2020

Summary of Benefits

SCAN Classic (HMO) and SCAN Prime (HMO) Orange County

January 1, 2020 - December 31, 2020

SCAN Classic (HMO) and SCAN Prime (HMO) are HMO plans with a Medicare contract. Enrollment in SCAN Health Plan depends on contract renewal.
The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage" by calling our Member Services Department at the phone number listed in this document or online at www.scanhealthplan.com.

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scan HEALTH PLAN®

SUMMARY OF BENEFITS JANUARY 1, 2020 – DECEMBER 31, 2020

PREMIUM AND BENEFITS	SCAN CLASSIC	SCAN PRIME	WHAT YOU SHOULD KNOW
Monthly Health Plan Premium	You pay $0	You pay $26 per month	You must continue to pay your Medicare Part B premium.
Deductible	You pay $0	You pay $0	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (this does not include prescription drugs)	$899 annually	$800 annually	The most you pay for copays and coinsurance for **Medicare-covered medical services** for the year.
Inpatient Hospital Coverage	You pay $0	You pay $0	Our plan covers an unlimited number of days for an inpatient hospital stay. **Prior authorization** rules apply.
Outpatient Hospital Services			**Prior authorization** rules apply for outpatient hospital services.
• Ambulatory Surgical Center	You pay $0	You pay $0	
• Outpatient Hospital	You pay $0	You pay $0	
Doctor Visits			
• Primary Care	You pay $0	You pay $0	
• Specialists	You pay $0	You pay $0	**Prior authorization** rules apply for specialist visits.
Preventive Care	You pay $0	You pay $0	Any additional preventive services approved by Medicare during the contract year will be covered. **Prior authorization** rules apply.

PREMIUM AND BENEFITS	SCAN CLASSIC	SCAN PRIME	WHAT YOU SHOULD KNOW
Emergency Care	You pay $90 copay per visit	You pay $90 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 $0	You pay $0	You are covered for worldwide urgent care services.
Diagnostic Services/Labs/ Imaging			**Prior authorization** rules apply for diagnostic, lab, and imaging services.
• Lab services	You pay $0	You pay $0	
• Diagnostic tests and procedures	You pay $0	You pay $0	
• Outpatient X-rays	You pay $0	You pay $0	
• Therapeutic radiology	You pay $50 copay per visit	You pay $50 copay per visit	
• Diagnostic radiology (e.g., MRI, CT)	You pay $0	You pay $0	

PREMIUM AND BENEFITS	SCAN CLASSIC	SCAN PRIME	WHAT YOU SHOULD KNOW
Hearing Services			
• Medicare-covered diagnostic hearing and balance exam	You pay $0	You pay $0	**Prior authorization** rules apply for Medicare-covered diagnostic hearing and balance exams.
• Non-Medicare-covered (routine) hearing exam	You pay $0 for up to 1 visit every 12 months	You pay $0 for up to 1 visit every 12 months	You must go to a SCAN-contracted provider to obtain a routine hearing exam and hearing aids.
• Non-Medicare-covered (routine) hearing aids	You pay $450 copay per aid for a TruHearing Advanced hearing aid or $750 copay per aid for a TruHearing Premium hearing aid You are covered for up to 2 hearing aids every 12 months	Your benefit includes 3 options: 1) A $200 copay per aid for TruHearing Advanced hearing aids, or 2) a $400 copay per aid for TruHearing Premium hearing aids, or 3) a $3,000 allowance toward the purchase of any hearing aid from the TruHearing Choice product line. You are covered for up to 2 hearing aids every 12 months	

