Stanford
HEALTH CARE ADVANTAGE

2019 Summary of Benefits

Benefits Effective January 1, 2019

Alameda, San Mateo and Santa Clara County, California

Stanford Health Care Advantage (HMO)

Summary of Benefits
Stanford Health Care Advantage

Platinum HMO H2986, Plan 001, 004, 006 and
Stanford Health Care Advantage Gold HMO H2986, Plan 002, 005, 007

This is a summary of drug and health services covered by
Stanford Health Care Advantage Platinum (HMO) and Stanford Health Care Advantage Gold (HMO)

January 1, 2019 - December 31, 2019

Stanford Health Care Advantage (HMO) is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal. The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage."

To join **Stanford Health Care Advantage (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in California: **Alameda, San Mateo and Santa Clara**

Stanford Health Care Advantage (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services

Services with a [1] may require prior authorization
Services with a [2] may require a referral from your doctor.

	Stanford Health Care Advantage Gold	Stanford Health Care Advantage Platinum
Monthly Plan Premium	Alameda, San Mateo and Santa Clara County - $69 You must continue to pay your Medicare Part B premium.	Alameda, San Mateo and Santa Clara County - $99 You must continue to pay your Medicare Part B premium.
Deductible	You pay nothing This plan does not have a deductible	You pay nothing. This plan does not have a deductible
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs, voluntary benefits, or plan premium)*	$5,900 for services you receive from in-network providers The most you pay for copays, coinsurance and other costs for medical services for the year.	$4,900 for services you receive from in-network providers The most you pay for copays, coinsurance and other costs for medical services for the year.
Inpatient Hospital Services [1]	$275 copay per day for days 1 through 7 $0 copay the remainder of your stay Our plan covers an unlimited number of days for an inpatient hospital stay.	$275 copay per day for days 1 through 7 $0 copay the remainder of your stay Our plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient Hospital Services [1, 2]	20% coinsurance	$240 Copay
Doctor Office Visits		
Primary	$10 copay	$10 copay
Specialists [1, 2]	$30 copay	$20 copay

	Stanford Health Care Advantage Gold	Stanford Health Care Advantage Platinum
Preventive Care	You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screenings • Colorectal cancer screenings • Depression screenings • Diabetes screenings • HIV screenings • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling • Vaccines, including flu shots, hepatitis B shots, pneumococcal shots • "Welcome to Medicare" preventive visit (one time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.	You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screenings • Colorectal cancer screenings • Depression screenings • Diabetes screenings • HIV screenings • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling • Vaccines, including flu shots, hepatitis B shots, pneumococcal shots • "Welcome to Medicare" preventive visit (one time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.

	Stanford Health Care Advantage Gold	Stanford Health Care Advantage Platinum
Emergency Care	$80 copay Waived if you are admitted to the hospital within 24 hours Emergency coverage in U.S. and territories only	$80 copay Waived if you are admitted to the hospital within 24 hours Worldwide emergency coverage: Outside the U.S. and its territories emergency care is covered with a $80 copay up to a maximum of $10,000 annually.
Urgently Needed Services [1,2]	$35 copay Waived if admitted to the hospital within 24 hours Emergency coverage in U.S. and territories only	$35 copay Waived if admitted to the hospital within 24 hours Worldwide emergency coverage: Outside the U.S. and its territories emergency care is covered with a $35 copay up to a maximum of $10,000 annually.
Lab Services [1,2]	$10 copay	$10 copay
Diagnostic Radiology Service *(e.g., MRI, CT scans)*	$210 copay	$210 copay
Diagnostic Tests, Procedures and X-Ray Services	$45 copay	$25 copay
Therapeutic Radiology Services *(such as radiation treatment for cancer)*	20% of cost	20% of cost
Hearing and Balance Exams	You pay nothing Hearing aids and exams for fitting hearing aids are not covered.	You pay nothing Hearing aids and exams for fitting hearing aids are not covered.

	Stanford Health Care Advantage Gold	Stanford Health Care Advantage Platinum
Dental Services	Not covered Optional supplemental benefits are available for an additional premium.	Not covered Optional supplemental benefits are available for an additional premium.
Vision Services	Medicare covered exam to diagnose and treat diseases and condition of the eye (including yearly glaucoma screening): $10-$20 copay. Eyeglasses or contacts lenses after cataract surgery: You pay nothing Optional supplemental benefits are available for an additional premium.	Medicare covered exam to diagnose and treat diseases and condition of the eye (including yearly glaucoma screening): $10-$20 copay. Eyeglasses or contacts lenses after cataract surgery: You pay nothing Optional supplemental benefits are available for an additional premium.
Mental Health Services [1,2]		
Inpatient	$270 copay for days 1 through 6 You pay nothing for days 7 through 90	$270 copay for days 1 through 6 You pay nothing for days 7 through 90
Outpatient group therapy	$20 copay	$20 copay
Outpatient individual therapy	$30 copay	$20 copay
Skilled Nursing Facility (SNF) [1,2]	You pay nothing for days 1 through 20 $150 copay per day for days 21 through 100 Our plan covers up to 100 days in a SNF No prior hospital stay required	You pay nothing for days 1 through 20 $100 copay per day for days 21 through 100 Our plan covers up to 100 days in a SNF No prior hospital stay required

