

SCAN Health Plan[®]
2014 Summary of Benefits



Section I — Introduction To Summary Of Benefits

Thank you for your interest in SCAN Classic (HMO). Our plan is offered by SCAN HEALTH PLAN, a Medicare Advantage Health Maintenance Organization (HMO) that contracts with the Federal government. 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 SCAN Classic (HMO) 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 SCAN Classic (HMO). 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 SCAN Classic (HMO) at the telephone 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 SCAN Classic (HMO) 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 SCAN Classic (HMO) available?

The service area for this plan includes: Ventura* County, CA. You must live in one of these areas to join the plan. *denotes partial county

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Who is eligible to join SCAN Classic (HMO)?

You can join SCAN Classic (HMO) 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 generally are not eligible to enroll in SCAN Classic (HMO) unless they are members of our organization and have been since their dialysis began.

Can I choose my doctors?

SCAN Classic (HMO) has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time.

You can ask for a current provider directory. For an updated list, visit us at <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?

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither the plan nor the Original Medicare Plan will pay for these services except in limited situations (for example, emergency care).

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

SCAN Classic (HMO) 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 if my doctor prescribes less than a month's supply?

In consultation with your doctor or pharmacist, you may receive less than a month's supply of certain drugs. Also, if you live in a long-term care facility, you will receive less than a month's supply of certain brand and generic drugs. Dispensing fewer drugs at a time can help reduce cost and waste in the Medicare Part D program, when this is medically appropriate.

The amount you pay in these circumstances will depend on whether you are responsible for paying coinsurance (a percentage of the cost of the drug) or a copay (a flat dollar amount for the drug). If you are responsible for coinsurance for the drug, you will continue to pay the applicable percentage of the drug cost. If you are responsible for a copay for the drug, a "daily cost-sharing rate" will be applied. If your doctor decides to continue the drug after a trial period, you should not pay more for a month's supply than you otherwise would have paid. Contact your plan if you have questions about cost-sharing when less than a one-month supply is dispensed.

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

SCAN Classic (HMO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

What is a prescription drug formulary?

SCAN Classic (HMO) 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 members 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 or get extra help with other Medicare costs?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare 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; and see <http://www.medicare.gov> 'Programs for People with Limited Income and Resources' in the publication Medicare & You.
- 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 calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of SCAN Classic (HMO), 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. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of SCAN Classic (HMO), 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. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

What is a Medication Therapy Management (MTM) Program?

A Medication Therapy Management (MTM) Program is a free service we 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 SCAN Classic (HMO) 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 SCAN Classic (HMO) 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 osteoporosis drugs for some women.
- Erythropoietin: 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 took place in a Medicare-certified facility and was paid for by Medicare or by a private insurance company that was the primary payer for Medicare Part A coverage.

- 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 administered through Durable Medical Equipment.

Where can I find information on 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 <http://www.medicare.gov> and select “Health and Drug Plans” then “Compare Drug and Health Plans” to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

Please call SCAN Health Plan for more information about SCAN Classic (HMO).

Visit us at <http://www.scanhealthplan.com> or, call us:

Customer Service Hours for October 1 - February 14:

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

Customer Service Hours for February 15 - September 30:

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

Current members should call locally or toll-free (800)559-3500 for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug program. (TTY/TDD 711)

Prospective members should call locally or toll-free (800)915-7226 for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug program. (TTY/TDD 711)

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 <http://www.medicare.gov> on the web.

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

Este documento puede estar disponible en otros idiomas. Para obtener más información, llame a servicio al cliente al número de teléfono mencionado anteriormente.

