

# 2010 Summary of Benefits



**My Choice**  
(HMO - POS)

# Section I, Introduction to the Summary of Benefits for My Choice (HMO-POS)

January 1, 2010 - December 31, 2010

My Choice (HMO-POS)

Los Angeles, Orange, Riverside and San Bernardino Counties

Thank you for your interest in My Choice (HMO-POS). Our plan is offered by SCAN HEALTH PLAN, a Medicare Advantage Health Maintenance Organization (HMO), with a point-of-service option (POS). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call My Choice (HMO-POS) and ask for the "Evidence of Coverage".

## You have choices in your health care

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like My Choice (HMO-POS). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call My Choice (HMO-POS) at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

## How can I compare my options?

You can compare My Choice (HMO-POS) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

## Where is My Choice (HMO-POS) available?

The service area for this plan includes: Los Angeles\*, Orange\*, Riverside\* and San Bernardino\* Counties, CA. You must live in one of these areas to join the plan.

## Who is eligible to join My Choice (HMO-POS)?

You can join My Choice (HMO-POS) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in My Choice (HMO-POS) unless they are members of our organization and have been since their dialysis began.

## Can I choose my doctors?

My Choice (HMO-POS) has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. In some cases, you may also go to doctors outside of our network. The health providers in our network can change at any time.

You can ask for a current Provider Directory or for an up-to-date list visit us at [www.scanhealthplan.com](http://www.scanhealthplan.com).

Our customer service number is listed at the end of this introduction.

## **What happens if I go to a doctor who's not in your network?**

You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network. For more information, please call the customer service number at the end of this introduction.

## **Does my plan cover Medicare Part B or Part D drugs?**

My Choice (HMO-POS) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

## **Where can I get my prescriptions if I join this plan?**

My Choice (HMO-POS) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at <http://www.scanhealthplan.com>. Our customer service number is listed at the end of this introduction.

## **What is a prescription drug formulary?**

My Choice (HMO-POS) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at <http://www.scanhealthplan.com>.

If you are currently taking a drug that is not on our

formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

## **How can I get extra help with my prescription drug plan costs?**

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or
- Your State Medicaid Office.

## **What are my protections in this plan?**

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of My Choice (HMO-POS), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file

a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Health Services Advisory Group (HSAG), (800) 841-1602.

As a member of My Choice (HMO-POS) you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the

right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Health Services Advisory Group (HSAG), (800) 841-1602.

### **What is a medication therapy management (MTM) program?**

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact My Choice (HMO-POS) for more details.

### **What types of drugs may be covered under Medicare Part B?**

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact My Choice (HMO-POS) for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.

- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and Infusion Drugs provided through DME.

Policies in Your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly at 1-800-559-3500 to obtain a copy of the plan ratings for this plan. TTY users call 1-800-735-2929.

## **Plan Ratings**

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on [www.medicare.gov](http://www.medicare.gov) and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap

**Please call SCAN Health Plan for more information about My Choice (HMO-POS).**

Visit us at [www.scanhealthplan.com](http://www.scanhealthplan.com) or, call us:

**Customer Service Hours:** Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday,  
7:00 a.m. - 8:00 p.m. Pacific

**Current members should call toll-free (877)-231-7226** for questions related to the Medicare Advantage Program. (TTY/TDD (800)-735-2929)

**Prospective members should call toll-free (800)-915-7226** for questions related to the Medicare Advantage Program. (TTY/TDD (800)-735-2929)

**Current members should call locally (877)-231-7226** for questions related to the Medicare Advantage Program. (TTY/TDD (800)-735-2929)

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**Prospective members should call locally (800)-915-7226** for questions related to the Medicare Part D Prescription Drug Program. (TTY/TDD (800)-735-2929)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit [www.medicare.gov](http://www.medicare.gov) on the web.