	Stanford Health Care Advantage Gold	Stanford Health Care Advantage Platinum
Rehabilitation Services [1,2]		
Occupational therapy visit	$30 copay	$20 copay
Physical therapy and speech and language therapy visit	$30 copay	$20 copay
Cardiac and pulmonary services	$30 copay	$25 copay
Ambulance Services	$210 copay	$200 copay
Transportation Benefit	Not covered	Not covered
Medicare Part B Drugs [1]	20% of the cost for chemotherapy drugs 20% of the cost for other Part B drugs	20% of the cost for chemotherapy drugs 20% of the cost for other Part B drugs
Foot Care (podiatry services) [1,2]	$30 copay for exams and treatment for diabetes-related nerve damage and/or certain conditions Routine foot care not covered	$20 copay for exams and treatment for diabetes-related nerve damage and/or certain conditions Routine foot care not covered
Medical Equipment/ Supplies [1,2]		
Durable Medical Equipment *(e.g., wheelchairs, oxygen)* **Prosthetics** *(e.g., braces, artificial limbs)*	20% coinsurance for Medicare covered items	20% coinsurance for Medicare covered items
Fitness Program	Not covered	$0 copay
Silver&Fit® Facility Membership or Home Fitness Program. *(Services offered which require additional payment are not covered.)*		$0 additional premium

	Stanford Health Care Advantage Gold	Stanford Health Care Advantage Platinum
Home Health Care [1,2]	You pay nothing For medically necessary care if you are homebound - as described by Medicare Including: • Part-time skilled nursing care • Physical therapy • Speech-language pathology • Occupational therapy • Medical social services • Home health aide services • Medical supplies	You pay nothing For medically necessary care if you are homebound - as described by Medicare Including: • Part-time skilled nursing care • Physical therapy • Speech-language pathology • Occupational therapy • Medical social services • Home health aide services • Medical supplies
Virtual Doctor Visits *(On-line, video visit or telephone visit)*	$10 copay	$10 copay
Acupuncture *(in-network)*	Not covered	$10 copay (Up to 15 visits per year)
Chiropractic *(in-network)* [1,2]	$20 copay for Medicare covered services Routine care not covered	$20 copay for Medicare covered services Routine care not covered
Outpatient Surgery and Services [1,2] *(Ambulatory surgical center and outpatient hospital)*	20% coinsurance	$240 copay
Diabetes Supplies [1,2]		
Diabetes monitoring supplies	You pay nothing	You pay nothing
Diabetes self-management training	You pay nothing	You pay nothing
Therapeutic shoes or inserts	You pay nothing	You pay nothing

OUTPATIENT PRESCRIPTION DRUGS

Stanford Health Care Advantage Platinum and Gold Plans

For **Stanford Health Care Advantage - Gold** members, there is a **$250 deductible** on tiers 3, 4 and 5 drugs. **You must pay the full cost of your tiers 3, 4 and 5 drugs** until you reach the plan's deductible amount. For all other drugs, you will not have to pay any deductible and will start receiving coverage immediately. For **Stanford Health Care Advantage - Platinum** members, there is **no deductible.**

Phase 1: Initial Coverage *(up to $3820 maximum RX cost)*

	Retail Pharmacy 34-Day Supply	Retail Pharmacy 90-day Supply	Preferred Mail Order Pharmacy 90-Day Supply
Tier 1: Preferred Generic	$5 Copay	$15 Copay	$10 Copay
Tier 2: Non-Preferred Generic	$15 Copay	$45 Copay	$30 Copay
Tier 3: Preferred Brand	$47 Copay	$141 Copay	$94 Copay
Tier 4: Non-Preferred Brand	$100 Copay	$300 Copay	$200 Copay
Tier 5: Specialty Tier	33% Coinsurance (Platinum) 28% Coinsurance (Gold)	Not Available	Not Available
Tier 6: Select Care	$2 Copay	$6 Copay	$4 Copay

Phase 2: Coverage Gap *(until out-of-pocket costs reach $5100)*

	Retail Pharmacy 34-Day Supply	Retail Pharmacy 90-day Supply	Preferred Mail Order Pharmacy 90-Day Supply
Tier 1: Preferred Generic	$5 Copay	$15 Copay	$10 Copay
Tier 2: Non-Preferred Generic	37% Coinsurance	37% Coinsurance	37% Coinsurance
Tier 3: Preferred Brand	25% Coinsurance	25% Coinsurance	25% Coinsurance
Tier 4: Non-Preferred Brand	25% Coinsurance	25% Coinsurance	25% Coinsurance
Tier 5: Specialty Tier	25% Coinsurance	Not Available	Not Available
Tier 6: Select Care	$2 Copay	$6 Copay	$4 Copay

Cost-Sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.

