2018

Summary of Benefits

SCAN Classic (HMO)
Orange County

January 1, 2018 - December 31, 2018

SCAN Classic (HMO) is an HMO plan with a Medicare contract. Enrollment in SCAN Health Plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage" by calling our Member Service Department at the phone number listed in this document or online at www.scanhealthplan.com.

Y0057_SCAN_10295_2017F File & Use Accepted 18C-SMB400

scan HEALTH PLAN®

SUMMARY OF BENEFITS JANUARY 1, 2018 – DECEMBER 31, 2018

PREMIUM AND BENEFITS	SCAN CLASSIC	WHAT YOU SHOULD KNOW
Monthly Health Plan Premium	You pay $0	You must continue to pay your Medicare Part B premium.
Deductible	You pay $0	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (this does not include prescription drugs)	$2,400 annually	The most you pay for copays and coinsurance for **Medicare-covered medical services** for the year.
Inpatient Hospital Coverage	You pay $0	Our plan covers an unlimited number of days for an inpatient hospital stay. **Prior authorization rules apply.**
Outpatient Hospital Coverage		**Prior authorization** is required for outpatient hospital services.
• Ambulatory Surgical Center	You pay $0	
• Outpatient Hospital	You pay $0	
Doctor Visits		**Prior authorization** is required for specialist visits.
• Primary Care	You pay $0	
• Specialists	You pay $0	
Preventive Care	You pay $0	Any additional preventive services approved by Medicare during the contract year will be covered. **Prior authorization rules apply.**
Emergency Care	You pay $80 copay per visit	The emergency room copay will be waived if you are immediately admitted to the hospital. You are covered for worldwide emergency services.
Urgently Needed Services	You pay $20 copay per visit	You are covered for worldwide urgent care services.

PREMIUM AND BENEFITS	SCAN CLASSIC	WHAT YOU SHOULD KNOW
Diagnostic Services/Labs/Imaging		**Prior authorization** is required for diagnostic, lab, and imaging services.
• Lab services	You pay $0	
• Diagnostic tests and procedures	You pay $0	
• Outpatient X-rays	You pay $0	
• Therapeutic radiology	You pay $50 copay per visit	
• Diagnostic radiology (e.g., MRI, CT)	You pay $0	
Hearing Services		**Prior authorization** is required for Medicare-covered diagnostic hearing and balance exams. You must go to a SCAN-contracted provider to obtain a routine hearing exam and hearing aids.
• Medicare-covered diagnostic hearing and balance exam	You pay $0	
• Non-Medicare-covered (routine) hearing exam	You pay $0 for up to 1 visit per year	
• Non-Medicare-covered (routine) hearing aids	You pay $699 copay per aid for Flyte 770 or $999 copay per aid for Flyte 990 You are covered for up to 2 hearing aids every year	
Dental Services		**Prior authorization** is required for Medicare-covered dental services. SCAN offers dental benefits for an additional cost. See the "Optional Supplemental Benefits" chart at the end of this document.
• Medicare-covered dental services	You pay $0	
• Non-Medicare-covered (routine) oral exam and cleaning	Not covered	
• Non-Medicare-covered (routine) dental fillings	Not covered	
• Non-Medicare-covered (routine) dentures	Not covered	

PREMIUM AND BENEFITS	SCAN CLASSIC	WHAT YOU SHOULD KNOW
Vision Services		**Prior authorization** is required for Medicare-covered vision exams and glasses after cataract surgery. Routine vision services do not require prior authorization. You must go to a SCAN-contracted vision provider to obtain routine vision services.
• Medicare-covered vision exam to diagnose/treat diseases of the eye	You pay $0	
• Medicare-covered glasses after cataract surgery	You pay $0	
• Non-Medicare-covered (routine) vision exam	You pay $0 for up to 1 visit per year	
• Non-Medicare-covered (routine) glasses or contact lenses	You pay $30 copay per pair every 2 years	
• Non-Medicare-covered (routine) vision coverage limit	You are covered for up to $175 for frames or contact lenses every 2 years	
Mental Health Services		**Prior authorization** is required for inpatient mental health hospitalization. You are covered for up to 90 days per benefit period.*
• Inpatient visit	You pay $0 per day for days 1-90	
• Outpatient individual/group therapy visit	You pay $10 copay per visit	**Prior authorization** is required for outpatient mental health services.
• Outpatient individual/ group therapy visit with a psychiatrist	You pay $0	
Skilled Nursing Facility	You pay $0 per day for days 1-20 You pay $50 copay per day for days 21-100	**Prior authorization** is required for skilled nursing facility services. You are covered for up to 100 days per benefit period.* No prior hospitalization is required.
Physical Therapy	You pay $0	**Prior authorization** is required for physical therapy services.

