Maricopa, Pima, and Pinal Counties

SCAN CLASSIC (HMO)

2027 Medicare Evidence of Coverage

Medicare Advantage Plan

scan™

January 1 – December 31, 2027

Evidence of Coverage for 2027:

Your Medicare Health Benefits and Services and Drug Coverage as a Member of SCAN Classic (HMO)

This document gives the details of your Medicare health and drug coverage from January 1 – December 31, 2027. **This is an important legal document. Keep it in a safe place.**

This document explains your benefits and rights. Use this document to understand:

- Your plan premium and cost-sharing
- Your medical and drug benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call Member Services at 1-855-650-7226 (TTY users call 711). Hours are 8 a.m. to 8 p.m., 7 days a week from October 1 to March 31. From April 1 to September 30, hours are 8 a.m. to 8 p.m., Monday through Friday. Messages received on holidays and outside of our business hours will be returned within one business day. This call is free.

This plan, SCAN Classic, is offered by SCAN Desert Health Plan, Inc. (SCAN Health Plan). When this *Evidence of Coverage* says "we," "us," or "our," it means SCAN Health Plan. When it says "plan" or "our plan," it means SCAN Classic.

This document is available for free in Spanish.

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

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2028.

Our formulary, pharmacy network, and/or provider network may change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

H1822-001
Y0057_SCAN_22701_2027_C

Table of Contents

CHAPTER 1: Get started as a member 4
SECTION 1 You're a member of SCAN Classic 4
SECTION 2 Plan eligibility requirements 4
SECTION 3 Important membership materials 5
SECTION 4 Summary of Important Costs for 2027 7
SECTION 5 More information about your monthly plan premium 12
SECTION 6 Keep your plan membership record up to date 14
SECTION 7 How other insurance works with our plan 15

CHAPTER 2: Phone numbers and resources 16
SECTION 1 SCAN Classic contacts 16
SECTION 2 Get help from Medicare 24
SECTION 3 State Health Insurance Assistance Program (SHIP) 25
SECTION 4 Quality Improvement Organization (QIO) 26
SECTION 5 Social Security 27
SECTION 6 Arizona Health Care Cost Containment System (AHCCCS) (Medicaid) 28
SECTION 7 Programs to help people pay for prescription drugs 29
SECTION 8 Railroad Retirement Board (RRB) 31
SECTION 9 If you have group insurance or other health insurance from an employer 32

CHAPTER 3: Using our plan for your medical services 33
SECTION 1 How to get medical care as a member of our plan 33
SECTION 2 Use providers in our plan's network to get medical care 34
SECTION 3 How to get services in an emergency, disaster, or urgent need for care 39
SECTION 4 What if you're billed directly for the full cost of covered services? 42
SECTION 5 Medical services in a clinical research study 43
SECTION 6 Rules for getting care in a religious non-medical health care institution 44
SECTION 7 Rules for ownership of durable medical equipment 45

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay) 47
SECTION 1 Understanding your out-of-pocket costs for covered services 47
SECTION 2 The Medical Benefits Chart shows your medical benefits and costs 48
SECTION 3 Services that aren't covered by our plan (exclusions) 113

CHAPTER 5: Using plan coverage for Part D drugs 120
SECTION 1 Basic rules for our plan's Part D coverage 120
SECTION 2 Fill your prescription at a network pharmacy or through our plan's mail-order service 120
SECTION 3 Your drugs need to be on our plan's Drug List 124
SECTION 4 Drugs with restrictions on coverage 126
SECTION 5 What you can do if one of your drugs isn't covered the way you'd like 127
SECTION 6 Our Drug List can change during the year 129
SECTION 7 Types of drugs we don't cover 131
SECTION 8 How to fill a prescription 132
SECTION 9 Part D drug coverage in special situations 133
SECTION 10 Programs on drug safety and managing medications 134

CHAPTER 6: What you pay for Part D drugs 137
SECTION 1 What you pay for Part D drugs 137
SECTION 2 Drug payment stages for SCAN Classic members 139
SECTION 3 Your *Part D Explanation of Benefits (EOB)* explains which payment stage you're in 139
SECTION 4 There is no deductible for SCAN Classic 141
SECTION 5 The Initial Coverage Stage 141
SECTION 6 The Catastrophic Coverage Stage 146
SECTION 7 Additional benefits information 146
SECTION 8 What you pay for Part D vaccines 146

CHAPTER 7: Asking us to pay our share of a bill for covered medical services or drugs 149
SECTION 1 Situations when you should ask us to pay our share for covered services or drugs 149
SECTION 2 How to ask us to pay you back or pay a bill you got 151
SECTION 3 We'll consider your request for payment and say yes or no 152

CHAPTER 8: Your rights and responsibilities 153
SECTION 1 Our plan must honor your rights and cultural sensitivities 153
SECTION 2 Your responsibilities as a member of our plan 168

CHAPTER 9: If you have a problem or complaint (coverage decisions, appeals, complaints) 169
SECTION 1 What to do if you have a problem or concern 169
SECTION 2 Where to get more information and personalized help 169
SECTION 3 Which process to use for your problem 170
SECTION 4 A guide to coverage decisions and appeals 170
SECTION 5 Medical care: How to ask for a coverage decision or make an appeal 173
SECTION 6 Part D drugs: How to ask for a coverage decision or make an appeal . . 180
SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon 189
SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon 193
SECTION 9 Taking your appeal to Levels 3, 4, and 5 197
SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns 200

CHAPTER 10: Ending membership in our plan 203
SECTION 1 Ending your membership in our plan 203
SECTION 2 When can you end your membership in our plan? 203
SECTION 3 How to end your membership in our plan 205
SECTION 4 Until your membership ends, you must keep getting your medical items, services, and drugs through our plan 206
SECTION 5 SCAN Classic must end your plan membership in certain situations . . . 206

CHAPTER 11: Legal notices 208
SECTION 1 Notice about governing law 208
SECTION 2 Notice about nondiscrimination 208
SECTION 3 Notice about Medicare Secondary Payer subrogation rights 208
SECTION 4 Binding Arbitration 208

CHAPTER 12: Definitions 212

CHAPTER 1: Get started as a member

SECTION 1 You're a member of SCAN Classic

Section 1.1 You're enrolled in SCAN Classic, which is a Medicare HMO

You're covered by Medicare, and you chose to get your Medicare health and your drug coverage through our plan, SCAN Classic. Our plan covers all Part A and Part B services. However, cost-sharing and provider access in this plan are different from Original Medicare.

SCAN Classic is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how SCAN Classic covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs* (formulary), and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for the months you're enrolled in SCAN Classic between January 1, 2027, and December 31, 2027.

Medicare allows us to make changes to our plans we offer each calendar year. This means we can change the costs and benefits of SCAN Classic after December 31, 2027. We can also choose to stop offering our plan in your service area, after December 31, 2027.

Medicare (the Centers for Medicare & Medicaid Services) must approve SCAN Classic each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare renews approval of our plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B.
- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be living in the geographic service area, even if they're physically located in it.
- You're a United States citizen or national, or an eligible noncitizen.

Section 2.2 Plan service area for SCAN Classic

SCAN Classic is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our service area. The service area is described below.

Our service area includes these counties in Arizona: Maricopa, Pima, and Pinal Counties.

If you move out of our plan's service area, you can't stay a member of this plan. Call Member Services at 1-855-650-7226 (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 2.3 U.S. citizen or national, or eligible noncitizen

You must be a U.S. citizen or national, or an eligible noncitizen to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify SCAN Classic if you're not eligible to stay a member of our plan on this basis. SCAN Classic must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan and for prescription drugs you get at network pharmacies. You should also show the provider your AHCCCS (Medicaid) card, if you have one. Sample plan membership card:

DON'T use your red, white, and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your SCAN Classic membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card

in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials).

If our plan membership card is damaged, lost, or stolen, call Member Services at 1-855-650-7226 (TTY users call 711) right away and we'll send you a new card.

Section 3.2 *Provider & Pharmacy Directory*

The *Provider & Pharmacy Directory* www.scanhealthplan.com lists our current network providers. **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization, you'll have to pay in full. The only exceptions are emergencies, urgently needed services when the network isn't available (that is, situations when it's unreasonable or not possible to get services in network), out-of-area dialysis services, and cases when SCAN Classic authorizes use of out-of-network providers.

Get the most recent list of providers on our website at www.scanhealthplan.com.

If you don't have a *Provider & Pharmacy Directory*, you can ask for a copy (electronically or in paper form) from Member Services at 1-855-650-7226 (TTY users call 711). Requested paper *Provider & Pharmacy Directories* will be mailed to you within 3 business days.

The *Provider & Pharmacy Directory* www.scanhealthplan.com/scan-members/member-benefit-materials-and-information/provider-and-pharmacy-directory lists our network pharmacies. **Network pharmacies** are pharmacies that agree to fill covered prescriptions for our plan members. Use the *Provider & Pharmacy Directory* to find the network pharmacy you want to use. Go to Chapter 5, Section 2.4 for information on when you can use pharmacies that aren't in our plan's network.

The *Provider & Pharmacy Directory* also shows which pharmacies in our network have preferred cost-sharing, which may be lower than the standard cost-sharing offered by other network pharmacies for some drugs.

If you don't have a *Provider & Pharmacy Directory*, you can ask for a copy from Member Services at 1-855-650-7226 (TTY users call 711). You can also find this information on our website at www.scanhealthplan.com/scan-members/member-benefit-materials-and-information/provider-and-pharmacy-directory.

Section 3.3 Drug List (formulary)

Our plan has a *List of Covered Drugs* (also called the Drug List or formulary). It tells which prescription drugs are covered under the Part D benefit included in SCAN Classic. The drugs on this list are selected by our plan, with the help of doctors and pharmacists. The Drug List meets all Medicare requirements. Drugs included in the Medicare Drug Price Negotiation

Program will be included on your Drug List unless they have been removed or replaced as described in Chapter 5, Section 6. Medicare approved the SCAN Classic Drug List.

The Drug List also tells if there are any rules that restrict coverage for a drug.

We'll give you a copy of the Drug List. To get the most complete and current information about which drugs are covered, visit (www.scanhealthplan.com/scan-members/member-benefit-materials-and-information/formulary-documents) or call Member Services at 1-855-650-7226 (TTY users call 711).

SECTION 4 Summary of Important Costs for 2027

	Your Costs in 2027
Monthly plan premium* * Your premium can be higher than this amount. Go to Section 4.1 for details.	**$0**
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered Part A and Part B services. (Go to Chapter 4, Section 1 for details.)	**$2,000**
Primary care office visits	**$0 per visit**
Specialist office visits	**$0 per visit**
Inpatient hospital stays Includes various inpatient hospital stays such as acute care rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	**$75 copayment per day for days 1-5 and** **$0 copayment per day for days 6 and beyond.**
Part D drug coverage (Go to Chapter 6 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	**Part D drug coverage deductible** **$0**

	Your Costs in 2027
Part D drug coverage (continued)	**Copayment/Coinsurance during the Initial Coverage Stage:** **Drug Tier 1:** **$7 per prescription** **(*Standard cost-sharing* 30-day supply)** **$0 per prescription** **(*Preferred cost-sharing* 30-day supply)** **Drug Tier 2:** **$15 per prescription** **(*Standard cost-sharing* 30-day supply)** **$0 per prescription** **(*Preferred cost-sharing* 30-day supply)** **Drug Tier 3:** **$47 per prescription for other drugs** **(*Standard cost-sharing* 30-day supply)** **You pay no more than $35 per month supply of each covered insulin product on this tier.** **(*Standard cost-sharing* 30-day supply)** **$42 per prescription for other drugs** **(*Preferred cost-sharing* 30-day supply)** **You pay no more than $35 per month supply of each covered insulin product on this tier.** **(*Preferred cost-sharing* 30-day supply)** **Drug Tier 4:** **35% of the total cost** **(*Standard cost-sharing* 30-day supply)** **35% of the total cost** **(*Preferred cost-sharing* 30-day supply)** **Drug Tier 5:** **33% of the total cost** **(*Standard cost-sharing* 30-day supply)** **33% of the total cost** **(*Preferred cost-sharing* 30-day supply)**

	Your Costs in 2027
Part D drug coverage (continued)	**Catastrophic Coverage Stage:** **During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.**

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)
- Medicare Prescription Payment Plan Amount (Section 4.5)

Section 4.1 Plan premium

You don't pay a separate monthly plan premium for SCAN Classic.

