Stanford MEDICINE
Health Care

2023
Medical Plan Comparison
for Retirees

2023 Medical Plan Comparison Chart – Pre-65 Retirees

The following charts indicate 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	AETNA CHOICE POS II PLAN WITH HSA			KAISER PERMANENTE HMO PLAN
	The core service area includes Alameda, Contra Costa, 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) will apply.	TIER 1 STANFORD HEALTH CARE, STANFORD CHILDREN'S HEALTH AND STANFORD TRI-VALLEY NETWORK	TIER 2 AETNA NETWORK	TIER 3 OUT-OF-NETWORK[1]	
General Information					
Annual Deductible *Applies to services that require coinsurance; not required before copayments, unless noted.*	$400/person $1,000/family	$1,500/employee-only coverage $3,000/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 HealthySteps to Wellness program				
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				
Choice of Physicians	You must use an assigned or selected SHCA primary care physician (PCP) who acts as your dedicated personal doctor. A referral from your PCP is required for most specialty services. The SHCA Plan core service area includes Alameda, Contra Costa, 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) will apply.	You must use SHC (including Faculty Practice), LPCHS, LPCHS Faculty Practice Organization, PCHA, Stanford Tri-Valley , 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			Yes	No, except for non-Kaiser emergency services

2023 Medical Plan Comparison Chart – Pre-65 Retirees (cont.)

SERVICES	STANFORD HEALTH CARE ALLIANCE (SHCA) PLAN The core service area includes Alameda, Contra Costa, 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) will apply.	AETNA CHOICE POS II PLAN WITH HSA TIER 1 STANFORD HEALTH CARE, STANFORD CHILDREN'S HEALTH AND STANFORD TRI-VALLEY NETWORK	TIER 2 AETNA NETWORK	TIER 3 OUT-OF-NETWORK[1]	KAISER PERMANENTE HMO PLAN
Office Care					
Primary Care Physician (PCP) Visit	$20/visit	$20/visit after deductible	You pay 20% after deductible	You pay 40% of UCR charges after deductible	$20/visit
Routine Annual Physical	No charge	No charge	No charge	You pay 40% of UCR charges after deductible	No charge
Preventive Services (adult and child)	No charge	No charge	No charge	You pay 40% of UCR charges after deductible	No charge
Immunizations	No charge	No charge	No charge	You pay 40% of UCR charges after deductible	No charge
Specialist Visit	$35/visit: A referral from your PCP is required for most specialty visits	$35/visit after deductible	You pay 20% after deductible	You pay 40% of UCR charges after deductible	$35/visit
Telemedicine Visit	PCP: $20/visit Specialty: $35/visit Mental Health: $20/visit	PCP: $20/visit Specialty: $35/visit	Teledoc: $49 consult fee for PCP and mental health until deductible is met; You pay 20% after deductible	Not covered	$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
Allergy Tests	PCP: $20/visit Specialty: $35/visit	PCP: $20/visit after deductible Specialist: $35/visit after deductible	You pay 20% after deductible	You pay 40% of UCR charges after deductible	$35/testing
Allergy Injections	No charge	No charge after deductible	You pay 20% after deductible	You pay 40% of UCR charges after deductible	$3/visit
Chiropractic Care	$35/visit; 12- visit max per calendar year	Not covered	You pay 20% after deductible; $30/visit maximum benefit; 12-visit max per calendar year (combined Tier 1, Tier 2 and out-of-network max)	You pay 40% of UCR charges after deductible; 30-visit maximum per calendar year (combined Tier 1, Tier 2 and out-of-network maximum)	25% off contracted provider standard fees. Available to all members. No referral needed. To find an acupuncturist, chiropractor or massage therapist, visit kp.org/choosehealthy
Acupuncture	$35/visit; 12- visit max per calendar year	$35/visit after deductible; 12-visit max per calendar year (combined Tier 1, Tier 2 and out-of-network max)	You pay 20% after deductible; $30/visit maximum benefit; 12-visit max per calendar year (combined Tier 1, Tier 2 and out-of-network max)	You pay 40% 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
Physical, Speech and Occupational Therapy *(restorative services only)*	$35/visit; 12- visit max per calendar year; 60-visit max per calendar year (combined with physical, occupational or speech therapy)	$35/visit after deductible; 60-visit max per calendar year (combined with physical, occupational or speech therapy; combined Tier 1, Tier 2 and out-of-network max)	You pay 20% 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)	You pay 40% 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