*If you have special needs, this document may be available in other formats.*

## Los Angeles County Service Area Zip Codes\*

90001	90034	90077	90266	90505	90723	91024	91324	91405	91746
90002	90035	90089	90270	90506	90731	91030	91325	91406	91747
90003	90036	90094	90272	90507	90732	91040	91326	91411	91748
90004	90037	90095	90274	90508	90733	91042	91330	91423	91749
90005	90038	90201	90275	90509	90744	91046	91331	91436	91750
90006	90039	90210	90277	90510	90745	91101	91334	91501	91754
90007	90040	90211	90278	90601	90746	91103	91335	91502	91755
90008	90041	90212	90280	90602	90747	91104	91340	91503	91765
90010	90042	90220	90290	90603	90755	91105	91342	91504	91766
90011	90043	90221	90291	90604	90801	91106	91343	91505	91767
90012	90044	90222	90292	90605	90802	91107	91344	91506	91768
90013	90045	90223	90293	90606	90803	91108	91345	91523	91770
90014	90046	90224	90301	90607	90804	91109	91350	91601	91773
90015	90047	90230	90302	90608	90805	91201	91351	91602	91775
90016	90048	90231	90303	90637	90806	91202	91352	91604	91776
90017	90049	90232	90304	90638	90807	91203	91354	91605	91780
90018	90056	90233	90305	90639	90808	91204	91355	91606	91789
90019	90057	90240	90306	90640	90809	91205	91356	91607	91790
90020	90058	90241	90307	90650	90810	91206	91364	91702	91791
90021	90059	90242	90308	90660	90813	91207	91367	91706	91792
90022	90061	90245	90309	90670	90814	91208	91371	91711	91793
90023	90062	90247	90310	90701	90815	91214	91381	91722	91801
90024	90063	90248	90401	90703	90822	91301	91382	91723	91803
90025	90064	90249	90402	90706	91001	91302	91383	91724	93534
90026	90065	90250	90403	90710	91006	91303	91384	91731	93535
90027	90066	90254	90404	90712	91007	91304	91387	91732	93536
90028	90067	90255	90405	90713	91008	91306	91390	91733	93543
90029	90068	90260	90501	90714	91010	91307	91394	91740	93550
90031	90069	90261	90502	90715	91011	91311	91401	91741	93551
90032	90071	90262	90503	90716	91016	91316	91402	91744	93552
90033	90073	90265	90504	90717	91020	91321	91403	91745	

\*Indicates partial county.

## Orange County Service Area Zip Codes\*

90620	90743	92625	92652	92675	92702	92782	92822	92842	92866
90621	92602	92626	92653	92676	92703	92799	92823	92843	92867
90622	92603	92627	92654	92677	92704	92801	92831	92844	92868
90623	92604	92628	92655	92678	92705	92802	92832	92845	92869
90630	92606	92629	92656	92679	92706	92803	92833	92846	92870
90631	92610	92630	92657	92683	92707	92804	92834	92856	92871
90632	92612	92637	92660	92688	92708	92805	92835	92857	92885
90633	92614	92646	92661	92691	92709	92806	92836	92859	92886
90680	92617	92647	92662	92692	92711	92807	92837	92861	92887
90720	92618	92648	92663	92694	92728	92808	92838	92862	
90740	92620	92649	92672	92697	92780	92809	92840	92864	
90742	92624	92651	92673	92701	92781	92821	92841	92865	

## Riverside County Service Area Zip Codes\*

91752	92234	92261	92501	92513	92530	92551	92563	92587	92879
92201	92236	92262	92502	92514	92532	92552	92567	92590	92880
92202	92240	92263	92503	92515	92536	92553	92570	92591	92881
92203	92241	92264	92504	92516	92539	92554	92571	92592	92882
92210	92253	92270	92505	92517	92543	92555	92582	92595	92883
92211	92254	92274	92506	92518	92544	92556	92583	92596	
92220	92255	92276	92507	92519	92545	92557	92584	92860	
92223	92258	92282	92508	92521	92548	92561	92585	92877	
92230	92260	92320	92509	92522	92549	92562	92586	92878	

## San Bernardino County Service Area Zip Codes\*

91701	91762	92284	92315	92334	92345	92373	92393	92406	92423
91708	91763	92285	92316	92335	92346	92374	92394	92407	92424
91709	91764	92301	92317	92336	92347	92375	92395	92408	92427
91710	91784	92305	92318	92337	92352	92376	92397	92410	
91729	91786	92307	92321	92338	92354	92377	92399	92411	
91730	92252	92308	92322	92339	92356	92382	92401	92412	
91737	92256	92311	92324	92340	92359	92385	92402	92413	
91739	92268	92312	92325	92341	92368	92386	92403	92414	
91743	92277	92313	92326	92342	92371	92391	92404	92415	
91761	92278	92314	92327	92344	92372	92392	92405	92418	

\*Indicates partial county.