We sent you a separate document, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, call Member Services at 1-855-650-7226 (TTY users call 711) and ask for the *LIS Rider*.

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums, check your copy of the *Medicare & You 2027* handbook, the section called *2027 Medicare Costs*. Download a copy from the Medicare website (Medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

You must continue paying your Medicare premiums to stay a member of our plan. This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

Section 4.3 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there was a period of 63 days or more in a row when you didn't have Part D or other creditable drug coverage. Creditable drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at

least as much as Medicare's standard drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable drug coverage. You'll generally have to pay this penalty for as long as you have Part D coverage.

When you first enroll in SCAN Classic, we let you know the amount of the penalty. If you don't pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

You **don't** have to pay the Part D late enrollment penalty if:

- You get Extra Help from Medicare to help pay your drug costs.
- You went less than 63 days in a row without Part D or other creditable coverage.
- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or in a newsletter from that plan. Keep this information because you may need it if you join a Medicare drug plan later.
    - **Note:** Any letter or notice must state that you had creditable prescription drug coverage that's expected to pay as much as Medicare's standard drug plan pays.
    - **Note:** Prescription drug discount cards, free clinics, and drug discount websites aren't creditable prescription drug coverage.

Medicare determines the amount of the Part D late enrollment penalty. Here's how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, our plan will count the number of full months you didn't have coverage.
- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2027, this average premium amount is $41.33.
- To calculate your monthly penalty, Medicare multiplies the number of uncovered months (penalty percentage) by 1% of the national base beneficiary premium and then rounds that amount to the nearest 10 cents. For example, if you go 14 months without Part D or other creditable coverage, the penalty would be 14% times $41.33, which equals $5.79. This rounds to $5.80. This amount would be added **to the monthly plan premium for someone with a Part D late enrollment penalty**.

Three important things to know about the monthly Part D late enrollment penalty:

- **The penalty may change each year** because the national base beneficiary premium can change each year.
- **You'll generally continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you're *under* 65 and enrolled in Medicare, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on

the months you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a reconsideration (appeal) of the penalty. The reconsideration is conducted by an independent review organization that is not connected with us. Generally, you must ask for this reconsideration **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you generally won't have another chance to ask for a reconsideration of that late enrollment penalty.

Important: Don't stop paying your Part D late enrollment penalty while you're waiting for a reconsideration of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit Medicare.gov/health-drug-plans/part-d/basics/costs.

If you have to pay an extra IRMAA, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you'll get a bill from Medicare. **You must pay the extra IRMAA to the government. It can't be paid with your monthly plan premium. If you don't pay the extra IRMAA, you'll be disenrolled from our plan and lose prescription drug coverage.**

If you disagree about paying an extra IRMAA, you can ask Social Security to review the decision. To find out how to do this, call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 4.5 Medicare Prescription Payment Plan Amount

If you're participating in the Medicare Prescription Payment Plan, each month you'll pay your plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 9 to make a complaint or appeal.

SECTION 5 More information about your monthly plan premium

Section 5.1 How to pay your Part D late enrollment penalty

There are 4 ways you can pay the penalty. You can set up your payment method of choice by calling SCAN Member Services (phone numbers for Member Services are printed on the back cover of this document). You can also make payments online by going to www.scanhealthplan.com/members/register and registering your SCAN member account online.

Option 1: Pay by check

You will receive a SCAN Health Plan statement in the mail each month. Simply tear off the payment stub and send it along with your payment to us in the envelope provided to: SCAN Health Plan, P.O. Box 511354, Los Angeles, CA 90051-7909. Your payment will be due the 1st of each month. Please make the check payable to "SCAN Health Plan," not Centers for Medicare and Medicaid Services (CMS) or Health and Human Services (HHS).

Option 2: You can have the Part D late enrollment penalty withdrawn from your bank account

You can have your Part D late enrollment penalty automatically withdrawn from your checking or savings account each month. The program is free and eliminates the need for you to send a check every month. To choose this option, please contact Member Services. We will be happy to help you set this up. Generally, we will withdraw the payment from your bank account on the 1st of each month. (Phone numbers for Member Services are printed on the back cover of this document.)

Option 3: You can pay your Part D late enrollment penalty by credit card or debit card

You can have the Part D late enrollment penalty charged to your credit card or debit card each month. To choose this option, please contact Member Services. We will be happy to help you set this up. Generally, we will charge your credit card or debit card on the 1st of each month.

Option 4: Have Part D late enrollment penalty deducted from your monthly Social Security check

Changing the way you pay your Part D late enrollment penalty. If you decide to change how you pay your Part D late enrollment penalty, it can take up to 3 months for your new payment method to take effect. While we process your new payment method, you're still responsible for making sure your Part D late enrollment penalty is paid on time. To change your payment method, you can set up your payment method of choice by calling SCAN Member Services (phone numbers for Member Services are printed on the back cover of this document). You

can also make payments online by going to www.scanhealthplan.com/members/register and registering your SCAN member account online.

If you have trouble paying your Part D late enrollment penalty

Your Part D late enrollment penalty is due in our office by the 1st of each month. If we don't get your payment by the 1st of each month, we'll send you a notice letting you know your plan membership will end if we don't get your Part D late enrollment penalty, if owed, within three calendar months. If you owe a Part D late enrollment penalty, you must pay the penalty to keep your drug coverage.

If you have trouble paying your Part D late enrollment penalty, if owed, on time, call Member Services at 1-855-650-7226 (TTY users call 711) to see if we can direct you to programs that will help with your costs.

If we end your membership because you didn't pay your Part D late enrollment penalty, if owed, you'll have health coverage under Original Medicare. You may not be able to get Part D drug coverage until the following year if you enroll in a new plan during the Open Enrollment Period. (If you go without creditable drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

At the time we end your membership, you may still owe us for unpaid penalties. We have the right to pursue collection of the amount you owe. If you want to enroll again in our plan (or another plan that we offer) in the future, you'll need to pay the amount you owe before you can enroll.

If you think we wrongfully ended your membership, you can make a complaint (also called a grievance). If you had an emergency circumstance out of your control that made you unable to pay your Part D late enrollment penalty, if owed, within our grace period, you can make a complaint. For complaints, we'll review our decision again. Go to Chapter 9 to learn how to make a complaint or call us at 1-855-650-7226 between October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week, April 1 to September 30, 8 a.m. to 8 p.m., Monday through Friday. TTY users call 711. You must make your complaint no later than 60 calendar days after the date your membership ends.

Section 5.2 Your monthly plan premium won't change during the year

We're not allowed to change our plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year, we'll tell you in September and the new premium will take effect on January 1.

However, in some cases, you may be able to stop paying a late enrollment penalty, if you owe one, or you may need to start paying a late enrollment penalty.

- If you currently pay a Part D late enrollment penalty and become eligible for Extra Help during the year, you'd be able to stop paying your penalty.

- If you lose Extra Help, you may be subject to the Part D late enrollment penalty if you disenroll from your plan and go 63 days or more in a row without Part D or other creditable prescription drug coverage.

Find out more about Extra Help in Chapter 2, Section 7.

SECTION 6 Keep your plan membership record up to date

Your membership record has information from your enrollment form, including your address and phone number. It shows your specific plan coverage including your Primary Care Provider and Medical Group or Independent Practice Association (IPA). A Medical Group is a group of physicians and other healthcare providers under contract to provide services to members of SCAN Health Plan. An IPA is an independent group of physicians and other healthcare providers under contract to provide services to members of SCAN Health Plan.

The doctors, hospitals, pharmacists, and other providers in your plan's network **use your membership record to know what services and drugs are covered and your cost-sharing amounts**. Because of this, it's very important you help to keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or AHCCCS (Medicaid))
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you participate in a clinical research study (**Note:** You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling Member Services at 1-855-650-7226 (TTY users call 711). You can also change your address and phone number online by going to www.scanhealthplan.com/members/register and registering your SCAN member account online.

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read over this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Member Services at 1-855-650-7226 (TTY users call 711). You may need to give your plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first ("the primary payer") pays up to the limits of its coverage. The insurance that pays second ("secondary payer") only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or end-stage renal disease (ESRD):
    - If you're under 65 and disabled and you (or your family member) are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
    - If you're over 65 and you (or your spouse or domestic partner) are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

CHAPTER 2:
Phone numbers and resources

SECTION 1 SCAN Classic contacts

For help with claims, billing, or member card questions, call or write to SCAN Classic Member Services. We'll be happy to help you.

Member Services – Contact Information	
Call	**1-855-650-7226** Calls to this number are free. Contact us October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week, April 1 to September 30, 8 a.m. to 8 p.m., Monday through Friday. **Note:** We are closed on most federal holidays. When we are closed you have an option to leave a message. Messages received on holidays and outside of our business hours will be returned within one business day. Member Services also has free language interpreter services for non-English speakers.
TTY	**711** Calls to this number are free. Contact us October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week, April 1 to September 30, 8 a.m. to 8 p.m., Monday through Friday. **Note:** We are closed on most federal holidays. When we are closed you have an option to leave a message. Messages received on holidays and outside of our business hours will be returned within one business day.
Fax	**1-562-989-5181**
Write	**SCAN Health Plan** Attention: Member Services Department P.O. Box 22616 Long Beach, CA 90801-5616
Website	www.scanhealthplan.com

How to ask for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical services or Part D drugs. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care or Part D drugs, go to Chapter 9.

Coverage Decisions for Medical Care – Contact Information	
Call	**1-855-650-7226** Calls to this number are free. Contact us October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week, April 1 to September 30, 8 a.m. to 8 p.m., Monday through Friday. **Note:** We are closed on most federal holidays. When we are closed you have an option to leave a message. Messages received on holidays and outside of our business hours will be returned within one business day.
TTY	**711** Calls to this number are free. Contact us October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week, April 1 to September 30, 8 a.m. to 8 p.m., Monday through Friday. **Note:** We are closed on most federal holidays. When we are closed you have an option to leave a message. Messages received on holidays and outside of our business hours will be returned within one business day.
Fax	**1-562-989-5181**
Write	**SCAN Health Plan** Attention: Member Services Department P.O. Box 22616 Long Beach, CA 90801-5616
Website	www.scanhealthplan.com

Coverage Decisions for Part D drugs – Contact Information	
Call	**1-844-424-8886** Calls to this number are free. A representative is available 24 hours a day, 7 days a week.
TTY	**1-800-716-3231** This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. A representative is available 24 hours a day, 7 days a week.
Fax	**1-877-251-5896** (Attention: Medicare Reviews)
Write	**Express Scripts, Inc.** Attention: Medicare Reviews P.O. Box 66571 St. Louis, MO 63166-6571
Website	www.express-scripts.com

Appeals for Medical Care – Contact Information	
Call	**1-855-650-7226** Calls to this number are free. Contact us October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week, April 1 to September 30, 8 a.m. to 8 p.m., Monday through Friday. **Note:** We are closed on most federal holidays. When we are closed you have an option to leave a message. Messages received on holidays and outside of our business hours will be returned within one business day.
TTY	**711** Calls to this number are free. Contact us October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week, April 1 to September 30, 8 a.m. to 8 p.m., Monday through Friday. **Note:** We are closed on most federal holidays. When we are closed you have an option to leave a message. Messages received on holidays and outside of our business hours will be returned within one business day.
Fax	**1-562-989-0958**
Write	**SCAN Health Plan** Attention: Grievance and Appeals Department P.O. Box 22644 Long Beach, CA 90801-5644
Website	www.scanhealthplan.com

Appeals for Part D drugs – Contact Information	
Call	**1-855-650-7226** Calls to this number are free. Contact us October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week, April 1 to September 30, 8 a.m. to 8 p.m., Monday through Friday. **Note:** We are closed on most federal holidays. When we are closed you have an option to leave a message. Messages received on holidays and outside of our business hours will be returned within one business day.
TTY	**711** Calls to this number are free. Contact us October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week, April 1 to September 30, 8 a.m. to 8 p.m., Monday through Friday. **Note:** We are closed on most federal holidays. When we are closed you have an option to leave a message. Messages received on holidays and outside of our business hours will be returned within one business day.
Fax	**1-562-989-0958**
Write	**SCAN Health Plan** Attention: Grievance and Appeals Department P.O. Box 22644 Long Beach, CA 90801-5644
Website	www.scanhealthplan.com

How to make a complaint about your medical care

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 9.

