



2019
Medical Plan Comparison
for Retirees

2019 Medical Plan Comparison Chart – Pre-65 Retirees

The following charts indicate the percentage each plan pays, as well as the copayments, deductibles, or other charges you pay for services. For details, please refer to your health plan Evidence of Coverage booklets and your Summary Plan Description.

Services	Stanford Health Care Alliance (SHCA) Plan <small>The core service area includes Alameda, Contra Costa (NEW), San Francisco, San Mateo and Santa Clara counties. If you enroll in this plan and seek services outside of the core service area, the Aetna network (excluding Sutter doctors and facilities, except Alta Bates) will apply.</small>	Aetna Choice POS II Plan with HSA			Kaiser Permanente HMO Plan
		Tier 1 — Stanford Health Care, Stanford Children's Health and Stanford Health Care – ValleyCare Network	Tier 2 — Aetna Network	Tier 3 — Out-of-Network*	
Annual Deductible Applies to services that require coinsurance; not required before copayments, unless noted	\$400/person \$1,000/family	\$1,350/employee-only coverage \$2,700/employee + one or more covered dependents		\$2,700/employee-only coverage \$5,400/employee + one or more covered dependents	\$400/person \$1,000/family
Wellness Incentive	Based on participation in the <i>HealthySteps to Wellness</i> program while still actively employed				
Annual Out-of-Pocket Maximum Includes deductible, copays and pharmacy	\$1,800/person \$3,600/family	\$2,700/employee-only coverage \$5,400/employee + one or more covered dependents		\$5,400/employee-only coverage \$10,800/employee + one or more covered dependents	\$1,800/person \$3,600/family
Maximum Lifetime Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Choice of Physicians	You must use SHCA physicians. The SHCA Plan core service area includes Alameda, Contra Costa (NEW), San Francisco, San Mateo and Santa Clara counties. If you enroll in this plan and seek services outside of the core service area, the Aetna network (excluding Sutter doctors and facilities, except Alta Bates) will apply.	You must use SHC (including Facility Practice), LPCH, LPCH Facility Practice Organization, PCHA, Stanford Health Care – ValleyCare, Stanford Health Care Reference Lab and UHA	You must use Aetna network providers for in-network benefits	You may use any licensed provider	You must use Kaiser facilities; all care and covered services must be approved by a Kaiser physician
		Not all services are available through Tier 1 providers. If you would like to know if a certain service has Tier 1 providers, please call Aetna Concierge at 888.277.4041 for confirmation.			
Claim Forms	No, except for out-of-network emergency services	No, except for out-of-network emergency services	No, except for out-of-network emergency services	Yes	No, except for non-Kaiser emergency services
Hospital Care Room and Board, Surgeon, Physician Visit and Anesthesiologist	Facility charges: 90% after deductible; no charge at SHC/LPCH and Stanford Health Care – ValleyCare hospitals (precertification required)**	Facility charges: No charge after deductible (precertification required)**	Facility charges: 80% after deductible (precertification required)	Facility charges: 60% of UCR charges after deductible (precertification required or \$300/admission penalty applies; waived if emergency admission)	Facility charges: 90% after deductible
	Professional charges: No charge	Professional charges: No charge after deductible	Professional charges: 80% after deductible	Professional charges: 60% of UCR charges after deductible	Professional charges: 90% after deductible
Office Care					
Primary Care Physician (PCP) Visit	\$20/visit	\$20/visit after deductible	80% after deductible	60% of UCR charges after deductible	\$20/visit
Routine Annual Physical	No charge	No charge	No charge	60% of UCR charges after deductible	No charge

