STANFORD
UNIVERSITY HUMAN RESOURCES

2013 RETIREE BENEFITS SUMMARY

Effective January 1, 2013




Dear Retiree,

Stanford University is committed to providing you with competitive medical and dental plans to meet your and your family's health care needs during your retirement. It is your responsibility to select the plans and options that are right for you and your eligible dependents.

In this Retiree Benefits Summary, you will find an overview of the health plans and programs Stanford offers to its official retirees. Whether you are planning to retire or are currently retired and making benefits elections during Open Enrollment, this guide will help you make educated choices and get the most out of your Stanford benefits.

In good health,

Stanford University

@StanfordInsider

Contents

Benefits highlighted in this publication are governed by Stanford University plan contracts and policies, applicable state and federal law, and university policy. If there is a conflict between the wording of this document and the group policies and contracts, the policies, contracts, and applicable laws govern. Stanford reserves the right to alter, amend, or terminate any of the benefits described in this summary at any time.

Getting Ready to Retire

When you retire, you'll have to make some important decisions about your financial and health benefits. It pays to be prepared ahead of time.

Choosing and personalizing your benefits depends on your specific needs, preferences and budget. We've made it easier for you to do your homework, research plans and get answers to your questions.

- **Online information.**
  Visit the Stanford Benefits website to read an overview of what to expect, called *When Employment Ends—Retirement*. Plus, you can download the *Retirement Checklist* and other retiree-related documents.
- **Easy enrollment.**
  If you're going to enroll using the Stanford Benefits website, ***My*BENEFITS** has step-by-step instructions and coaching tips on every screen.
- **Personalized resources.**
  When it's time to enroll in your retiree health care benefits, you will receive a personalized *Enrollment Worksheet* in an enrollment packet, also available to view online. It includes your medical plan options and contributions for 2013.

Health Care Options

As an official retiree of Stanford University, you have a choice of retiree medical plans and a dental care option. The university contributes a portion of the cost for medical and dental coverage. Your medical plan choices include:

- For retirees who are not enrolled in Medicare, non-Medicare plans provided through the HMO, EPO, and PPO options.
- Medicare Advantage plans provided through the HMO options.
- Medicare Supplement plans.

Long-Term Care

If not already enrolled in Long-Term Care Insurance, you may apply at any time for you, your spouse/registered domestic partner, and certain other family members. For more information, see page 11.

University Contributions

The amount Stanford contributes toward the cost of your medical benefits depends on when you were originally hired and the length of your benefits-eligible employment before retirement. These conditions determine if you receive a contribution under the Grandfathered Contribution or Non-grandfathered Contribution (also called "Defined Contribution") method.

Unsure of Your Status?
If you're not sure which contribution method applies to you, call Stanford Benefits at 877-905-2985 and press option 9.

Who's Eligible?

You

All official retirees are eligible to participate. How you qualify to become an official retiree depends on when you were hired.

If you were hired before January 1, 1992, you have two options:

1. You must complete at least 10 years of benefits-eligible service and be at least age 55, or
2. You can qualify under the "Rule of 75" (see below).

If you were hired on or after January 1, 1992, you only have one option—the Rule of 75.

The Rule of 75
You must complete at least 10 years of benefits-eligible service, and your age plus years of benefits-eligible service must equal at least 75.

For each month you work at least one day in a benefits-eligible position at Stanford, that month counts toward a year of service. Each 12-month period is counted as a year of service.

Your Family Members

Your dependents may also be eligible for coverage. Eligible dependents include your:

- Spouse, if not legally separated
- Registered domestic partner (see page 3)
- Surviving spouse until remarried or surviving registered domestic partner until entered into another registered domestic partner relationship
- Children to age 26
- Natural children
- Stepchildren
- Legally adopted children
- Children for whom you are the legal guardian
- Foster children
- Children placed with you for adoption
- Children of your registered domestic partner who depend on you for support and live with you in a regular parent/child relationship
- Unmarried children for whom you are legally responsible to provide health coverage under the terms of a Qualified Medical Child Support Order (QMCSO)
- Unmarried children over the age limit if:
  - ✔ They are dependent on you for primary financial support and maintenance due to physical or mental disability;
  - ✔ They are incapable of self-support; and
  - ✔ The disability existed before reaching age 19. You may be asked to provide documentation or proof of disability to your medical plan for its review and approval of continued coverage.

    In most cases, coverage for a disabled child can continue for as long as the child is incapable of self-support, unmarried, and fully dependent on you for support.

If you die while eligible for the retiree health care program, your eligible dependents can still receive coverage. Your surviving spouse/registered domestic partner must notify us of your death and request to enroll (if not already enrolled), to postpone or continue coverage. If your eligible surviving spouse/registered domestic partner dies, then coverage continues for the remaining eligible children.

While Stanford provides access to these health care benefits for your eligible dependents, the surviving dependents must pay their portion of the cost.

If You Add a Dependent to Coverage

We require proof of dependent eligibility for the dependents you cover. A document that lists acceptable forms of proof, titled "Dependent Eligibility Documentation Requirements," is available under the *Resource Library* tab on the Stanford Benefits website at benefits.stanford.edu.

Your Registered Domestic Partner

You can cover your domestic partner if your partnership is registered with the State of California. You do not have to live in California to register with the state. The State of California registers same-sex domestic partners, as well as opposite-sex partners when one partner is age 62 or older and qualified for Social Security benefits. For more information, go to the California Domestic Partners Registry page at www.ss.ca.gov/dpregistry.

Generally, you can register your domestic partner if you share a common residence and your domestic partner is:

- Age 18 or older
- A member of your household for the coverage period
- Not related to you in any way that would prohibit legal marriage
- Not legally married to anyone else or the same-sex domestic partner of anyone else

Participation

Your Options at Retirement

When you become eligible for retiree health care and are ready to retire, you have three options:

1. **Enroll** for coverage to start at retirement.
2. **Postpone** the start of coverage until a later date.
3. **Waive** coverage and permanently lose future eligibility and access to coverage through Stanford's program.

Your decision is very important, and you should carefully consider these choices.

1. **Enroll for coverage to start at retirement**: You may elect coverage before you leave Stanford, so benefits begin the first day of the month after your retirement date. This coverage stays in effect until the end of the calendar year in which you enroll, unless you have a Life Event change or fail to pay your contributions on time. Failure to pay your monthly contributions will result in your benefits being waived and losing future eligibility in Stanford retiree health care benefits.