# Section II, Summary of Benefits

## My Choice (HMO-POS)

Los Angeles, Orange, Riverside and San Bernardino Counties

If you have any questions about this plan's benefits or costs, please contact **SCAN Health Plan** for details.

Benefit Category	Original Medicare	MY Choice (HMO-POS)
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### Important Information

<p><b>1. Premium and Other Important Information</b></p>	<p>In 2009 the monthly Part B Premium was \$96.40 and will change for 2010 and the yearly Part B deductible amount was \$135 and will change for 2010.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, starting January 1, 2010, some people will pay a higher premium because of their yearly income. (For 2009, this amount was \$85,000 for singles, \$170,000 for married couples. This amount may change for 2010.) For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p><b>General</b> \$40 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p><b>In-Network</b> \$1,050 out-of-pocket limit.</p> <p>This limit includes only Medicare-covered services.</p>
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Benefit Category	Original Medicare	MY Choice (HMO-POS)
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**Important Information**(*cont.*)

<p><b>2. Doctor and Hospital Choice</b> (For more information, see Emergency #15 and Urgently Needed Care #16)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p><b>In-Network</b> No referral required for network doctors, specialists, and hospitals.</p>
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**Summary of Benefits — Inpatient Care**

<p><b>3. Inpatient Hospital Care</b> (includes Substance Abuse and Rehabilitation Services)</p>	<p>In 2009 the amounts for each benefit period were:  Days 1 - 60: \$1068 deductible  Days 61 - 90: \$267 per day  Days 91 - 150: \$534 per lifetime reserve day</p> <p>These amounts will change for 2010.</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p><b>In-Network</b> For Medicare-covered hospital stays:  Days 1 - 10: \$100 copay per day  Days 11 - 90: \$0 copay per day  \$0 copay for additional hospital days  No limit to the number of days covered by the plan each benefit period.</p>
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Benefit Category	Original Medicare	MY Choice (HMO-POS)
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**Summary of Benefits — Inpatient Care(cont.)**

<p><b>4. Inpatient Mental Health Care</b></p>	<p>Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above). 190 day lifetime limit in a Psychiatric Hospital.</p>	<p><b>In-Network</b> For Medicare-covered hospital stays: Days 1 - 10: \$100 copay per day Days 11 - 90: \$0 copay per day You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<p><b>5. Skilled Nursing Facility (SNF)</b> (in a Medicare certified skilled nursing facility)</p>	<p>In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1 - 20: \$0 per day Days 21 - 100: \$133.50 per day These amounts will change for 2010. 100 days for each benefit period. A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit-period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p><b>In-Network</b> For SNF stays: Days 1 - 20: \$30 copay per day Days 21 - 100: \$100 copay per day Plan covers up to 100 days each benefit period. No prior hospital stay is required.</p>

Benefit Category	Original Medicare	MY Choice (HMO-POS)
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**Summary of Benefits — Inpatient Care***(cont.)*

<p><b>6. Home Health Care</b> (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>\$0 copay.</p>	<p><b>In-Network</b> \$10 copay for each Medicare-covered home health visits.</p>
<p><b>7. Hospice</b></p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care.  You must get care from a Medicare-certified hospice.</p>	<p><b>General</b> You must get care from a Medicare-certified hospice.</p>