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		Tier 1 — Stanford Health Care, Stanford Children's Health and Stanford Health Care – ValleyCare Network	Tier 2 — Aetna Network	Tier 3 — Out-of-Network*	
Adult Preventive Services	No charge	No charge	No charge	60% of UCR charges after deductible	No charge
Child Preventive Services	No charge	No charge	No charge	60% of UCR charges after deductible	No charge
Telemedicine	Teladoc; \$20 copay (same as PCP office visit)	Not available	\$40 consult fee until deductible is met, then subject to 80% coinsurance	Not available	\$0 to visit with KP physician through the My Health Manager feature; applicable office visit copay if it is an interactive video visit at a KP medical center
Specialist Visit	\$35/visit	\$35/visit after deductible	80% after deductible	60% of UCR charges after deductible	\$35/visit
Allergy Tests	\$20/visit for PCP or \$35/visit for Specialist	\$20/visit after deductible for PCP or \$35/visit after deductible for Specialist	80% after deductible	60% of UCR charges after deductible	\$35/testing
Allergy Injections	No charge	No charge after deductible	80% after deductible	60% of UCR charges after deductible	\$3/visit
Immunizations	No charge	No charge	No charge	60% of UCR charges after deductible	No charge
Lab and X-ray (non-preventive)	Basic: 90% after deductible; \$25/visit at SHC/LPCH hospitals, Stanford Health Care – ValleyCare or a SHCA physician's office	Basic: No charge after deductible	Basic: 80% after deductible	Basic: 60% of UCR charges after deductible	Basic: 90%, deductible waived
	Complex: 90% after deductible; \$100/visit at SHC/LPCH hospitals, Stanford Health Care – ValleyCare or a SHCA physician's office	Complex: No charge after deductible	Complex: 80% after deductible	Complex: 60% of UCR charges after deductible	Complex: 90%, deductible waived (deductible applies if provided in an outpatient/ambulatory surgery center or in a hospital operating room)
Outpatient Surgery	90% after deductible; \$200 facility charge at SHC/LPCH or Stanford Health Care-Valley Care hospitals. Professional services are no charge, deductible waived	\$200/visit after deductible	80% after deductible	60% of UCR charges after deductible	90% after deductible
Chiropractic Care	\$35/visit; 30-visit maximum per calendar year	No charge after deductible; 30-visit maximum per calendar year (combined Tier 1, Tier 2 and out-of-network maximum)	80% after deductible; 30-visit maximum per calendar year (combined Tier 1, Tier 2 and out-of-network maximum)	60% of UCR charges after deductible; 30-visit maximum per calendar year (combined Tier 1, Tier 2 and out-of-network maximum)	Discounts apply through Kaiser Permanente's ChooseHealthy program

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		Tier 1 — Stanford Health Care, Stanford Children's Health and Stanford Health Care – ValleyCare Network	Tier 2 — Aetna Network	Tier 3 — Out-of-Network*	
Acupuncture	\$35/visit; 12-visit maximum per calendar year	\$35/visit after deductible; 12-visit maximum per calendar year (combined Tier 1, Tier 2 and out-of-network maximum)	80% after deductible; \$30/visit maximum benefit; 12-visit maximum per calendar year (combined Tier 1, Tier 2 and out-of-network maximum)	60% of UCR charges after deductible; \$30/visit maximum benefit; 12-visit maximum per calendar year (combined Tier 1, Tier 2 and out-of-network maximum)	Discounts apply through Kaiser Permanente's ChooseHealthy program
Infertility Care	Includes assisted reproductive technologies (procedures and medication), counseling and consultation, infertility studies and tests. Payable in accordance with the type of expense incurred and the place where service is provided After member cost share, the plan will pay up to \$10,000 for medical expenses and up to \$5,000 for pharmacy expenses per lifetime for assisted reproductive technologies	Includes assisted reproductive technologies (procedures and medication), counseling and consultation, infertility studies and tests. Payable in accordance with the type of expense incurred and the place where service is provided	80% after deductible; covered expenses include counseling and consultation, infertility studies and tests only	60% of UCR charges after deductible; covered expenses include counseling and consultation, infertility studies and tests only	50% for all services related to covered infertility treatment. Services related to conception by artificial means (other than artificial insemination) are excluded, including in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT).
Physical, Speech and Occupational Therapy (restorative services only)	\$35/visit; 60-visit maximum per calendar year (combined with physical, occupational or speech therapy)	\$35/visit after deductible; limited to a 60-visit maximum per calendar year (combined with physical, occupational or speech therapy; combined Tier 1, Tier 2 and out-of-network maximum)	80% after deductible; limited to a 60-visit maximum per calendar year (combined with physical, occupational or speech therapy; combined Tier 1, Tier 2 and out-of-network maximum)	60% of UCR charges after deductible; limited to a 60-visit maximum per calendar year (combined with physical, occupational or speech therapy; combined Tier 1, Tier 2 and out-of-network maximum)	\$20/visit
Emergency and Urgent Care					
Emergency In Area	\$200/visit	No charge after deductible	80% after deductible		90% after deductible
Emergency Out-of-Network	\$200/visit	No charge after deductible	80% after deductible		90% after deductible
Urgent Care	\$20/visit	No charge after deductible	No charge after deductible		\$20/visit at Kaiser facilities
Ambulance	No charge	No charge after deductible		No charge after Aetna Choice POS II In-Network deductible (UCR is waived for true emergency)	No charge; plan deductible does not apply
Skilled Nursing Facility	90% after deductible; 100-visit maximum per calendar year	Not covered under Tier 1; see Tier 2 for benefit coverage	80% after deductible; 100-visit maximum per calendar year (combined Tier 2 and out-of-network maximum)	60% of UCR charges after deductible; 100-visit maximum per calendar year (combined Tier 2 and out-of-network maximum)	90% up to 100 days per benefit period
Home Health Care	90% after deductible; 100-visit maximum per calendar year	Not covered under Tier 1; see Tier 2 for benefit coverage	80% after deductible; 100-visit maximum per calendar year (combined Tier 2 and out-of-network maximum)	60% of UCR charges after deductible; 100-visit maximum per calendar year (combined Tier 2 and out-of-network maximum)	No charge with Kaiser approval; part-time or intermittent only; 100-visit maximum per calendar year (must live within the service area)