   During each annual Open Enrollment period, you'll receive information that allows you to change your current benefit elections for the following calendar year. If you do not change your benefits during the Open Enrollment period, your elections will continue through the following year as long as the plan is still available and you remain eligible for that plan. In addition, you must pay the new costs. You cannot make any changes until the next Open Enrollment period, unless you have a Life Event change.

2. **Postpone the start of coverage until a later date**: You may choose not to enroll at retirement but reserve the right to enroll in your retiree benefits during any future Open Enrollment period, or if you have a Life Event change. You may postpone only once. After you have enrolled in a Stanford retiree medical plan, you no longer have the option to stop coverage and start again at a later date.

   If you die while eligible for the retiree health care program, your eligible surviving dependents have a one-time option to postpone coverage. If your eligible surviving spouse or registered domestic partner then dies, your surviving children likewise have a one-time option to postpone coverage.

If you do not enroll or apply to postpone coverage within 31 days of your retirement, you will be automatically placed in postpone status indefinitely until you contact Stanford Benefits.

3. **Waive coverage**: You may decline or drop retiree health care coverage at retirement or at any time, permanently waiving your right to retiree health care. If you wish to waive coverage, Stanford Benefits will ask you to confirm your decision.

To learn more about Life Event changes and other conditions of participation, go to the Stanford Benefits website. If you do not have access to the Internet, call us at 877-905-2985 and press option 9 to speak with a Benefits representative.

Remember: *If you enroll for coverage and then terminate coverage for any reason, you cannot re-enroll. You and your eligible dependents lose all future eligibility for Stanford retiree health care.*

If You Are Rehired or Recalled

If you return to Stanford University and work fewer than 20 hours a week, you remain covered under your retiree health care plan.

If you return to work at Stanford University in a benefits-eligible position and work at least 20 hours a week, the following will apply depending on your situation. If you are:

- Rehired or recalled within the same calendar year you retired, you will receive the health and life plans you had as an active employee.
- Recalled or rehired after a year. You will be asked to enroll in one of the active employee medical plans offered at that time.
- Enrolled in Medicare, your Stanford active health care benefits become primary and Medicare becomes secondary.
- Enrolled in a Medicare Advantage health plan and return to Stanford, contact us to help you disenroll from the plan during your period of employment.
- In "postpone" status when you are recalled or rehired, you go back to postpone status when you terminate employment again.
- Enrolled in a Stanford retiree health care plan when you are recalled or rehired, you may either re-enroll in retiree health care or waive coverage when you terminate employment and return to retiree status. If you waive coverage, you lose all future eligibility for retiree health care.

When Coverage Begins

Your active medical and dental benefits stop on the last day of the month in which you retire. Your retiree benefits begin on the first day of the following month.

For example, if your retirement date is May 15, your active benefits continue through May 31. Your retiree benefits begin on June 1, if you elected your new retiree benefits by May 15. If you miss your election deadline—which is always the 15th of the month—your retiree health benefits are delayed and you must find other coverage until your retiree health coverage begins. A Benefits representative can give you more information if you miss your election deadline.

Paying for Benefits

When you retire, you'll be sent information on the cost of coverage and how to pay. You have the option of mailing your payments each month using payment coupons, or using the SurePay program, which automatically debits your bank account.

SurePay is easy to set up. Just fill out the *SurePay Enrollment Form* in the *Resource Library* section at benefits.stanford.edu.

Each year before Open Enrollment begins, we will send you contribution information for the following year. Remember to make your payments in order to remain eligible for retiree health care benefits.

Non-grandfathered retirees should contact Stanford Benefits for this information.

Benefits Tools to Help Make Smart Decisions

The Stanford Benefits website helps you before you enroll and throughout the year:

- The *Medical & Life* section has benefits summaries, contribution and comparison charts, and Frequently Asked Questions.
- ***My*BENEFITS** has everything you need to enroll for 2013, such as your personalized *Enrollment Worksheet,* and plan highlights.
- The *Resource Library* is a handy place to find claim forms and plan summaries with more detailed information.

Which Plan Is Right for You?

The best medical plan for you depends on a number of factors:

- What are your anticipated medical expenses?
- What can you afford to pay out-of-pocket (in terms of deductibles, copayments and monthly contributions) if you or a dependent need health care?
- Do you have medical coverage elsewhere (through your spouse's employer, for example)?
- Do you have a doctor that you want to keep seeing?

Deductibles, copayments and other costs depend on the plan you select and how you utilize the plan.

Travel Often? Or Have Children Needing Out-of-State Care?

If you are often away from the Stanford area or your child needs routine medical care in an out-of-state location, all Blue Shield plans give you the flexibility to go to any Blue Shield network provider.

Remember: All medical plans provide emergency care anywhere in the world.

Want to Use Doctors and Facilities Close to Campus?

To receive care at...	Enroll in one of these plans...
Palo Alto Medical Foundation (PAMF) **Note**: To verify that PAMF contracts with your health plan, visit www.pamf.org/physicians/healthplans.html.	**Retirees Under Age 65:** Blue Shield EPO Blue Shield PPO Blue Shield High-Deductible Health Plan **Retirees Over Age 65:** Blue Shield Retiree Plan Health Net Seniority Plus Health Net Medicare (COB) United Healthcare Senior Supplement
Stanford Hospital and Clinics Lucile Packard Children's Hospital Menlo Medical Clinic Welch Road Pediatrics	**Retirees Under Age 65:** Blue Shield EPO Blue Shield PPO Plan Blue Shield High-Deductible Health Plan **Retirees Over Age 65:** Blue Shield Retiree Plan United Healthcare Senior Supplement

L.A. Cicero / Stanford News Service

Medical Plans

Types of Plans

Your medical plan options depend on your and your dependents' Medicare eligibility:

- **Non-Medicare Plans:** If you and your covered dependents are under age 65 and are not in Medicare, read about the Non-Medicare Plans on this page.
- **Medicare Plans:** If you and all your covered dependents are in Medicare, read about the Medicare Plans on page 8.
- **Non-Medicare + Medicare = Split Family**: If your family includes both Non-Medicare eligible and Medicare eligible members, read both the Non-Medicare and Medicare Plans, and the Split Family section on page 9.