Ventura County Service Area Zip Codes*

90265; 91319; 91360; 93001; 93012; 93022; 93035; 93060; 93066
91304; 91320; 91361; 93003; 93015; 93023; 93036; 93061;
91307; 91358; 91362; 93004; 93020; 93030; 93040; 93063;
91311; 91359; 91377; 93010; 93021; 93033; 93041; 93065;

*indicates partial county

Section II — Summary Of Benefits

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

Benefit	Original Medicare	SCAN CLASSIC (HMO)
Important Information		
1. Premium and Other Important Information	<p>In 2013 the monthly Part B Premium was \$104.90 and may change for 2014 and the annual Part B deductible amount was \$147 and may change for 2014.</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, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p>General \$26 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>In-Network \$5,000 out-of-pocket limit for Medicare-covered services.</p> <p>See page 29 for additional information about Premium and Other Important Information.</p>
2. Doctor and Hospital Choice (For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>In-Network You must go to network doctors, specialists, and hospitals.</p> <p>Referral required for network hospitals and specialists (for certain benefits).</p>

Summary of Benefits — Inpatient Care

<p>3. Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p>	<p>In 2013 the amounts for each benefit period were:</p> <p>Days 1 - 60: \$1,184 deductible Days 61 - 90: \$296 per day Days 91 - 150: \$592 per lifetime reserve day</p> <p>These amounts may change for 2014.</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>In-Network</p> <p>No limit to the number of days covered by the plan each hospital stay.</p> <p>For Medicare-covered hospital stays:</p> <ul style="list-style-type: none"> - Days 1 - 5: \$200 copay per day - Days 6 - 90: \$0 copay per day <p>\$0 copay for additional non-Medicare-covered hospital days</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<p>4. Inpatient Mental Health Care</p>	<p>In 2013 the amounts for each benefit period were:</p> <p>Days 1 - 60: \$1,184 deductible Days 61 - 90: \$296 per day Days 91 - 150: \$592 per lifetime reserve day</p> <p>These amounts may change for 2014.</p> <p>You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p>	<p>In-Network</p> <p>You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> <p>For Medicare-covered hospital stays:</p> <ul style="list-style-type: none"> - Days 1 - 5: \$200 copay per day - Days 6 - 90: \$0 copay per day <p>Plan covers 60 lifetime reserve days. \$0 copay per lifetime reserve day.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>

Benefit	Original Medicare	SCAN CLASSIC (HMO)
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Inpatient Care *(cont.)*

<p>5. Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)</p>	<p>In 2013 the amounts for each benefit period after at least a 3-day Medicare-covered hospital stay were:</p> <p>Days 1 - 20: \$0 per day</p> <p>Days 21 - 100: \$148 per day</p> <p>These amounts may change for 2014.</p> <p>100 days for each benefit period.</p> <p>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>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period</p> <p>No prior hospital stay is required.</p> <p>For Medicare-covered SNF stays:</p> <ul style="list-style-type: none"> - Days 1 - 10: \$0 copay per day - Days 11 - 20: \$25 copay per day - Days 21 - 100: \$75 copay per day
<p>6. Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>\$0 copay.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits</p>
<p>7. Hospice</p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must get care from a Medicare-certified hospice.</p>	<p>General You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.</p>

Outpatient Care

<p>8. Doctor Office Visits</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$10 copay for each Medicare-covered primary care doctor visit.</p> <p>\$10 copay for each Medicare-covered specialist visit.</p>
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Benefit	Original Medicare	SCAN CLASSIC (HMO)
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Outpatient Care (cont.)

<p>9. Chiropractic Services</p>	<p>Supplemental 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).</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$10 copay for each Medicare-covered chiropractic visit</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).</p>
<p>10. Podiatry Services</p>	<p>Supplemental routine care not covered.</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$10 copay for each Medicare-covered podiatry visit</p> <p>Medicare-covered podiatry visits are for medically necessary foot care.</p>
<p>11. Outpatient Mental Health Care</p>	<p>20% coinsurance for most outpatient mental health services</p> <p>Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible.</p> <p>“Partial hospitalization program” is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for each Medicare-covered individual therapy visit \$25 copay for each Medicare-covered group therapy visit \$25 copay for each Medicare-covered individual therapy visit with a psychiatrist \$25 copay for each Medicare-covered group therapy visit with a psychiatrist \$25 copay for Medicare-covered partial hospitalization program services</p>

Benefit	Original Medicare	SCAN CLASSIC (HMO)
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Outpatient Care (cont.)