Phase 3: Catastrophic Coverage

	Retail Pharmacy 34-Day Supply	Retail Pharmacy 90-day Supply	Preferred Mail Order Pharmacy 90-Day Supply
Tier 1: Preferred Generic	$3.40 copay or 5% whichever is greater	$10.20 copay or 5% whichever is greater	$6.80 copay or 5% whichever is greater
Tier 2: Non-Preferred Generic	$3.40 copay or 5% whichever is greater	$10.20 copay or 5% whichever is greater	$6.80 copay or 5% whichever is greater
Tier 3: Preferred Brand	$8.50 copay or 5% whichever is greater	$25.50 copay or 5% whichever is greater	$17.00 copay or 5% whichever is greater
Tier 4: Non-Preferred Brand	$8.50 copay or 5% whichever is greater	$25.50 copay or 5% whichever is greater	$17.00 copay or 5% whichever is greater
Tier 5: Speciality Tier	$8.50 copay or 5% whichever is greater)	Not Available	Not Available
Tier 6: Select Care	$3.40 Copay or 5% whichever is greater	$10.20 Copay or 5% whichever is greater	$6.80 Copay or 5% whichever is greater

Optional Supplemental Benefits

In addition to the benefits that come with your plan, you can choose to add optional supplemental benefits. These optional supplemental benefits offer dental and vision coverage for an additional monthly premium that is added to your monthly plan premium.

Additional Monthly Premium	$20
WellVision Exam	$25 copay every calendar year
Prescription Glasses	
• **Frame** (included in prescription glasses)	$150 allowance for a wide selection of frames every other calendar year
• **Lenses** (included in prescription glasses)	Single vision, lined bifocal, and lined trifocal lenses every other calendar year
Contacts (instead of glasses)	$150 allowance for contacts every other calendar year $60 maximum copay for contact lens exam (fitting and evaluation) every other calendar year
Comprehensive Dental Services	
• **Preventive Service** Initial/routine oral exams, teeth cleaning, fluoride treatment, sealant, x-rays as part of a general exam, nutritional counseling and oral hygiene instructions	$0 copay
• **General Services** Fillings, general anesthetics, consultation, palliative treatment of dental pain	$0-$125 copay
• **Major Services** Initial/routine oral exams, teeth cleaning, fluoride treatment, sealant, x-rays as part of a general exam, nutritional counseling and oral hygiene instructions	$5-$445 copay

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-844-205-8422.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit StanfordHealthCareAdvantage.org or call 1-855-996-8422 to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2019.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. This document is available in other formats such as Braille, large print or audio.

For more information, please call us at the phone number below or visit us at StanfordHealthCareAdvantage.org.

Toll-free 1-855-996-8422, TTY users should call 711.

From October 1 to March 31, you can call us seven days a week (except Thanksgiving and Christmas) from 8am to 8pm Pacific.

From April 1 to September 30, you can call us Monday through Friday (except holidays) from 8am to 8pm Pacific.

You can see our plan's provider directory at our website at StanfordHealthCareAdvantage.org.

You can see our plan's pharmacy directory at our website at StanfordHealthCareAdvantage.org.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at StanfordHealthCareAdvantage.org.

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. Call 1-855-996-8422 (TTY: 711) for more information.

Discrimination is Against the Law

Stanford Health Care Advantage (HMO) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Stanford Health Care Advantage does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Stanford Health Care Advantage:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Care Services.

If you believe that Stanford Health Care Advantage has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Member Care Services
P.O. 72530, Oakland, CA 94612-8730
1- 855-996-8422
Advantage@stanfordhealthcare.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Member Care Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-996-8422 (TTY: 711).

Spanish: SATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-996-8422 (TTY: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-996-8422 (TTY: 711)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-996-8422 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-996-8422 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-996-8422 (TTY: 711) 번으로 전화해 주십시오.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-855-996-8422 (TTY (հեռատիպ)՝ 711):

Persian: توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماسبگیرید.(TTY: 711) 1-855-996-8422

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-996-8422 (телетайп: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-996-8422（TTY:711）まで、お電話にてご連絡ください。

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 855-996-8422 (رقم هاتف الصم والبكم: 711).

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-855-996-8422 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Mon-Khmer, Cambodian: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-996-8422 (TTY: 711)។

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-996-8422 (TTY: 711).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-996-8422 (TTY: 711) पर कॉल करें।

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-996-8422 (TTY: 711).

Stanford
HEALTH CARE ADVANTAGE

Stanford Health Care Advantage
P.O. Box 72530
Oakland, CA 94612
www.StanfordHealthCareAdvantage.org

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