2023 Medical Plan Comparison Chart – Pre-65 Retirees (cont.)

SERVICES	STANFORD HEALTH CARE ALLIANCE (SHCA) PLAN The core service area includes Alameda, Contra Costa, 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) will apply.	AETNA CHOICE POS II PLAN WITH HSA TIER 1 STANFORD HEALTH CARE, STANFORD CHILDREN'S HEALTH AND STANFORD TRI-VALLEY NETWORK	TIER 2 AETNA NETWORK	TIER 3 OUT-OF-NETWORK[1]	KAISER PERMANENTE HMO PLAN
Hospital Care					
Room and Board, Surgeon, Physician Visit and Anesthesiologist	No charge at SHC, LPCHS or Stanford Tri-Valley hospitals Other in-network facilities: You pay 10% after deductible Professional charges: No charge	No charge after deductible at SHC, LPCHS or Stanford Tri-Valley hospitals Professional charges: No charge after deductible	You pay 20% after deductible (precertification is required) Professional charges: You pay 20% after deductible	Facility charges: You pay 40% of UCR charges after deductible (precertification required or $300/ admission penalty applies; waived if emergency admission) Professional charges: You pay 40% of UCR charges after deductible	Facility charges: You pay 10% after deductible Professional charges: You pay 10% after deductible
Outpatient					
Lab and X-ray *(non-preventive)*	Basic: $25/visit at SHC/LPCHS, Stanford Tri-Valley hospitals or a SHCA physicians office Other facilities: You pay 10% after deductible	Basic: no charge after deductible	Basic: You pay 20% after deductible	Basic: You pay 40% of UCR charges after deductible	Basic: You pay 10%, deductible waived
	Complex: $100/visit at SHC/LPCHS, Stanford Tri-Valley hospitals or a SHCA physicians office Other facilities: You pay 10% after deductible	Complex: no charge after deductible	Complex: You pay 20% after deductible	Complex: You pay 40% of UCR charges after deductible	Complex: 10%, deductible waived (deductible applies if provided in an outpatient/ambulatory surgery center or in a hospital operating room)
Outpatient Surgery	$200 facility fee and no charge for professional services at SHC/LPCHS, Stanford Tri-Valley hospitals Other facilities: You pay 10% after deductible	$200/visit after deductible	You pay 20% after deductible	You pay 40% of UCR charges after deductible	You pay 10% after deductible
Emergency and Urgent Care					
Emergency in Area	$200/visit	No charge after deductible	You pay 20% after deductible		You pay 10% after deductible
Emergency Out-of-Area	$200/visit	No charge after deductible	You pay 20% after deductible		You pay 10% 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; plan deductible does not apply
Mental or Nervous Disorders					
Inpatient	Facility charges: You pay 10% after deductible; No charge at SHC/LPCHS and Stanford Tri-Valley hospitals Professional charges: No charge	Facility charges: No charge after deducible Professional charges: No charge after deductible	Facility charges: You pay 20% after deductible Professional charges: You pay 20% after deductible	Facility charges: You pay 40% of UCR charges after deductible (precertification required or $300/ admission penalty applies; waived if emergency admission) Professional charges: You pay 40% of UCR charges after deductible	Facility charges: You pay 10% after deductible Professional charges: You pay 10% after deductible
Outpatient	$20/visit	Office setting: $20/visit after deductible; Other outpatient services: No charge after deductible	You pay 20% after deductible	You pay 40% of UCR charges after deductible	Individual: $20/visit; Group: $10/visit