PREMIUM AND BENEFITS	SCAN CLASSIC	SCAN PRIME	WHAT YOU SHOULD KNOW
Dental Services			
• Medicare-covered dental services	You pay $0	You pay $0	**Prior authorization** rules apply for Medicare-covered dental services.
• Non-Medicare-covered (routine) oral exam	You pay $0 for up to 2 visits every 12 months	You pay $10 copay for up to 2 visits every 12 months	Routine dental benefits are available with an additional premium. See the "Optional Supplemental Benefits" chart at the end of this document.
• Non-Medicare-covered (routine) dental cleaning	You pay $0 for up to 2 visits every 12 months	You pay $5 copay for up to 2 visits every 12 months	
• Non-Medicare-covered (routine) dental X-rays	You pay $0 for up to 2 series every 12 months	You pay $15 copay for up to 1 series every 6 months	
Vision Services			
• Medicare-covered vision exam to diagnose/treat diseases of the eye	You pay $0	You pay $0	**Prior authorization** rules apply for Medicare-covered vision exam and glasses after cataract surgery.
• Medicare-covered glasses after cataract surgery	You pay $0	You pay $0	
• Non-Medicare-covered (routine) vision exam	You pay $0 for up to 1 visit every 12 months	You pay $0 for up to 1 visit every 12 months	Routine vision services do not require a prior authorization.
• Non-Medicare-covered (routine) glasses or contact lenses	You pay $30 copay per pair every 24 months	You pay $30 copay per pair every 24 months	You must go to a SCAN-contracted vision provider to obtain routine vision services.
• Non-Medicare-covered (routine) vision coverage limit	You are covered for up to $175 for frames or contact lenses every 24 months	You are covered for up to $175 for frames or contact lenses every 24 months	

PREMIUM AND BENEFITS	SCAN CLASSIC	SCAN PRIME	WHAT YOU SHOULD KNOW
Mental Health Services			
• Inpatient visit	You pay $0 per day for days 1-90	You pay $0 per day for days 1-90	**Prior authorization** rules apply for inpatient mental health hospitalization. You are covered for up to 90 days per benefit period.*
• Outpatient individual/ group therapy visit	You pay $0	You pay $0	**Prior authorization** rules apply for outpatient mental health services.
• Outpatient individual/ group therapy visit with a psychiatrist	You pay $0	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	You pay $0 per day for days 1-20 You pay $50 copay per day for days 21-100	**Prior authorization** rules apply 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	You pay $0	**Prior authorization** rules apply for outpatient physical therapy services.
Ambulance	You pay $100 copay per one-way trip	You pay $100 copay per one-way trip	
Transportation (Non-Medicare-covered—routine)	You pay $0 for up to 24 one-way trips per year 75-mile limit applies to each one-way trip	You pay $0 for up to 24 one-way trips per year 75-mile limit applies to each one-way trip	**Prior authorization** rules apply 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	You pay 20% of the total cost for chemotherapy and other Part B drugs	**Prior authorization** rules apply to select drugs.

*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.

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 $7	You pay $0	You pay $14	You pay $0
Tier 2 (Generic)	You pay $5	You pay $15	You pay $10	You pay $30	You pay $0
Tier 3 (Preferred Brand)	You pay $42	You pay $47	You pay $106	You pay $121	You pay $106
Tier 4 (Non-Preferred Drug)	You pay $95	You pay $100	You pay $265	You pay $280	You pay $265
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 $4,020. 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 25% of the negotiated price (and a portion of the dispensing fee) for your brand name drugs and 25% of the cost for your generic drugs.

Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs reach $6,350, you pay the greater of: – 5% of the cost, or – $3.60 copay for generic (including drugs that are treated like a generic) and $8.95 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. Cost-sharing may change depending on the pharmacy you choose 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.

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

Your cost-sharing may differ depending on the pharmacy you choose (e.g., Preferred Retail, Standard Retail, Mail-Order, Long Term Care (LTC) or Home infusion, etc.) and whether you receive a 30- or 90-day supply. For more information on the pharmacy-specific copays, please call SCAN Member Services Department at the phone number in this document or access your Evidence of Coverage online.