**Outpatient Care**

<p><b>8. Doctor Office Visits</b></p>	<p>20% coinsurance</p>	<p><b>General</b> See "Physical Exams," for more information.</p> <p><b>In-Network</b> \$10 copay for each primary care doctor visit for Medicare-covered benefits.  \$25 copay for each in-area, network urgent care Medicare-covered visit.  \$20 copay for each specialist visit for Medicare-covered benefits.</p>
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Benefit Category	Original Medicare	MY Choice (HMO-POS)
<b>Outpatient Care</b> <i>(cont.)</i>		
<b>9. Chiropractic Services</b>	<p>Routine care not covered.</p> <p>20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$20 copay for each Medicare-covered visit</p> <p>\$10 copay for up to 10 routine visit(s) every year</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>
<b>10. Podiatry Services</b>	<p>Routine care not covered.</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$20 copay for each Medicare-covered visit</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>
<b>11. Outpatient Mental Health Care</b>	<p>45% coinsurance for most outpatient mental health services.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$25 copay for each Medicare-covered individual or group therapy visit.</p>
<b>12. Outpatient Substance Abuse Care</b>	<p>20% coinsurance</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$25 copay for Medicare-covered individual or group visits.</p>

Benefit Category	Original Medicare	MY Choice (HMO-POS)
<b>Outpatient Care</b> <i>(cont.)</i>		
<b>13. Outpatient Services/Surgery</b>	20% coinsurance for the doctor 20% of outpatient facility charges	<b>In-Network</b> \$50 copay for each Medicare-covered ambulatory surgical center visit.  \$100 copay for each Medicare-covered outpatient hospital facility visit.
<b>14. Ambulance Services</b> (medically necessary ambulance services)	20% coinsurance	<b>General</b> Authorization rules may apply.  <b>In-Network</b> \$100 copay for Medicare-covered ambulance benefits.
<b>15. Emergency Care</b> (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor 20% of facility charge, or a set copay per emergency room visit  You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.  NOT covered outside the U.S. except under limited circumstances.	<b>General</b> \$50 copay for Medicare-covered emergency room visits.  Worldwide coverage.  If you are immediately admitted to the hospital, you pay \$0 for the emergency room visit.
<b>16. Urgently Needed Care</b> (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance, or a set copay  NOT covered outside the U.S. except under limited circumstances.	<b>General</b> \$25 copay for Medicare-covered urgently needed care visits.

Benefit Category	Original Medicare	MY Choice (HMO-POS)
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**Outpatient Care***(cont.)*

<p><b>17. Outpatient Rehabilitation Services</b> (Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>20% coinsurance</p>	<p><b>In-Network</b> \$20 copay for Medicare-covered Occupational Therapy visits.  \$20 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p>
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**Outpatient Medical Services and Supplies**

<p><b>18. Durable Medical Equipment</b> (includes wheelchairs, oxygen, etc.)</p>	<p>20% coinsurance</p>	<p><b>General</b> Authorization rules may apply.  <b>In-Network</b> 0% to 10% of the cost for Medicare-covered items.</p>
<p><b>19. Prosthetic Devices</b> (includes braces, artificial limbs and eyes, etc.)</p>	<p>20% coinsurance</p>	<p><b>General</b> Authorization rules may apply.  <b>In-Network</b> 0% to 10% of the cost for Medicare-covered items.</p>
<p><b>20. Diabetes Self-Monitoring Training, Nutrition Therapy and Supplies</b> (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p>	<p>20% coinsurance  Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p><b>In-Network</b> \$0 copay for Diabetes self-monitoring training.  \$0 copay for Nutrition Therapy for Diabetes.  \$0 copay for Diabetes supplies.</p>

Benefit Category	Original Medicare	MY Choice (HMO-POS)
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**Outpatient Medical Services and Supplies***(cont.)*

<p><b>21. Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</b></p>	<p>20% coinsurance for diagnostic tests and x-rays</p> <p>\$0 copay for Medicare-covered lab services</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>	<p><b>In-Network</b></p> <p>0% of the cost for Medicare-covered lab services.</p> <p>0% to 20% of the cost for Medicare-covered diagnostic procedures and tests.</p> <p>0% of the cost for Medicare-covered X-rays.</p> <p>10% of the cost for Medicare-covered diagnostic radiology services.</p> <p>10% of the cost for Medicare-covered therapeutic radiology services.</p>
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**Preventive Services**