<p>12. Outpatient Substance Abuse Care</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for Medicare-covered individual substance abuse outpatient treatment visits \$25 copay for Medicare-covered group substance abuse outpatient treatment visits</p>
<p>13. Outpatient Services</p>	<p>20% coinsurance for the doctor's services</p> <p>Specified copayment for outpatient hospital facility services Copay cannot exceed the Part A inpatient hospital deductible.</p> <p>20% coinsurance for ambulatory surgical center facility services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$10 to \$125 copay for each Medicare-covered ambulatory surgical center visit \$10 to \$175 copay or 20% of the cost for each Medicare-covered outpatient hospital facility visit</p> <p>See page 29 for additional information about Outpatient Services.</p>
<p>14. Ambulance Services (medically necessary ambulance services)</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$225 copay for Medicare-covered ambulance benefits.</p>

Benefit	Original Medicare	SCAN CLASSIC (HMO)
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Outpatient Care *(cont.)*

<p>15. Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>20% coinsurance for the doctor's services</p> <p>Specified copayment for outpatient hospital facility emergency services.</p> <p>Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital.</p> <p>You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit.</p> <p>Not covered outside the U.S. except under limited circumstances.</p>	<p>General</p> <p>\$65 copay for Medicare-covered emergency room visits</p> <p>Worldwide coverage.</p> <p>If you are immediately admitted to the hospital, you pay \$0 for the emergency room visit.</p>
<p>16. Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>20% coinsurance, or a set copay</p> <p>If you are admitted to the hospital within 3 days for the same condition, you pay \$0 for the urgently-needed-care visit.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>General</p> <p>\$35 copay for Medicare-covered urgently-needed-care visits</p> <p>See page 29 for additional information about Urgently Needed Care.</p>
<p>17. Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>20% coinsurance</p> <p>Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered.</p> <p>In-Network</p> <p>\$15 copay for Medicare-covered Occupational Therapy visits</p> <p>\$15 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits</p>

Outpatient Medical Services and Supplies

18. Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered durable medical equipment
19. Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance 20% coinsurance for Medicare-covered medical supplies related to prosthetics, splints, and other devices.	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered prosthetic devices 20% of the cost for Medicare-covered medical supplies related to prosthetics, splints, and other devices
20. Diabetes Programs and Supplies	20% coinsurance for diabetes self-management training 20% coinsurance for diabetes supplies 20% coinsurance for diabetic therapeutic shoes or inserts	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered Diabetes self-management training \$0 copay for Medicare-covered: - Diabetes monitoring supplies - Therapeutic shoes or inserts Diabetic Supplies and Services are limited to specific manufacturers, products and/or brands. Contact the plan for a list of covered supplies. See page 29 for additional information about Diabetes Programs and Supplies.

Outpatient Medical Services and Supplies *(cont.)*

<p>21. Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</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 supplemental routine screening tests, like checking your cholesterol.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"> - lab services - diagnostic procedures and tests - X-rays <p>20% of the cost for Medicare-covered diagnostic radiology services (not including X-rays)</p> <p>20% of the cost for Medicare-covered therapeutic radiology services</p> <p>See page 30 for additional information about Diagnostic Tests, X-Rays, Lab Services, and Radiology Services.</p>
<p>22. Cardiac and Pulmonary Rehabilitation Services</p>	<p>20% coinsurance for Cardiac Rehabilitation services</p> <p>20% coinsurance for Pulmonary Rehabilitation services</p> <p>20% coinsurance for Intensive Cardiac Rehabilitation services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$15 copay for Medicare-covered Cardiac Rehabilitation Services</p> <p>\$15 copay for Medicare-covered Intensive Cardiac Rehabilitation Services</p> <p>\$15 copay for Medicare-covered Pulmonary Rehabilitation Services</p>

Preventive Services

<p>23. Preventive Services</p>	<p>No coinsurance, copayment or deductible for the following:</p> <ul style="list-style-type: none"> - Abdominal Aortic Aneurysm Screening - Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. - Cardiovascular Screening - Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. - Colorectal Cancer Screening - Diabetes Screening - Influenza Vaccine - Hepatitis B Vaccine for people with Medicare who are at risk - HIV Screening. \$0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. - Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. 	<p>General Authorization rules may apply. \$0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare.</p> <p>In-Network \$0 copay for a supplemental annual physical exam See page 30 for additional information about Preventive Services.</p>
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Preventive Services *(cont.)*