Medical Plans If You're Not in Medicare

These plans are only available if you and all your enrolled dependents are not eligible for Medicare, or if you are in a "Split Family" (see page 9).

Stanford offers a variety of medical insurance plans, all of which provide coverage for pre-existing conditions, prescription drugs, and mental health and substance abuse. Choosing and personalizing your benefits depends on your specific health care needs, doctor preferences, budget, and the type of plan you prefer.

Kaiser Permanente: Your Health Maintenance Organization (HMO) Option

Kaiser Permanente is a managed care group that provides services and supplies through its own network of doctors, hospitals, and other health care facilities. Kaiser covers your expenses only if you go to a Kaiser provider or facility. You are also covered if you have a life-threatening emergency when you are outside the Kaiser service area.

When you enroll in Kaiser, you may select a primary care physician (PCP) to manage your care using Kaiser's network of physicians and facilities. Most likely, you'll need approval from your PCP before seeing a specialist.

Your Medical Plan Choices

If you are Medicare Eligible	Non-Medicare Eligible
Medicare Advantage Plans:	Kaiser Permanente HMO
Health Net Seniority Plus	Blue Shield EPO
Kaiser Permanente Senior Advantage	Blue Shield PPO
United Healthcare Group Medicare Advantage	Blue Shield High-Deductible Health Plan
Medicare Supplement Plans:	
Blue Shield Retiree Medical Plan	
United Healthcare Senior Supplement	
Health Net COB Plan	

Kaiser offers cost-effective managed care and places a strong emphasis on wellness and preventive care. With Kaiser, you:

- Have NO deductible
- Have NO claims to file
- Pay a fixed copay for each office visit, emergency room visit and hospital stay

To enroll in Kaiser, you must live within their service area (based on your home ZIP code).

Blue Shield Exclusive Provider Organization (EPO)

An EPO is similar to an HMO because you must use the physicians and facilities within the EPO network. When you see a provider in the EPO's network there are no deductibles or claims to file. You pay a fixed copayment for each office visit, emergency room visit, and hospital stay. If you go to a doctor or hospital outside Blue Shield's EPO provider network, you pay the full cost. With the EPO, you do not need to select a primary care physician. You may go to any doctor, specialist or hospital within the network.

Blue Shield Preferred Provider Organization (PPO)

A PPO is also similar to an HMO because you can see physicians within a network and pay a copayment.

This plan also allows you the freedom to go to the provider or medical facility of your choice. However, your out-of-pocket cost is less when you go to a provider within Blue Shield's network.

- **In-network**: You pay a deductible and then the plan pays 80 percent of most covered costs. You do not have to file a claim—your provider will submit it to Blue Shield for you. For routine office visits, you pay $20 for each visit ($35 for a specialist). Preventive care is provided at no charge.
- **Out-of-network**: Your annual deductible is larger. The plan pays 60 percent of most covered costs (based on Blue Shield's allowed amount), and you must file a claim in order to be reimbursed for out-of-pocket costs. You are also responsible for any remaining amounts that Blue Shield does not pay.

Blue Shield High Deductible Health Plan (HDHP)

An HDHP is a PPO plan, but there are no fixed copays, and you are responsible for paying a larger deductible for all services before the plan starts paying a benefit. This is the only plan available through Stanford that works in combination with a Health Savings Account (see explanation below).

- **In-network**: After you have paid the deductible, the plan pays 80 percent of most covered costs. You do not have to file a claim—your provider will submit the claims to Blue Shield for you. Preventive care is provided at no charge.
- **Out-of-network**: Your annual deductible is the same as your in-network deductible. The plan pays 60 percent of most covered costs (based on Blue Shield's allowed amount) and you must file a claim in order to be reimbursed for out-of-pocket costs. You are also responsible for any remaining amounts that Blue Shield does not pay. Remember, preventive care is not covered out-of-network.

Health Savings Account (HSA) Compatible (Only available if you are not enrolled in Medicare)

The Blue Shield High-Deductible Health Plan meets federal guidelines for a Health Savings Account (HSA), allowing you to set aside tax-deductible funds for future health care expenses.

Because of the tax savings and flexibility to reimburse yourself for medical expenses, an HSA is worth considering. Find more information about HSAs in the *Medical & Life* section of the Stanford Benefits website at benefits.stanford.edu. You should also consult your tax adviser.

If you are enrolled in the Blue Shield High-Deductible Health Plan, you may be able to set up an HSA directly with Blue Shield or through a financial institution of your choice.

You can locate Blue Shield's worldwide network of doctors for all Blue Shield plans at the Blue Shield website. Link to Blue Shield from the Contacts section of the Stanford Benefits website at ***benefits.stanford.edu****.*

Medical Plans If You're in Medicare

A Word about You and Medicare

Once you become eligible for Medicare, you must be enrolled in Medicare Parts A and B to participate in any of Stanford's retiree medical plans. Any covered eligible dependents who are 65 or older, or who receive Social Security Disability Insurance (SSDI), must also be enrolled in Medicare Parts A and B.

Prescription Drug coverage is included in our retiree medical plans, so do not enroll in a Medicare Part D prescription drug plan.

If you have questions about enrolling in Medicare, contact the Social Security Administration at 800-772-1213 or online at www.socialsecurity.gov.

Stanford offers a variety of plans that work with your Medicare coverage.

You have your choice of Medicare Advantage or Medicare Supplement plans.

Important

If you or a covered dependent will reach age 65 or become eligible for Medicare in October 2012 through January 2013, you will be offered Medicare-eligible plans during Open Enrollment and must be enrolled in one of the Medicare offered plans. If enrolling in a Medicare HMO plan, you must complete a Medicare Advantage Form by December 15, 2012. If you fail to send in the appropriate paperwork by the deadline, your Medicare coverage may be delayed.

Medicare Advantage Plans

Medicare Advantage plans require you to enroll in an HMO and then assign your Medicare benefits to that HMO. An HMO is a managed care group that provides services and supplies through its own network of doctors, hospitals and other health care facilities. It covers your expenses only if you go to a health care provider within its network of providers (unless it's a life-threatening emergency).

When you enroll in an HMO plan, you may be required to select a primary care physician (PCP) who manages your care using the HMO network's physicians and facilities. Most likely, you'll need approval from your PCP before seeing a specialist.