SCAN PRIME

	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 $5	You pay $0	You pay $10	You pay $0
Tier 2 (Generic)	You pay $5	You pay $12	You pay $10	You pay $24	You pay $0
Tier 3 (Preferred Brand)	You pay $42	You pay $47	You pay $106	You pay $121	You pay $106
Tier 4 (Non-Preferred Drug)	You pay $95	You pay $100	You pay $265	You pay $280	You pay $265
Tier 5 (Specialty Tier)	You pay 33%	You pay 33%	Not available	Not available	Not available

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

Your cost-sharing may differ depending on the pharmacy you choose (e.g., Preferred Retail, Standard Retail, Mail-Order, Long Term Care (LTC) or Home infusion, etc.) and whether you receive a 30- or 90-day supply. For more information on the pharmacy-specific copays, please call SCAN Member Services Department at the phone number in this document or access your Evidence of Coverage online.

ADDITIONAL BENEFITS

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

BENEFITS	SCAN CLASSIC	SCAN PRIME	WHAT YOU SHOULD KNOW
Acupuncture Services	You pay $15 copay for up to 30 visits per year combined with routine chiropractic services	You pay $0 for up to 20 visits per year combined with routine chiropractic and therapeutic massage services	You do not need a referral for an initial acupuncture visit. Any subsequent visits require **prior authorization.**
Chiropractic Services			
• Medicare-covered chiropractic care	You pay $0	You pay $0	**Prior authorization** rules apply
• Routine chiropractic care	You pay $15 copay for up to 30 visits per year combined with acupuncture services	You pay $0 for up to 20 visits per year combined with acupuncture and therapeutic massage services	You do not need a referral for an initial routine chiropractor visit. Any subsequent visits require **prior authorization**.
Home Health Care (Medicare-covered)	You pay $0	You pay $0	**Prior authorization** rules apply
Medical Equipment/Supplies			**Prior authorization** rules apply for covered durable medical equipment, prosthetic devices, and certain diabetic supplies.
• Durable Medical Equipment (e.g., wheelchairs, oxygen)	You pay 0% to 20% of the total cost	You pay 0% to 20% of the total cost	
• Prosthetics (e.g., braces, artificial limbs)	You pay 0% to 20% of the total cost	You pay 0% to 20% of the total cost	
• Diabetic supplies	You pay $0	You pay $0	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.

BENEFITS	SCAN CLASSIC	SCAN PRIME	WHAT YOU SHOULD KNOW
Telehealth Services	You pay $0	You pay $0	A visit with a board-certified doctor in the comfort of your own home. This benefit is for non-life threatening conditions such as, but not limited to, cough, flu, nausea, sore throat, fever, and allergies. Visits with doctors can be conducted either by telephone or secure video capabilities from your computer or smart phone.

OPTIONAL SUPPLEMENTAL BENEFITS

Dental Services – SCAN CLASSIC ONLY

Essential Dental Plan	
Monthly Premium	$10 per month

- Access to a large network of Delta Dental DHMO providers
- Over 290 dental procedures included
- Predictable copayments
- Additional comprehensive dental coverage
- Only available in the SCAN Classic Plan

SCAN Classic and **SCAN Prime** have 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 CLASSIC AND SCAN PRIME	
Who can join?	**You must:** - have both Medicare Part A and Part B - live in the plan service area (Orange County, California) - be a United States citizen or be lawfully present in the United States - 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 March 31:** 8 A.M. to 8 P.M., 7 days a week **April 1 to September 30:** 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.
Website	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 call 1-877-486-2048.

This information is not a complete description of benefits. Call 1-800-559-3500 (TTY: 711) for more information.

You can get prescription drugs shipped to your home through our network mail-order delivery program, which is called Express Scripts Pharmacy[SM]. 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 March 31. From April 1 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: 711.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-877-870-4867 (TTY users call 711) Hours are 8 A.M. to 8 P.M., seven days a week from October 1 to March 31. From April 1 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.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit www.scanhealthplan.com or call 1-877-870-4867 to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2021.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

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.

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)

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-559-3500 (TTY: 711).