23. Preventive Services <i>(cont.)</i>	<ul style="list-style-type: none"> - Medical Nutrition Therapy Services 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 and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease - Personalized Prevention Plan Services (Annual Wellness Visits) - Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. - Prostate Cancer Screening - Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. - Smoking and Tobacco Use Cessation (counseling to stop smoking and tobacco use). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. - Screening and behavioral counseling interventions in primary care to reduce alcohol misuse - Screening for depression in adults - Screening for sexually transmitted infections (STI) and high-intensity behavioral counseling to prevent STIs - Intensive behavioral counseling for Cardiovascular Disease (bi-annual) 	
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Benefit	Original Medicare	SCAN CLASSIC (HMO)
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Preventive Services *(cont.)*

<p>23. Preventive Services <i>(cont.)</i></p>	<ul style="list-style-type: none"> - Intensive behavioral therapy for obesity - Welcome to Medicare Preventive Visits (initial preventive physical exam) When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Preventive Visits or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months. 	
<p>24. Kidney Disease and Conditions</p>	<p>20% coinsurance for renal dialysis</p> <p>20% coinsurance for kidney disease education services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered renal dialysis</p> <p>\$0 copay for Medicare-covered kidney disease education services</p>

Prescription Drug Benefits

<p>25. Outpatient Prescription Drugs</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>Drugs covered under Medicare Part B General 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs.</p> <p>Drugs covered under Medicare Part D General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.scanhealthplan.com on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> - have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Service) providers. <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). 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 a Part D 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. Your provider must get prior authorization from SCAN Classic (HMO) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider</p>
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Prescription Drug Benefits *(cont.)*

<p>25. Outpatient Prescription Drugs <i>(cont.)</i></p>		<p>coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, 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 SCAN Classic (HMO) approves the exception, you will pay Tier 4: Non-Preferred Brand cost sharing for that drug.</p> <p>In-Network \$0 deductible.</p> <p>Initial Coverage You pay the following until total yearly drug costs reach \$2,850:</p> <p>Retail Pharmacy Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.</p> <p>You can get drugs the following way(s):</p> <p>Tier 1: Preferred Generic</p> <ul style="list-style-type: none"> - \$7 copay for a one-month (31-day) supply of drugs in this tier - \$14 copay for a two-month (60-day) supply of drugs in this tier - \$21 copay for a three-month (90-day) supply of drugs in this tier <p>Tier 2: Non-Preferred Generic</p> <ul style="list-style-type: none"> - \$10 copay for a one-month (31-day) supply of drugs in this tier - \$20 copay for a two-month (60-day) supply of drugs in this tier
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Prescription Drug Benefits *(cont.)*

<p>25. Outpatient Prescription Drugs <i>(cont.)</i></p>		<ul style="list-style-type: none"> - \$30 copay for a three-month (90-day) supply of drugs in this tier <p>Tier 3: Preferred Brand</p> <ul style="list-style-type: none"> - \$40 copay for a one-month (31-day) supply of drugs in this tier - \$80 copay for a two-month (60-day) supply of drugs in this tier - \$120 copay for a three-month (90-day) supply of drugs in this tier <p>Tier 4: Non-Preferred Brand</p> <ul style="list-style-type: none"> - \$85 copay for a one-month (31-day) supply of drugs in this tier - \$170 copay for a two-month (60-day) supply of drugs in this tier - \$255 copay for a three-month (90-day) supply of drugs in this tier <p>Tier 5: Specialty Tier</p> <ul style="list-style-type: none"> - 33% coinsurance for a one-month (31-day) supply of drugs in this tier <p>Tier 6: Select Care Drugs</p> <ul style="list-style-type: none"> - \$10 copay for a one-month (31-day) supply of drugs in this tier - \$20 copay for a two-month (60-day) supply of drugs in this tier - \$30 copay for a three-month (90-day) supply of drugs in this tier <p>Long Term Care Pharmacy Long term care pharmacies must dispense brand name drugs in amounts less than a 14 days supply at a time. They may also dispense less than a month's supply of generic drugs at a time. Contact your plan if you have questions about cost sharing or billing when less than a one-month supply is dispensed.</p>
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Prescription Drug Benefits *(cont.)*