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		Tier 1 — Stanford Health Care, Stanford Children's Health and Stanford Health Care – ValleyCare Network	Tier 2 — Aetna Network	Tier 3 — Out-of-Network*	
Well Child Vision Screening	No charge	No charge	No charge	Not covered	No charge
Hearing Exams	\$35/visit; well-child screening: No charge	No charge after deductible less copay; well-child screening: No charge	80% after deductible; well-child screening: No charge	60% of UCR charges after deductible	\$20/visit or \$35/visit; well-child screening: No charge
Dental Benefits	Not covered, except for emergency treatment; 90% after deductible	Not covered, except for emergency treatment; No charge after deductible	Not covered, except for emergency treatment; 80% after deductible	Not covered, except for emergency treatment; 60% of UCR charges after deductible	Not covered
Durable Medical Equipment	90% after deductible; includes hearing aids (limited to one pair of hearing aids every 2 years)	Not covered under Tier 1; see Tier 2 for benefit coverage	80% after deductible; includes hearing aids (limited to one pair of hearing aids every two years). Prior authorization may be required	60% of UCR charges after deductible; includes hearing aids (limited to one pair of hearing aids every two years)	80% when prescribed by a Kaiser physician (must live within the service area) 50% for external sexual dysfunction devices
Transplant Services	90% after deductible; must be performed at an Institute of Excellence facility and subject to utilization review; No charge at SHC/LPCH and Stanford Health Care – ValleyCare hospitals	No charge after deductible	80% after deductible; must be performed at an Institute of Excellence facility and subject to utilization review	Must use Institute of Excellence	For covered transplant services, you pay the same cost sharing as other services not related to a transplant
Mental or Nervous Disorders	Mental health care provided through SHCA	Mental health care provided through Aetna	Mental health care provided through Aetna	Mental health care provided through Aetna	Mental health care provided through Kaiser Permanente
Inpatient	Facility charges: 90% after deductible; No charge at SHC/LPCH and Stanford Health Care – ValleyCare hospitals	Facility charges: No charge after deductible	Facility charges: 80% after deductible	Facility charges: 60% of UCR charges after deductible (precertification required or \$300/admission penalty applies; waived if emergency admission)	Facility charges: 90% after deductible
	Professional charges: No charge	Professional charges: No charge after deductible	Professional charges: 80% after deductible	Professional charges: 60% of UCR charges after deductible	Professional charges: 90% after deductible
Outpatient	\$20/visit	\$20/visit after deductible	80% after deductible	60% of UCR charges after deductible	Individual: \$20/visit; Group: \$10/visit
Substance Abuse	Substance abuse care Provided through SHCA	Substance abuse care provided through Aetna	Substance abuse care provided through Aetna	Substance abuse care provided through Aetna	Substance abuse care provided through Kaiser Permanente

