

Stanford University Postdocs
 Custom ASO PPOSM 300-90/70
 Benefit Summary
 (Uniform 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 PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Blue Shield of California

Highlights: A description of the prescription drug coverage is provided separately

Effective January 1, 2012

	Preferred Providers ¹	Non-Preferred Providers ¹
Calendar year Medical Deductible² (All providers combined)	\$300 per individual / \$600 per 2- persons/ \$900 per family	
Calendar year Copayment Maximum² (Copayments for Preferred Providers accrue to both Preferred and Non-Preferred Provider Calendar-year Copayment Maximum amounts.)	\$2,000 per individual / \$4,000 per 2-persons/ \$6,000 per family	\$5,000 per individual / \$10,000 per 2-persons/ \$15,000 per family
LIFETIME BENEFIT MAXIMUM	None	

Covered Services **Member Copayment**

PROFESSIONAL SERVICES	Preferred Providers ¹	Non-Preferred Providers ¹
Professional (Physician) Benefits		
• Physician and specialist office visits	\$25 per visit (Not subject to the Calendar-Year Deductible)	30%
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine ³ (prior authorization is required)	10%	30%
• Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities) ³	10%	30%
Allergy Testing and Treatment Benefits		
• Office visits (includes visits for allergy serum injections)	10%	30%
Preventive Health Benefits		
Preventive Health Services (see the description of Preventive Health Services in the definitions section of the Plan Contract for more information)		
• Annual routine physical examination office visit: including the physical examination office visit, routine eye/ear screening, including diagnostic laboratory services for members ages 7 and older and pediatric and adult immunizations and the immunization agent.	No Charge (Not subject to the Calendar-Year Deductible)	Not Covered
• Annual routine gynecological office visit: including the gynecological examination office visit, routine mammography, routine Papanicolaou (Pap) test or other FDA approved cervical cancer screening test, human papillomavirus (HPV) screening tests and prostate cancer screening (One per calendar year)	No Charge (Not subject to the Calendar-Year Deductible)	30% Not subject to the Calendar-Year Deductible
• Well Baby/Well Child office visit: including examination office visit, pediatric immunizations and the immunization agent, vision and hearing screening birth through age six	No Charge (Not subject to the Calendar-Year Deductible)	30% (Plan payment up to \$25 per visit and \$12 per immunization)
• Well Baby/Well Child routine laboratory Services	No Charge (Not subject to the Calendar-Year Deductible)	30%

OUTPATIENT SERVICES

Hospital Benefits (Facility Services)

The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-preferred hospital is \$350 per day. Members are responsible for 30% of this \$350 per day, plus all charges in excess of \$350.

	Preferred Providers ¹	Non-Preferred Providers ¹
• Outpatient surgery performed at an Ambulatory Surgery Center ⁴	10%	30%
• Outpatient surgery in a hospital	10%	30%
• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation benefits")	10%	30%
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required) ³	10%	30%
• Other outpatient X-ray, pathology and laboratory performed in a hospital ³	10%	30%

• Bariatric Surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) ⁵	10%	30% ⁵
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
• Inpatient Physician Services	10%	30%
• Inpatient Non-emergency Facility Services (Semi-private room and board, medically necessary services and supplies)	\$250 per admission + 10%	30% ⁶
• Bariatric Surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) ⁵	\$250 per admission + 10%	30% ⁶
Skilled Nursing Facility Benefits (Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations)		
• Services by a free-standing Skilled Nursing Facility	10%	10% ⁷
• Skilled Nursing Unit of a Hospital	10%	30% ⁶
EMERGENCY HEALTH COVERAGE		
• Emergency room Services not resulting in admission (If ER services do not result in a direct admission the Calendar-Year Deductible does not apply)	\$75 per visit + 10%	\$75 per visit + 10%
• Emergency room Services resulting in admission (When the member is admitted directly from the ER)	\$250 per admission + 10%	\$250 per admission + 10%
• Emergency room Physician Services	10%	10%
AMBULANCE SERVICES		
• Emergency or authorized transport	20%	20%
PRESCRIPTION DRUG COVERAGE		
Outpatient Prescription Drug Benefits	A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug summary that goes with this benefit summary, please contact your benefits administrator or call Customer Services.	
PROSTHETICS/ORTHOTICS		
• Prosthetic equipment and devices (Separate office visit copay may apply)	10%	30%
• Orthotic equipment and devices (Separate office visit copay may apply)	10%	30%
DURABLE MEDICAL EQUIPMENT		
• Durable Medical Equipment	10%	30%
MENTAL HEALTH SERVICES (PSYCHIATRIC)⁸		
• Inpatient Hospital and Residential Treatment Center Services	\$250 per admission + 10%	30% ⁶
• Outpatient Mental Health Services	\$25 per visit (Not subject to the Calendar-Year Deductible)	30%
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)⁹		
• Inpatient Hospital and Residential Treatment Center Services	\$250 per admission + 10%	30% ⁶
• Outpatient Chemical dependency and substance abuse services	\$25 per visit (Not subject to the Calendar-Year Deductible)	30%
HOME HEALTH SERVICES¹⁰		
• Home health care agency Services (Maximum of 100 prior authorized visits per Calendar Year)	10%	Not Covered ¹⁰
• Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency (See "Prescription Drug Coverage" for specialty drugs)	10%	Not Covered ¹⁰
OTHER		
Hospice Program Benefits¹⁰		
• Routine home care	No Charge	Not Covered ¹⁰
• Inpatient Respite Care	No Charge	Not Covered ¹⁰
• 24-hour Continuous Home Care	20%	Not Covered ¹⁰
• General Inpatient care	20%	Not Covered ¹⁰
Chiropractic Benefits¹¹		
• Chiropractic Services - provided by a chiropractor (Up to 24 visits per calendar year combined with Rehabilitation services)	10%	30% (Plan payment up to \$25 per visit)
Acupuncture Benefits¹¹		
• Acupuncture (Up to 12 visits per calendar year; Plan payment up to \$30 per visit)	10%	10%
Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)		
• Office location (Up to 24 visits per calendar year combined with chiropractic services)	10%	30% (Plan payment up to \$25 per visit)