<p><b>22. Bone Mass Measurement</b> (for people with Medicare who are at risk)</p>	<p>20% coinsurance</p> <p>Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</p>	<p><b>In-Network</b></p> <p>\$0 to \$50 copay for Medicare-covered bone mass measurement</p>
<p><b>23. Colorectal Screening Exams</b> (for people with Medicare age 50 and older)</p>	<p>20% coinsurance</p> <p>Covered when you are high risk or when you are age 50 and older.</p>	<p><b>In-Network</b></p> <p>\$0 to \$100 copay for Medicare-covered colorectal screenings.</p>

Benefit Category	Original Medicare	MY Choice (HMO-POS)
<b>Preventive Services</b> ( <i>cont.</i> )		
<p><b>24. Immunizations</b> (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)</p>	<p>\$0 copay for Flu and Pneumonia vaccines</p> <p>20% coinsurance for Hepatitis B vaccine.</p> <p>You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.</p>	<p><b>In-Network</b></p> <p>\$0 copay for Flu and Pneumonia vaccines.</p> <p>\$0 copay for Hepatitis B vaccine.</p> <p>No referral needed for Flu and Pneumonia vaccines.</p> <p>Separate Office Visit cost sharing of \$10 copay may apply.</p> <p>No referral needed for other immunizations.</p>
<p><b>25. Mammograms (Annual Screening)</b> (for women with Medicare age 40 and older)</p>	<p>20% coinsurance</p> <p>No referral needed.</p> <p>Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.</p>	<p><b>In-Network</b></p> <p>\$0 copay for Medicare-covered screening mammograms.</p>
<p><b>26. Pap Smears and Pelvic Exams</b> (for women with Medicare)</p>	<p>\$0 copay for Pap smears</p> <p>Covered once every 2 years. Covered once a year for women with Medicare at high risk.</p> <p>20% coinsurance for Pelvic Exams</p>	<p><b>In-Network</b></p> <p>\$0 copay for Medicare-covered pap smears and pelvic exams.</p> <p>Separate Office Visit cost sharing of \$10 copay may apply.</p>
<p><b>27. Prostate Cancer Screening Exams</b> (for men with Medicare age 50 and older)</p>	<p>20% coinsurance for the digital rectal exam.</p> <p>\$0 for the PSA test; 20% coinsurance for other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p>	<p><b>In-Network</b></p> <p>\$0 copay for Medicare-covered prostate cancer screening</p>

Benefit Category	Original Medicare	MY Choice (HMO-POS)
<b>Preventive Services</b> (cont.)		
<p><b>28. End-Stage Renal Disease</b></p>	<p>20% coinsurance for renal dialysis</p> <p>20% coinsurance for Nutrition Therapy for End-Stage Renal Disease</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p><b>In-Network</b></p> <p>\$0 copay for renal dialysis</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease</p>
<p><b>29. Prescription Drugs</b></p>	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p><b>Drugs covered under Medicare Part B</b></p> <p><b>General</b></p> <p>20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p><b>Drugs covered under Medicare Part D</b></p> <p><b>General</b></p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <a href="http://www.scanhealthplan.com">http://www.scanhealthplan.com</a> on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> <li>- have limited incomes,</li> <li>- live in long term care facilities, or</li> <li>- have access to Indian/Tribal/Urban (Indian Health Service).</li> </ul> <p>The plan offers national in-network prescription coverage (i.e.,</p>

Benefit Category	Original Medicare	MY Choice (HMO-POS)
<b>Preventive Services</b> <i>(cont.)</i>		
<b>29. Prescription Drugs</b> <i>(cont.)</i>		<p>this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from My Choice (HMO-POS) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and My Choice (HMO-POS) approves the exception, you will pay Specialty cost-sharing for that drug.</p>