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		Tier 1 — Stanford Health Care, Stanford Children's Health and Stanford Health Care – ValleyCare Network	Tier 2 — Aetna Network	Tier 3 — Out-of-Network*	
Inpatient	Facility charges: 90% after deductible; No charge at SHC/LPCH and Stanford Health Care – ValleyCare hospitals	Facility charges: No charge after deductible	Facility charges: 80% after deductible	Facility charges: 60% of UCR charges after deductible (precertification required or \$300/admission penalty applies; waived if emergency admission)	Facility charges: 90% after deductible
	Professional charges: No charge	Professional charges: No charge after deductible	Professional charges: 80% after deductible	Professional charges: 60% of UCR charges after deductible	Professional charges: 90% after deductible
Outpatient	\$20/visit	\$20/visit after deductible	80% after deductible	60% of UCR charges after deductible	Individual: \$20/visit; Group: \$5/visit
Prescription Drugs	Prescription drugs provided by Aetna	Prescription Drugs provided through CVS/caremark		Prescription Drugs provided through CVS/caremark	Prescription Drugs provided through Kaiser Permanente
Preventive	Retail 30-day Supply Generic: \$10/prescription Brand Formulary: \$25/prescription Brand Non-Formulary: \$50/prescription Mail-Order 90-day Supply Generic: \$20/prescription Brand Formulary: \$50/prescription Brand Non-Formulary: \$100/prescription	Retail 30-day Supply Generic, Brand Formulary and Non-Brand Formulary: No charge, no deductible Mail-Order 90-day Supply Generic, Brand Formulary and Non-Brand Formulary: No charge; no deductible		Retail 60% after deductible Mail-Order Not covered	Retail 30-day Supply Generic: \$10/prescription Brand Formulary and Specialty: \$25/prescription when prescribed by a plan physician Mail-Order 100-day Supply Generic: \$20/prescription Brand Formulary: \$50/prescription
Non-Preventive	Same as Preventive above	Provided through CVS/caremark See Tier 2	80% after deductible	Same as Preventive above	Same as Preventive above
Women's Contraceptives	Provided through Aetna	Provided through CVS/caremark See Tier 2	Provided through CVS/caremark	Provided through CVS/caremark	Provided through Kaiser Permanente Pharmacy
Contraceptives examples include: oral, patch, emergency For a full list, visit www.healthysteps4u.org	Retail & Mail-Order Generic and Brand Formulary: No charge Brand Non-Formulary: \$50/prescription (retail); \$100/prescription (mail-order)	Provided through CVS/caremark See Tier 2	Retail & Mail-Order Generic, Brand Formulary and Non-Brand Formulary: No charge, no deductible	Retail: 60% of UCR charges after deductible Mail-Order: Not covered	No charge (See Kaiser Permanente Evidence of Coverage Booklet for details)

Preferred medication coverage: The list of medications considered preferred for their quality, effectiveness and value (formulary list) changes regularly, and will be updated for 2019. Choosing a preferred medication from the formulary list can keep your costs lower, so be sure to review the list with your doctor. In addition, certain medications may be excluded from coverage because they have an appropriate alternative on the list. If a medication you're taking today will not be covered in 2019, you will receive notification from Aetna. Please work with your doctor to determine the most appropriate alternative. The SHCA Plan uses Aetna's Standard Formulary.