* A benefit period begins the day you go into a hospital or SNF. The benefit period ends when you haven't received any inpatient hospital or SNF care for 60 days in a row.

PREMIUM AND BENEFITS	SCAN CLASSIC	WHAT YOU SHOULD KNOW
Ambulance	You pay $100 copay per one-way trip	
Transportation (Non-Medicare-covered - routine)	You pay $0 for up to 12 one-way trips per year 75-mile limit applies to each one-way trip	**Prior authorization** is required for routine transportation services. You must use a SCAN-contracted provider to obtain routine transportation services.
Medicare Part B Drugs	You pay 20% of the total cost for chemotherapy and other Part B drugs	**Prior authorization rules apply** to select drugs.

OUTPATIENT PRESCRIPTION DRUGS

You pay the following:

SCAN CLASSIC

	Preferred Retail Pharmacy 30-day supply cost-sharing	Standard Retail Pharmacy 30-day supply cost-sharing	Preferred Retail Pharmacy 90-day supply cost-sharing	Standard Retail Pharmacy 90-day supply cost-sharing	Mail-Order Pharmacy 90-day supply cost-sharing
Initial Coverage Stage					
Tier 1 (Preferred Generic)	You pay $0	You pay $0	You pay $0	You pay $0	You pay $0
Tier 2 (Generic)	You pay $5	You pay $10	You pay $10	You pay $20	You pay $10
Tier 3 (Preferred Brand)	You pay $42	You pay $47	You pay $116	You pay $131	You pay $116
Tier 4 (Non-Preferred Drug)	You pay $95	You pay $100	You pay $275	You pay $290	You pay $275
Tier 5 (Specialty Tier)	You pay 33%	You pay 33%	Not available	Not available	Not available

Coverage Gap Stage	Begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750. You pay the same copays as in the Initial Coverage Stage for Tier 1 and Tier 2 drugs. For drugs in other tiers, you pay 35% of the negotiated price (and a portion of the dispensing fee) for your brand name drugs and 44% of the cost for your generic drugs.

Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs reach $5,000, you pay the greater of: – 5% of the cost, or – $3.35 copay for generic (including brand drugs treated as generic) and a $8.35 copay for all other drugs

Some of our network pharmacies have preferred cost-sharing. You may pay less for certain drugs if you use these pharmacies rather than pharmacies that offer standard cost-sharing.

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

Cost-Sharing may change depending on the pharmacy you choose (e.g., Preferred Retail, Standard Retail, Mail-Order, Long Term Care (LTC) or Home infusion, etc.), whether you receive a 30, 60 or 90-day supply, and when you enter another phase of the Part D benefit. For more information, please call our Member Services Department at the number provided in this document or access your Evidence of Coverage online.

ADDITIONAL BENEFITS

PREMIUM AND BENEFITS	SCAN CLASSIC	WHAT YOU SHOULD KNOW
Medical Equipment/Supplies		**Prior authorization** is required for covered durable medical equipment, prosthetic devices, and certain diabetic supplies. SCAN covers diabetic supplies such as glucose monitors, test strips, and control solution from a select manufacturer. Lancets are also covered and are available from all manufacturers.
• Durable Medical Equipment (e.g., wheelchairs, oxygen)	You pay 0% to 20% of the total cost	
• Prosthetics (e.g., braces, artificial limbs)	You pay 0% to 20% of the total cost	
• Diabetic supplies	You pay $0	
Wellness Programs		You are covered for SCAN-contracted health clubs in your area.
• Health club membership	You pay $0	

OPTIONAL SUPPLEMENTAL BENEFITS

Dental Services – SCAN CLASSIC	
PACKAGE 1: Basic Dental Plan	
Monthly Premium	$6 per month
Routine dental office visit	$8 per visit
Routine dental exam	$0 per visit
Routine cleaning	$5 per visit for up to 2 visits per year
Routine dental X-rays	$0 — limited to 1 series every 6 months