Speech Therapy Benefits

- Office location 10% 30%

Pregnancy and Maternity Care Benefits

- Prenatal and Postnatal Physician Office Visits (For inpatient hospital services, see "Hospitalization Services.") \$25 per visit, initial visit (Not subject to the Calendar-Year Deductible), thereafter 10% 30%

Family Planning Benefits

- Counseling and consulting \$25 per visit (Not subject to the Calendar-Year Deductible) 30%
- Diagnosis and treatment of the cause of infertility (Plan payment maximum for covered services up to \$2,000 per calendar year) 50%² 50%²
- Elective abortion¹² 10% 30%
- Tubal ligation¹² 10% 30%
- Vasectomy¹² 10% 30%

Diabetes Care Benefits

- Devices, equipment, and non-testing supplies (For testing supplies, see "Outpatient Prescription Drug Benefits.") 10% 30%
- Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment) \$25 per visit (Not subject to the Calendar-Year Deductible) 30%

Hearing Benefits

- Audiological examination \$25 per visit (Not subject to the Calendar-Year Deductible) 30%
- Hearing aid and ancillary equipment (One hearing aid per ear every 24 months) 10% 30%

Care Outside of Plan Service Area Benefits provided through BlueCard[®]

Program, for out-of-state emergency and non-emergency care, are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider.

- Within US: BlueCard Program See Applicable Benefit See Applicable Benefit
- Outside of US: BlueCard Worldwide See Applicable Benefit See Applicable Benefit

1 Member is responsible for copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of allowable amounts. Preferred providers accept Blue Shield's allowable amount as full payment for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or copayment maximum.

2 Deductible and copayments marked with a (2) do not accrue to calendar-year copayment maximum. Copayments and charges for services not accruing to the member's calendar-year copayment maximum continue to be the member's responsibility after the calendar-year copayment maximum is reached. Deductible does not apply toward the calendar-year maximum. Please refer to the Plan Contract for exact terms and conditions of coverage.

3 Participating non Hospital based ("freestanding") outpatient X-ray, pathology and laboratory facilities centers may not be available in all areas. Regardless of their availability, you can obtain outpatient X-ray, pathology and laboratory services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your health plan's hospital services benefits.

4 Participating ambulatory surgery facilities centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital with payment according to your health plan's hospital services benefits.

5 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura Counties ("Designated Counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider and there is no coverage for bariatric services from non-preferred Providers. In addition, if prior authorized by Blue Shield of California, a member in a Designated County who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Plan Contract for further benefit details.

6 The maximum allowed charges for non-emergency hospital services received from a non-preferred hospital is \$600 per day. Members are responsible for 30 percent of this \$600 per day, plus all charges in excess of \$600.

7 Services may require prior authorization by Blue Shield. When these services are prior authorized, members pay the preferred or participating provider amount.

8 Mental health services are accessed through Blue Shield using preferred and non-participating providers..

9 Inpatient services for acute detoxification are covered under the medical benefit; see hospitalization services for benefit details. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield's preferred providers or non-preferred providers.

10 Out of network home health care, home infusion and hospice services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Preferred Provider copayment.

11 All outpatient acupuncture, chiropractic and rehabilitation therapy visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.

12 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.

Plan designs may be modified to ensure compliance with federal requirements.