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		Tier 1 — Stanford Health Care, Stanford Children's Health and Stanford Health Care – ValleyCare Network	Tier 2 — Aetna Network	Tier 3 — Out-of-Network*	
Women's Contraceptives covered under the Medical Plan	Services through Aetna	Services through Stanford Health Care, Stanford Children's Health Network and Stanford Health Care – ValleyCare	Services through Aetna	Services through any licensed provider	Services through Kaiser Permanente
Contraceptive injections and contraceptive devices such as, IUDs, implants, (including the insertion and removal) See medical plan for additional details	No charge	No charge	No charge	60% of UCR charges after deductible	No charge
Infertility Pharmacy	Provided through Aetna Retail 30-day Supply Generic: \$10/prescription Brand Formulary: \$25/prescription Brand Non-Formulary: \$50/prescription Mail-Order 90-day Supply Generic: \$20/prescription Brand Formulary: \$50/prescription Brand Non-Formulary: \$100/prescription Prior authorization may apply	Provided through CVS/caremark See Tier 2	Provided through CVS/caremark Retail 30-day Supply Generic, Brand and Non-Brand Formulary: 80% after deductible Mail-Order 90-day Supply Generic, Brand and Non-Brand Formulary: 80% after deductible Prior authorization may apply	Provided through CVS/caremark Retail 30-day Supply 60% of UCR charges after deductible Mail-Order Not covered Prior authorization may apply	Provided through Kaiser Permanente Pharmacy Retail 30-day Supply Generic: \$10/prescription Brand Formulary: \$25/prescription when prescribed by a plan physician Mail-Order 100-day Supply Generic: \$20/prescription Brand Formulary: \$50/Prescription Drugs on the generic and brand tier prescribed to treat infertility only

* Out-of-Network means out of the Tier 2 network. Usual Customary and Reasonable (UCR) charges are the fees normally charged for medical services or supplies in a particular geographic location.

** Includes El Camino and Sequoia hospital facility charges and professional charges for delivery and newborn services only.

Copay is determined on where test is performed.

SHCA Plan Only — An out-of-area plan is offered to college student dependents of SHCA subscribers who reside outside the SHCA service area. Enrollees in this plan have access to physicians who are part of Aetna's national network. For more information, please refer to the Frequently Asked Questions document on www.healthysteps4u.org or call SHCA Member Care Services at 855.345.7422.

Transgender services are covered under all plans and benefits are payable in accordance with the type of expense incurred and the place where service is provided.

2019 Medical Plan Comparison Chart – Retirees/Dependents Age 65 and Over

The following charts indicate the percentage each plan pays, as well as the copayment, deductibles, or other charges you pay for services. For details, please refer to your health plan Evidence of Coverage booklets and your Summary Plan Description. Retirees in Groups B, C, or D are not eligible for the Medicare Coordination Plan. AARP plans are offered by each state in addition to the plans detailed below.

