Stanford
HEALTH CARE ADVANTAGE

Santa Clara County and Alameda County - Stanford Health Care Advantage Gold and Platinum Plans

2018 Benefit Highlights

For more information, call 1-844-205-8422 (TTY 711), 8 am to 8 pm, seven days a week (except Thanksgiving and Christmas) from October 1 through February 14 and Monday through Friday (except holidays) from February 15 through September 30, or visit StanfordHealthCareAdvantage.org to view benefits, provider directory's, or enroll.

2018 PLAN BENEFITS		
	GOLD	**PLATINUM**
Monthly Premium	Santa Clara County - $55 Alameda County - $79	Santa Clara County - $104 Alameda County - $109
Medical Deductible	$0	$0
Maximum Out of Pocket	$5900	$4900
Comprehensive Care		
Primary Care Office visit	$10	$10
Specialist Office visit* *(referral required)*	$30	$20
Virtual Physician visit	$10	$10
Lab services	$10	$10
X-rays	$45	$25
MRI, CT scans	$200	$200
Preventive Services	$0	$0
Annual Wellness Visit	$0	$0
Hospital and Emergency		
Inpatient Hospital care	$275/day (1-7) $0/day (7+)	$275/day (1-7) $0/day (7+)
Skilled Nursing facility	$0/day (1-20) $150/day (21-100)	$0/day (1-20) $100/day (21-100)
Outpatient Surgery	20% coinsurance/event	$240/event
Emergency Care	$80 (U.S. Only) $0 if admitted	$80 (World-wide) $10,000 max $0 if admitted
Urgent Care	$35 (U.S. Only) $0 if admitted	$35 (World-wide) $0 if admitted
Ambulance Services	$210 per one-way trip	$200 per one-way trip
Rehabilitation (PT, OT, ST)	$30/visit	$20/visit
Cardiac Rehabilitation visits	$30/visit (maximum 36 visits)	$25/visit (maximum 36 visits)

2018 PLAN BENEFITS		
	GOLD	**PLATINUM**
Vision and Dental		
Vision Services *(Routine)*	Not covered	$25/visit
Eye Exam	Not covered	$25/1x per year
Glasses and Contacts copay	Not covered	$25
Coverage for Frames	Not covered	$150/credit towards frames or contacts 1x every 2 years
Dental *(Routine)* **Deductible** *waived for preventive and diagnostic services	Not covered	$0 In network $100 Out of network*
Preventive and Diagnostic Services	Not covered	10% In network 20% Out of network
Basic Services	Not covered	50% In and out of network
Major Services	Not covered	60% In and out of network
Dental maximum	Not covered	$1000 per year (in and out of network combined)
Additional Benefits		
Acupuncture	Not covered	$10/visit (max 15 visits/yr)
Chiropractic* *(Medicare coverage only)*	$20	$20
Gym Membership *(Silver&Fit®)*	Not covered	$0
Durable Medical Equipment	20%	20%

OUTPATIENT PRESCRIPTION DRUGS			
STANFORD HEALTH CARE ADVANTAGE PLATINUM AND GOLD PLANS			
Rx Deductible	Gold Plan: $250 for Tiers 3, 4 and 5 Platinum Plan: No Deductible		
INITIAL COVERAGE LIMIT $3750 in 2018			
	Retail Pharmacy 30-Day Supply	**Retail Pharmacy 90-Day Supply**	**Preferred Mail-Order (PPS) 90-Day Supply**
Tier 1 Preferred Generics	$5 Copay	$15 Copay	$10 Copay
Tier 2 Non-Preferred Generics	$15 Copay	$45 Copay	$30 Copay
Tier 3 Preferred Brands	$47 Copay	$141 Copay	$94 Copay
Tier 4 Non-Preferred Brands	$100 Copay	$300 Copay	$200 Copay
Tier 5 Specialty Drugs	33% Coinsurance (Platinum) 28% Coinsurance (Gold)	Not Available	Not Available
Tier 6 Select Care	$2 Copay	$6 Copay	$4 Copay
COVERAGE GAP $5000 in 2018			
	Retail Pharmacy 30-Day Supply	**Retail Pharmacy 90-Day Supply**	**Preferred Mail-Order (PPS) 90-Day Supply**
Tier 1 Preferred Generics	$5 Copay	$15 Copay	$10 Copay
Tier 6 Select Care	$2 Copay	$6 Copay	$4 Copay
For all other tiers in the Coverage Gap, you pay 44% coinsurance for generic drugs and 35% coinsurance for brand-name drugs			
CATASTROPHIC COVERAGE			
	Retail Pharmacy 30-Day Supply	**Retail Pharmacy 90-Day Supply**	**Preferred Mail-Order (PPS) 90-Day Supply**
Tier 1, 2 & 6 Generics	$3.35 or 5%	$10.05 or 5%	$6.70 or 5%
Tier 3 & 4 Brands	$8.35 or 5%	$25.05 or 5%	$16.70 or 5%
Tier 5 Specialty Tier	$8.35 or 5%	Not Available	Not Available

Stanford Health Care Advantage is a HMO with a Medicare contract. Enrollment in Stanford Health Care Advantage depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. You must continue to pay your Medicare Part B premium. This information is available for free in other languages. Please call our customer service number at 1-844-205-8422 from 8 am to 8 pm, seven days a week (except Thanksgiving and Christmas) from October 1 through February 14 and Monday through Friday (except holidays) from February 15 through September 30. TTY users can call 711.