Benefit Category	Original Medicare	MY Choice (HMO-POS)
<b>Preventive Services</b> ( <i>cont.</i> )		
<b>29. Prescription Drugs</b> ( <i>cont.</i> )		<p><b>In-Network</b> \$0 deductible.</p> <p>Some covered drugs don't count toward your out-of-pocket drug costs.</p> <p><b>Initial Coverage</b> You pay the following until total yearly drug costs reach \$3,000:</p> <p><b>Retail Pharmacy</b> <b>Select Generic</b></p> <ul style="list-style-type: none"> <li>- \$0 copay for a one-month (31-day) supply of drugs in this tier.</li> <li>- \$0 copay for a three-month (90-day) supply of drugs in this tier.</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p><b>Generic</b></p> <ul style="list-style-type: none"> <li>- \$5 copay for a one-month (31-day) supply of drugs in this tier.</li> <li>- \$15 copay for a three-month (90-day) supply of drugs in this tier.</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p><b>Brand</b></p> <ul style="list-style-type: none"> <li>- \$32 copay for a one-month (31-day) supply of drugs in this tier.</li> <li>- \$96 copay for a three-month (90-day) supply of drugs in this tier.</li> </ul>

Benefit Category	Original Medicare	MY Choice (HMO-POS)
<b>Preventive Services</b> (cont.)		
<b>29. Prescription Drugs</b> (cont.)		<p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p><b>Additional Brand</b></p> <ul style="list-style-type: none"> <li>- \$60 copay for a one-month (31-day) supply of drugs in this tier.</li> <li>- \$180 copay for a three-month (90-day) supply of drugs in this tier.</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p><b>Specialty</b></p> <ul style="list-style-type: none"> <li>- 33% coinsurance for a one-month (31-day) supply of drugs in this tier.</li> </ul> <p><b>Long Term Care Pharmacy</b></p> <p><b>Select Generic</b></p> <ul style="list-style-type: none"> <li>- \$0 copay for a one-month (31-day) supply of drugs in this tier.</li> </ul> <p><b>Generic</b></p> <ul style="list-style-type: none"> <li>- \$5 copay for a one-month (31-day) supply of drugs in this tier.</li> </ul> <p><b>Brand</b></p> <ul style="list-style-type: none"> <li>- \$32 copay for a one-month (31-day) supply of drugs in this tier.</li> </ul> <p><b>Additional Brand</b></p> <ul style="list-style-type: none"> <li>- \$60 copay for a one-month (31-day) supply of drugs in this tier.</li> </ul>

Benefit Category	Original Medicare	MY Choice (HMO-POS)
<b>Preventive Services</b> (cont.)		
29. Prescription Drugs(cont.)		<p><b>Specialty</b> - 33% coinsurance for a one-month (31-day) supply of drugs in this tier.</p> <p><b>Mail Order</b> <b>Select Generic</b> - \$0 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p><b>Generic</b> - \$12.50 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p><b>Brand</b> - \$80 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p><b>Additional Brand</b> - \$150 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>

Benefit Category	Original Medicare	MY Choice (HMO-POS)
<b>Preventive Services</b> (cont.)		
<b>29. Prescription Drugs</b> (cont.)		<p><b>Coverage Gap</b>  The plan covers all generics (100% of formulary generic drugs) through the coverage gap.</p> <p>You pay the following:</p> <p><b>Retail Pharmacy</b></p> <p><b>Select Generic</b></p> <ul style="list-style-type: none"> <li>- \$0 copay for a one-month (31-day) supply of all drugs covered in this tier.</li> <li>- \$0 copay for a three-month (90-day) supply of all drugs covered in this tier.</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p><b>Generic</b></p> <ul style="list-style-type: none"> <li>- \$5 copay for a one-month (31-day) supply of all drugs covered in this tier.</li> <li>- \$15 copay for a three-month (90-day) supply of all drugs covered in this tier.</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p><b>Long Term Care Pharmacy</b></p> <p><b>Select Generic</b></p> <ul style="list-style-type: none"> <li>- \$0 copay for a one-month (31-day) supply of all drugs covered in this tier.</li> </ul> <p><b>Generic</b></p> <ul style="list-style-type: none"> <li>- \$5 copay for a one-month (31-day) supply of all drugs covered in this tier.</li> </ul>