<p>25. Outpatient Prescription Drugs <i>(cont.)</i></p>		<p>You can get drugs the following way(s):</p> <p>Tier 1: Preferred Generic</p> <ul style="list-style-type: none"> - \$7 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 2: Non-Preferred Generic</p> <ul style="list-style-type: none"> - \$10 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 3: Preferred Brand</p> <ul style="list-style-type: none"> - \$40 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 4: Non-Preferred Brand</p> <ul style="list-style-type: none"> - \$85 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 5: Specialty Tier</p> <ul style="list-style-type: none"> - 33% coinsurance for a one-month (31-day) supply of drugs in this tier <p>Tier 6: Select Care Drugs</p> <ul style="list-style-type: none"> - \$10 copay for a one-month (31-day) supply of drugs in this tier <p>Mail Order</p> <p>Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.</p> <p>You can get drugs the following way(s):</p> <p>Tier 1: Preferred Generic</p> <ul style="list-style-type: none"> - \$7 copay for a one-month (31-day) supply of drugs in this tier - \$14 copay for a two-month (60-day) supply of drugs in this tier - \$14 copay for a three-month (90-day) supply of drugs in this tier
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Prescription Drug Benefits *(cont.)*

25. Outpatient Prescription Drugs <i>(cont.)</i>		<p>Tier 2: Non-Preferred Generic</p> <ul style="list-style-type: none"> - \$10 copay for a one-month (31-day) supply of drugs in this tier - \$20 copay for a two-month (60-day) supply of drugs in this tier - \$20 copay for a three-month (90-day) supply of drugs in this tier <p>Tier 3: Preferred Brand</p> <ul style="list-style-type: none"> - \$40 copay for a one-month (31-day) supply of drugs in this tier - \$80 copay for a two-month (60-day) supply of drugs in this tier - \$80 copay for a three-month (90-day) supply of drugs in this tier <p>Tier 4: Non-Preferred Brand</p> <ul style="list-style-type: none"> - \$85 copay for a one-month (31-day) supply of drugs in this tier - \$170 copay for a two-month (60-day) supply of drugs in this tier - \$170 copay for a three-month (90-day) supply of drugs in this tier <p>Tier 5: Specialty Tier</p> <ul style="list-style-type: none"> - 33% coinsurance for a one-month (31-day) supply of drugs in this tier <p>Tier 6: Select Care Drugs</p> <ul style="list-style-type: none"> - \$10 copay for a one-month (31-day) supply of drugs in this tier - \$20 copay for a two-month (60-day) supply of drugs in this tier - \$20 copay for a three-month (90-day) supply of drugs in this tier
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Prescription Drug Benefits *(cont.)*

<p>25. Outpatient Prescription Drugs <i>(cont.)</i></p>		<p>Coverage Gap After your total yearly drug costs reach \$2,850, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 72% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach \$4,550.</p> <p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:</p> <ul style="list-style-type: none"> - 5% coinsurance, or - \$2.55 copay for generic (including brand drugs treated as generic) and a \$6.35 copay for all other drugs. <p>Out-of-Network 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. You may have to pay more than your normal cost-sharing amount 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 SCAN Classic (HMO).</p> <p>You can get out-of-network drugs the following way:</p>
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Prescription Drug Benefits *(cont.)*

<p>25. Outpatient Prescription Drugs <i>(cont.)</i></p>		<p>Out-of-Network Initial Coverage You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,850:</p> <p>Tier 1: Preferred Generic</p> <ul style="list-style-type: none"> - \$7 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 2: Non-Preferred Generic</p> <ul style="list-style-type: none"> - \$10 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 3: Preferred Brand</p> <ul style="list-style-type: none"> - \$40 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 4: Non-Preferred Brand</p> <ul style="list-style-type: none"> - \$85 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 5: Specialty Tier</p> <ul style="list-style-type: none"> - 33% coinsurance for a one-month (31-day) supply of drugs in this tier <p>Tier 6: Select Care Drugs</p> <ul style="list-style-type: none"> - \$10 copay for a one-month (31-day) supply of drugs in this tier <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> <p>Out-of-Network Coverage Gap You will be reimbursed up to 28% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).</p>
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Prescription Drug Benefits *(cont.)*