Complaints about Medical Care – Contact Information	
Call	**1-855-650-7226** Calls to this number are free. Contact us October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week, April 1 to September 30, 8 a.m. to 8 p.m., Monday through Friday. **Note:** We are closed on most federal holidays. When we are closed you have an option to leave a message. Messages received on holidays and outside of our business hours will be returned within one business day.
TTY	**711** Calls to this number are free. Contact us October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week, April 1 to September 30, 8 a.m. to 8 p.m., Monday through Friday. **Note:** We are closed on most federal holidays. When we are closed you have an option to leave a message. Messages received on holidays and outside of our business hours will be returned within one business day.
Fax	**1-562-989-0958**
Write	**SCAN Health Plan** Attention: Grievance and Appeals Department P.O. Box 22644 Long Beach, CA 90801-5644
Medicare website	To submit a complaint about SCAN Classic directly to Medicare, go to Medicare.gov/my/medicare-complaint.

Complaints about Part D drugs – Contact Information	
Call	**1-855-650-7226** Calls to this number are free. Contact us October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week, April 1 to September 30, 8 a.m. to 8 p.m., Monday through Friday. **Note:** We are closed on most federal holidays. When we are closed you have an option to leave a message. Messages received on holidays and outside of our business hours will be returned within one business day.
TTY	**711** Calls to this number are free. Contact us October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week, April 1 to September 30, 8 a.m. to 8 p.m., Monday through Friday. **Note:** We are closed on most federal holidays. When we are closed you have an option to leave a message. Messages received on holidays and outside of our business hours will be returned within one business day.
Fax	**1-562-989-0958**
Write	**SCAN Health Plan** Attention: Grievance and Appeals Department P.O. Box 22644 Long Beach, CA 90801-5644
Medicare website	To submit a complaint about SCAN Classic directly to Medicare, go to Medicare.gov/my/medicare-complaint.

How to ask us to pay our share of the cost for medical care or a drug you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 7 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 9 for more information.

Payment Requests – Contact Information	
Call	**1-855-650-7226** Calls to this number are free. Contact us October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week, April 1 to September 30, 8 a.m. to 8 p.m., Monday through Friday. **Note:** We are closed on most federal holidays. When we are closed you have an option to leave a message. Messages received on holidays and outside of our business hours will be returned within one business day.
TTY	**711** Calls to this number are free. Contact us October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week, April 1 to September 30, 8 a.m. to 8 p.m., Monday through Friday. **Note:** We are closed on most federal holidays. When we are closed you have an option to leave a message. Messages received on holidays and outside of our business hours will be returned within one business day.
Fax	**1-562-989-5181**
Write	**SCAN Health Plan** Attention: Member Services Department P.O. Box 22616 Long Beach, CA 90801-5616
Website	www.scanhealthplan.com

SECTION 2 Get help from Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with Medicare Advantage organizations including our plan.

Medicare – Contact Information	
Call	**1-800-MEDICARE (1-800-633-4227)** Calls to this number are free. 24 hours a day, 7 days a week.
TTY	**1-877-486-2048** This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at Medicare.gov/talk-to-someone.
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit Medicare.gov to tell Medicare about any complaints you have about SCAN Classic.

Medicare – Contact Information	
	To submit a complaint to Medicare, go to Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In Arizona, the SHIP is called Arizona State Health Insurance Assistance Program (SHIP).

Arizona State Health Insurance Assistance Program (SHIP) is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Arizona State Health Insurance Assistance Program (SHIP) counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and straighten out problems with your Medicare bills. Arizona State Health Insurance Assistance Program (SHIP) counselors can also help you with Medicare questions or problems, help you understand your Medicare plan choices, and answer questions about switching plans.

Arizona State Health Insurance Assistance Program (SHIP) (Arizona's SHIP) – Contact Information	
Call	**1-800-432-4040**
Write	Division of Aging and Adult Services Arizona Department of Economic Security 1789 West Jefferson, Site Code 950A Phoenix AZ 85007
Website	azship.org

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For Arizona, the Quality Improvement Organization is called Commence Health.

Commence Health has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. Commence Health is an independent organization. It's not connected with our plan.

Contact Commence Health in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

Commence Health (Arizona's Quality Improvement Organization) – Contact Information	
Call	**1-877-588-1123** Monday through Friday, 9 a.m. to 5 p.m.; Saturday, Sunday, and holidays, 10 a.m. to 4 p.m.
TTY	**1-855-887-6668** This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	**Commence Health LLC** BFCC-QIO Area 9 10820 Guilford Rd, Suite 202 Annapolis Junction, MD 20701-1105
Website	www.livantaqio.cms.gov

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment. Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, contact Social Security to let them know.

Social Security – Contact Information	
Call	**1-800-772-1213** Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	**1-800-325-0778** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 am to 7 pm, Monday through Friday.
Website	SSA.gov

SECTION 6 Arizona Health Care Cost Containment System (AHCCCS) (Medicaid)

AHCCCS (Medicaid) is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for AHCCCS (Medicaid). Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full AHCCCS (Medicaid) benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full AHCCCS (Medicaid) benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about AHCCCS (Medicaid) and Medicare Savings Programs, contact the Arizona Health Care Cost Containment System (AHCCCS).

Arizona Health Care Cost Containment System (AHCCCS) – Contact Information	
Call	**AHCCCS** **1-855-432-7587** Monday through Friday, 8 a.m. to 5 p.m.; excluding state holidays
TTY	**1-800-842-6520**
Write	**AHCCCS** 150 N. 18th Ave Phoenix, AZ 85007
Website	www.azahcccs.gov

SECTION 7 Programs to help people pay for prescription drugs

The Medicare website (Medicare.gov/basics/costs/help/drug-costs) has information on ways to lower your prescription drug costs. The programs below can help people with limited incomes.

Extra Help from Medicare

Medicare and Social Security have a program called Extra Help that can help pay drug costs for people with limited income and resources. If you qualify, you get help paying for your Medicare drug plan's monthly plan premium, yearly deductible, and copayments. Extra Help also counts toward your out-of-pocket costs.

If you automatically qualify for Extra Help, Medicare will mail you a purple letter to let you know. If you don't automatically qualify, you can apply anytime. To see if you qualify for getting Extra Help:

- Visit https://secure.ssa.gov/i1020/start to apply online
- Call Social Security at 1-800-772-1213. TTY users call 1-800-325-0778.

When you apply for Extra Help, you can also start the application process for a Medicare Savings Program (MSP). These state programs provide help with other Medicare costs. Social Security will send information to your state to initiate an MSP application, unless you tell them not to on the Extra Help application.

If you qualify for Extra Help and you think that you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help you get evidence of the right copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

- If you would like to request assistance with obtaining best available evidence and for providing this evidence, please contact Member Services (phone numbers are printed on the back cover of this document).
- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make the payment directly to the state. Call Member Services at 1-855-650-7226 (TTY users call 711) if you have questions.

What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the Arizona Department of Health Services.

Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of state residence and HIV status, low income (as defined by the state), and uninsured/ under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call 1-800-334-1540 or 1-602-364-3610.

Arizona Department of Health Services - AIDS Drug Assistance Program (ADAP)
150 N. 18th Ave
Phoenix, AZ 85007
1-800-334-1540 or 1-602-364-3610 (Phone)
1-602-364-3263 (Fax)
www.azdhs.gov/phs/hiv/adap/index.htm

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across **the calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027; you do not need to submit a new election request to continue participating in 2027.** To learn more about this payment option, call Member Services at 1-866-845-1803 (TTY users call 1-800-716-3231) or visit Medicare.gov.

Medicare Prescription Payment Plan – Contact Information	
Call	**1-866-845-1803** Calls to this number are free. Our hours are 24 hours a day, 7 days a week. Member Services also has free language interpreter services for non-English speakers.
TTY	**1-800-716-3231** This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Our hours are 24 hours a day, 7 days a week.
Write	Express Scripts Medicare Prescription Payment Plan P.O. Box 2 Saint Louis, MO 63166
Website	https://www.express-scripts.com/mppp

SECTION 8 Railroad Retirement Board (RRB)

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information	
Call	**1-877-772-5772** Calls to this number are free. Press "0" to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press "1" to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	**1-312-751-4701** This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren't free.
Website	https://RRB.gov

SECTION 9 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Services at 1-855-650-7226 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

If you have other drug coverage through your (or your spouse or domestic partner's) employer or retiree group, contact **that group's benefits administrator.** The benefits administrator can help you understand how your current drug coverage will work with our plan.

CHAPTER 3:
Using our plan for your medical services

SECTION 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered. For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **Covered services** include all the medical care, health care services, supplies, equipment, and prescription drugs that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

Section 1.2 Basic rules for your medical care to be covered by our plan

As a Medicare health plan, SCAN Classic must cover all services covered by Original Medicare and follow Original Medicare’s coverage rules.

SCAN Classic will generally cover your medical care as long as:

- **The care you get is included in our plan’s Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary**. Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.1 for more information).
    - In most situations, your network PCP or our plan must give you approval in advance (a referral) before you can use other providers in our plan’s network, such as

specialists, hospitals, skilled nursing facilities, or home health care agencies. For more information, go to Section 2.3.

- You don't need referrals from your PCP for emergency care or urgently needed services. To learn about other kinds of care you can get without getting approval in advance from your PCP, go to Section 2.2.

- **You must get your care from a network provider** (go to Section 2). In most cases, care you get from an out-of-network provider (a provider who's not part of our plan's network) won't be covered. This means you have to pay the provider in full for services you get. Here are 3 exceptions:
  - Our plan covers emergency care or urgently needed services you get from an out-of-network provider. For more information, and to see what emergency or urgently needed services are, go to Section 3.
  - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost-sharing you normally pay in-network. You must obtain authorization before seeking out-of-network care. Your PCP can assist you with obtaining authorization. In this situation, you pay the same as you'd pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, go to Section 2.4.
  - Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never be higher than the cost sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider that's outside our plan's network, your cost sharing can't be higher than the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network, your cost sharing for the dialysis may be higher.

SECTION 2 Use providers in our plan's network to get medical care

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care

What is a PCP and what does the PCP do for you?

Your PCP is a provider who meets state requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a member of our Plan. For example, in order for you to see a specialist, you will usually need to get your PCP's approval first (this is called getting a "referral" to a specialist). Your PCP will provide most of your care and will help you arrange or coordinate the rest of the covered services you get as a member of our Plan.

This includes:

- X-rays
- Laboratory tests
- Therapies
- Care from providers who are specialists
- Hospital admissions, and
- Follow-up care

“Coordinating” your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, you must get written approval in advance from your PCP (such as giving you a referral to see a specialist). In some cases, your PCP will need to get prior authorization (prior approval) from SCAN Health Plan or your PCP’s medical group. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP’s office.

There are several types of providers that may serve as your PCP. These include: Family Practice, General Practice and Internal Medicine.

How to choose a PCP

To view a list of available PCPs, please review our *Provider & Pharmacy Directory* or visit our website at www.scanhealthplan.com. After you have reviewed the list of available providers in your area, please call Member Services (phone numbers are printed on the back cover of this document).

Please note: If you do not select a PCP within 30 days of your enrollment, SCAN Health Plan will assign you a PCP.

Your relationship with your PCP is an important one. That’s why we strongly recommend that you choose a PCP close to your home. Having your PCP nearby makes receiving medical care and developing a trusting and open relationship that much easier. It is important to schedule your initial health assessment appointment with your new PCP within 90 days of enrollment. This provides your PCP with a baseline of information for treating you.