2023 Medical Plan Comparison Chart – Pre-65 Retirees (cont.)

SERVICES	STANFORD HEALTH CARE ALLIANCE (SHCA) PLAN	AETNA CHOICE POS II PLAN WITH HSA			KAISER PERMANENTE HMO PLAN
	The core service area includes Alameda, Contra Costa, 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) will apply.	TIER 1 STANFORD HEALTH CARE, STANFORD CHILDREN'S HEALTH AND STANFORD TRI-VALLEY NETWORK	TIER 2 AETNA NETWORK	TIER 3 OUT-OF-NETWORK[1]	
Substance Abuse					
Inpatient	Facility charges: You pay 10% after deductible; No charge at SHC/LPCHS and Stanford Tri-Valley hospitals	Facility charges: No charge after deducible	Facility charges: You pay 20% after deductible	Facility charges: You pay 40% of UCR charges after deductible (precertification required or $300/ admission penalty applies; waived if emergency admission)	Facility charges: You pay 10% after deductible
	Professional charges: No charge	Office setting: $20/visit after deductible; Other outpatient services: No charge after deductible	Professional charges: You pay 20% after deductible	Professional charges: You pay 40% of UCR charges after deductible	Professional charges: You pay 10% after deductible
Outpatient	$20/visit	Office setting: $20/copay; Provider charges: 100%, no deductible; SHC/LPCHS and Stanford Tri-Valley hospitals: $20/ copay; All other facilities: 90% after deductible	You pay 20% after deductible	You pay 40% of UCR charges after deductible	Individual: $20/visit; Group: $5/visit
Reproductive Health					
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	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	You pay 20% after deductible; for diagnosis and treatment of medical condition only	You pay 40% of UCR charges after deductible; for diagnosis and treatment of med	You pay 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)
	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				
Sperm and Oocyte Preservation, Donor Eggs and Sperm, Cryopreservation of Fertilized Embryos[3]	Care provided at SHC/LPCHS or Stanford HealthCare – Tri-Valley hospitals	Care provided at SHC/LPCHS or Stanford Tri-Valley hospitals	Not covered	Not covered	Not covered
Womens Contraceptives covered under the Medical Plan, examples include: • *Contraceptive injections* • *Contraceptive devices such as, IUDs, implants, (including the insertion and removal) See medical plan for details*	No charge	No charge	No charge	You pay 40% of UCR charges after deductible	No charge
Gender affirming care					
Mastopexy and Reconstructive and Complementary Procedures *All diagnosed members with Gender Dysphoria who meet criteria*	Care provided at SHC/LPCHS or Stanford Tri-Valley hospitals	Care provided at SHC/LPCHS or Stanford Tri-Valley hospitals	Not covered	Not covered	Not covered
Inpatient	No charge after deductible	No charge after deductible	Not covered	Not covered	Not covered
Outpatient	$200/visit	$200/visit after deductible	Not covered	Not covered	Not covered
Office Visit	$20 copay (copay waived if no office visit billed)	$20/visit after deductible (copay waived if no office visit billed)	Not covered	Not covered	Not covered