Benefit Category	Original Medicare	MY Choice (HMO-POS)
<b>Preventive Services</b> (cont.)		
<b>29. Prescription Drugs</b> (cont.)		<p><b>Mail Order</b></p> <p><b>Select Generic</b></p> <ul style="list-style-type: none"> <li>- \$0 copay for a three-month (90-day) supply of all drugs covered in this tier.</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p><b>Generic</b></p> <ul style="list-style-type: none"> <li>- \$12.50 copay for a three-month (90-day) supply of all drugs covered in this tier.</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>For all other covered drugs, after your total yearly drug costs reach \$3,000, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.</p> <p><b>Catastrophic Coverage</b></p> <p>After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:</p> <ul style="list-style-type: none"> <li>- A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or</li> <li>- 5% coinsurance</li> </ul> <p><b>Out-of-Network</b></p> <p>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy.</p> <p>You may have to pay more than your normal cost-sharing amount</p>

Benefit Category	Original Medicare	MY Choice (HMO-POS)
<b>Preventive Services(cont.)</b>		
<b>29. Prescription Drugs(cont.)</b>		<p>if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from My Choice (HMO-POS).</p> <p><b>Out-of-Network Initial Coverage</b> You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$3,000:</p> <p><b>Select Generic</b></p> <ul style="list-style-type: none"> <li>- \$0 copay for a one-month (31-day) supply of drugs in this tier.</li> </ul> <p><b>Generic</b></p> <ul style="list-style-type: none"> <li>- \$5 copay for a one-month (31-day) supply of drugs in this tier.</li> </ul> <p><b>Brand</b></p> <ul style="list-style-type: none"> <li>- \$32 copay for a one-month (31-day) supply of drugs in this tier.</li> </ul> <p><b>Additional Brand</b></p> <ul style="list-style-type: none"> <li>- \$60 copay for a one-month (31-day) supply of drugs in this tier.</li> </ul> <p><b>Specialty</b></p> <ul style="list-style-type: none"> <li>- 33% coinsurance for a one-month (31-day) supply of drugs in this tier.</li> </ul> <p><b>Out-of-Network Coverage Gap</b> You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:</p>

Benefit Category	Original Medicare	MY Choice (HMO-POS)
<b>Preventive Services</b> <i>(cont.)</i>		
<b>29. Prescription Drugs</b> <i>(cont.)</i>		<p><b>Select Generic</b></p> <ul style="list-style-type: none"> <li>- \$0 copay for a one-month (31-day) supply of all drugs covered in this tier.</li> </ul> <p><b>Generic</b></p> <ul style="list-style-type: none"> <li>- \$5 copay for a one-month (31-day) supply of all drugs covered in this tier.</li> </ul> <p><b>Brand</b></p> <ul style="list-style-type: none"> <li>- After your total yearly drug costs reach \$3,000, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by My Choice (HMO-POS) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to My Choice (HMO-POS) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</li> </ul> <p><b>Additional Brand</b></p> <ul style="list-style-type: none"> <li>- After your total yearly drug costs reach \$3,000, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by My Choice (HMO-POS) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to My Choice (HMO-POS) so we can add the amounts</li> </ul>

Benefit Category	Original Medicare	MY Choice (HMO-POS)
<b>Preventive Services</b> (cont.)		
		<p>you spent out-of-network to your total out-of-pocket costs for the year.</p> <p><b>Specialty</b></p> <ul style="list-style-type: none"> <li>- After your total yearly drug costs reach \$3,000, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by My Choice (HMO-POS) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to My Choice (HMO-POS) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</li> </ul> <p><b>Out-of-Network Catastrophic Coverage</b></p> <p>After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <ul style="list-style-type: none"> <li>- A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or</li> <li>- 5% coinsurance</li> </ul>
<b>30. Dental Services</b>	Preventive dental services (such as cleaning) not covered.	<p><b>In-Network</b></p> <p>In general, preventive dental benefits (such as cleaning) not covered.</p> <p>\$25 copay for Medicare-covered dental benefits.</p>