HMOs offer cost-effective managed care and place a strong emphasis on wellness and preventive care. With an HMO you:

- Have NO deductible
- Have NO claims to file
- Pay a fixed copay for each office visit, emergency room visit, hospital stay and other services
- Pay a fixed copay for prescriptions

How to Enroll in a Medicare Advantage Plan

To enroll in a Medicare Advantage plan, you must live in one of the HMO's service areas (based on your home zip code). Stanford offers these Medicare Advantage HMO plans:

- Health Net Seniority Plus
- Kaiser Permanente Senior Advantage
- United Healthcare Group Medicare Advantage

You must complete a *Medicare Advantage Enrollment Form* to assign your Medicare benefits to the HMO you elect whether you enroll for the first time or change from one Medicare Advantage plan to another.

A Medicare Advantage Enrollment Form will be sent to you if needed. You and your spouse can sign the same form when enrolling. In the event you change plans, you must disenroll. At that time, you and your spouse must sign separate forms. You may also call Stanford Benefits at 877-905-2985, and press option 9, if you need assistance.

Medicare Supplement Plans

Under a Medicare Supplement plan, Medicare is the primary medical plan for you and your dependents. They allow you to seek services from any doctor who accepts Medicare, but your costs will be lower if you see a provider who is in the plan's network. Medicare Supplement plans pay benefits for services after you receive payment from Medicare.

Stanford offers these Medicare Supplement plans:

- **Blue Shield Retiree Medical Plan** available anywhere in the United States and internationally, provided you keep your Medicare coverage
- **United Healthcare Senior Supplement** available in most U.S. locations

- **Health Net COB Plan** available only in certain California HMO service areas. You must receive care from a Health Net HMO provider. If you choose to go out-of-network, your care will be limited to services covered under Medicare and must be provided by a doctor who accepts Medicare assignments.

Changing from a Medicare Advantage Plan to a Medicare Supplement Plan

If you change from a Medicare Advantage plan to a Medicare Supplement plan, you must complete a *Medicare Advantage Disenrollment Form* to release your Medicare benefits back to you. You and your spouse must sign separate forms, which will be sent to you after you make your election.

If you need help completing the form(s), call us at 877-905-2985, press option 9, and a Benefits representative will assist you.

Move to Medicare Crossover Billing

You might be able to have your physician automatically send claims to Medicare for you. This is called "crossover billing." After Medicare pays its portion of the claim, they notify your medical plan of any outstanding balance, so there is less claims work for you.

To set up crossover billing, provide your medical plan with:

- Medicare Claim Number (usually your Social Security number, followed by the letter A or B), and
- The effective date of your Medicare Part A and Part B, as found on your Medicare Card.

For additional information on how to set up crossover billing, call your medical plan's Member Services number on your medical ID card.

Medical Plans If You're In a "Split Family"

"Split Family" describes a family whose members are not all in Medicare or not all in non-Medicare plans. If you're in a split family, you and your dependents must enroll in medical plans offered by the same insurance company, if available.

For example, if you are eligible for Medicare and elect coverage with the Kaiser Permanente Senior Advantage plan, your non-Medicare-eligible dependents must enroll in the Kaiser Permanente HMO.

If you are in one of the Health Net or United Healthcare Medicare plans, your non-Medicare eligible dependents may enroll in one of the Blue Shield plans.

Rules for a Split Family

1. Any family member who is in Medicare must be enrolled in Medicare Parts A and B.
2. Any family member who is in Medicare may need to complete special paperwork. See the Medicare plans section on page 8 for information on the need to fill out the *Medicare Advantage Enrollment Form* or *Disenrollment Form*.

Prescription Drugs

Prescription drug coverage is provided through your medical plan, so be sure to use your medical plan's ID card when you have a prescription filled.

Blue Shield High-Deductible Health Plan requires you to pay 20 percent of the cost for all prescription drugs after you have satisfied the deductible. If you fill your prescriptions at a Blue Shield network pharmacy, your costs are lower.

For all other plans, the cost of your prescription depends on if it can be dispensed in its generic form and if it is included in your plan's list of approved drugs (known as a formulary).

Mental Health and Substance Abuse

Mental health and substance abuse treatment are covered by your medical plan. For details, contact your plan or see the comparison charts at the back of this booklet.

Faculty and Staff Help Center

Stanford's Faculty & Staff Help Center provides up to 10 sessions of professional, confidential, short-term counseling and consultation services free of charge to Stanford employees, retirees and their dependents. You can learn more about the services by going to its website at www.stanford.edu/dept/helpcenter.

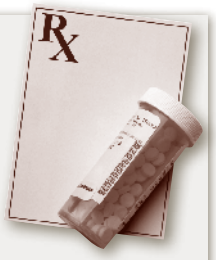
Dental Care

Good dental care can affect your overall health and wellness. In addition to coverage for basic and major services, our plan includes diagnostic and preventive checkups and cleaning.

The Delta Dental PPO plan gives you the freedom to choose your own dentist, though out-of-pocket costs will be lower if you see a dentist in Delta's PPO network. Delta's website can help you find a dentist in your area.

Compare network and non-network dental costs at the end of this booklet or see the *Medical & Life* section of the Stanford Benefits website. For your 2013 rates, see your *Enrollment Worksheet* in your Open Enrollment packet or call us at 877-905-2985, and press option 9.

Smart Decisions Can Add Up to Savings



No matter which plan you're in, you can save money by:

Switching to Generic Drugs

Generic drugs are chemically equivalent to brand-name drugs but sold under their generic names, usually at a significantly lower price. If your medication does not have a generic equivalent on the market yet, ask your doctor if there is a similar generic drug for your condition.

Using Mail-Order Service

Each medical plan offers a home delivery prescription drug program through its mail-order prescription benefit. If appropriate to your situation, ask your doctor to write you a prescription that specifies up to a 90-day quantity (100-day for Kaiser Permanente) and includes three refills. Then, mail your prescription and order form to your plan's mail-order service.

If this is not an option, you can save money by filling your prescriptions at participating pharmacies.

Checking the Preferred Drug List

Each medical plan has a list of approved drugs, known as a formulary. If your prescription is not included in your plan's formulary, you'll probably end up paying a higher copay. Talk with your doctor about whether a formulary alternative is appropriate.