2023 Medical Plan Comparison Chart – Pre-65 Retirees (cont.)

SERVICES	STANFORD HEALTH CARE ALLIANCE (SHCA) PLAN The core service area includes Alameda, Contra Costa, 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) will apply.	AETNA CHOICE POS II PLAN WITH HSA TIER 1 STANFORD HEALTH CARE, STANFORD CHILDREN'S HEALTH AND STANFORD TRI-VALLEY NETWORK	TIER 2 AETNA NETWORK	TIER 3 OUT-OF-NETWORK[1]	KAISER PERMANENTE HMO PLAN
Transplant Services					
Transplant Services	You pay 10% after deductible; must be performed at an Institute of Excellence facility and subject to utilization review; No charge at SHC/LPCHS and Stanford Health Care – Tri-Valley hospitals	No charge after deductible	You pay 20% 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
Other Services					
Durable Medical Equipment	You pay 10% 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	You pay 20% after deductible; includes hearing aids (limited to one pair of hearing aids every two years). Prior authorization may be required	You pay 40% of UCR charges after deductible; includes hearing aids (limited to one pair of hearing aids every two years)	You pay 20% when prescribed by a Kaiser physician (must live within the service area)
Skilled Nursing Facility	You pay 10% after deductible; 100-day maximum per calendar year	Not covered under Tier 1; see Tier 2 for benefit coverage	You pay 20% after deductible; 100-day maximum per calendar year (combined Tier 2 and out-of-network maximum)	You pay 40% of UCR charges after deductible; 100-day maximum per calendar year (combined Tier 2 and out-of-network maximum)	You pay 10% up to 100 days per benefit period; plan deductible does not apply
Home Health Care	You pay 10% after deductible; 100-day maximum per calendar year	Not covered under Tier 1; see Tier 2 for benefit coverage	You pay 20% after deductible; 100-day maximum per calendar year (combined Tier 2 and out-of-network maximum)	You pay 40% of UCR charges after deductible; 100-day maximum per calendar year (combined Tier 2 and out-of-network maximum)	No charge with Kaiser approval; part-time or intermittent only; 100-day maximum per calendar year (must live within the service area)
Hearing Exams	$35/visit; well-child screening: No charge	No charge after deductible less copay; well-child screening: No charge	You pay 20% after deductible; well-child screening: No charge	You pay 40% of UCR charges after deductible	$20/visit with audiologist to determine the need for hearing correction; $35/visit with Physician Specialist to diagnose and treat hearing problems Not covered: hearing aid(s), including fitting, counseling, adjustment, cleaning, and inspection.
Well Child Vision Screening	No charge	No charge	No charge	Not covered	No charge for routine eye exams with a plan optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses; plan deductible does not apply
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; you pay %20 after deductible	Not covered, except for emergency treatment; you pay 40% of UCR charges after deductible	Not covered

2023 Medical Plan Comparison Chart – Pre-65 Retirees (cont.)

SERVICES	STANFORD HEALTH CARE ALLIANCE (SHCA) PLAN The core service area includes Alameda, Contra Costa, 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) will apply.	AETNA CHOICE POS II PLAN WITH HSA TIER 1 STANFORD HEALTH CARE, STANFORD CHILDREN'S HEALTH AND STANFORD TRI-VALLEY NETWORK	TIER 2 AETNA NETWORK	TIER 3 OUT-OF-NETWORK[1]	KAISER PERMANENTE HMO PLAN
Pharmacy Services					
Prescription Drugs	Prescription drugs provided by CVS Caremark	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 ($0/prescription at a Stanford pharmacy) **Mail-Order 90-day Supply** • Generic: $20/prescription • Brand Formulary: $50/prescription • Brand Non-Formulary: $100/prescription ($0/prescription at a Stanford pharmacy)	**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** You pay 40% 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	You pay 20% after deductible	Same as Preventive above	Same as Preventive above
Womens Contraceptives covered under the Prescription Drug Plan, examples include: • **Oral** • **Patch** • **Emergency** For a full list, visit http://healthysteps4u.org	Provided through CVS Caremark	Provided through CVS Caremark; see Tier 2	Provided through CVS Caremark	Provided through CVS Caremark	Provided through Kaiser Permanente Pharmacy
	Retail & Mail-Order • Generic and Brand Formulary: No charge • Brand Non-Formulary: $0/prescription (Stanford pharmacy); $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:** You pay 40% of UCR charges after deductible **Mail-Order:** Not covered	No charge (See Kaiser Permanente Evidence of Coverage Booklet for details)
Infertility Pharmacy **Medication to Treat Weight Gain or Androgenic Alopecia (Hair Loss)** **All diagnosed members who meet certain criteria**	Provided through CVS Caremark **Retail 30-day Supply** • Generic: $10/prescription • Brand Formulary: $25/prescription • Brand Non-Formulary: $50/prescription ($0/prescription at a Stanford pharmacy) **Mail-Order 90-day Supply** • Generic: $20/prescription • Brand Formulary: $50/prescription • Brand Non-Formulary: $100/prescription ($0/prescription at a Stanford pharmacy) 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: You pay 20% after deductible **Mail-Order 90-day Supply** Generic, Brand and Non-Brand Formulary: You pay 20% after deductible Prior authorization may apply	Provided through CVS Caremark **Retail 30-day Supply** You pay 40% 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