Each plan PCP has certain plan specialists they use for referrals. This means that the PCP you select may determine the specialists you may see.

How to change your PCP

You can change your PCP for any reason, at any time. It’s also possible that your PCP might leave our plan’s network of providers, and you’d need to choose a new PCP.

If you wish to change your PCP within your contracted medical group or Independent Practice Association (IPA), this change will be effective on the first of the following month. If you wish to change your PCP to one affiliated with a different contracted medical group or IPA, your

request must be received on or before the 20th of the month. The change will then be effective the first of the following month. To change your PCP, call Member Services (phone numbers are printed on the back cover of this document).

When changing your PCP that is affiliated with a different medical group, it may result in being limited to specific specialists or hospitals to which the PCP refers (i.e., sub-network, referral circles).

When you call, be sure to tell Member Services if you are seeing specialists or obtaining other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Member Services will confirm if the specialty provider is part of the medical group or Independent Practice Association (IPA) you selected and will help make sure that you can continue with the specialty care and other services you have been obtaining when you change your PCP if they are not part of the provider network. They will also check to be sure the PCP you want to switch to is accepting new patients.

Member Services will tell you when the change to your new PCP will take effect. They will also send you a new membership card that shows the name and phone number of your new PCP.

Sometimes a network provider you are using might leave the plan. If this happens, you will have to switch to another provider who is part of our plan. You can call Member Services to assist you in finding and selecting another provider or we will select another PCP within your contracted medical group or Independent Practice Association (IPA) for you. You always have the option to call us to change your PCP if you are not happy with the PCP we select for you.

Section 2.2 Medical care you can get without a PCP referral

You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, including breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider
- Flu shots, COVID-19 vaccines, Hepatitis B vaccines, and pneumonia vaccines as long as you get them from a network provider
- Emergency services from network providers or from out-of-network providers
- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area. If possible, call Member Services at

1-855-650-7226 (TTY users call 711) before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. For example:

- Oncologists care for patients with cancer
- Cardiologists care for patients with heart conditions
- Orthopedists care for patients with certain bone, joint, or muscle conditions

It is very important to get a written referral (approval in advance) from your PCP before you see a plan specialist or certain other providers (there are a few exceptions, listed in Section 2.2 above). If you don't have a written referral (approval in advance) before you get services from a specialist, you may have to pay for these services yourself.

For some types of referrals, your PCP may need to get approval in advance from SCAN Health Plan (this is called getting "prior authorization"). Prior authorization is approval in advance to get services. Some in-network medical services are covered only if your doctor or other network provider obtains "prior authorization" from our plan. Covered services that need prior authorization are marked by a footnote in the Benefits Chart in Chapter 4, Section 2.

If the specialist wants you to come back for more care, check first to be sure that the referral (approval in advance) you got from your PCP for the first visit covers more visits to the specialist.

If there are specific specialists you want to use, find out whether your PCP sends patients to these specialists. Each plan's PCP has certain plan specialists they use for referrals. This means that the PCP you select may determine the specialists you may see. If there are specific hospitals you want to use, you must first find out whether your PCP uses these hospitals.

When a specialist or another network provider leaves our plan

We may make changes to the hospitals, doctors, and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
    - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.

- If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.

- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing. Authorization may be required.
- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 9).

Section 2.4 How to get care from out-of-network providers

SCAN Classic does not cover out-of-network services rendered with the exceptions of the following:

- Emergency care or urgently needed services that you get from an out-of-network provider. This includes worldwide coverage if covered by your plan.
- If you need medical care that Medicare requires our plan to cover and providers in our network cannot provide this care, you can get this care from an out-of-network provider. For these types of referrals you must obtain authorization before seeking care. Your PCP can assist you with obtaining authorization. In this situation, we will cover these services as if you got the care from a network provider. If you do not have a prior authorization before you receive services from an out-of-network provider, you may have to pay for these services yourself.
- Renal dialysis services when you are temporarily outside the service area, or when prior authorized.

(For information about this, see Section 2.1 and Section 2.3 of this chapter). To obtain information on these places of service, please call Member Services (phone numbers are printed on the back cover of this document).

SECTION 3 How to get services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical emergency

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're not part of our network. Our plan also covers emergency services worldwide as long as the reason for receiving care meets the definition of medical emergency that is given above. Please refer to Chapter 4 for more information.
- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Contact information can be found in Chapter 2, and on the back cover page of this document.

Covered services in a medical emergency

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors giving you emergency care will decide when your condition is stable and when the medical emergency is over.

After the emergency is over, you're entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan.

If your emergency care is provided by out-of-network providers, we'll try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow. If you need emergency care in a U.S. territory outside of the U.S., present your SCAN member card so the provider can bill SCAN directly. Follow-up care after the emergency is not covered outside of the U.S. or its territories.

If you receive emergency or urgently-needed services outside of the U.S. or its territories, you generally will be required to pay the bill at the time you receive the services. Most foreign

providers are not eligible to receive reimbursement directly from Medicare or SCAN, nor will they accept reimbursement from Medicare or SCAN and will ask you to pay for the services directly.

It is your responsibility to provide SCAN a written statement of events, medical records (where possible), detailed bill or receipt showing the specific services provided to you. Send a copy of the itemized bill or an itemized receipt for us to reimburse you for the covered services. SCAN reimburses you **at the Original Medicare reimbursement rates** less any cost sharing for services you received. This means you may receive less reimbursement than what you paid for the services. You should be prepared to assist us in obtaining any additional information necessary to properly process your request for reimbursement, including medical records.

SCAN will reimburse you for services needed during the emergency, including ambulance services from the point of the emergency to the nearest medical facility or provider. SCAN will **not** cover transportation from the foreign location back to the U.S.

You should contact SCAN if your emergency requires you to stay in the hospital for one or more nights or requires a surgical procedure. Notification should happen as soon as possible once you are stable. You can find SCAN's Member Services phone number on the back of your Member Card.

Follow up care, prescriptions taken while in the U.S., and routine care are not covered when traveling.

A medical travel insurance policy would protect you from paying higher out-of-pocket medical expenses for services not covered by your health plan and cover unforeseen medical expenses incurred while traveling internationally. It is encouraged to purchase a medical travel insurance policy prior to traveling outside of the country. If you have an emergency and purchase travel insurance, include your policy when submitting your documentation for reimbursement. SCAN will be able to coordinate payment with the insurance carrier.

Worldwide emergency and urgent care coverage is not covered by Original Medicare and is considered a supplemental benefit. SCAN will reimburse for covered out-of-network emergency and urgent care services outside of the U.S. and its territories **at Original Medicare reimbursement rates**. You will be responsible for any costs above what Original Medicare would pay, and your portion of cost-sharing for the services you received.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care—thinking that your health is in serious danger—and the doctor may say that it wasn't a medical emergency after all. If it turns out that it wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

However, after the doctor says it wasn't an emergency, we'll cover additional care *only* if you get the additional care in one of these 2 ways:

- You go to a network provider to get the additional care, or

- The additional care you get is considered urgently needed services and you follow the rules below for getting this urgent care.

Section 3.2 Get care when you have an urgent need for services

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits such as annual checkups aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

You can access urgently needed services four (4) ways:

- An in-person visit to an urgent care center
    - While you can go to any urgent care center, you should go to the urgent care center that your doctor works with, when you are in your plan's service area. Ask your doctor for a list of urgent care centers he or she works with before you need to go to one.
- A telephonic visit using Nurse Advice Line at $0 copayment. Please refer to Nurse Advice Line in the Medical Benefits Chart in Chapter 4.
- A virtual visit if offered by your medical group (you will pay your office visit copay for a virtual visit). Ask your doctor if virtual visits are offered, and how to access them, before you need it.
- A virtual Urgent Care Telehealth visit at $0 copayment. Please refer to Urgent Care Telehealth under Telehealth Services in the Medical Benefits Chart in Chapter 4.

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances: emergency services, including emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. Transportation back to the United States from another country is **not** covered. Pre-scheduled, pre-planned treatments (including chronic dialysis) for any ongoing known conditions and/or elective procedures are **not** covered. Any follow-up care including after-care, rehabilitation, physician visits, and skilled nursing facility stay are **not** considered emergent or urgently needed care and are **not** covered.

If you receive emergency or urgently-needed services outside of the U.S. or its territories, you generally will be required to pay the bill at the time you receive the services. Most foreign providers are not eligible to receive reimbursement directly from Medicare or SCAN, nor will they accept reimbursement from Medicare or SCAN and will ask you to pay for the services directly. Ask for a written, detailed bill or receipt showing the specific services provided to you. Send a copy of the itemized bill or an itemized receipt for us to reimburse you for the covered services **at the Original Medicare reimbursement rates** less any cost sharing for services you

received. You should be prepared to assist us in obtaining any additional information necessary to properly process your request for reimbursement, including medical records.

A medical travel insurance policy would protect you from paying higher out-of-pocket medical expenses for services not covered by your health plan and cover unforeseen medical expenses incurred while traveling internationally. It is encouraged to purchase a medical travel insurance policy prior to traveling outside of the country.

Worldwide emergency and urgent care coverage is not covered by Original Medicare and is considered a supplemental benefit. SCAN will reimburse for covered out-of-network emergency and urgent care services outside of the U.S. and its territories **at Original Medicare reimbursement rates**. You will be responsible for any costs above what Original Medicare would pay, less any cost-sharing for the services you received.

Section 3.3 Get care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you're still entitled to care from our plan.

Visit www.scanhealthplan.com for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost-sharing. If you can't use a network pharmacy during a disaster, you may be able to fill your prescriptions at an out-of-network pharmacy. Go to Chapter 5, Section 2.4.

SECTION 4 What if you're billed directly for the full cost of covered services?

If you paid more than our plan cost-sharing for covered services, or if you get a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 7 for information about what to do.

Section 4.1 If services aren't covered by our plan, you must pay the full cost

SCAN Classic covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan or you get services out-of-network without authorization that are not emergency or urgently needed services, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. Once a covered medical benefit limit is reached, any additional medical expenses incurred will not count toward your maximum out-of-pocket limit. You can call Member Services when you want to know how much of your benefit limit you have already used.

SECTION 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us you're in a qualified clinical trial, you're only responsible for the in-network cost sharing for the services in that trial. If you paid more—for example, if you already paid the Original Medicare cost-sharing amount—we'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network. (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

While you don't need our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study not approved by Medicare, you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it's part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost-sharing in Original Medicare and your in-network cost-sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit

documentation showing how much cost-sharing you paid. Go to Chapter 7 for more information on submitting requests for payments.

> *Example of cost-sharing in a clinical trial:* Let's say you have a lab test that costs $100 as part of the research study. Your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would notify our plan that you got a qualified clinical trial service and submit documentation, (like a provider bill) to our plan. Our plan would then directly pay you $10. This makes your net payment for the test $10, the same amount you'd pay under our plan's benefits.

When you're in a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.
- Items or services provided only to collect data and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free of charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies*, available at Medicare.gov/coverage/clinical-research-studies. You can also call 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.

SECTION 6 Rules for getting care in a religious non-medical health care institution

Section 6.1 A religious non-medical health care institution

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we'll instead cover care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 How to get care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you're conscientiously opposed to getting medical treatment that is **non-excepted**.

- **Non-excepted** medical care or treatment is any medical care or treatment that's *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment you get that's *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan only covers *non-religious* aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - – *and* – you must get approval in advance from our plan before you're admitted to the facility, or your stay won't be covered.

You are covered up to 90 days per benefit period from a religious non-medical health care provider. You will pay the same cost share as inpatient hospital care. Please refer to the Medical Benefits Chart in Chapter 4.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of SCAN Classic, you usually won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan.** You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count towards these 13 payments.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don't count.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage SCAN Classic will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave SCAN Classic or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

What happens if you leave our plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for applicable cost-sharing for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of SCAN Classic. This section also gives information about medical services that aren't covered and explains limits on certain services. Go to the Addenda in Section 4 of this chapter for additional information on limitations and exclusions.