25. Outpatient Prescription Drugs <i>(cont.)</i>		<p>You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach \$4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).</p> <p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of:</p> <ul style="list-style-type: none"> - 5% coinsurance, or - \$2.55 copay for generic (including brand drugs treated as generic) and a \$6.35 copay for all other drugs. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>
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Benefit	Original Medicare	SCAN CLASSIC (HMO)
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Outpatient Medical Services and Supplies

<p>26. Dental Services</p>	<p>Preventive dental services (such as cleaning) not covered.</p>	<p>In-Network This plan covers some preventive dental benefits for an extra cost (see “Optional Supplemental Benefits.”) \$10 copay for Medicare-covered dental benefits</p>
<p>27. Hearing Services</p>	<p>Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.</p>	<p>General Authorization rules may apply. In-Network In general, supplemental routine hearing exams and hearing aids are not covered. \$10 copay for Medicare-covered diagnostic hearing exams</p>
<p>28. Vision Services</p>	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye, including an annual glaucoma screening for people at risk Supplemental routine eye exams and eyeglasses (lenses and frames) not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p>	<p>In-Network \$0 to \$10 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening for people at risk \$0 copay for up to 1 supplemental routine eye exam(s) every year \$10 copay for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery. \$35 copay for up to 1 pair(s) of eyeglasses (lenses and frames) every two years \$35 copay for up to 1 pair(s) of contact lenses every two years \$35 copay for up to 1 pair(s) of eyeglass lenses every two years \$35 copay for up to 1 frame(s) every two years \$105 plan coverage limit for contact lenses every two years. \$105 plan coverage limit for eyeglass frames every two years. See page 30 for additional information about Vision Services.</p>

Benefit	Original Medicare	SCAN CLASSIC (HMO)
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Outpatient Medical Services and Supplies *(cont.)*

Wellness/Education and Other Supplemental Benefits & Services	Not covered.	<p>In-Network This plan does not cover supplemental education/wellness programs.</p>
Over-the-Counter Items	Not covered.	<p>General The plan does not cover Over-the-Counter items.</p>
Transportation (Routine)	Not covered.	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for up to 12 one-way trip(s) to plan-approved location every year</p> <p>See page 30 for additional information about Transportation (Routine).</p>
Acupuncture and Other Alternative Therapies	Not covered.	<p>In-Network This plan does not cover Acupuncture and other alternative therapies.</p>

Optional Supplemental Package #1

Premium and Other Important Information		<p>General Package: 1 - Basic Dental: \$8 monthly premium, in addition to your \$26 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits:</p> <ul style="list-style-type: none"> - Preventive Dental
Dental Services		<p>In-Network \$0 copay for supplemental oral exams \$5 copay for up to 2 supplemental cleaning(s) every year \$0 copay for up to 1 supplemental dental x-ray(s) every six months See page 31 for additional information about Optional Supplemental Benefits.</p>

Optional Supplemental Package #2

Premium and Other Important Information		<p>General Package: 2 - Enhanced Dental: \$16 monthly premium, in addition to your \$26 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits:</p> <ul style="list-style-type: none"> - Preventive Dental
Dental Services		<p>In-Network \$0 copay for supplemental oral exams \$5 copay for up to 1 supplemental cleaning(s) every six months \$0 copay for up to 1 supplemental dental x-ray(s) every six months See page 31 for additional information about Optional Supplemental Benefits.</p>

Section III — Important information about your plan

1. Premium and Other Important Information

Maximum Out-of-Pocket (MOOP)—The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services in 2014 is \$5,000.

- The amounts you pay for copayments and coinsurance for in-network covered Part A and Part B services count toward this maximum out-of-pocket amount.
- The amounts you pay for your plan premiums and prescription drugs do not count toward the maximum out-of-pocket amount.
- In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount such as routine chiropractic services, eyeglasses, etc.

If you reach the maximum out-of-pocket amount of \$5,000, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

13. Outpatient Services

You pay copays for outpatient services performed in an Ambulatory Surgery Center (ASC) or an outpatient hospital. Additional coinsurance will apply if you receive Part B covered drugs while in an outpatient setting.