[1] 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.

[2] Includes El Camino and Sequoia hospital facility charges and professional charges for delivery and newborn services only.

[3] Benefits subject to a $10,000 fertility benefit lifetime maximum. Tissue freezing (eggs, sperm, embryos) will only be for the personal use of the employee or covered member. Frozen tissue will not be covered for the purposes of being donated or sold. The use of donor eggs and sperm are covered under the AI/OI/ or ART benefit and subject to a $10,000 fertility benefit lifetime maximum; the purchase of donor eggs and donor sperm are not covered.
Copay is determined on where test is performed.

SHCA Plan Only — When searching for SHCA providers, use the link on stanfordhealthcarealliance.org or create/login to your member account on aetna.com. Out-of-area members have access to Aetna's national network, excluding Sutter. For more information, call SHCA Member Care Services at 855.345.7422.

2023 Medical Plan Comparison Chart
Retirees/Dependents Age 65 and Over

The following charts indicate 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	ESSENCE ADVANTAGE GOLD	ESSENCE ADVANTAGE PLATINUM
Office Care				
How Plans Work with Medicare	Plan benefits are reduced by Medicare benefits	Plan provides Medicare benefits, plus extra coverage	Plan provides Medicare benefits, plus extra coverage. Under this plan, Medicare coverage is "bundled" to include Medicare Parts A (Hospital Insurance), B (Medical Insurance), and D (Prescription Drug Coverage	Plan provides Medicare benefits, plus extra coverage. Under this plan, Medicare coverage is "bundled" to include Medicare Parts A (Hospital Insurance), B (Medical Insurance), and D (Prescription Drug Coverage)
Annual Deductible	$300/person	None	None	None
Annual Out-of-Pocket Maximum	$1,000/person $2,500/family (does not include deductible)	$1,000/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
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 a contracted 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 a contracted 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**
Office Care				
Primary Care Physician (PCP) Visit	You pay 20% of allowable charges, after deductible	$20/visit	$5/visit	No charge
Routine Annual Physical	No charge	No charge	No charge	No charge
Well-Woman Care	No charge	No charge	$35/visit	$30/visit
Immunizations	No charge	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)
Specialist Care	You pay 20% of allowable charges, after deductible	$20/visit	$35/visit	$30/visit
Telemedicine	Teladoc: $49 consult fee until deductible is met, then you pay 20% coinsurance (Teladoc does not coordinate with Medicare	Kaiser Permanente telehealth program; no cost	$10/visit per primary care visit through Teladoc	$10/visit per primary care visit through Teladoc
Allergy Tests	You pay 20% of allowable charges, after deductible	$20/testing	$10-$45 for Medicare covered services	$10-$25 for Medicare covered services
Allergy Injections	You pay 20% 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
Chiropractic Care	You pay 20% 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
Acupuncture	You pay 20% of allowable charges, after deductible; $30/visit maximum; max. of 12 visits per calendar year	Discounts apply through Kaiser Permanente's Healthyroads program (www.kp.org/healthyroads)	Medicare-covered services (chronic low back pain), up to 20 visits per calendar year: $35 copay per visit	Medicare-covered services (chronic low back pain), up to 20 visits per calendar year: $30 copay per visit. Supplemental services, up to 15 visits per calendar year: $10 copay per visit
Physical, Speech and Occupational Therapy (restorative services only)	You pay 20% of allowable charges, after deductible; 60-visit maximum per calendar year	$20/visit when Medicare guidelines are met	$30/visit	$20/visit