Services	Medicare Coordination Plan	Kaiser Permanente Senior Advantage	Stanford Health Care Advantage Gold	Stanford Health Care Advantage Platinum
How Plans Work with Medicare	Plan benefits are reduced by Medicare benefits	Plan provides Medicare benefits, plus extra coverage	Medicare Advantage Plans (sometimes called Part C or MA Plans) are an all-in-one alternative to Original Medicare. Under this plan, Medicare coverage is “bundled” to include Medicare Parts A (Hospital Insurance), B (Medical Insurance), and D (Prescription Drug Coverage)	Medicare Advantage Plans (sometimes called Part C or MA Plans) are an all-in-one alternative to Original Medicare. Under this plan, Medicare coverage is “bundled” to include Medicare Parts A (Hospital Insurance), B (Medical Insurance), and D (Prescription Drug Coverage)
Choice of Physicians	You may receive care from any licensed doctor	You must use Kaiser facilities. All care and covered services must be approved by a Kaiser physician.	You must use an SHCA provider, with limited exceptions. You may be limited to providers (e.g., Specialists and Hospitals) within your Primary Care Provider’s (PCP’s) and/or Medical Group’s network.	You must use an SHCA provider, with limited exceptions. You may be limited to providers (e.g., Specialists and Hospitals) within your Primary Care Provider’s (PCP’s) and/or Medical Group’s network.
Claim Forms	Yes	No, except for non-Kaiser emergency services	No, but you may need to submit a request for reimbursement in some cases**	No, but you may need to submit a request for reimbursement in some cases**
Annual Deductible	\$300/person	None	None	None
Annual Out-of-Pocket Maximum	\$1,000/person \$2,500/family (does not include deductible)	\$1,500/person \$3,000/family unit (two people or more)	\$5,900 for in-network services/person (does not include prescription drugs, voluntary benefits or plan premium)	\$4,900 for in-network services/person (does not include prescription drugs, voluntary benefits or plan premium)
Maximum Lifetime Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Hospital Care Room and Board, Surgeon, Physician Visit and Anesthesiologist	80% of allowable charges, after deductible	100% after \$250 copayment per admission	Inpatient: \$275/day up to 7 days; no cost for remainder of stay Outpatient: 20% of allowable charges	Inpatient: \$275/day up to 7 days; no cost for remainder of stay Outpatient: \$240 copay
Office Care				
Physician Visit	80% of allowable charges, after deductible	\$20/visit	\$10/visit	\$10/visit
Routine Physical	No charge	No charge	No charge	No charge
Well-Woman Care	No charge	No charge	\$30/visit	\$20/visit
Specialist Care	80% of allowable charges, after deductible	\$20/visit	\$30/visit	\$20/visit
Allergy Tests	80% of allowable charges, after deductible	\$20/testing	\$10-\$45 for Medicare covered services	\$10-\$25 for Medicare covered services
Allergy Injections	80% of allowable charges, after deductible	\$3/visit/injection	Varies depending on type of Medicare-covered injection; please refer to the plan’s formulary	Varies depending on type of Medicare-covered injection; please refer to the plan’s formulary
Immunizations	80% of allowable charges, after deductible	No charge	No charge for Pneumonia vaccine, annual Flu shot (with additional flu shots if medically necessary), Hepatitis B vaccine (if at high or intermediate risk) or other vaccines (if at risk and they meet Medicare Part B rules, or if under Medicare Part D)	No charge for Pneumonia vaccine, annual Flu shot (with additional flu shots if medically necessary), Hepatitis B vaccine (if at high or intermediate risk) or other vaccines (if at risk and they meet Medicare Part B rules, or if under Medicare Part D)
Lab and X-ray	80% of allowable charges, after deductible	No charge	\$10/visit for Lab Services	\$10/visit for Lab Services
Outpatient Surgery	80% of allowable charges, after deductible	\$100/procedure	20% of allowable charges	\$240/visit

