Stanford
HEALTH CARE ADVANTAGE

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

2020 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.

2020 PLAN BENEFITS		
	GOLD	**PLATINUM**
Monthly Premium	$69	$99
Medical Deductible	No medical deductible	No medical deductible
Maximum Out of Pocket	$5,900	$4,900
Comprehensive Care		
Primary Care Office Visit	$10 copay	$10 copay
Specialist Office Visit* *(referral required)*	$30 copay	$20 copay
Primary Care Telehealth Visit *Teladoc®*	$10 copay	$10 copay
Lab Services	$10 copay	$10 copay
X-rays	$45 copay	$25 copay
MRI, CT Scans	$210 copay	$210 copay
Preventive Services	You pay nothing	You pay nothing
Annual Wellness Visit	You pay nothing	You pay nothing
Hospital and Emergency		
Inpatient Hospital Care	$275 copay per day (1-7) $0 copay per day (7+)	$275 copay per day (1-7) $0 copay per day (7+)
Skilled Nursing Facility	$0 copay per day (1-20) $150 copay per day (21-100)	$0 copay per day (1-20) $100 copay per day (21-100)
Outpatient Surgery	20% coinsurance per event	$240 copay per event
Emergency Care	$80 copay (U.S. Only) No copay if admitted	$80 copay (World-wide) $10,000 maximum coverage No copay if admitted
Urgent Care	$35 copay (U.S. Only) No copay if admitted	$35 copay (World-wide) No copay if admitted
Ambulance Services	$210 copay per one-way trip	$200 copay per one-way trip
Rehabilitation (PT, OT, ST)	$30 copay per visit	$20 copay per visit
Cardiac Rehabilitation Visits	$30 copay per visit (max 36 visits per year)	$25 copay per visit (max 36 visits per year)

2020 PLAN BENEFITS		
	GOLD	**PLATINUM**
Additional Benefits		
Acupuncture	Not covered	$10 copay per visit (max 15 visits per year)
Chiropractic* *(Medicare coverage only)*	$20 copay	$20 copay
Transportation	You pay nothing (24 one-way trips per year)	You pay nothing (24 one-way trips per year)
Post Discharge Meal Benefit	You pay nothing	You pay nothing
Gym Membership *Silver&Fit®*	Not covered	You pay nothing
Durable Medical Equipment	20% coinsurance	20% coinsurance

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 $4,020			
	Retail Pharmacy 30-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
VSP	
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
DeltaCare® USA (DHMO)	
• **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** Crowns, removable and fixed bridges, complete and partial dentures, oral surgery, periodontics, endodontics	$5-$445 copay

Stanford Health Care Advantage is a HMO with a Medicare contract. Enrollment in Stanford Health Care Advantage depends on contract renewal.

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）。