2023 Medical Plan Comparison Chart
Retirees/Dependents Age 65 and Over (cont.)

SERVICES	MEDICARE COORDINATION PLAN	KAISER PERMANENTE SENIOR ADVANTAGE	ESSENCE ADVANTAGE GOLD	ESSENCE ADVANTAGE PLATINUM
Hospital Care				
Hospital Care *Room and Board, Surgeon, Physician Visit and Anesthesiologist*	You pay 20% of allowable charges, after deductible	$250/admission	Inpatient acute: $315/day up to 7 days; no charge for the remainder of stay Outpatient Surgery: You pay 20% of allowable charges	Inpatient acute: $300/day up to 7 days; no charge for the remainder of stay Outpatient Surgery: $240 copay
Outpatient				
Lab and X-ray	You pay 20% of allowable charges, after deductible	No charge	$10/visit for Lab Services $45 copay for X-ray	$10/visit for Lab Services $25 copay for X-ray
Outpatient Surgery	You pay 20% of allowable charges, after deductible	$100/procedure	You pay 20% coinsurance	$240/visit
Emergency and Urgent Care				
Emergency in Area	You pay 20% of allowable charges, after deductible	$50 copayment per visit (waived if admitted within 24 hours for same condition)	$110/visit; waived if admitted within 24 hours	$110/visit; waived if admitted within 24 hours
Emergency Out-of-Area	You pay 20% 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.	$110/visit; Worldwide coverage provided for emergency services due to unforeseen illness or injury. You must file a claim form.	$110/visit; Worldwide coverage provided for emergency services due to unforeseen illness or injury. You must file a claim form.
Urgent Care	You pay 20% of allowable charges, after deductible	$20 copayment per visit	$35/visit; Worldwide coverage provided for emergency services due to unforeseen illness or injury	$35/visit; Worldwide coverage provided for emergency services due to unforeseen illness or injury
Ambulance	You pay 20% of allowable charges, after deductible	100% after $50 copayment, when medically indicated and authorized by a plan physician	$210 copay	$200 copay
Mental Health				
Mental Health Care Services	All Mental Health Care provided through Aetna	All Mental Health Care provided through Kaiser	All Mental Health Care provided through Essence Advantage	All Mental Health Care provided through Essence Advantage
Inpatient Hospital **Inpatient clinician visits** *(psychotherapy, psychological testing or rehabilitative care)*	You pay 20% of allowable charges, after deductible You pay 20% of allowable charges, after deductible No lifetime maximum	$250/admission	$270/day up to 6 days; no charge for the remainder of stay	$270/day up to 6 days; no charge for the remainder of stay
Outpatient day treatment services **Outpatient clinician visits** *(psychotherapy, psychological testing or rehabilitative care)*	You pay 20% of allowable charges, after deductible You pay 20% 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: $10/visit
Substance Abuse				
Substance Abuse Care Services	All Substance Abuse Care provided through the plan	All Substance Abuse Care provided through Kaiser Permanente	All Substance Abuse Care provided through Essence Advantage	All Substance Abuse Care provided through Essence Advantage
Inpatient hospital **Inpatient clinician visits** *(psychotherapy, psychological testing or rehabilitative care)*	You pay 20% of allowable charges, after deductible You pay 20% of allowable charges, after deductible No lifetime maximum	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	$270/day up to 6 days; no charge for the remainder of stay	$270/day up to 6 days; no charge for the remainder of stay
Outpatient day treatment services **Outpatient clinician visits** *(psychotherapy, psychological testing or rehabilitative care)*	You pay 20% of allowable charges, after deductible You pay 20% of allowable charges, after deductible No lifetime maximum	Individual: $20/visit Group: $5/visit	Individual: $30/visit Group: $20/visit	Individual: $20/visit Group: $10/visit