PACKAGE 2: Enhanced Dental Plan	
Monthly Premium	$16 per month
Routine dental office visit	$0 per visit
Routine dental exam	$0 per visit
Routine cleaning	$5 per visit for up to 2 visits per year
Routine dental X-rays	$0 — limited to 1 series every 6 months

SCAN Classic has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

ABOUT SCAN	
Who can join?	**You must:** - have both Medicare Part A and Part B - live in the plan service area (Orange County, California) - not be medically determined to have End-Stage Renal Disease (ESRD)
Phone Number (Members)	**1-800-559-3500**
Phone Number (Non-Members)	**1-877-870-4867** (Calling this number will direct you to a licensed insurance agent)
TTY	**711**
Hours of Operation	**October 1 to February 14:** 8:00 am to 8:00 pm, 7 days a week **February 15 to September 30:** 8:00 am to 8:00 pm, Monday through Friday (messages received on holidays and outside of our business hours will be returned within one business day)
Website	http://www.scanhealthplan.com
Provider & Pharmacy Directory link	http://www.scanhealthplan.com
Formulary link	http://www.scanhealthplan.com
Link to Evidence of Coverage	http://www.scanhealthplan.com

To get more information about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at https://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. Other providers are available in our network. You must continue to pay your Medicare Part B premium. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. Premium, copays, coinsurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.

You can get prescription drugs shipped to your home through our network mail-order delivery program. Typically, you should expect to receive your prescription drugs within 14 days from the time that the mail-order pharmacy receives the order. If you do not receive your prescription drug(s) within this time, please contact SCAN Health Plan's Member Services at 1-800-559-3500, 8 A.M. to 8 P.M., 7 days a week from October 1 to February 14. From February 15 to September 30, hours are 8 A.M. to 8 P.M. Monday through Friday (messages received on holidays and outside of our business hours will be returned within one business day). TTY users call 711.

SCAN Health Plan complies with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of, or because of, race, color, national origin, age, disability, or sex.

SCAN Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).

SCAN Health Plan provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact SCAN Member Services.

If you believe that SCAN Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by phone, mail, or fax, at:

SCAN Member Services
Attention: Grievance and Appeals Department
P.O. Box 22616, Long Beach, CA 90801-5616
1-800-559-3500 (TTY: 711)
FAX: 1-562-989-5181

Or by filling out the “File a Grievance” form on our website at:
https://www.scanhealthplan.com/contact-us/file-a-grievance

If you need help filing a grievance, SCAN Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 (TTY: 1-800-537-7697)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

SCAN Health Plan is an HMO plan with a Medicare contract. Enrollment in SCAN Health Plan depends on contract renewal.

Multi-language Interpreter Services

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-559-3500. (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-559-3500. (TTY: 711).

Chinese Traditional: 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-800-559-3500。(TTY: 711)。

Chinese Simplified: 注意：如果您使用中文，您可以免费获得语言援助服务，请致电 1-800-559-3500。(TTY: 711)。

Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin vui lòng gọi số 1-800-559-3500. (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-559-3500. (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-559-3500 번으로 연락해 주십시오. (TTY: 711).

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա Ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարե՛ք 1-800-559-3500 հեռախոսահամարով: Հեռատիպի համարն է՝ 711:

Persian: **توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با شماره 1-800-559-3500 تماس بگیرید. (TTY: 711).

Russian: ВНИМАНИЕ! Если вы говорите по-русски, вы можете бесплатно получить услуги перевод;а. Звоните по телефону 1-800-559-3500 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。お問合せ先 1-800-559-3500. (TTY: 711).

Arabic: ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-559-3500. (الهاتف النصي: 711).

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-559-3500 ਉੱਤੇ ਕਾਲ ਕਰੋ। (TTY: 711)।

Mon-Khmer, Cambodian: សូមយកចិត្តទុកដាក់៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ អាចមានសំរាប់បំរើអ្នក។ សូមទូរស័ព្ទទៅលេខ 1-800-559-3500 ។ (TTY: 711) ។

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob (Ntawv Suav - Hmoob), muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-559-3500. (TTY: 711).

Hindi: **ध्यान दें**: **यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।** **कॉल करें** 1-800-559-3500, (TTY: 711)।

Thai: โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-559-3500 (TTY: 711)