Benefit Category	Original Medicare	MY Choice (HMO-POS)
<b>Preventive Services</b> <i>(cont.)</i>		
<p><b>31. Hearing Services</b></p>	<p>Routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.</p>	<p><b>In-Network</b></p> <p>\$0 copay for up to 2 hearing aid(s) every three years.</p> <ul style="list-style-type: none"> <li>- \$25 copay for Medicare-covered diagnostic hearing exams.</li> <li>- \$25 copay for up to 1 routine hearing test(s) every year.</li> <li>- \$25 copay for up to 1 hearing aid fitting evaluation(s) every three years.</li> </ul> <p>\$400 limit for hearing aids every three years.</p>
<p><b>32. Vision Services</b></p>	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p><b>In-Network</b></p> <ul style="list-style-type: none"> <li>- \$25 copay for one pair of eyeglasses or contact lenses after cataract surgery</li> <li>- \$25 copay for exams to diagnose and treat diseases and conditions of the eye</li> <li>- \$30 copay for up to 1 routine eye exam(s) every year</li> <li>- \$25 copay for up to 1 pair(s) of glasses every two years</li> <li>- \$25 copay for up to 1 pair(s) of contacts every two years</li> </ul> <p>\$75 limit for eye glasses (lenses and frames) every two years</p> <p>\$100 limit for contact lenses every two years.</p>

Benefit Category	Original Medicare	MY Choice (HMO-POS)
<b>Preventive Services</b> <i>(cont.)</i>		
<b>33. Physical Exams</b>	<p>20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage</p> <p>When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p><b>In-Network</b>            \$0 copay for routine exams            Limited to 1 exam(s) every year.</p>
<b>Health/Wellness Education</b>	<p>Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.</p>	<p><b>In-Network</b>            The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> <li>- Written health education materials, including Newsletters</li> <li>- Nutritional benefit</li> <li>- Health Club Membership/ Fitness Classes</li> <li>- Nursing Hotline</li> </ul> <p>\$0 copay for each Medicare-covered smoking cessation counseling session.</p>
<b>Transportation</b> (Routine)	Not covered.	<p><b>In-Network</b>            This plan does not cover routine transportation.</p>
<b>Acupuncture</b>	Not covered.	<p><b>General</b>            Authorization rules may apply.</p> <p><b>In-Network</b>            \$10 copay per visit up to 10 visit(s) every year.</p>

Benefit Category	Original Medicare	MY Choice (HMO-POS)
<b>Preventive Services</b> <i>(cont.)</i>		
<b>Point of Service</b>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p><b>Out-of-Network</b>  Point of Service coverage is available for the following benefits:</p> <ul style="list-style-type: none"> <li>- Inpatient Hospital Care</li> <li>- Skilled Nursing Facility (SNF)</li> <li>- Home Health Care</li> <li>- Doctor Office Visits</li> <li>- Chiropractic Services</li> <li>- Podiatry Services</li> <li>- Outpatient Services/Surgery</li> <li>- Ambulance Services</li> <li>- Outpatient Rehabilitation Services</li> <li>- Diabetes Self-Monitoring Training and Nutrition Therapy</li> <li>- Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</li> <li>- Bone Mass Measurement</li> <li>- Colorectal Screening Exam</li> <li>- Immunizations</li> <li>- Mammograms (Annual Screenings)</li> <li>- Pap Smears and Pelvic Exams</li> <li>- Prostate Cancer Screening Exams</li> <li>- Dental Services</li> <li>- Hearing Services</li> <li>- Physical Exams</li> <li>- Comprehensive Outpatient Rehabilitation Facility (CORF)</li> <li>- Diagnostic Radiological Services</li> <li>- Therapeutic Radiological Services</li> <li>- Outpatient X-Rays</li> <li>- Cardiac Rehabilitation Services</li> <li>- Outpatient Blood</li> <li>- Nutrition Therapy for Diabetes and Renal Disease</li> </ul> <p>20% of the cost per hospital stay.  20% of the cost for each SNF stay.</p>

Benefit Category	Original Medicare	MY Choice (HMO-POS)
<b>Optional Supplemental Package #1</b>		
<b>Premium and Other Important Information</b>		<p><b>General</b>            Package: 1 - Dental Buy-Up:            \$8 monthly premium, in addition to your \$40 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits:</p> <ul style="list-style-type: none"> <li>- Dental Services</li> </ul>
<b>Dental Services</b>		<p><b>In-Network</b></p> <ul style="list-style-type: none"> <li>- \$5 copay for up to 2 cleaning(s) every year</li> <li>- \$0 copay for up to 2 oral exam(s) every year</li> <li>- \$0 copay for up to 1 dental x-ray visit(s) every six months</li> </ul>

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