2023 Medical Plan Comparison Chart
Retirees/Dependents Age 65 and Over (cont.)

SERVICES	MEDICARE COORDINATION PLAN	KAISER PERMANENTE SENIOR ADVANTAGE	ESSENCE ADVANTAGE GOLD	ESSENCE ADVANTAGE PLATINUM
Other Services				
Durable Medical Equipment	You pay 20% of allowable charges, after deductible; includes hearing aids (limited to one pair of hearing aids every two years)	You pay 20% copayment when medically necessary, prescribed by Kaiser physician, and in accordance with Medicare DME Formulary guidelines (must live within service area)	You pay 20% of allowable charges for Medicare- covered items	You pay 20% of allowable charges for Medicare- covered items
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	$0 copay per day (1-20) $150 copay per day (21-100)	$0 copay per day (1-20) $100 copay per day (21-100)
Home Health Care	You pay 20% 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
Hearing Screening Exam	No charge	No charge	Medicare-covered exam to diagnose and treat hearing and balance issues: $0 copay	Medicare-covered exam to diagnose and treat hearing and balance issues: $0 copay
Non-Preventive Hearing Exam	You pay 20% after deductible (1 per 24 months)	$20 copay	Not covered	Not covered
Optical Services	Not covered	No charge; $150 eyewear allowance every 24 months for lenses and frames, or for contact lenses	Not covered	Not covered
Dental Benefits	Not covered	Not covered	Not covered	Not covered
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	**Retail Pharmacy (30-day Supply):** • Preferred Generic: $5/prescription • Non-Preferred Generic: $15/ prescription • Brand Formulary: $47/prescription • Brand Non-Formulary: $100/ prescription • Specialty Drug: 33% • Select Care: $0/prescription **Mail Order (90-day Supply for a 2-month copay):** • Preferred Generic: $10/prescription • Non-Preferred Generic: $30/prescription • Preferred Brand Formulary: $94/ prescription • Non-Preferred Brand Non-Formulary: $200/prescription • Select Care: $0/prescription The copayments above apply until the member reaches the Initial Coverage Limit (ICL) of $4,660. Once the member meets the Out-of-Pocket Threshold of $7,400, the member pays the greater of a copayment of $4.15 for generic or a drug treated like a generic/$10.35 for other drugs (one-month supply) or 5% coinsurance.	**Retail Pharmacy (30-day Supply):** • Preferred Generic: $5/prescription • Non-Preferred Generic: $15/ prescription • Brand Formulary: $47/prescription • Brand Non-Formulary: $100/ prescription • Specialty Drug: 33% • Select Care: $0/prescription **Mail Order (90-day Supply for a 2-month copay):** • Preferred Generic: $10/prescription • Non-Preferred Generic: $30/prescription • Preferred Brand Formulary: $94/ prescription • Non-Preferred Brand Non-Formulary: $200/prescription • Select Care: $0/prescription The copayments above apply until the member reaches the Initial Coverage Limit (ICL) of $4,660. Once the member meets the Out-of-Pocket Threshold of $7,400, the member pays the greater of a copayment of $4.15 for generic or a drug treated like a generic/$10.35 for other drugs (one-month supply) or 5% coinsurance.

* 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 2023. 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 Vita Concierge Team at 650-966-1492.
- Contact CareCounsel for help understanding the details of your health plan options by calling 888-227-3334, Monday - Friday from 6:30 AM to 5PM PST or by emailing staff@carecounsel.com.

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 and SHCA Plan participants)	1-844-214-2607	http://www.caremark.com
Aetna (Mental health coverage 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
Essence Healthcare	1-855-966-8422	http://www.essencehealthcare.com
Medicare Coordination Plan	1-888-277-4041	http://www.aetna.com https://retiree.uhc.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 MEDICINE

Health Care

The information in this guide provides an overview of your Stanford Health Care 2023 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.

Updated 11/16/22