blue of california

Summary of Benefits

Stanford University
Effective January 1, 2024
PPO Plan

ASO Full PPO 100

This Summary of Benefits shows the amount you will pay for Covered Services under this Claims Administrator benefit plan. It is only a summary and it is included as part of the Benefit Booklet.[1] Please read both documents carefully for details.

Provider Network: Medicare approved provider Network

This Plan uses a specific network of Health Care Providers, called the Medicare approved provider Network. Providers in this network are called Medicare approved providers. You pay less for Covered Services when you use a Medicare approved provider than when you use a Non-Medicare approved provider.

Calendar Year Deductibles (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Claims Administrator pays for Covered Services under the Plan.

		When using a Medicare approved [3] or Non-Medicare approved [4] provider
Calendar Year medical Deductible	*Individual coverage*	$100
	Family coverage	$100: individual
		$300: Family

Calendar Year Out-of-Pocket Maximum[5]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

	When using a Medicare approved [3] or Non-Medicare approved [4] provider
Individual coverage	$1,000
Family coverage	$1,000: individual
	$0: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Claims Administrator will pay for Covered Services.

Benefits[6]	Your payment			
	When using a Medicare approved provider[3]	CYD[2] applies	When using a Non-Medicare approved provider[4]	CYD[2] applies
Preventive Health Services[7]				
Preventive Health Services	$0		$0	
Physician services				
Primary care office visit	$0		20%	✔
Specialist care office visit	$0		20%	✔
Physician home visit	$0		20%	✔
Physician or surgeon services in an Outpatient Facility	$0		20%	✔
Physician or surgeon services in an inpatient facility	$0		20%	✔
Other professional services				
Other practitioner office visit *Includes nurse practitioners, physician assistants, and therapists.*	$0		20%	✔
Acupuncture services *Up to 20 visits per Member, per Calendar Year.*	$0		20%	
Chiropractic services *Up to plan payment maximum of $1,500 per Member, Per Calendar Year.*	$0		20%	✔
Family planning				
Counseling, consulting, and education	$0		20%	✔
• Injectable contraceptive	$0		20%	✔
• Diaphragm fitting	$0		20%	✔
• Intrauterine device (IUD)	$0		20%	✔
• Insertion and/or removal of intrauterine device (IUD)	$0		20%	✔
• Implantable contraceptive	$0		20%	✔
• Tubal ligation	$0		20%	✔
• Vasectomy	$0		20%	✔
• Diagnosis and Treatment of the Cause of Infertility	Not covered		Not covered	
• Podiatric services	$0		20%	✔
Medical nutrition therapy, not related to diabetes	$0		20%	✔
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	$0		20%	✔
Physician services for pregnancy termination	$0		20%	✔

Benefits[6]	Your payment			
	When using a Medicare approved provider[3]	CYD[2] applies	When using a Non-Medicare approved provider[4]	CYD[2] applies
Emergency Services				
Emergency room services	$100/visit		$100/visit plus 20%	
If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Medicare approved *provider payment under Inpatient facility services/ Hospital services and stay.*				
Emergency room Physician services	$0		$0	
Urgent care center services	$0		20%	✔
Ambulance services *This payment is for emergency or authorized transport.*	$50/transport		$50/transport plus 20%	✔
Outpatient Facility services				
Ambulatory Surgery Center	$0		20%	✔
Outpatient Department of a Hospital: surgery	$0		20%	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0		20%	✔
Inpatient facility services				
Hospital services and stay	$0		20%	✔
Transplant services *This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.*				
Special transplant facility inpatient services	$0		Not covered	
• Physician inpatient services	$0		Not covered	
• **Bariatric surgery services**				
Inpatient facility services	$0		20%	✔
Outpatient Facility services	$0		20%	✔
Physician services	$0		20%	✔
Diagnostic x-ray, imaging, pathology, and laboratory services				

Benefits[6]	Your payment			
	When using a Medicare approved provider[3]	CYD[2] applies	When using a Non-Medicare approved provider[4]	CYD[2] applies
This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.				
Laboratory and pathology services				
Includes diagnostic Papanicolaou (Pap) test.				
Laboratory center	$0		20%	✔
• Outpatient Department of a Hospital	$0		20% Subject to a Benefit maximum of $350/day	✔
• Basic imaging services *Includes plain film X-rays, ultrasounds, and diagnostic mammography.*				
Outpatient radiology center	$0		20%	✔
• Outpatient Department of a Hospital	$0		20% Subject to a Benefit maximum of $350/day	✔
• Other outpatient non-invasive diagnostic testing *Testing to diagnose illness or injury such as vestibular function tests, EKG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.*				
Office location	$0		20%	✔
• Outpatient Department of a Hospital	$0		20% Subject to a Benefit maximum of $350/day	✔
• Advanced imaging services *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*				
Outpatient radiology center	$0		20%	✔
• Outpatient Department of a Hospital	$0		20% Subject to a Benefit maximum of $350/day	✔
• **Rehabilitative and Habilitative Services**				

