

**CLAREMONT UNIFIED SCHOOL DISTRICT  
PacifiCare HMO - Schedule of Benefits**

<b>PacifiCare HMO 2006/07 Plan</b>	
<b>Maximum Benefit While covered</b>	Unlimited
<b>Calendar Year Deductible</b>	0
<b>Annual Copayment Maximum ( 2 individual maximum per family)</b>	\$1500/Individual
<b>Office Visits</b>	\$15
<b>Well-Baby Care</b> (preventive health service, including immunizations for children under two years of age. Office visit copayment applies to infants that are ill at time of service)	Paid in Full
<b>Hospitalization</b>	Paid in Full
<b>Emergency Services</b>	\$75 Copay (waived if admitted as an inpatient)
<b>Urgent Care</b> (medically necessary services required outside your service area)	\$75 Copay (waived if admitted as an inpatient)
<b>Allergy Testing/Treatment</b> (serum is covered)	\$15
<b>Ambulance</b>	Paid in Full
<b>Bone Marrow Transplants</b> (donor searches limited to \$15,000 per procedure)	Paid in Full
<b>Durable Medical Equipment, Corrective Appliances and Prosthetics</b> (Unlimited)	Paid in Full
<b>Family Planning</b>	
Vasectomy	\$50 Copayment
Tubal Ligation	\$100 Copayment
Insertion/Removal IUD	\$15
Intra-Uterine Device (IUD)	\$50
Removal of Norplant	\$15
Depo-Provera Injection	\$15
Depo-Provera Medication (limited to one injection every 90 days)	\$35 Copayment
<b>Voluntary Interruption of Pregnancy</b>	
1st Trimester	\$125
2nd Trimester (12-20 weeks)	\$125
After 20 weeks	Not Covered (unless mother's life is in jeopardy or non-viable fetus)
<b>Health Education Services</b>	Paid in Full
<b>Hearing &amp; Vision Exams</b>	\$15
<b>Home Health Care</b> (Up to 100 visits per calendar year)	Paid in Full
<b>Hospice Care - Outpatient</b> (prognosis of life expectancy of one year or less)	Paid in Full
<b>Hospice Care - Inpatient</b> (prognosis of life expectancy of one year or less)	Paid in Full
<b>Immunizations</b>	\$15
<b>Infertility Services</b>	50% of Cost Copay
<b>Maternity &amp; Newborn Care, Tests and Procedures</b>	Paid in Full
<b>Outpatient Surgery</b>	Paid in Full
<b>Periodic Health Evaluations</b>	\$15
<b>Physician Visit to Hospital or Skilled Nursing Facility</b>	Paid in Full
<b>Rehabilitation Care-Inpatient</b> (physical, occupational and speech therapy)	Paid in Full
<b>Rehabilitation Therapy-Outpatient</b> (physical, occupational and speech therapy)	\$15
<b>Skilled Nursing Care</b> (Up to 100 consecutive calendar days from the first treatment per disability)	Paid in Full
<b>Prescription Drug Coverage</b>	\$10 generic/\$20 Brand/\$25 non-formulary for a 30-day supply at a participating pharmacy. \$20 generic/\$40 Brand/\$50 non-formulary for a 90-day supply via mail order
<b>Mental Health/Chemical Dependency Benefits provided by PacifiCare Behavioral Health</b>	

NOTE: This is not a contract--This benefit comparison constitutes only a summary of the health plan. The Evidence of Coverage (EOC) and the Medical and Hospital Group Subscriber Agreement 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.