2021

Summary of Benefits

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

Serving the California counties of
Alameda, San Mateo, and Santa Clara

Stanford
HEALTH CARE ADVANTAGE

Summary of Benefits
Stanford Health Care Advantage

Stanford Health Care Advantage Platinum HMO H2986, Plan 001, 004, 006 and
Stanford Health Care Advantage Gold HMO H2986, Plan 002, 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, 2021 – December 31, 2021

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.

	Stanford Health Care Advantage Gold	Stanford Health Care Advantage Platinum
Monthly Plan Premium	Alameda, San Mateo, and Santa Clara Counties: $69 You must continue to pay your Medicare Part B premium.	Alameda, San Mateo, and Santa Clara Counties: $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)*	$6,500 for services you receive from in-network providers The most you pay for copays, coinsurance, and other costs for medical services for the year.	$5,250 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 per day for days 8 and beyond Copays apply to each admission If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay a network hospital.	$275 copay per day for days 1 through 7 $0 copay per day for days 8 and beyond Copays apply to each admission If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay a network hospital.
Outpatient Surgery and Services [1, 2] *(Ambulatory surgery center and outpatient hospital)*	Ambulatory surgical center: 20% coinsurance Outpatient hospital: 20% coinsurance	Ambulatory surgical center: $240 copay Outpatient hospital: $240 copay
Doctor Office Visits		
Primary	$10 copay	$10 copay
Specialists [1, 2]	$30 copay	$20 copay

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
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 risk reduction (behavioral therapy) • Cardiovascular disease testing • 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, and 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 risk reduction (behavioral therapy) • Cardiovascular disease testing • 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, and 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 same hospital for the same condition within 24 hours Emergency coverage in U.S. and territories only	$80 copay Waived if you are admitted to the same hospital for the same condition within 24 hours Worldwide emergency coverage: Outside the U.S. and its territories emergency care is covered with an $80 copay. The worldwide maximum for emergency and urgently needed services is $50,000.
Urgently Needed Services	$35 copay Emergency coverage in U.S. and territories only	$35 copay Worldwide emergency coverage: Outside the U.S. and its territories urgent care is covered with a $35 copay. The worldwide maximum for emergency and urgently needed services is $50,000.
Diagnostic Services/Labs/ Imaging [1, 2]		
Lab Services	$10 copay	$10 copay
Diagnostic Radiology Service *(e.g., MRI, CT scans)*	$210 copay Diagnostic mammograms: $0 copay	$210 copay Diagnostic mammograms: $0 copay
Diagnostic Tests, Procedures, and X-Ray Services	$45 copay Diagnostic colonoscopies: $0 copay	$25 copay Diagnostic colonoscopies: $0 copay
Therapeutic Radiology Services *(such as radiation treatment for cancer)*	20% coinsurance	20% coinsurance
Hearing and Balance Exams	$0 copay Hearing aids and exams for fitting hearing aids are not covered.	$0 copay Hearing aids and exams for fitting hearing aids are not covered.

	Stanford Health Care Advantage Gold	Stanford Health Care Advantage Platinum
Dental Services	Preventive and comprehensive dental not covered Optional supplemental benefits are available for an additional premium.	Preventive and comprehensive dental not covered Optional supplemental benefits are available for an additional premium.
Vision Services	Medicare-covered exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $10-$30 copay. Eyeglasses or contact lenses after cataract surgery: $0 copay Optional supplemental benefits are available for an additional premium.	Medicare-covered exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $10-$20 copay. Eyeglasses or contact lenses after cataract surgery: $0 copay Optional supplemental benefits are available for an additional premium.
Mental Health Services [1,2]		
Inpatient	$270 copay per day for days 1 through 6; $0 copay for days 7 and beyond Applies to each admission	$270 copay per day for days 1 through 6; $0 copay for days 7 and beyond Applies to each admission
Outpatient group therapy	$20 copay	$10 copay
Outpatient individual therapy	$30 copay	$20 copay
Skilled Nursing Facility (SNF) [1,2]	$0 copay for days 1 through 20 $150 copay per day for days 21 through 100 Copays apply to each admission Our plan covers up to 100 days in a SNF per admission No prior hospital stay required	$0 copay for days 1 through 20 $100 copay per day for days 21 through 100 Copays apply to each admission Our plan covers up to 100 days in a SNF per admission No prior hospital stay required
Physical Therapy [1,2]	$30 copay	$20 copay
Ambulance Services [1]	$210 copay	$200 copay

	Stanford Health Care Advantage Gold	Stanford Health Care Advantage Platinum
Transportation Benefit [1,2]	$0 copay 24 one-way trips to plan-approved health-related locations per year.	$0 copay 24 one-way trips to plan-approved health-related locations per year.
Medicare Part B Drugs [1]	20% of the cost for covered Part B drugs	20% of the cost for covered Part B drugs