Each medical plan's formulary is updated throughout the year, so call your medical plan's Member Services at the number listed on your medical plan ID card or visit your plan's website if you want information on a specific prescription drug.

Long-Term Care (LTC) Insurance

LTC insurance is an optional benefit that helps pay many of the day-to-day expenses for nursing home and in-home care not generally covered by medical or disability plans, Medicare or Medicaid.

LTC is available for Stanford retirees, covered spouses/registered domestic partners, and enrolled dependents.

Stanford offers LTC insurance at group rates through CNA. Enrollment and all customer service issues are handled directly through CNA.

You can apply at any time through CNA. All applicants must complete an Evidence of Insurability form (long form application). Coverage is not guaranteed. If the application is approved, CNA will begin billing you directly.

If you were enrolled in LTC as an active employee, you and any enrolled dependents can continue participating in the program. Contact CNA within 31 days after you retire to request continuation of coverage. Your cost will remain the same but you will be billed directly by CNA.

Program details can be found in the *Medical & Life* section at benefits.stanford.edu. Call CNA to request an application packet (see the contact information at the end of this guide) or stop by the Stanford Benefits office or at SLAC's Human Resources lobby.

Tuition Grant Program (TGP) for Dependents

Stanford will assist with up to four years of undergraduate college tuition costs at approved colleges and universities for eligible dependent children of Stanford retirees, based on the majority of your service time when employed.

If you worked in full-time positions:

- For more than half your years of benefits-eligible employment at Stanford, you receive 100 percent of the program benefit.
- Less than half your years of benefits-eligible employment at Stanford, the grant amount is prorated.

For more information on the TGP, call 877-905-2985 (press option 5), or visit TGP at hreap.stanford.edu.

Other Retiree Resources and Services

As a Stanford retiree, you have access to various benefits, services, resources and amenities on campus, such as:

- Use of libraries and athletic facilities
- Discounts at the Stanford bookstore
- Access to Faculty and Staff Help Center mental health services for you and your family members
- Exercise classes and health seminars through the Health Improvement Program (HIP)
- Membership in the Stanford Federal Credit Union
- Membership in Stanford Staffers

Get the latest news and headlines from the *Stanford Report* delivered to your email address daily. Just sign up at news.stanford.edu/subscribe.

Faculty and Senior Staff emeriti may be eligible for some additional privileges and services. For questions, retired faculty should call 650-723-3622 or email facultyaffairs@stanford.edu. Retired staff emeriti should contact their Human Resources Manager.

Use of Facilities

Visit www.stanford.edu for details on attending lectures, plays, concerts, films, exhibits and library usage—often at no cost or at special rates. For access to athletic facilities on campus, call 650-723-1949.

Keep Your Stanford Identification Card

Many programs require a Stanford ID card. Your Stanford ID card serves as your official retiree ID and is needed for benefits enrollment and access to on-campus facilities.

Replacement ID cards are available at George Forsythe Hall on the Stanford University campus. Bring a driver's license or passport. Your spouse may also receive an ID card for an additional fee. The ID card office is open Monday through Friday 8 a.m. to 5 p.m.

Call 650-498-2273 for information and campus location.

Determining Your Monthly Premium

Grandfathered Retirees

Review the *Enrollment Worksheet* in your initial or open enrollment packet for monthly contribution and rate amounts.

Non-Grandfathered Retirees

Please call us at 877-905-2985 and press option 9. A Benefits Representative will help you determine your plan costs.

Split Family Worksheet for Grandfathered Retirees

This worksheet will help you calculate your monthly costs. The *Enrollment Worksheet* in your initial or open enrollment packet shows you the amounts to use.

Calculate Your Monthly Costs	
1. Medicare plan you elect:	
2. Cost of Medicare plan for you and/or your family members	$
3. Non-Medicare plan you elect:	
4. Cost of non-Medicare plan for you and/or your family members	$
Total monthly cost for Split Family (line 2 + line 4)	$

Is Everything Correct?

If you think you made an error during your enrollment process, call us to make corrections. For Open Enrollment, all corrections must be made by 5 p.m. PST on November 15, 2012.

When you receive your first bill from Vita Administration Company with your new payment amounts, compare it to your Confirmation Statement. If the amount is not correct, call Vita at 800-424-3052 by the end of December 2012.

What Happens If I Don't Enroll?

If you do not elect a new medical plan for coverage during the Open Enrollment period, your benefit elections from 2012 will roll over automatically. However, the cost will reflect the 2013 contribution amounts.

Need Medical Services Before You Receive Your ID Card?

If you remain in the same medical plan: Simply use your current medical ID card. Generally, your medical plan does not send a new card each year. You receive a new card only if you change medical plans or if your medical plan issues a new card because of a change of information on the card.

If you change medical plans for 2013: You should receive your ID card by the end of 2012. If you have not received it and need medical care on or after January 1, 2013, print a copy of your Confirmation Statement as proof of coverage until you receive your new ID card.

Your doctor's office or pharmacy can also verify coverage by calling Stanford Benefits at 877-905-2985, and press option 9. If you need a prescription filled while waiting for your ID card, you might have to pay the full cost and then submit a claim to your medical plan for reimbursement.

2013 Benefits Comparison Charts – Non-Medicare*

Medical Care Options for Retirees *Who Are Not Eligible for Medicare*

	Blue Shield EPO Plan	Blue Shield PPO Plan	Blue Shield High-Deductible Health Plan	Kaiser Permanente HMO (California)
Office Copay	$20 copay primary/ $35 copay specialist	Network: $20 copay primary/ $35 copay specialist Non-Network: 60% after deductible	Network: 80% after deductible Non-Network: 60% after deductible	$20 copay
Deductible	No deductible	Network: $500 per individual/$1,500 per family Non-Network: $1,000 per individual/$3,000 family	$1,500 per individual/ $3,000 per family Combined Network or Non-Network	No deductible
Out-of-Pocket Maximum	$3,000 per individual/ $6,000 family	Network: $3,500 per individual/$7,000 family Non-Network: $7,500 per individual/$15,000 family	$3,500 per individual/ $7,000 family Combined Network or Non-Network	$1,500 per individual/ $3,000 family
Overall Lifetime Maximum Benefit	No maximum	No maximum	No maximum	No maximum
Allergy Tests and Treatment	100% Office copay may apply.	Network: $35 copay Non-Network: 60% after deductible	Network: 80% after deductible Non-Network: 60% after deductible	$20 copay for tests $5 copay for injections
Ambulance Charges	100%	Network or Non-Network: 80% after deductible (if medically necessary)	Network or Non-Network: 80% after deductible (if medically necessary)	100%
Chiropractors	Not covered Discount program available. Contact Blue Shield for more information.	Network: 80% after deductible Non-Network: 60% after deductible $1,500 max benefit per year combined between Network and Non-Network	Network: 80% after deductible Non-Network: 60% after deductible $1,500 max benefit per year combined between Network and Non-Network	Not covered
Emergency Room	$50 copay (waived if admitted)	100% after $50 copay (waived if admitted) Lab/ancillary/professional charges paid at 80% after deductible Network or Non-Network	Network: 80% after deductible Non-Network: 80% after deductible Lab/ancillary/professional charges paid at 80% after deductible Network or Non-Network	$50 copay (waived if admitted)