Section 1.1 Out-of-pocket costs you may pay for covered services

Types of out-of-pocket costs you may pay for covered services include:

- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance:** the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart tells you more about your coinsurance.)

Most people who qualify for AHCCCS (Medicaid) or for the Qualified Medicare Beneficiary (QMB) program don't pay deductibles, copayments, or coinsurance. If you're in one of these programs, be sure to show your proof of AHCCCS (Medicaid) or QMB eligibility to your provider.

Section 1.2 What's the most you'll pay for Medicare Part A and Part B covered medical services?

Medicare Advantage Plans have limits on the total amount you have to pay out of pocket each year for in-network medical services covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2027 the MOOP amount is $2,000.**

The amounts you pay for copayments, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for your late enrollment penalty, if any, and for your Part D prescription drugs don't count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of $2,000, you won't 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 the Medicare Part B premium (unless your Part B premium is paid for you by AHCCCS (Medicaid) or another third party).

Section 1.3 Providers aren't allowed to balance bill you

As a member of SCAN Classic, you have an important protection because you only have to pay your cost-sharing amount when you get services covered by our plan. Providers can't bill you for additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service, and even if there's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works:

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15.00), you pay only that amount for any covered services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
    - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
    - If you get covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or for urgently needed services outside the service area.)
- If you think a provider has balance billed you, call Member Services at 1-855-650-7226 (TTY users call 711).

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services SCAN Classic covers and what you pay out of pocket for each service (Part D drug coverage is in Chapter 5). The services listed in the Medical Benefits Chart are covered only when these are met:

- Your Medicare-covered services must be provided according to the Medicare coverage guidelines.

- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- You get your care from a network provider. In most cases, care you get from an out-of-network provider won't be covered, unless it's emergency or urgent care or unless our plan or a network provider gave you a referral. This means you pay the provider in full for out-of-network services you get.
- You have a primary care provider (a PCP) providing and overseeing your care. In most situations, your PCP must give you approval in advance (a referral) before you can see other providers in our plan's network.
- Some services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization). Covered services that need approval in advance are marked in the Medical Benefits Chart by a footnote.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2027* handbook. View it online at Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.

This apple shows preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Covered Service	What you pay
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. Cost-sharing may apply for other services you receive during the visit. **Prior authorization rules may apply**
Acupuncture for chronic low back pain (Medicare-covered) Covered services include: Up to 12 visits in 90 days are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.) • Not associated with surgery • Not associated with pregnancy An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. **Provider Requirements:** Physicians may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,	$0 copayment for each office visit. **Prior authorization rules may apply**

Covered Service	What you pay
Acupuncture for chronic low back pain (Medicare-covered) (continued) • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations.	
Acupuncture services (Routine/Non-Medicare-covered)* You are covered for routine acupuncture services when they are medically necessary and provided by a contracted plan provider. Coverage is provided through participating providers in the plan's contracted network. Services received from non-contracted providers are not covered. **Coverage and Limits** • You are covered for up to 10 acupuncture visits per year • The annual visit limit is combined with routine (non-Medicare-covered) chiropractic services • Services must be determined to be medically necessary **Referrals and Prior Authorization** • A referral is not required for the initial acupuncture visit • Prior authorization is required for additional visits after the initial visit • Authorization requirements are managed through the contracted provider network **Important Information** • You must use contracted plan providers • This benefit does not apply toward your maximum out-of-pocket amount • Covered services include routine acupuncture treatments provided during an office visit Services not covered include treatment provided by non-contracted providers and services not determined to be medically necessary. *This benefit does not apply to your maximum out-of-pocket amount.	$20 copayment for each office visit for up to 10 visits per year (combined with routine/non-Medicare-covered chiropractic services). **Prior authorization rules may apply**

Covered Service	What you pay
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. Emergency ambulance services are covered worldwide. See Chapter 3, Section 3.1 for more information. A copayment will not apply to scheduled, non-emergency inter-facility transports such as: • From one acute hospital to another acute hospital • From an acute hospital to a Skilled Nursing Facility (SNF) • From a SNF to a medical facility that provides covered services or treatment not otherwise available at the SNF, including dialysis centers. (Urgent care and doctors' offices are not considered facilities for the purpose of this benefit.) Paramedic intercept services are covered under limited circumstances as defined by Medicare.	$250 copayment for each one-way trip. **Prior authorization rules apply for non-emergency ambulance services.**
Annual physical examination* You are covered for one routine physical examination per year. This exam includes screening laboratory services as needed. *This benefit does not apply to your maximum out-of-pocket amount.	$0 copayment for the office visit.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare*	There is no coinsurance, copayment, or deductible for the annual wellness visit. Cost-sharing may apply for other services you receive during the visit.

Covered Service	What you pay
Annual wellness visit (continued) visit to be covered for annual wellness visits after you've had Part B for 12 months.	
At-home support* SCAN members who are eligible can receive the at-home support service(s) below. For additional information regarding the scope of services supported, please refer to the At-Home Support page on the SCAN website. **Respite Care** Respite care provides temporary, in-home support that allows your full-time, unpaid caregiver to take time away from their caregiving responsibilities to attend to personal needs. To qualify for this benefit, the member must have a full-time, unpaid caregiver. If the member qualifies, SCAN will arrange for up to 20 hours of respite care per year in the member's home where the primary caregiving takes place. This service must be used in 4-hour increments and cannot exceed more than 8 hours in a single day. This benefit does not include services which require the caregiver to remain overnight, drive or operate the member's vehicle, handle the member's finances, provide skilled nursing services, perform heavy lifting, or provide care or services to other individuals in the home. **In-Home Care** In-home care provides support with activities of daily living such as bathing, dressing, bed-changing, and light housekeeping. To qualify for this benefit, the member must have documented record of 1 or more of the following: • Member needs assistance with 2 or more Activities of Daily Living (ADLs) • Member has been recently discharged from a hospital or skilled nursing facility • Member has recently undergone outpatient knee or hip surgery If the member qualifies, SCAN will arrange for up to 40 hours of in-home care visits per year. This service must be used in 4-hour increments and must be requested within 15 business	$0 copayment **Prior authorization rules may apply**

Covered Service	What you pay
At-home support* (continued) days of being discharged from the hospital or skilled nursing facility. This benefit does not include services which require the caregiver to drive or operate the member's vehicle, handle the member's finances, provide skilled nursing services, perform heavy lifting, or provide care or services to other individuals in the home. *This benefit does not apply to your maximum out-of-pocket amount.	
Best Buy Health Tech* Technology support benefit to help you use your computer, tablet, or smartphone to access healthcare services and health-related information. Covered services include: • Setting up devices and software • Troubleshooting software and system issues • Saving, transferring, and organizing important information • Assistance with accessing online health portals, account login issues, and password resets • General technical support and troubleshooting Services are available by phone, remote support, or in person at participating Best Buy locations. In-person visits must be scheduled in advance and are limited to four (4) visits per calendar year. To use the Tech Support Benefit, call 1-855-930-1692. This benefit does not cover the cost of home internet or any devices, equipment, or computer hardware or software. *This benefit does not apply to your maximum out-of-pocket amount.	$0 copayment
Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. **Prior authorization rules may apply**

Covered Service	What you pay
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms. You do not need a referral for an annual mammography screening within your network (1 exam every 12 months). Routine mammography screening does not include MRI. **Prior authorization rules may apply**
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's referral. Our plan covers these comprehensive programs if you've had at least one of these conditions: • Heart attack in the last 12 months • Coronary artery bypass surgery • Stable angina pectoris (chest pain) • Heart valve repair or replacement • Coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open) • Heart or heart and lung transplant • Stable chronic heart failure Coverage limitations: You can get up to 36 cardiac rehabilitation sessions. You can have 2 sessions per day (each lasting 1 hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period.	$20 copayment for each office visit. **Prior authorization rules may apply**

Covered Service	What you pay
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. **Prior authorization rules may apply**
Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years. **Prior authorization rules may apply**
Cervical and vaginal cancer screening Covered services include: • Pap tests and pelvic exams once every 24 months for all women • One pap test every 12 months if at high risk of cervical or vaginal cancer or if of childbearing age and have had an abnormal pap test within the past 3 years	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. You do not need a referral for a routine preventive care visit to an OB/GYN within your network. **Prior authorization rules may apply**
Chiropractic services (Medicare-covered) Covered services include: • We cover only manual manipulation of the spine to correct a vertebral subluxation Medicare-covered chiropractic services are covered only through your assigned medical group.	$0 copayment for each visit. **Prior authorization rules may apply**

Covered Service	What you pay
Chiropractic services (Routine/Non-Medicare-covered)* Routine chiropractic services cover necessary routine care provided by a licensed chiropractor. You are covered for up to 10 total visits per year, combined across routine chiropractic and routine acupuncture services. Services must be received from a SCAN Health Plan–contracted routine chiropractic provider. No referral is required for the first visit. Prior authorization is required for subsequent visits. *This benefit does not apply to your maximum out-of-pocket amount.	$20 copayment for each office visit for up to 10 visits per year, combined across routine chiropractic and routine acupuncture services. **Prior authorization rules may apply**
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, coverage of a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.	There is no coinsurance, copayment, or deductible for the colorectal cancer screening benefit. If during your screening, a diagnostic procedure is required, you will not be responsible for additional copayments. Virtual colonoscopy is not a covered procedure. **Prior authorization rules may apply**

Covered Service	What you pay
Colorectal cancer screening (continued) • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	
Dental services (Medicare-covered) In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. See the **"Services we do not cover (exclusions)"** section later in this chapter for information regarding additional dental procedures that are not covered.	$0 copayment for each office visit. **Prior Authorization Required for Dental Services (Medicare-covered)**
Dental services (Routine/Non-Medicare-covered)* In addition to the services noted above, SCAN Classic offers coverage for routine dental services as outlined within the **"Dental services (Routine/Non-Medicare-covered)"** section at the end of this chart. *This benefit does not apply to your maximum out-of-pocket amount.	See the **"Dental services (Routine/Non-Medicare-covered)"** section at the end of this chart for details. **Prior authorization rules may apply**
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible

Covered Service	What you pay
Depression screening (continued)	for an annual depression screening visit. **Prior authorization rules may apply**
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. **Prior authorization rules may apply**
Diabetes self-management training, diabetic services, and supplies For all people who have diabetes (insulin and non-insulin users), covered services include: • Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease**, one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes) including fitting • Diabetes self-management training under certain conditions **As defined by Medicare. Continuous glucose monitors and related supplies are considered durable medical equipment. Please see **"Durable medical equipment (DME) and related supplies"** later in this chart.	$0 copayment for supplies to monitor your blood glucose levels. 20% of the Medicare-approved amount for diabetic therapeutic shoes and inserts. $0 copayment for diabetes self-management training. Blood glucose monitors, test strips, and control solutions are only available from one manufacturer (Abbott). Lancets are available from any manufacturer. (Please contact Member Services for more information). **Prior authorization rules apply to diabetes**

Covered Service	What you pay
Diabetes self-management training, diabetic services, and supplies (continued)	**self-management training, therapeutic shoes, and inserts.**
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, go to Chapter 12 and Chapter 3.) Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies (such as continuous glucose monitors), hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.scanhealthplan.com. DME supplies are limited to equipment and devices which do not duplicate the function of another piece of equipment or device covered by SCAN Classic and are appropriate for use in the home. Coverage does not include items to be used outside of the home, such as oxygen, ramps, portable nebulizers, and other equipment. Repairs and replacements of DME are covered due to breakage, wear, or a significant change in your physical condition. Repairs and/or replacements will be made when medically necessary and covered by Medicare. For information on medication used with DME, please see "**Medicare Part B prescription drugs**" section in this chart. DME items that are considered personal use items, i.e., commode chair, oxygen tubing, CPAP masks are not allowed to be returned to the provider.	You pay $0 copayment for DME items when the Medicare-approved amount is $0 to $499. If the Medicare-approved amount is $500 or more, you pay 20% of the Medicare-approved amount. $0 copayment for continuous glucose monitors. Preferred Continuous Glucose Monitors (i.e., Dexcom and Freestyle Libre) are available at network pharmacies with a prescription. **Prior authorization and other limits may apply** Cost-sharing applies to each individual item and is based upon the cost of the item regardless of whether it is purchased or rented. Your cost-sharing for Medicare oxygen equipment coverage is 0%-20%, every month. Your cost-sharing will not change after being

Covered Service	What you pay
Durable medical equipment (DME) and related supplies (continued)	enrolled for 36 months in SCAN Classic. **Prior authorization rules may apply**
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services • Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Cost-sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. If you require monitoring or a period of recovery after your emergency care, you may be placed in "observation" status. This may require you to stay at the facility for several hours or overnight if needed. In this event, you will only pay your emergency care copayment while under observation.	$90 copayment for each visit. The copayment is waived if you are admitted to the hospital as an inpatient either immediately or after a period of observation. If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost-sharing you would pay at a network hospital. If your condition allows you to return to a network hospital, care will be arranged as medically necessary (including transfer).
Emergency care – Worldwide coverage* Worldwide emergency and urgently needed care is covered for services to evaluate or stabilize an emergency medical condition when outside of the United States. Worldwide coverage for emergency services: • This includes emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. • Transportation back to the U.S. from another country is not covered.	$90 copayment for worldwide emergency services. Please see Chapter 3, Sections 3.1-3.2 and Chapter 7, Section 1.1 for expense reimbursement information for worldwide services.

