participating Provider	Non-Participating Provider Limited Fee Schedule <sup>1</sup>	Participating Provider	Non-Participating Provider Limited Fee Schedule <sup>1</sup>
<b>Calendar Year Deductible<sup>2</sup> Individual/Family</b>	\$2,000/\$4,000		\$3,500/\$7,000	
<b>Additional Deductibles Per Occurrence</b> (Services are subject to applicable Calendar Year Deductible, coinsurance, and any benefit maximums)				
■ Inpatient services	NA	NA	NA	NA
■ Emergency room services – Waived if admitted		\$250		\$100
■ Failure to obtain Preauthorization of services Waived with Preauthorization of services	\$250	\$500	\$250	\$500
<b>Coinsurance Maximum Individual/Family</b>	\$3,000/\$6,000		\$2,000/\$4,000	
<b>Policy Maximum</b>	\$5,000,000		\$5,000,000	
<b>Professional Services</b>				
<b>Physician Office Visits</b>	30% <sup>4</sup>	50% <sup>5</sup>	30% <sup>4</sup>	50% <sup>5</sup>
<b>Periodic Health Evaluations for children</b> (through age 18)				
<b>Periodic Health Evaluations</b> (age 19 and over) Maximum \$400 per Calendar Year				
<b>Laboratory Services</b>	30% <sup>4</sup>	50% <sup>5</sup>	30% <sup>4</sup>	50% <sup>5</sup>
<b>Maternity Care, Tests or Procedures</b>	30% <sup>4</sup>	50% <sup>5</sup>	30% <sup>4</sup>	50% <sup>5</sup>
<b>Outpatient Services</b>				
<b>Outpatient Surgery</b>	30% <sup>4</sup>	50% <sup>5</sup> \$750 maximum benefit per day <sup>3</sup>	30% <sup>4</sup>	50% <sup>5</sup> \$750 maximum benefit per day <sup>3</sup>
<b>Hospitalization Services</b>				
<b>Inpatient Hospital Services</b>	30% <sup>4</sup>	50% <sup>5</sup> \$1,000 maximum benefit per day <sup>3</sup>	30% <sup>4</sup>	50% <sup>5</sup> \$1,000 maximum benefit per day <sup>3</sup>
<b>Inpatient Physician Services</b>	30% <sup>4</sup>	50% <sup>5</sup> \$1,000 maximum benefit per day <sup>3</sup>	30% <sup>4</sup>	50% <sup>5</sup> \$1,000 maximum benefit per day <sup>3</sup>
<b>Inpatient Skilled Nursing Facility Care</b> (Up to 90 days Inpatient per Calendar Year)	30% <sup>4</sup>	Covered Person responsible for all charges over \$200 maximum benefit per day <sup>3</sup>	30% <sup>4</sup>	Covered Person responsible for all charges over \$200 maximum benefit per day <sup>3</sup>
<b>Emergency Health Coverage</b>				
<b>Emergency Room Services</b>		30% <sup>4</sup>		30% <sup>4</sup>
<b>Urgent Care Services</b>	30% <sup>4</sup>	50% <sup>5</sup>	30% <sup>4</sup>	50% <sup>5</sup>
<b>Ambulance Services</b>		40% <sup>4</sup>		40% <sup>4</sup>
<b>Durable Medical Equipment</b>				
<b>Durable Medical Equipment</b> (\$2,000 per Calendar Year)	30% <sup>4</sup>	50% <sup>5</sup>	30% <sup>4</sup>	50% <sup>5</sup>
<b>Mental Health Services</b>				
<b>Severe Mental Illness (SMI) Services</b> Specified diagnosis only	30% <sup>4</sup>	Not covered	30% <sup>4</sup>	Not covered
<b>Mental Illness Services (non-SMI)<sup>2</sup></b>				
■ <b>Inpatient<sup>3</sup></b> (\$2,500 per Calendar Year)	30% <sup>4</sup>	50% <sup>5</sup> \$200 maximum benefit per day	30% <sup>4</sup>	50% <sup>5</sup> \$200 maximum benefit per day
■ <b>Outpatient<sup>3</sup></b> (One visit per day; 20 visits per Calendar Year)	30% <sup>4</sup>	50% <sup>5</sup>	30% <sup>4</sup>	50% <sup>5</sup>
<b>Chemical Dependency Services</b>				
<b>Alcohol, Drug or Other Substance Abuse<sup>3</sup></b> (Detoxification only)				
■ <b>Inpatient</b> (\$2,500 per Calendar Year)	30% <sup>4</sup>	50% <sup>5</sup> \$200 maximum benefit per day	30% <sup>4</sup>	50% <sup>5</sup> \$200 maximum benefit per day
■ <b>Outpatient</b> (One visit per day; 20 visits per Calendar Year)	30% <sup>4</sup>	50% <sup>5</sup>	30% <sup>4</sup>	50% <sup>5</sup>
<b>Home Health Services</b>				
<b>Home Health Care</b> (100 visits per Calendar Year)	30% <sup>4</sup>	50% <sup>5</sup>	30% <sup>4</sup>	50% <sup>5</sup>
<b>Other Services</b>				
<b>Infertility Services</b> (\$2,000 while insured)	30% <sup>4</sup>	50% <sup>5</sup>	30% <sup>4</sup>	50% <sup>5</sup>
<b>Injectable Drugs</b>	30% <sup>4</sup>	50% <sup>5</sup>	30% <sup>4</sup>	50% <sup>5</sup>
<b>Outpatient Prescription Drugs<sup>3</sup></b>	<b>Participating Pharmacy</b> 0% after Copayment of:	<b>Non-Participating Pharmacy</b> 20% after Copayment of:	<b>Participating Pharmacy</b> 0% after Copayment of:	<b>Non-Participating Pharmacy</b> 20% after Copayment of:
<b>Generic Formulary/Brand-Name Formulary/Non-Formulary</b>	\$10/\$35/\$50 \$250 Combined Deductible for Formulary and Non-Formulary Drugs		\$10/\$35/\$50 \$250 Combined Deductible for Formulary and Non-Formulary Drugs	

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3 Coinsurance for this type of Covered Expense does not apply toward the Coinsurance Maximum, and the percentage payable for this type of Covered Expense does not increase to 100% due to satisfaction of any Coinsurance Maximum.

4 Coinsurance level of Covered Expense after satisfying the Deductible.

5 Coinsurance level of Limited Fee Schedule after satisfying the Deductible.



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The Definity Health Savings Account (HSA) high deductible health plan (HDHP) is a medical plan, built upon UnitedHealthcare products, that complies with IRS requirements and qualifies enrollees to open a Health Savings Account with a bank of their choice or through Exante Bank. "Definity HSA" refers generally to the Definity HSA product, which includes a HDHP, although at times "Definity HSA" may refer only and specifically to the Definity Health Savings Account, and not to the associated HDHP. UnitedHealthcare's Definity<sup>SM</sup> Health Reimbursement Account, or HRA, combines the flexibility of a medical benefit plan with an employer-funded account.