



Stanford
HEALTH CARE ADVANTAGE



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

2019 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 March 31 and Monday through Friday (except holidays) from April 1 through September 30, or visit StanfordHealthCareAdvantage.org to view benefits, provider directory's, or enroll.

Benefit Highlights

for Stanford Health Care Advantage Platinum (HMO)
and Stanford Health Care Advantage Gold (HMO)



2019 PLAN BENEFITS		
	GOLD	PLATINUM
Monthly Premium	\$69	\$99
Medical Deductible	\$0	\$0
Maximum Out of Pocket	\$5900	\$4900
Comprehensive Care		
Primary Care Office visit	\$10	\$10
Specialist Office visit* <i>(referral required)</i>	\$30	\$20
Virtual Physician visit	\$10	\$10
Lab services	\$10	\$10
X-rays	\$45	\$25
MRI, CT scans	\$210	\$210
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)

2019 PLAN BENEFITS		
	GOLD	PLATINUM
Additional Benefits		
Acupuncture	Not covered	\$10/visit (max 15 visits/yr)
Chiropractic* <i>(Medicare coverage only)</i>	\$20	\$20
Gym Membership <i>(Silver&Fit®)</i>	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 \$3820			
	Retail Pharmacy 34-Day Supply	Retail Pharmacy 90-Day Supply	Preferred Mail-Order 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
Cost-Sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit.			

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
<p>Vision Services</p> <p>WellVision Exam</p> <p>Prescription Glasses</p> <ul style="list-style-type: none"> • Frame (included in prescription glasses) • Lenses (included in prescription glasses) <p>Contacts (instead of glasses)</p>	<p>\$25 copay every calendar year</p> <p>\$150 allowance for a wide selection of frames every other calendar year</p> <p>Single vision, lined bifocal, and lined trifocal lenses every other calendar year</p> <p>\$150 allowance for contacts every other calendar year</p> <p>\$60 maximum copay for contact lens exam (fitting and evaluation) every other calendar year</p>
<p>Comprehensive Dental Services</p> <ul style="list-style-type: none"> • 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 • General Services Fillings, general anesthetics, consultation, palliative treatment of dental pain • 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 	<p>\$0 copay</p> <p>\$0-\$125 copay</p> <p>\$5-\$445 copay</p>

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 1-844-205-8422 (TTY: 711) for more information.

Discrimination is Against the Law. Stanford Health Care Advantage cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Stanford Health Care Advantage 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-996-8422 (TTY: 711). ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-996-8422 (TTY: 711). 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) 。