Ambulatory Surgery Center (ASC)—You pay the following for services performed in an ASC:

- \$10 for Medicare-covered non-surgical services
- \$125 copay for Medicare-covered surgical services

Outpatient hospital—You pay the following for services performed in an outpatient hospital or an outpatient department of a hospital:

- \$10 for Medicare-covered non-surgical services
- \$175 for Medicare-covered surgical services
- 20% of the total cost for diagnostic/therapeutic radiological services

16. Urgently Needed Care

You are covered for worldwide urgently needed care. You pay \$35 per visit.

20. Diabetes Programs and Supplies

Diabetes monitoring supplies—You pay \$0 for select manufacturer glucose monitors, test strips, lancets and control solution.

Therapeutic shoes and inserts—For people with diabetes who have severe diabetic foot disease (as defined by Medicare). Specific criteria apply. You pay \$0 copay.

21. Diagnostic Tests, X-Rays, Lab Services, and Radiology Services

You pay the following copays for these services:

- Lab services – You pay \$0 copay. This includes tests such as blood and urine tests.
- Diagnostic procedures and tests – You pay \$0 copay per visit. This includes tests such as EKG, ECG, etc.
- X-rays – You pay \$0 copay per visit.
- Diagnostic radiology – You pay 20% of the total cost per visit. This includes procedures that require specialized equipment beyond normal x-ray equipment and which must be performed by specially-trained and/or certified personnel. These services include, but are not limited to CT, SPECT, MRI, MRA, Myelogram, Cystogram, and Angiogram, and ultrasound.
- Therapeutic radiology – You pay 20% of the total cost per visit. This includes, but is not limited to radiation therapy, gamma knife, and cyber knife procedures.

23. Preventive Services

Annual physical exam—This exam is a comprehensive, hands-on evaluation performed by your physician that may include vital signs and specimen testing. This exam can be performed once every calendar year. You pay \$0 for this exam. You may pay an office visit copay if you have this visit in conjunction with other services performed during your physician office visit.

Annual wellness visit—If you had Part B for longer than 12 months, you can have an annual “wellness” visit to develop or update a personalized prevention help plan based on your current health and risk factors. This visit typically involves completing a health questionnaire to help your physician keep you healthy. This visit is covered once every 12 months (11 full months must have passed since your last “wellness” visit). You pay \$0 for this visit. You may pay an office visit copay if you receive other services during your physician office visit.

28. Vision Services

You are able to self-refer to a SCAN-contracted vision provider for the following routine services and copays:

- Routine eye exam - \$0 copay for 1 visit per year
- Glasses or contact lenses or eyeglass lenses or standard frames - \$35 copay every 2 years
- Standard frame (or contact lens) coverage up to \$105 every 2 years
- Contact lens coverage to include the cost of the exam, professional fees, and materials
- You pay any remaining costs beyond what SCAN will cover

Transportation (Routine)

You pay \$0 copay for up to 12 one-way trips per year for qualifying medical services such as doctor appointments, picking up your prescriptions at the pharmacy, dental appointments, etc. SCAN does not cover transportation to a health club facility. You must use SCAN-contracted transportation providers and transportation is provided only when you are being transported to SCAN-contracted providers and facilities within the SCAN service area.

Optional Supplemental Benefits

This plan offers the following dental plans for an additional cost:

- Basic Dental Plan - \$8 monthly premium
- Enhanced Dental Plan - \$16 monthly premium

If you are already a SCAN member, you may add or change your dental package by calling Member Services, or by sending us the dental enrollment form. All add or change requests must be received before December 7, 2013 (during the annual election period October 15 - December 7), for coverage to become effective on January 1, 2014.

If you are enrolling either as a new member or because of a special election, you can add the optional dental plan within 60 days of enrolling in the plan. Coverage is effective the first of the month following the date we receive your completed enrollment form.

You can terminate your optional dental coverage anytime. You may mail or fax to us a signed letter requesting disenrollment from the dental plan or you may call Member Services to request a disenrollment form. Your letter must clearly state that you wish to disenroll from the optional dental plan and include your printed name and SCAN membership identification number. Disenrollment requests received by the last day of the month will be effective the first day of the following month. Members will be responsible for their Optional Supplemental Plan premium payment if the disenrollment request is received after the last day of the month.

Disenrollment from the dental plan will not disenroll you from your Medicare Advantage enrollment with SCAN Health Plan.