Services	Medicare Coordination Plan	Kaiser Permanente Senior Advantage	Stanford Health Care Advantage Gold	Stanford Health Care Advantage Platinum
Chiropractic Care	80% of allowable charges, after deductible; 60-visit maximum per calendar year	\$20/visit when Medicare guidelines are met	\$20/visit when Medicare guidelines are met	\$20/visit when Medicare guidelines are met
Telemedicine	Teladoc: \$40 consult fee until deductible is met, then subject to 80% coinsurance (Teladoc does not coordinate with Medicare)	Kaiser Permanente telehealth program; no cost	\$10/visit	\$10/visit
Acupuncture	80% of allowable charges, after deductible; \$30/visit maximum; maximum of 12 visits per calendar year	Discounts apply through Kaiser Permanente's Healthroads program (www.kp.org/healthroads)	Not covered	\$10/visit; 15-visit maximum per calendar year
Physical, Speech and Occupational Therapy (restorative services only)	80% of allowable charges, after deductible; 60-visit maximum per calendar year	\$20/visit when Medicare guidelines are met	\$30/visit	\$20/visit
Emergency & Urgent Care				
Emergency in Area	80% of allowable charges, after deductible	\$50 copayment per visit (waived if admitted within 24 hours for same condition)	\$80/visit; waived if admitted within 24 hours	\$80/visit; waived if admitted within 24 hours
Emergency Out-of-Area	80% of allowable charges, after deductible	Worldwide coverage provided for emergency services due to unforeseen illness or injury. \$50 copayment per emergency room visit. You must file a claim form.	If in-network providers cannot provide care, the plan covers Medicare-required services received from an out-of-network provider at the in-network rate. Authorization must be obtained from the plan prior to seeking care. The plan covers kidney dialysis services from Medicare-certified dialysis facility when the member is temporarily outside the plan's service area.	\$80/visit; \$10,000 maximum per calendar year
Urgent Care	80% of allowable charges, after deductible	\$20 copayment per visit	\$35/visit; waived if admitted within 24 hours	\$35/visit; waived if admitted within 24 hours
Ambulance	80% of allowable charges, after deductible	100% after \$50 copayment, when medically indicated and authorized by a plan physician	\$210 copay	\$200 copay
Prescription Drugs				
Medicare Part D Note: If you enroll in Medicare Part D with another vendor, you will no longer have medical coverage with Stanford Health Care/Lucile Packard Children's Health Stanford	Provided through CVS/ caremark Retail (30-day supply): Generic: \$10/prescription Brand Formulary: \$20/prescription Brand Non-Formulary: \$60/prescription Mail-Order (90-day supply): Generic: \$20/prescription Brand Formulary: \$40/prescription Brand Non-formulary: \$120/prescription	When provided through Kaiser Retail (30-day supply): Generic: \$10/prescription Brand Formulary: \$20/prescription Mail-Order (100-day supply)*: Generic: \$20/prescription Brand Formulary: \$40/prescription	\$250 deductible on Brand Formulary and Brand Non-Formulary Retail Pharmacy (34-day Supply): Generic: \$5/prescription Brand Formulary: \$47/prescription Brand Non-Formulary: \$100/prescription Mail Order (90-day Supply): Generic: \$10/prescription Brand Formulary: \$94/prescription Brand Non-Formulary: \$200/prescription Initial coverage up to \$3,850 maximum; Coinsurance rates apply after maximum until out-of-pocket costs reach \$5,100	No deductible Retail Pharmacy (34-day Supply): Generic: \$5/prescription Brand Formulary: \$47/prescription Brand Non-Formulary: \$100/prescription Mail Order (90-day Supply): Generic: \$10/prescription Brand Formulary: \$94/prescription Brand Non-Formulary: \$200/prescription Initial coverage up to \$3,850 maximum; Coinsurance rates apply after maximum until out-of-pocket costs reach \$5,100
Optical Services	Not covered	No charge; \$150 eyewear allowance every 24 months for lenses and frames, or for contact lenses	No charge for eyeglasses or contact lenses after cataract surgery; \$10-\$20 copay for Medicare covered exams for diagnosis and treatment of diseases and conditions of the eye	No charge for eyeglasses or contact lenses after cataract surgery; \$10-\$20 copay for Medicare covered exams for diagnosis and treatment of diseases and conditions of the eye
Hearing Screening Exam	No charge	No charge	No charge	No charge