Covered Service	What you pay
Emergency care – Worldwide coverage* (continued) • Pre-scheduled, pre-planned, and/or elective procedures are not considered emergency/urgently needed care and are not covered. • Follow-up care including after-care, rehabilitation, and skilled nursing facility stay is not considered emergency or urgently needed care and is not covered. Non-emergency medications obtained outside the United States are not covered. See Chapter 3, Section 3.1 for more information on emergency care outside of the U.S. See "**Services we do not cover (exclusions)**" section later in this chapter for more information. *This benefit does not apply to your maximum out-of-pocket amount.	
FlexEssentials* You are covered for up to $30 per quarter with the FlexEssentials card. This amount can be spent on over-the-counter (OTC) items. Once qualified, you will receive the prepaid debit card, which you will need to activate. Follow the instructions on the card. • The amount is reloaded on the first day of each quarter and expires at the end of the quarter. • Unused amounts do not rollover to the next quarter. • You can only pay for your own items and the benefit cannot be converted into cash. • To find participating stores and eligible items, log onto www.scanhealthplan.com. • Once you have used your allowance, you are responsible for the remaining cost of your purchases. For more information on OTC products see "**Over-the-counter (OTC) products**" later in this chart. *This benefit does not apply to your maximum out-of-pocket amount.	$0 copayment
Health club membership* SCAN Classic provides a membership at participating fitness facilities. You can select a fitness club or fitness studio from SCAN Classic's network of contracted facilities.	$0 copayment for membership at participating fitness clubs and studios.

Covered Service	What you pay
Health club membership* (continued) Digital on-line fitness classes as well as an at-home fitness kit is also available for members who do not reside near a participating club or studio or prefer to exercise at home. You may order one fitness kit per year. Please call Member Services for more information. *This benefit does not apply to your maximum out-of-pocket amount.	Membership includes standard fitness facility services. Any services that typically require an additional fee are not included. Participating fitness clubs and studios may have limitations on number of visit.
Hearing services (Medicare-covered) Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.	$0 copayment for each office visit. **Prior authorization rules may apply**
Hearing services (Routine/Non-Medicare-covered)* Covered services include: • Routine hearing exams • Hearing aids • Hearing aid fitting/evaluation You do not need a referral for a visit to a contracted routine audiology provider for a hearing screening to determine the need for hearing aids. Hearing aids are covered when determined to be necessary and obtained from a contracted provider. Hearing aid fitting and 3 follow-up visits, with the original provider, are covered within 12 months after the purchase of a SCAN-covered hearing aid. Hearing aid coverage includes a 60-day trial period, a 3-year manufacturer warranty, and a 3-year supply of batteries, if required for the hearing aid, is included with each hearing aid purchased (up to 60 disposable batteries per hearing aid per year). First set of earmolds, when clinically appropriate. *This benefit does not apply to your maximum out-of-pocket amount.	**In-Network** **Routine hearing exam** $0 copayment (1 routine hearing exam every 12 months). **Hearing aid fitting/ evaluation** $0 copayment (fittings/ evaluations for hearing aids are covered in the twelve months after purchasing a hearing aid from a contracted vendor). **Hearing aids** $550 copayment per aid for a NationsHearing Basic hearing aid or $950 copayment per aid for a NationsHearing Prime hearing aid (2 hearing aids every 12 months).

Covered Service	What you pay
Hearing services (Routine/Non-Medicare-covered)* (continued)	**Out-of-Network** Not covered
HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. **Prior authorization rules may apply**
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	$0 copayment Coinsurance payments will apply for Medicare-covered outpatient injectables and intravenous drugs administered in a home health setting. See "**Medicare Part B Prescription Drugs**" section in this chart. **Prior authorization rules may apply**
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring	**You pay the following per visit:** **Home infusion therapy professional services including training and education and monitoring services** $0 copayment **Durable medical equipment** Please refer to the "Durable medical

Covered Service	What you pay
Home infusion therapy (continued) • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier The components needed to perform home infusion such as the infusion drug, equipment and supplies are covered under the DME benefit.	equipment (DME) and related supplies" section in this chapter for the cost share amount. For cost-share on infusion drugs used with DME see 'Medicare Part B prescription drugs' section in this chapter. **Prior authorization rules may apply**
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. **For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost-sharing. **For services covered by Medicare Part A or B not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not SCAN Classic.

Covered Service	What you pay
Hospice care (continued) these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare **For services covered by SCAN Classic but not covered by Medicare Part A or B:** SCAN Classic will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. **For drugs that may be covered by our plan's Part D benefit:** If these drugs are unrelated to your terminal hospice condition, you pay cost-sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost-sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.4. **Note**: If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you've never received a complete series, you don't know your vaccination history, or you have any other condition that puts you at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 8 for more information.	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. **Prior authorization rules may apply**

Covered Service	What you pay
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. There is no limit to the number of medically necessary hospital days covered by the plan. Covered services include but aren't limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services (Also see "**Inpatient mental health care**" later in this chart.) • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If SCAN Classic provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. Prior authorization rules apply. Contact Member Services for details regarding the plan's policy for transplant travel coverage.	**For each inpatient hospital stay (admission to discharge), you pay the following:** $75 copayment per day for days 1-5. $0 copayment for additional hospital days. A deductible and/or other cost-sharing is charged for each inpatient stay. Your inpatient benefits are based upon the date of admission. If you are admitted to the hospital in 2027 and are not discharged until 2028, the 2027 copayments will apply until you are discharged from the hospital or transferred to a skilled nursing facility. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital. **Prior authorization rules may apply**

Covered Service	What you pay
Inpatient hospital care (continued) • Blood - including storage and administration. Coverage of whole blood and packed red cells (as well as other components of blood) begins with the first pint of blood that you need. • Physician services **Note**: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. • Get more information from the Medicare fact sheet *Medicare Hospital Benefits* available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. You are covered for 90 days per benefit period. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. There is a 190-day lifetime limit for inpatient services in a freestanding psychiatric hospital. The 190-day limit does not apply to mental health services provided in a psychiatric unit of a general hospital.	**For inpatient mental health stays, you pay per benefit period:** $200 copayment per day for days 1-7. $0 copayment per day for days 8-90. Your inpatient benefits are based upon the date of admission. If you are admitted to an inpatient mental health facility in 2027 and are not discharged until 2028, the 2027 copayments will apply until you have not received any inpatient care in an acute hospital, a skilled nursing facility, or an inpatient mental health facility for 60 days in a row. **Prior authorization rules may apply**

Covered Service	What you pay
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	You will pay the applicable cost-sharing for these services as though they were provided on an outpatient basis. Please refer to the applicable benefit section in this chart. **Prior authorization rules may apply**
Meals (home-delivered)* SCAN members can receive temporary delivery of meals to their home to support recovery after a hospitalization or management of a chronic condition. **Post-Acute Meals** To qualify for this benefit, the member must have been recently discharged from a hospital or skilled nursing facility. If the member qualifies, SCAN will arrange for up to 3 weeks of meals delivered to your home per year. This benefit is provided in weekly increments consisting of 21 meals per week and must be requested within 7 days of discharge. If fewer than 21 meals per week are requested, the meals received will count as 1 week increment. **Chronic-Condition Meals** To qualify for this benefit, the member must have record of one or more of the following conditions: cancer, ESRD,	$0 copayment **Prior authorization rules may apply**

Covered Service	What you pay
Meals (home-delivered)* (continued) diabetes, cardiovascular disorders, congestive heart failure, dementia, or Parkinson's Disease. If the member qualifies, SCAN will arrange for up to 3 weeks of meals delivered to your home per year. This benefit is provided in weekly increments consisting of 21 meals per week and the meals must be appropriate for your applicable medical condition. If fewer than 21 meals per week are requested, the meals received will count as 1 week increment. *This benefit does not apply to your maximum out-of-pocket amount.	
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. **Prior authorization rules may apply**
Medicare Diabetes Prevention Program (MDPP) **MDPP services are covered for eligible people under all Medicare health plans.** MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustain weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit. **Prior authorization rules may apply**

Covered Service	What you pay
Medicare Part B drugs **These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:** • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi® (generic name lecanemab) is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does	You pay no more than 20% coinsurance for Part B chemotherapy and other Part B drugs. You pay no more than $35 for a one-month supply of a Part B insulin furnished through an item of durable medical equipment, such as a medically necessary insulin pump. **Prior authorization rules may apply** **Select Medicare Part B drugs may be subject to step therapy.**

Covered Service	What you pay
Medicare Part B drugs (continued) • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) Select Medicare Part B drugs in the categories listed above may be subject to Step Therapy. This link will take you to a list of Part B drugs that may be subject to Step Therapy: www.scanhealthplan.com/part-b-step-therapy-preferred-drug-list-2027. We also cover some vaccines under Part B and most adult vaccines under our Part D drug benefit. Chapter 5 explains our Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for Part D drugs through our plan is explained in Chapter 6.	
Nurse Advice Line* The Nurse Advice Line gives you access to a registered nurse 24 hours a day, 7 days a week. You can call when you have questions about your health or need help understanding what to do based on your symptoms. **A nurse can:** • Answer health-related questions • Help you manage symptoms	$0 copayment

Covered Service	What you pay
Nurse Advice Line* (continued) • Help you decide where and how to get the right care You can use this benefit by phone or secure video from your computer, tablet, or smartphone. **To use the Nurse Advice Line:** • Call 1-855-431-5537, or • Visit included.scanhealthplan.com *This benefit does not apply to your maximum out-of-pocket amount.	
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. **Prior authorization rules may apply**
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	$20 copayment per visit. **Prior authorization rules may apply**
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings	**You pay the following per visit:** **Standard X-rays** $0 copayment

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies (continued) • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells (as well as other components of blood) begins with the first pint of blood that you need. • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem • Other outpatient diagnostic tests You may be responsible for additional cost-sharing for services received in an outpatient setting which include, but are not limited to, Part B drugs and radiological tests. Please see the "**Medicare Part B prescription drug**" section in this chart.	**Standard laboratory services** $0 copayment **Standard diagnostic procedures and tests** $0 copayment Examples of non-radiological diagnostic services include, but are not limited to, EKG's, pulmonary function tests, sleep studies and treadmill stress tests. **Blood services** $0 copayment **Medical supplies** You pay $0 copayment for items when the Medicare-approved amount is $0 to $499. If the Medicare-approved amount is $500 or more, you pay 20% of the Medicare-approved amount. **Therapeutic radiological procedures** (such as Radiation Therapy, Gamma Knife, and Cyber Knife procedures) 20% of the Medicare-approved amount.