*See page 16 for important notes about this chart.

2013 Benefits Comparison Charts – Non-Medicare*

Medical Care Options for Retirees *Who Are Not Eligible for Medicare*

	Blue Shield EPO Plan	Blue Shield PPO Plan	Blue Shield High-Deductible Health Plan	Kaiser Permanente HMO (California)
Home Health Care	100%	Network: 80% after deductible Non-Network: 60% after deductible	Network: 80% after deductible Non-Network: 60% after deductible	100% Up to 100 two-hour visits/ calendar year [3 visits per day max]
Hospital Stay	Pre-authorization required by you or your provider. $100 copay per admission	Pre-authorization required by you or your provider. Network: 80% after deductible Non-Network: 60% after deductible	Pre-authorization required by you or your provider. Network: 80% after deductible Non-Network: 60% after deductible	$100 copay per admission
Immunizations	100% Travel immunizations not covered.	Network: 100% Non-Network: Not covered Travel immunizations not covered	Network: 100% Non-Network: Not covered Travel immunizations not covered	100% Office visit copay applies if provided during doctor office visit
Infertility Treatment	50% of Blue Shield allowed charges for professional and diagnostic services; limited to three cycles of intrauterine insemination (IUI). In Vitro, GIFT, and ZIFT: Not covered Fertility drugs: see Pharmacy	Network: 50% of Blue Shield allowed charges after deductible for professional and lab services; limited to three cycles of intrauterine insemination (IUI). Non-Network: Not covered In Vitro, GIFT, and ZIFT: Not covered Fertility drugs: see Pharmacy	Network: 50% of Blue Shield allowed charges after deductible for professional and lab services; limited to three cycles of intrauterine insemination (IUI). Non-Network: Not covered In Vitro, GIFT, and ZIFT: Not covered Fertility drugs are covered at 50% after deductible, up to $5,000 lifetime maximum	50% Fertility Drugs: Covered under drug benefits at 50% In Vitro, GIFT, and ZIFT: Not covered
Mammograms	100%	Network: 100% if part of annual well-woman visit Non-Network: Not covered	Network: 100% if part of annual well-woman visit Non-Network: Not covered	100%

*See page 16 for important notes about this chart.

2013 Benefits Comparison Charts – Non-Medicare*

Medical Care Options for Retirees *Who Are Not Eligible for Medicare*

	Blue Shield EPO Plan	Blue Shield PPO Plan	Blue Shield High-Deductible Health Plan	Kaiser Permanente HMO (California)
Mental Health and Substance Abuse ***Inpatient Care***	Pre-authorization is required by you or your provider. $100 copay per admission	Pre-authorization is required by you or your provider. Network: 100% after deductible Non-Network: 60% after deductible	Pre-certification is required by you or your provider. Network: 80% after deductible Non-Network: 60% after deductible	Kaiser must approve mental health care. $100 copay per admission
Mental Health and Substance Abuse ***Outpatient Care***	Pre-authorization is required by you or your provider. [no visit limit] $20 copay per visit	Pre-authorization is required by you or your provider. [no visit limit] Network: $20 copay primary/ $35 copay specialist Non-Network: 60% after deductible	Pre-authorization is required by you or your provider. [no visit limit] Network: 80% after deductible Non-Network: 60% after deductible	[no visit limit] $20 copay per visit, individual
Pap Smears	100% [as part of the office visit]	Network: 100% if part of annual well-woman visit Non-Network: Not covered	Network: 100% if part of annual well-woman visit Non-Network: Not covered	100%
Pharmacy (Retail)	Blue Shield Network pharmacy: $10 generic; $30 brand name; $75 non-formulary—up to a 30-day supply Non-Network pharmacy: member pays copayment plus 25% of billed charges Fertility drugs covered at 50%; benefit max $5,000 per lifetime	Blue Shield Network pharmacy: $10 generic; $30 brand name; $75 non-formulary—up to a 30-day supply Non-Network pharmacy: member pays copayment plus 25% of billed charges Fertility drugs covered at 50% (deductible does not apply); benefit max $5,000 per lifetime	Network or Non-Network: 80% after deductible Fertility drugs: see Infertility Treatment	Kaiser Pharmacy: $10 generic; $30 brand name; up to a 30-day supply
Pharmacy Mail Order Drug Program	$20 generic; $60 brand name; $150 non-formulary—up to a 90-day supply Must use Blue Shield mail-order service	$20 generic; $60 brand name; $150 non-formulary—up to a 90-day supply Must use Blue Shield mail-order service	80% after deductible Must use Blue Shield mail-order service	Generic: $10 up to a 30-day supply; $20 for a 31-100 day supply Brand: $30 up to a 30-day supply; $60 for a 31-100 day supply Must use Kaiser mail order pharmacy

*See page 16 for important notes about this chart.