Services	Medicare Coordination Plan	Kaiser Permanente Senior Advantage	Stanford Health Care Advantage Gold	Stanford Health Care Advantage Platinum
Non-Preventive Hearing Exam	80% after deductible (1 per 24 months)	\$20 copay	No charge for diagnostic hearing exams	No charge for diagnostic hearing exams
Dental Benefits	Not covered	Not covered	Not covered	Not covered
Skilled Nursing Facility (SNF)	No charge up to allowable charge; 100-day maximum per calendar year	No charge; up to 100 days per benefit period in accordance with Medicare guidelines	No charge up to 20 visits; \$150/day up to 100-visit maximum per calendar year	No charge up to 20 visits; \$100/day up to 100-visit maximum per calendar year
Home Health Care	80% of allowable charges, after deductible; 100-visit maximum per calendar year; one visit by a home health aide equals four hours or less	Covered in full when Medicare guidelines are met (must live within service area)	No charge for medically necessary care if you are homebound, as described by Medicare	No charge for medically necessary care if you are homebound, as described by Medicare
Durable Medical Equipment	80% of allowable charges, after deductible; includes hearing aids (limited to one pair of hearing aids every two years)	20% copayment when medically necessary, prescribed by Kaiser physician, and in accordance with Medicare DME Formulary guidelines (must live within service area)	20% of allowable charges for Medicare-covered items	20% of allowable charges for Medicare-covered items
Mental Health	All Mental Health Care provided through Aetna	All Mental Health Care provided through Kaiser	All Mental Health Care provided through Stanford Health Care Advantage	All Mental Health Care provided through Stanford Health Care Advantage
Inpatient hospital Inpatient clinician visits for psychotherapy, psychological testing or rehabilitative care	80% of allowable charges, after deductible 80% of allowable charges, after deductible No lifetime maximum	100% after \$250 copayment per Admission	\$270/day up to 6 days; no charge for days 7 through 90	\$270/day up to 6 days; no charge for days 7 through 90
Outpatient day treatment services Outpatient clinician visits for psychotherapy, psychological testing or rehabilitative care	80% of allowable charges, after deductible 80% of allowable charges, after deductible No lifetime maximum	Individual: \$20/visit Group: \$10/visit Unlimited visits per calendar year	Individual: \$30/visit Group: \$20/visit	Individual: \$20/visit Group: \$20/visit
Substance Abuse	All Substance Abuse Care provided through the plan	All Substance Abuse Care provided through Kaiser Permanente	All Substance Abuse Care provided through Stanford Health Care Advantage	All Substance Abuse Care provided through Stanford Health Care Advantage
Inpatient hospital Inpatient clinician visits for psychotherapy, psychological testing or rehabilitative care	Same as mental health coverage above Same as mental health coverage above	100% after \$250 copayment per admission when medically necessary for detoxification only Counseling and educational classes are available at the time of detoxification Transitional Residential Recovery Services (TRRS), \$100 copayment per admission	\$275/day up to 7 days; no charge for the remainder of stay	\$275/day up to 7 days; no charge for the remainder of stay
Outpatient day treatment services Outpatient clinician visits for psychotherapy, psychological testing or rehabilitative care	Same as mental health coverage above Same as mental health coverage above	Individual: \$20/visit Group: \$5/visit	Individual: \$30/visit Group: \$20/visit	Individual: \$30/visit Group: \$20/visit

* Drugs related to sexual dysfunction require a 50% coinsurance for up to a 100-day supply.

** You can request a Direct Member Reimbursement Form (DMR Form) from Member Services by calling 1-855-996-8422.

NOTE: Transgender services are covered under all plans and benefits are payable in accordance with the type of expense incurred and the place where service is provided.

Check Out Your Resources

You've got lots of resources when it comes to making your benefit decisions and enrolling for 2019. For more information on benefits, you can:

- Contact the **health plan's member services or website** to get specific information about benefits or find out if your doctor is in the network (see the chart below).
- If you have questions, call the HealthySteps Benefits Service Center at 1-855-278-7157.

Benefit Plan	Phone Number	Website
For Individuals Under Age 65		
Aetna Choice POS II Plan	1-888-277-4041	http://www.aetna.com
Stanford Health Care Alliance Plan	1-855-345-SHCA (7422)	http://stanfordhealthcarealliance.org/
CVS/caremark (Rx coverage for Aetna Choice POS II Plan participants)	1-844-214-2607	http://www.caremark.com
Aetna (Mental health coverage and Rx for SHCA Plan participants; mental health coverage for Aetna Choice POS II Plan participants)	1-855-345-SHCA (7422)	http://stanfordhealthcarealliance.org/
Kaiser Permanente HMO Plan	1-800-464-4000	http://my.kp.org/ca/stanfordmed
For Individuals Age 65 and Over		
AARP	1-800-545-1797	http://www.aarphealthcare.com
Medicare Coordination Plan	1-888-277-4041	http://www.aetna.com
Mental health coverage for Medicare Coordination Plan	1-888-277-4041	http://www.aetna.com
CVS/caremark (Rx coverage for Medicare Coordination plan participants)	1-844-214-2607	http://www.caremark.com
Kaiser Permanente Senior Advantage	1-800-443-0815	http://my.kp.org/ca/stanfordmed
Stanford Health Care Advantage Gold and Platinum Plans	1-855-996-8422	https://stanfordhealthcareadvantage.org/Enroll/Home



The information in this guide provides an overview of your Stanford Health Care and Lucile Packard Children's Hospital Stanford 2019 retiree benefit plans. More complete descriptions of the plans are contained in your plan documents that govern these plans. If there is a discrepancy between this guide and the plan documents, the plan documents will govern in all cases.