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies (continued)	**Diagnostic radiological procedures** (specialized scans such as CT, SPECT, MRI, MRA, Myelogram, Cystogram, ultrasound, and diagnostic nuclear scans) $0 copayment for ultrasounds. $50 copayment for other diagnostic radiological procedures. **Prior authorization rules may apply**
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. Get more information from the Medicare fact sheet *Medicare Hospital Benefits* available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	There is no additional copay for observation services. However, you will be responsible for the emergency care or outpatient hospital facility copay if you visited one of these facilities prior to your observation stay. Please refer to the "Emergency Care" or "Outpatient Surgery, Including Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers" sections in this chart.
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.	

Covered Service	What you pay
Outpatient hospital services (continued) Covered services include, but aren't limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery	**Emergency services** Please refer to "Emergency Care" section in this chart. **Observation services** Please refer to "Emergency Care" or "Outpatient Surgery, Including Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers" sections in this chart. **Outpatient surgery** Please refer to "Outpatient Surgery, Including Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers" section in this chart.
• Laboratory and diagnostic tests billed by the hospital • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts	**Laboratory and diagnostic tests, X-rays, radiological services, and medical supplies** Please refer to "Outpatient Diagnostic Tests and Therapeutic Services and Supplies" section in this chart.
• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it	**Mental health care and partial hospitalization** Please refer to "Outpatient Mental Health Care" and "Partial Hospitalization Services" sections in this chart.

Covered Service	What you pay
Outpatient hospital services (continued) • Chemical dependency care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it	**Chemical dependency care** Please refer to "Outpatient Substance Use Disorder Services" section in this chart.
• Certain drugs and biologicals you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. Cost-sharing will apply for Medicare-covered outpatient injectables and intravenous drugs administered in an outpatient setting. See "**Medicare Part B Prescription Drugs**" section in this chart.	**Drugs and biologicals that you can't give yourself** Please refer to "Medicare Part B Prescription Drugs" section in this chart. **Prior authorization rules may apply**
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker (CSW), clinical nurse specialist (CNS), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	**Psychiatrist visit** $0 copayment for each therapy visit in a group or individual setting at a CareMore Care Center. $20 copayment for each therapy visit in a group or individual setting at any other location. **Non-Psychiatrist visit** $0 copayment for each therapy visit in a group or individual setting at a CareMore Care Center. $20 copayment for each therapy visit in a group or individual setting at any other location. **Prior authorization rules may apply**

Covered Service	What you pay
Outpatient rehabilitation services Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	$0 copayment for each visit at a CareMore Care Center. $10 copayment for each office visit at any other location. **Prior authorization rules may apply**
Outpatient substance use disorder services You are covered for services to treat chemical dependency in an outpatient setting (group or individual therapy).	$20 copayment for each therapy visit in a group or individual setting. **Prior authorization rules may apply**
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers You are covered for outpatient services performed in an ambulatory surgical center or an outpatient hospital facility. **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. You may be responsible for additional cost-sharing for services received in an outpatient hospital setting which include, but are not limited to, Part B drugs and radiological tests. Please refer to the applicable benefit sections in this chart. If you require monitoring or a period of recovery after your care at an outpatient hospital, you may be placed in "observation" status. This may require you to stay at the facility for several hours or overnight if needed. In this event, you will pay your outpatient hospital copayment while under observation.	$0 copayment **Prior authorization rules may apply**

Covered Service	What you pay
Over-the-counter (OTC) products* You get $30 every quarter to spend on eligible over-the-counter health items. This includes things like vitamins, pain relievers, cold and allergy medicines, diabetes care supplies, and more. You can use your benefit in the way that's easiest for you: • Shop in person at participating CVS retail locations • Order through the mobile app • Log in to your member portal at cvs.com/benefits • Or place a phone/catalog order for home delivery You'll receive a preloaded OTC debit card, and your allowance automatically reloads at the start of each quarter: January, April, July, and October. Any unused amount will not roll over to the next quarter. When shopping in-store, you can use the in-app barcode scanner to check if an item is covered. You can also review your OTC catalog or log in to your member portal to see eligible items. For eligible FlexEssentials benefits, you may request reimbursement for eligible items or services purchased from a retailer or provider when reimbursement is permitted under the benefit. Reimbursement requests must be submitted with the required documentation and are subject to benefit eligibility, benefit limits, applicable plan requirements, and available benefit funds. If you disagree with a reimbursement determination, you have the right to request an appeal. See the Appeals section of this *Evidence of Coverage* for additional information. **Additional Information for SCAN Members** • If you have questions about reimbursement eligibility, covered items or services, or submitting a reimbursement request, please contact the number below. • Items purchased in-store may be returned based on the retailer's return and exchange policies. • If your physical or digital card is not working or you experience a technical issue, please contact the number below. • SCAN is not responsible for lost or stolen cards. • Your Flex Essentials card is for your personal use only. It cannot be sold, transferred, or converted to cash. For help, call 1-844-428-8135.	**In-Network** $0 per order **Out-of-Network** Not covered

Covered Service	What you pay
Over-the-counter (OTC) products* (continued) *This benefit does not apply to your maximum out-of-pocket amount.	
Partial hospitalization services and Intensive outpatient services *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally Qualified Health Center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization. Partial hospitalization also includes chemical dependency treatment.	$20 copayment for each partial hospitalization visit. **Prior authorization rules may apply**
Personal Emergency Response System (PERS)* Medical alert devices are available to members who meet specific criteria. Available options include At Home (Landline or Cellular), On the Go+, and Watch Wearable devices. Contact Member Services for more information (phone numbers are printed on the back cover of this document). *This benefit does not apply to your maximum out-of-pocket amount.	$0 copayment
Physician/practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist	**Primary care visit** $0 copayment for each office visit.

Covered Service	What you pay
Physician/practitioner services, including doctor's office visits (continued) • Basic hearing and balance exams performed by your PCP, if your doctor orders it to see if you need medical treatment • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if:** ◦ You're not a new patient **and** ◦ The check-in isn't related to an office visit in the past 7 days **and** ◦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: ◦ You're not a new patient **and** ◦ The evaluation isn't related to an office visit in the past 7 days **and** ◦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery (see "**How to Obtain a Second Opinion**" in Chapter 4, Section 4) • Allergy testing and treatment performed in a physician's office (coverage includes allergy serum and injection services)	**Specialist visit** $0 copayment for each office visit. **Prior authorization rules may apply**

Covered Service	What you pay
Physician/practitioner services, including doctor's office visits (continued) Members may receive a home visit in lieu of a physician office visit when medically necessary. **Prior authorization rules may apply.** Coinsurance payments will apply for Medicare-covered outpatient injectables and intravenous drugs administered in a physician office setting. See "**Medicare Part B Prescription Drugs**" section in this chart.	
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	$0 copayment for visits at a podiatry specialist in your medical group. **Prior authorization rules may apply**
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication including the fee for injecting the drug, if applicable • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months • Up to 8 HIV screenings every 12 months • A one-time hepatitis B virus screening	There is no coinsurance, copayment, or deductible for the PrEP benefit.
Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test or digital rectal exam. **Prior authorization rules may apply**

Covered Service	What you pay
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to *Vision Care* later in this table for more detail. Outpatient medical/therapeutic supplies, appliances and devices include: Surgical dressings, and splints, casts; leg, arm, back, and neck braces and other devices used for reduction of fractures and dislocations. Repairs and replacements of prosthetics and orthotics are covered due to breakage, wear, or a significant change in your physical condition. Repairs and/or replacements will be made when medically necessary and covered under Original Medicare. Prosthetic devices implanted in an inpatient/outpatient setting are covered under the inpatient hospital/outpatient surgery benefit and no additional copayment will apply.	You pay $0 copayment for items when the Medicare-approved amount is $0 to $499. If the Medicare-approved amount is $500 or more, you pay 20% of the Medicare-approved amount. **Prior authorization rules may apply**
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	$20 copayment for each pulmonary rehab visit. **Prior authorization rules may apply**
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. **Prior authorization rules may apply**

Covered Service	What you pay
Screening for Hepatitis C virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we cover a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, an LDCT is covered every 12 months. **Eligible members are** people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT. **Prior authorization rules may apply**
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and

Covered Service	What you pay
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs (continued) We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	counseling for STIs preventive benefit. **Prior authorization rules may apply**
Services to treat kidney disease Kidney disease and dialysis services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table. Routine dialysis is not covered outside of the United States and its territories. See Chapter 3, Section 2.2 for rules regarding out-of-area dialysis services.	**Kidney disease education services** $0 copayment **Dialysis services** 20% coinsurance for each Medicare-covered dialysis treatment. This includes both professional (nephrologist dialysis clinic visits) and dialysis facility visits, and home dialysis. Dialysis received as a hospital inpatient will be covered under your hospital inpatient benefit. **Prior authorization rules may apply**
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.) You are covered for 100 days per benefit period. No prior hospital stay is required. You must meet medical necessity	**For skilled nursing facility stays, you pay per benefit period:** $0 copayment per day for days 1-20.

Covered Service	What you pay
Skilled nursing facility (SNF) care (continued) criteria for daily skilled care and must get the care from, or under the supervision of, skilled nursing or therapy staff. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. Covered services include but aren't limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy and speech therapy • Drugs administered to you as part of our plan of care (this includes substances naturally present in the body, such as blood clotting factors) • Blood - including storage and administration. Coverage of whole blood and packed red cells (as well as other components of blood) begins with the first pint of blood that you need. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	$150 copayment per day for days 21-100. Your skilled nursing facility benefits are based upon the date of admission. If you are admitted to a skilled nursing facility in 2027 and are not discharged until 2028, the 2027 copayments will apply until you have not received any inpatient care in an acute hospital, a SNF, or an inpatient mental health facility for 60 days in a row. **Prior authorization rules may apply**

Covered Service	What you pay
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. **Prior authorization rules may apply**
Supervised exercise therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	$0 copayment for each office visit. **Prior authorization rules may apply**
Telehealth services* **Urgent Care Telehealth** Urgent Care Telehealth lets you see a licensed doctor from home using secure video on your computer, tablet, or smartphone.	$0 per virtual visit.

Covered Service	What you pay
Telehealth services* (continued) This service is for non-emergency health concerns that need timely attention when your primary care doctor is not available, such as: • Cold, flu, or cough symptoms • Sore throat or fever • Nausea or stomach issues • Allergies or rashes Urgent Care Telehealth is available 24 hours a day, 7 days a week, year-round. Important to know: • Visits are conducted through secure video • Doctors can provide guidance and may prescribe medication when appropriate • This service does not replace your primary care doctor or specialist • It is not for emergencies. If you have a life-threatening condition, call 911 or go to the nearest emergency room To use this benefit, you will need to create an account and register the first time you access the service. **Behavioral Telehealth** Behavioral Telehealth allows you to connect with licensed mental health professionals through secure video visits. You can receive care from: • Licensed psychologists • Master's-level therapists • Psychiatrists Appointments are available 7 days a week, with flexible scheduling that may include evenings, weekends, and same-day appointments, depending on availability. Important to know: • Visits are provided by appointment through secure video • Behavioral Telehealth supports mental and emotional health needs • This service does not replace in-person care when medically necessary or emergency mental health services To access Behavioral Telehealth, visit the SCAN Health Plan website or use the designated app. You will need to set up an account and register the first time you use the service. For more information, go to www.scanhealthplan.com.	