2013 Benefits Comparison Charts – Non-Medicare

Medical Care Options for Retirees *Who Are Not Eligible for Medicare*

	Blue Shield EPO Plan	Blue Shield PPO Plan	Blue Shield High-Deductible Health Plan	Kaiser Permanente HMO (California)
Physical Exams	100%	Network: 100% Non-Network: Not covered	Network: 100% Non-Network: Not covered	100%
Prenatal Visits	100%	Network: $20 copay (first visit) Non-Network: 60% after deductible	Network: 80% after deductible Non-Network: 60% after deductible	100%
Well-Woman Visits	100%	Network: 100% Non-Network: Not covered	Network: 100% Non-Network: Not covered	100%
X-ray and Lab Charges	100%	Network: 80% after deductible Non-Network: 60% after deductible	Network: 80% after deductible Non-Network: 60% after deductible	100%

Notes

- "Copay" is the amount you pay at the time of service. The amount is per visit, admission or prescription.
- "After deductible" indicates your coverage or benefit after you have met your health plan's deductible.
- Unless stated otherwise, you must meet a PPO plan's deductible before the plan pays any benefits.
- A percentage presents the amount the plan pays for the service or prescription drug.
- These highlights are not intended to replace the detailed information in each plan's Summary Plan Description or Summary of Coverage. Please refer to those resources for limitations and exclusions, pre-admission review requirements and referral procedures. Failure to follow rules as detailed in plan resource materials may result in a reduction in your benefits and a higher cost to you.
- All benefits must be medically necessary and are subject to carrier, government, and plan rules and limitations.
- Non-network care in the Blue Shield PPO and High-Deductible Health Plan is subject to balance billing. Call Blue Shield at 800-873-3605 for more information.

2013 Benefits Comparison Charts – Medicare*

Medical Care Options for *Medicare-Eligble Retirees*

	Blue Shield Retiree Medical Plan	Health Net Seniority Plus	Health Net Medicare COB	Kaiser Permanente Senior Advantage	United Healthcare Group Medicare Advantage	United Healthcare Senior Supplement
Office Copay	Medicare-Approved: 100% Non-Medicare Approved: 80% after deductible	$20 copay	$20 copay	$20 copay	$20 copay	100%
Deductible	Medicare-Approved: Deductibles Waived Non-Medicare Approved: $100 per individual $300 per family	No deductible	No deductible	No deductible	No deductible	No deductible
Out-of-Pocket Maximum	Medicare-Approved or Non-Medicare Approved: $1,000 per individual	$3,400 per individual	$1,500 per individual $4,500 per family	$1,500 per individual $3,000 per family	$3,400 per individual	No out-of-pocket maximum
Overall Lifetime Maximum Benefit	No maximum	No maximum	No maximum	No maximum	No maximum	No maximum
Allergy Tests and Treatment	Medicare-Approved: 100% Non-Medicare Approved: 80% after deductible	100% Office copay may apply	100% Office copay may apply	$20 copay for tests $3 copay for injections	$20 copay	Medicare-Approved: 100%
Ambulance Charges	Medicare-Approved: 100% Non-Medicare Approved: 80% after deductible	100%	100%	100%	100%	Medicare-Approved: 100%
Chiropractors	Up to $1,500 max benefit per calendar year Medicare-Approved: 100% Non-Medicare Approved: 80% after deductible	$20 copay Coverage is limited to manual manipulation of the spine to correct subluxation. Limited to Medicare allowable coverage. You pay the full cost of routine care. Discount program available.	Not covered Discount program available	$20 copay Coverage is limited to manual manipulation of the spine to correct subluxation. Routine care is not covered.	$20 copay	Plan pays 100% after you pay $10 copay; $50 maximum per visit, up to 30 visits per calendar year

*See page 20 for important notes about this chart.

2013 Benefits Comparison Charts – Medicare*

Medical Care Options for *Medicare-Eligble Retirees*

	Blue Shield Retiree Medical Plan	Health Net Seniority Plus	Health Net Medicare COB	Kaiser Permanente Senior Advantage	United Healthcare Group Medicare Advantage	United Healthcare Senior Supplement
Emergency Room	Includes lab/ancillary charges Medicare-Approved: 100% after $50 facility copay per visit (waived if admitted) Non-Medicare Approved: 80% after $50 facility copay per visit (waived if admitted)	$50 copay (waived if admitted)	$50 copay (waived if admitted)	$25 copay (waived if admitted)	$50 copay (waived if admitted)	Medicare-Approved: 100%
Home Health Care	Medicare-Approved: 100% Non-Medicare Approved: 80% after deductible	100%	100%	100%	100%	Medicare-Approved: 100%
Hospital Stay	Medicare Approved: 100% Non-Medicare Approved: 80% after deductible	100%	100%	100%	100%	100% of Medicare Approved services up to a 365-day lifetime maximum
Immunizations	Travel immunizations not covered	100% 80% when office visit not required or for foreign travel immunizations	100% $20 copay when office visit not required or for foreign travel immunizations	100% when office visit not required	100% Travel immunizations not covered	100% when office visit not required. Travel immunizations not covered
Infertility Treatment	Not covered	Not covered	50% Fertility Drugs: Covered under drug benefits; In Vitro, GIFT, and ZIFT: Not covered	$20 copay Fertility Drugs: Covered under drug benefits; In Vitro, GIFT, and ZIFT: Not covered	Not covered	Not covered
Mammograms	100%	100%	100%	100%	100%	Included as part of $250 annual physical exam allowance

*See page 20 for important notes about this chart.

2013 Benefits Comparison Charts – Medicare*

Medical Care Options for *Medicare-Eligble Retirees*

	Blue Shield Retiree Medical Plan	Health Net Seniority Plus	Health Net Medicare COB	Kaiser Permanente Senior Advantage	United Healthcare Group Medicare Advantage	United Healthcare Senior Supplement
Mental Health and Substance Abuse *Inpatient Care*	Pre-authorization is required by you or your provider. Medicare Approved: 100% Non-Medicare Approved: 60% after deductible	Pre-authorization is required by you or your provider. 100%	Pre-authorization is required by you or your provider. 100%	Pre-authorization is required by you or your provider. 100% Detoxification: 100%	Pre-authorization is required by you or your provider. 100% 190-day lifetime maximum	Medicare Approved: 100%
Mental Health and Substance Abuse *Outpatient Care*	[no visit limit] Medicare Approved: 100% Non-Medicare Approved: 80% after deductible	[no visit limit] $20 copay per visit	[no visit limit] $20 copay per visit	[no visit limit] $20 copay per visit, individual session $5 copay per visit, group session	[no visit limit] $20 copay per visit	[no visit limit] Medicare Approved: 100%
Pap Smears	100%	100%	100%	100%	Included with office visit copay for annual well-woman care	Included as part of $250 annual physical exam allowance
Pharmacy (Retail)	Blue Shield Network pharmacy: $10 generic; $30 brand name; $75 non-formulary—up to a 30-day supply Non-Network Pharmacy: 80%, no deductible In-Network only: Infertility Drugs covered at 50% up to a $5,000 lifetime maximum. Drugs for intrauterine insemination (IUI) are limited to three cycles.	$10 Tier I; $30 Tier II (formulary brand); $75 Tier III Up to a 30-day supply	$10 Tier I; $30 Tier II (formulary brand); $75 Tier III Up to a 30-day supply	Kaiser Pharmacy $10 generic; $30 brand name; up to a 30-day supply	$10 generic; $30 brand; $75 non-formulary Up to 30 day supply	$10 generic; $30 brand; $75 non-formulary Up to 30 day supply

*See page 20 for important notes about this chart.