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 $4,130 maximum RX cost)*

	Retail Pharmacy 30-Day Supply	Retail Pharmacy 90-Day Supply	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 $6,550)*

	Retail Pharmacy 30-Day Supply	Retail Pharmacy 90-Day Supply	Mail Order Pharmacy 90-Day Supply
Tier 1: Preferred Generic	$5 copay or 25%, whichever is lower	$15 copay or 25%, whichever is lower	$10 copay or 25%, whichever is lower
Tier 2: Non-Preferred Generic	25% coinsurance	25% coinsurance	25% 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 or 25%, whichever is lower	$6 copay or 25%, whichever is lower	$4 copay or 25%, whichever is lower

Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. Costs may differ based on pharmacy type or status. For more information, please call us or access our Evidence of Coverage online.

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Catastrophic Coverage	Member pays the greater of: • 5% coinsurance or • $3.70 for generic or a drug treated like a generic and $9.20 for other drugs (one-month supply).	Member pays the greater of: • 5% coinsurance or • $3.70 for generic or a drug treated like a generic and $9.20 for other drugs (one-month supply).
Chiropractic [1]	$20 copay for Medicare-covered services Routine care not covered	$20 copay for Medicare-covered services Routine care not covered
Diabetes Supplies [1]		
Diabetes monitoring supplies	0% coinsurance	0% coinsurance
Diabetes self-management training	$0 copay	$0 copay
Therapeutic shoes or inserts	0% coinsurance	0% coinsurance
Durable Medical Equipment *(e.g., wheelchairs, oxygen)* [1]	20% coinsurance for Medicare-covered items	20% coinsurance for Medicare-covered items
Foot Care (Podiatry Services) [1,2]	$30 copay for exams and treatment for diabetes-related nerve damage and/or certain conditions Routine foot care for members with certain medical conditions affecting the lower limbs	$20 copay for exams and treatment for diabetes-related nerve damage and/or certain conditions Routine foot care for members with certain medical conditions affecting the lower limbs
Home Health Care [1,2]	$0 copay For medically necessary care if you are homebound, it is 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	$0 copay For medically necessary care if you are homebound, it is 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

	Stanford Health Care Advantage Gold	Stanford Health Care Advantage Platinum
Hospice Care	You pay nothing for hospice care from any Medicare-certified hospice program. Please contact us for more details.	You pay nothing for hospice care from any Medicare-certified hospice program. Please contact us for more details.
Outpatient Substance Abuse [1,2]	Group visit: $20 copay Individual visit: $30 copay	Group visit: $10 copay Individual visit: $20 copay
Prosthetic Devices *(e.g., braces, artificial limbs)* [1]	20% coinsurance for Medicare-covered items	20% coinsurance for Medicare-covered items
Outpatient Rehab Services (Rehabilitation Services) [1,2]		
Occupational therapy visit	$30 copay	$20 copay
Speech and language therapy visit	$30 copay	$20 copay
Cardiac and pulmonary services	$30 copay	$25 copay
Dialysis Treatment/ESRD	20% coinsurance	20% coinsurance
Primary Care Physician Telehealth Visits **Teladoc®** *(Services offered through Teladoc® App on your iPhone or Android smart-phone, via Teladoc.com or by calling toll-free at 1-800-Teladoc)*	$10 copay	$10 copay
Fitness/Wellness Programs **Silver&Fit® Facility Membership or Home Fitness Program** *(Services offered which require additional payment are not covered.)*	Not covered	You pay nothing.

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Acupuncture [1,2]	Medicare-covered services (chronic low back pain): $30 copay	Medicare-covered services (chronic low back pain): $20 copay Supplemental: $10 copay (up to 15 visits per year)
Post-Discharge Meal Benefit [1,2]		
Immediately following surgery or inpatient hospital stay	$0 copay for up to 28 days, maximum of 56 meals per year	$0 copay for up to 28 days, maximum of 56 meals per year
Chronic condition including, but not limited to, cardiovascular disorders, COPD, or diabetes	$0 copay for up to 14 days, maximum of 28 meals per year	$0 copay for up to 14 days, maximum of 28 meals per year

Optional Supplemental Benefits

In addition to the benefits that come with your plan, you can choose to add optional supplemental benefits that offer dental and vision coverage for an additional monthly 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 or contacts, 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)	$25 copay on eyewear every other calendar year $60 maximum copay for a 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, and palliative treatment of dental pain	$0 – $125 copay
• **Major Services** Crowns, removable and fixed bridges, complete and partial dentures, oral surgery, periodontics, and endodontics	$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 1-855-996-8422.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that require a routine checkup with your 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/coinsurance may change on Jan. 1, 2022.
- ☐ 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 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: 711, 8 a.m. to 8 p.m., seven days a week

You may reach a messaging service on weekends from April 1 through Sept. 30 and holidays. Please leave a message, and your call will be returned the next business day.

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.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Stanford
HEALTH CARE ADVANTAGE

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