Benefits[6]	Your payment			
	When using a Medicare approved provider[3]	CYD[2] applies	When using a Non-Medicare approved provider[4]	CYD[2] applies
Includes physical therapy, occupational therapy, and respiratory therapy.				
Office location	$0		20%	✔
Outpatient Department of a Hospital	$0		20%	✔
Speech Therapy services				
Office location	$0		20%	✔
Outpatient Department of a Hospital	$0		20%	✔
Durable medical equipment (DME)				
DME	$0		20%	✔
Breast pump	$0		Not covered	
Orthotic equipment and devices	$0		20%	✔
Prosthetic equipment and devices	$0		20%	✔
Home health care services *Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.*	$0		Not covered	
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	$0		Not covered	
Hemophilia home infusion services *Includes blood factor products.*	$0		Not covered	
Skilled Nursing Facility (SNF) services *Up to 120 days per Member, per benefit period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.*				
Freestanding SNF	$0		$0 with prior authorization	
Hospital-based SNF	$0		20%	✔
Hospice program services				

Benefits[6]	Your payment			
	When using a Medicare approved provider[3]	CYD[2] applies	When using a Non-Medicare approved provider[4]	CYD[2] applies
Pre-Hospice consultation	$0		Not covered	
Routine home care	$0		Not covered	
24-hour continuous home care	$0		Not covered	
Short-term inpatient care for pain and symptom management	$0		Not covered	
Inpatient respite care	$0		Not covered	
Other services and supplies				
Diabetes care services				
Devices, equipment, and supplies	$0		20%	✔
• Self-management training	$0		20%	✔
• Medical nutrition therapy	$0		20%	✔
• Dialysis services	$0		20%	✔
PKU product formulas and special food products	$0		Not covered	
Allergy serum billed separately from an office visit	$0		20%	✔
Travel immunizations and vaccinations	$0		$0	
Hearing Services				
Audiological evaluation	$0		20%	✔
• Vision Services				
Eye Refraction	$0		$0	
• *1 per Member, per Calendar Year.*				

Mental Health and Substance Use Disorder Benefits	Your payment			
	When using a Medicare approved provider[3]	CYD[2] applies	When using a Non-Medicare approved provider[4]	CYD[2] applies
Outpatient services				
Office visit, including Physician office visit	$0		20%	✔
Intensive outpatient care	$0		20%	✔
Behavioral Health Treatment in an office setting	$0		20%	✔
Behavioral Health Treatment in home or other non-institutional setting	$0		20%	✔
Office-based opioid treatment	$0		20%	✔
Partial Hospitalization Program	$0		20%	✔

Mental Health and Substance Use Disorder Benefits

Your payment

	When using a Medicare approved provider[3]	CYD[2] applies	When using a Non-Medicare approved provider[4]	CYD[2] applies
Psychological Testing	$0		20%	✔
Inpatient services				
Physician inpatient services	$0		20%	✔
Hospital services	$0		20%	✔
Residential Care	$0		20%	✔

Fitness Your Way Membership

Members are eligible to purchase a monthly Fitness Your Way membership for $25 per month plus a one-time enrollment fee of $25, which provides for access to participating network fitness locations.

Prior Authorization

The following are some frequently-utilized Benefits that require prior authorization:

- Advanced imaging services
- Outpatient mental health services, except office visits and office-based opioid treatment
- Inpatient facility services
- Hospice program services
- Home health services from non-Medicare approved providers

Please review the Benefit Booklet for more about Benefits that require prior authorization.

Notes

1 Benefit Booklet:

The Benefit Booklet describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the Benefit Booklet for more details of coverage outlined in this Summary of Benefits. You can request a copy of the Benefit Booklet at any time.

Capitalized terms are defined in the Benefit Booklet. Refer to the Benefit Booklet for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Calendar Year Deductible is the amount you pay each Calendar Year before the Claims Administrator pays for Covered Services under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

Notes

Family coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year.

3 Using Medicare approved providers:

Medicare approved providers have a contract to provide health care services to Members. When you receive Covered Services from a Medicare approved provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

"Allowable Amount" is defined in the Benefit Booklet. In addition:

- Coinsurance is calculated from the Allowable Amount.

4 Using Non-Participating Providers:

- *Non-*Medicare approved *providers do not have a contract to provide health care services to Members.* When you receive Covered Services from a Non-Medicare approved provider, you are responsible for:
- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount.

"Allowable Amount" is defined in the Benefit Booklet. In addition:

- Coinsurance is calculated from the Allowable Amount, which is subject to any stated Benefit maximum.
- Charges above the Allowable Amount do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.

5 Calendar Year Out-of-Pocket Maximum (OOPM):

Calendar Year Out-of-Pocket Maximum explained. The Out-of-Pocket Maximum is the most you are required to pay for Covered Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, the Claims Administrator will pay 100% of the Allowable Amount for Covered Services for the rest of the Calendar Year.

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for services that are not covered and charges above the Allowable Amount.

This Plan has a combined Medicare approved provider and Non-Medicare approved provider OOPM.

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

6 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit payment in addition to an allergy serum payment when you visit the doctor for an allergy shot.

7 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

Plans may be modified to ensure compliance with Federal requirements.

JW082223;111623