2013 Benefits Comparison Charts – Medicare

Medical Care Options for *Medicare-Eligble Retirees*

	Blue Shield Retiree Medical Plan	Health Net Seniority Plus	Health Net Medicare COB	Kaiser Permanente Senior Advantage	United Healthcare Group Medicare Advantage	United Healthcare Senior Supplement
Pharmacy Mail Order Drug Program	Must use Blue Shield mail order service $20 generic; $60 brand name; $150 non-formulary—up to a 90-day supply	Prescription drug coverage is provided by Health Net. $20 Tier I; $60 Tier II (formulary brand); $150 Tier III Up to a 90-day supply	Prescription drug coverage is provided by Health Net. $20 Tier I; $60 Tier II (formulary brand); $150 Tier III Up to a 90-day supply	Must use Kaiser mail order pharmacy Generic: $10 up to a 30-day supply; $20 for a 31 – 100 day supply Brand: $30 up to a 30-day supply; $60 for a 31 – 100 day supply	$20 generic; $60 formulary brand/ preferred; $150 non-formulary/non-preferred Up to a 90-day supply	$20 generic; $60 formulary brand/ preferred; $150 non-formulary/non-preferred Up to a 90-day supply
Physical Exams	100% Annual exam Exams for children: Not covered	100% According to plan's periodic health evaluation schedule.	100% According to plan's periodic health evaluation schedule.	100%	100%	$250 annual allowance
Prenatal Visits	Medicare Approved: 100% Non-Medicare Approved: 80% after deductible	$20 copay	100%	100%	$20 copay First visit only	Not covered
Well-Woman Visits	100%	100%	100%	100%	100%	Included as part of $250 annual physical exam allowance
X-ray and Lab Charges	Medicare-Approved: 100% Non-Medicare Approved: 80% after deductible	100%	100%	100%	100%	Medicare-Approved: 100%

Notes

- "Copay" is the amount you pay at the time of service. The amount is per visit, admission or prescription.
- "After deductible" indicates your coverage or benefit after you have met your health plan's deductible.
- Unless stated otherwise, you must meet a PPO plan's deductible before the plan pays any benefits.
- A percentage presents the amount the plan pays for the service or prescription drug.
- These highlights are not intended to replace the detailed information in each plan's Summary Plan Description or Summary of Coverage. Please refer to those resources for limitations and exclusions, pre-admission review requirements and referral procedures. Failure to follow rules as detailed in plan resource materials may result in a reduction in your benefits and a higher cost to you.
- All benefits must be medically necessary and are subject to carrier, government, and plan rules and limitations.

2013 Benefits Comparison Charts*

Your Dental Care Options

	Delta Dental PPO Plan #1149	
	Network	Non-Network
Dentist Selection	You choose a dentist from a panel of contracted dentists in Delta's PPO network.	You choose any dentist.
Annual Deductible		
Individual	None	$50
Family	None	$150
Annual Plan Maximum	$1,000 per person, network and non-network combined	
Preventive & Diagnostic Benefits *For example:* Oral Exams (two per year) Bitewing X-rays (two per year under age 18, one per year over 18) Cleaning (two per year) Fluoride Treatment Space Maintainers	100%	50% of U&C No deductible
Basic Procedures *For example:* Fillings Stainless Steel Crowns Extractions Sealants (for children under age 14) Removal of Impacted Teeth Root Canal Therapy Periodontal Surgery General Anasthesia (for Oral Surgery)	80%	50% of U&C after deductible

*See page 22 for important notes about this chart.

2013 Benefits Comparison Charts

Your Dental Care Options

	Delta Dental PPO Plan #1149	
	Network	Non-Network
Major Restorative Procedures *For example:* Inlays, Onlays and Crowns Dentures Bridges Dental implants	50%	50% of U&C after deductible
Orthodontia	Not covered	Not covered

Notes

- To find network dentists or get information on specific procedures, call Delta Dental at 800·765·6003 or visit www.deltadentalca.org/stanford.
- "U&C" refers to the "usual and customary" amount charged by dentists in your area. You pay any amount over the U&C when you go to a non-network dentist.

Benefits Contact Information

Medical		
All Blue Shield Plans www.blueshieldca.com/stanford/	Medical Plans Mail-Order Prescriptions	800-873-3605 866-346-7200
Health Net HMO www.healthnet.com	Medical Plans Mail-Order Prescriptions	800-522-0088 888-624-1139
Kaiser Permanente www.kp.org	HMO Mail-Order Prescriptions	800-464-4000 800-464-4000
United Healthcare www.uhcwest.com	Medical Plans Mail-Order Prescriptions	800-624-8822 800-562-6223
Vita Administration Company www.vitacompanies.com	Direct Pay Administrator for Retiree Health Care	800-424-3052
Dental		
Delta Dental www.deltadentalca.org/stanford		888-335-8227
Mental Health and Substance Abuse Counseling		
Stanford Faculty & Staff Help Center www.stanford.edu/dept/helpcenter		650-723-4577
Retirement Plans		
Stanford Retirement Manager www.netbenefits.com		888-793-8733
TIAA-CREF www.tiaa-cref.org		800-842-2888
Staff Retirement Annuity Plan (SRAP)		650-736-2985 press option 3

ONLINE BENEFITS TOOLS HELP MAKE WISE DECISIONS

The Stanford Benefits website is designed to help you find important benefits information before you enroll and throughout the year. The site makes it easy for you to learn, decide and enroll.

Visit benefits.stanford.edu.

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