Covered Service	What you pay
Telehealth services* (continued) Additional Information *This benefit does not apply to your maximum out-of-pocket amount.	
Transportation (Routine/Non-Medicare-covered)* This benefit covers routine, non-emergency one-way trip. Trips may be covered for getting to and from plan-approved medical-related visits. Please refer to the Ambulance Services section in this chart for information on non-emergency ambulance services. All transportation, including wheelchair transports, must meet plan criteria reference below. You can use this benefit for one-way trip, or you can schedule a round trip by using two one-way trips. Each one-way trip may not exceed 50 miles. This benefit does not include rides to non-medical destinations such as grocery stores, health clubs, and senior centers. Modes of approved transportation may include: Rideshare (Uber/Lyft), Passenger vehicle, or Wheelchair transport. You must use the plan-approved vendor and schedule trips in advance (excluding weekends): • Rideshare (Uber/Lyft): Minimum 24 hours notice • Passenger vehicle: Minimum 48 hours notice • Wheelchair transport: Minimum 48 hours notice Call the SCAN Transportation Department at 1-844-714-2218 to schedule a ride. When scheduling your ride, let the vendor know if you are in a wheelchair, if you need help, or if someone will be coming with you. If a ride is not canceled before the driver has been dispatched to get you, the ride will count and will be deducted from your annual ride limit. See "**Important information about the routine transportation benefit**" at the end of this section for a detailed description of the transportation benefit. *This benefit does not apply to your maximum out-of-pocket amount.	$0 copayment for each one-way ride. You are covered for up to 10 one-way rides per year (50-mile limit each way) when using SCAN Classic-contracted transportation providers and when being transported to SCAN Classic-covered providers and facilities. **Prior authorization rules may apply**

Covered Service	What you pay
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost-sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. When you are in your plan's service area, you must receive urgent care services from an in-network provider, when available. Coinsurance payments will apply for Medicare-covered outpatient injectables and intravenous drugs administered in an urgent care setting. See "**Medicare Part B Prescription Drugs**" section in this chart.	$0 copayment for each visit.
Urgently needed services – Worldwide coverage* Worldwide emergency and urgently needed care is covered for services to evaluate or stabilize an urgent or emergent medical condition when outside of the United States. Worldwide coverage for urgently needed services: • This includes emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. • Transportation back to the U.S. from another country is not covered. • Pre-scheduled, pre-planned, and/or elective procedures are not considered emergency/urgently needed care and are not covered. • Follow-up care including after-care, rehabilitation, and skilled nursing facility stay is not considered emergency or urgently needed care and is not covered. Non-emergency medications obtained outside the United States are not covered.	$0 copayment for each visit.

Covered Service	What you pay
Urgently needed services – Worldwide coverage* (continued) See Chapter 3, Section 3.2 for more information on urgently needed care when you are away from home or outside of the U.S. See "**Services we do not cover (exclusions)**" section later in this chapter for more information. *This benefit does not apply to your maximum out-of-pocket amount.	
Vision care (Medicare-covered) Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery Medically necessary eye exams require a referral from a Plan Physician to a Plan Specialist to diagnose and treat diseases of the eye including glaucoma and cataracts. **Intraocular lens** There is no charge for a standard intraocular lens (IOL). However, for an additional fee, you may request the insertion of a presbyopia-correcting IOL (e.g. Crystalens™, AcrySof RESTOR™, and ReZoom™) in place of a conventional IOL following cataract surgery. You will pay an additional fee for non-conventional IOLs recommended or directed by your physician. You are responsible for payment of that portion of the charge for the presbyopia-correcting IOL and associated	$0 copayment for medically necessary eye exams and treatment. $0 copayment for one glaucoma screening exam per 12-month period if you are at high risk for glaucoma. 20% of the Medicare-approved amount for Medicare-covered eyewear after cataract surgery. **Prior authorization rules may apply**

Covered Service	What you pay
Vision care (Medicare-covered) (continued) services that exceed the charge for insertion of a conventional IOL following cataract surgery. You should discuss the extra cost with your ophthalmologist PRIOR to surgery so that you clearly understand the extent of your financial responsibility.	
Vision care (Routine/Non-Medicare-covered)* In addition to medically necessary vision services covered under Original Medicare, SCAN Classic offers the following routine vision care services through the Eye Med Select optometry provider network. • Routine eye exams, limited to one exam per calendar year. • Lenses (single vision, bifocal, or trifocal), standard frames, or eyeglasses (both lenses and frames). Limited to one pair every year. SCAN Classic offers a vision coverage amount to apply toward the cost of standard frames and lenses when purchased at a plan provider location. You must pay any remaining costs beyond this coverage. • Allowance may be used on contact lenses instead of eyeglasses (one allowance per year) SCAN Classic offers a coverage amount to apply toward the cost of contact lenses when purchased at a plan provider location. You must pay any remaining costs beyond this coverage, i.e., contact lens fitting, retinal imaging. **Limitations and Exclusions** • Replacement of lenses or frames due to loss or breakage is not covered, unless the item is otherwise eligible for replacement under the plan's frequency limits. • All services and materials must be obtained from a plan provider location, unless otherwise specified. **See "Services we do not cover (exclusions)" section later in this chapter for additional eye wear limitations.** *This benefit does not apply to your maximum out-of-pocket amount.	**In-Network** **Routine eye exam** $0 copayment You do not need a referral for visits to contracted vision providers for routine eye exams (refractions). Retinal imaging exam may be available for additional cost. Check with your provider for available discounts. **Routine glasses or contacts** Eyewear materials are included within the eyewear allowance. **Eyewear allowance** You have an annual allowance for routine eyewear: • $100 if using an EyeMed Select vision provider • $150 if using an EyeMed PLUS vision provider Contact lens coverage to include the cost of the exam, professional fees, and materials. You pay any remaining costs beyond what SCAN Classic will cover.

Covered Service	What you pay
Vision care (Routine/Non-Medicare-covered)* (continued)	**Out-of-Network** Not covered
Welcome to Medicare preventive visit Our plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed. **Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your *Welcome to Medicare* preventive visit.	There is no coinsurance, copayment, or deductible for the Welcome to Medicare preventive visit.

Dental services (Routine/Non-Medicare-covered)*

SCAN Classic offers coverage for routine dental services described below.

Provider Network

Routine dental services are covered through a SCAN Classic contracted network provider.

SCAN Classic contracted network provider can be found:

- **Online:** Use the "Find a Dentist" tool on the NationsBenefits website (SCAN.NationsBenefits.com).
- **Phone:** Call NationsBenefits Member Services at 1-888-527-7904 (TTY: 711) 8:00 am to 5:00 pm, Monday through Friday (excluding holidays).
- **Dental Office:** If you call your dental office, keep these tips in mind:
    - Your dental network changed in 2027.
    - You are not assigned to a dental provider.
    - The dental network is not an "HMO" or a "PPO".
- Services performed by an out-of-network provider are not covered and will be member responsibility.

Benefit Maximum & Member Cost-Share

- The $3,000 benefit maximum is offered on a calendar year basis. Any unused amount expires the earlier of your plan termination date or end of the year and does not carry over.
- Amounts paid by the plan for covered comprehensive dental services count toward the benefit maximum. You are responsible for comprehensive dental expenses above the maximum benefit amount.
- In addition to your applicable cost-share (if applicable), you are responsible for costs related to:
    - Non-covered services.
    - Services received more often than limitations allow.
    - Charges for comprehensive services that exceed your benefit maximum.
    - Services received from an out-of-network dental provider.
- This benefit does not apply to your maximum out-of-pocket amount.

Covered Services

- Any dental procedure which is not listed within the schedule of benefits is not covered and will be member responsibility.
- All covered dental services are subject to limitations and exclusions, including frequency limits and consideration of prior tooth history where applicable. Please note

that page breaks do not affect applicable limitations. A limitation may apply to services or code groups listed on more than one page.

- To confirm eligibility, request an organization determination. This may also be referred to as a pre-treatment estimate or prior authorization by your dental office.

Organization Determination

Dentists may ask you to sign an in-office treatment plan or consent document outlining the risks, benefits, costs, and alternative treatment options. You do not have to make a decision right away and you always have the right to decline any procedure.

If you have questions about treatment costs, coverage available, or proposed services, do not move forward with the treatment and do not sign an agreement. Instead, request a no-cost organization determination (prior authorization/pre-treatment estimate) from your dentist.

Dental Card

You will receive a dental specific card which has been loaded with your benefit allowance amount. You will need to activate this card.

This card is authorized for use at in-network dental providers for dental services included within the dental schedule of benefits below.

To order a card replacement, contact NationsBenefits Member Services or visit SCAN.NationsBenefits.com.

How to Use Your Dental Card

1. **Activate your Dental Card:**
    - **Online:** Visit SCAN.NationsBenefits.com/Activate
    - **Phone:** Call 1-888-527-7904 (TTY: 711)
2. **Present your Dental Card:** Your dentist will use your dental card to confirm your available balance, review your dental schedule of benefits, and submit services for payment.
3. **Review your treatment plan:** Carefully review the proposed services, including how your benefits are applied and any out-of-pocket costs.
4. **Ask Questions:** Ask your dentist questions to make sure you have explored and understand your options, such as:
    - Are there lower cost materials or alternative treatment options?
    - Which services are most important now and which can happen later?
5. **Receive dental services:** Once you agree to the services, timeline, and cost of your treatment plan, sign the member consent form and receive care.

6. **Apply your Dental Card:** Once dental services have been completed, provide your dental card to issue payment to your in-network dental provider.
    - If your Dental Card cannot be used at the time of service, contact NationsBenefits. They can help troubleshoot the matter or provide guidance on how to submit request for reimbursement.
7. **Pay Remaining Balance (if any):** If necessary, provide a secondary form of payment to cover the costs related to:
    - Member cost-share (when applicable).
    - Non-covered services.
    - Services received more often than limitations allow.
    - Charges for comprehensive services that exceed your benefit maximum.
    - Services received from an out-of-network dental provider.

Questions

For questions on how to find a provider, order a card replacement, confirm remaining benefit maximum, and more, contact NationsBenefits Member Services or visit SCAN.NationsBenefits.com.

Schedule of Benefits

Code	Description	Limitations	Cost-Share
Diagnostic: Exams			
D0120	periodic oral evaluation - established patient	2 of this code group every year.	$0
D0160	detailed and extensive oral eval-problem focused, by report		
D0170	re-evaluation, limited problem focused		
D0140	limited oral evaluation-problem focused	3 every year. Not allowed with other services on the same day.	$0
D0150	comprehensive oral evaluation - new or established patient	1 of this code group every 3 years.	$0
D0180	comprehensive periodontal evaluation - new or established patient		
Diagnostic: X-Rays Reimbursement for all eligible radiographic images taken on the same date of service, regardless of procedure code combination, will be limited to the allowable amount for a comprehensive intraoral series.			

Code	Description	Limitations	Cost-Share
D0210	Intraoral - comprehensive series of radiographic images	1 of this code group every 3 years.	$0
D0277	vertical bitewings - 7 to 8 films		
D0330	panoramic radiographic image		
D0372	intraoral tomosynthesis - comprehensive series of radiographic images		
D0220	intraoral - periapical first radiographic image	1 per date of service.	$0
D0230	intraoral - periapical each additional radiographic image		$0
D0240	intraoral - occlusal radiographic image	2 every 2 years.	$0
D0270	bitewing - single radiographic image	1 of this code group every year.	$0
D0272	bitewings - two radiographic images		
D0273	bitewings - three radiographic images		
D0274	bitewings - four radiographic images		
D0373	intraoral tomosynthesis - bitewing radiographic image		
D0374	intraoral tomosynthesis - periapical radiographic image	1 every year.	$0
Preventive: Cleanings			
D1110	prophylaxis - adult	2 of this code group every year.	$0
D4346	scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation		
D4910	periodontal maintenance procedures		
D4341	periodontal scaling and root planing - four or more teeth per quadrant	1 of this code group per quadrant every 3 years.	$0
D4342	periodontal scaling and root planing - one to three teeth per quadrant		
D4355	full mouth debridement to enable a comprehensive oral periodontal evaluation and diagnosis on a subsequent visit	1 every 3 years.	$0
Preventive: Application of Fluoride & Desensitizing Medicament			
D1206	topical application of fluoride varnish	2 of this code group every year.	$0

Code	Description	Limitations	Cost-Share
D1208	topical application of fluoride - excluding varnish	2 of this code group every year. (continued)	$0
D9910	application of desensitizing medicament		
Restorative Services: Filling / Inlay / Onlay / Crown			
D2140	amalgam - one surface, primary or permanent	1 of this code group per tooth, per surface, every 2 years. Service may not be completed after a crown.	$0
D2150	amalgam - two surfaces, primary or permanent		
D2160	amalgam - three surfaces, primary or permanent		
D2161	amalgam - four or more surfaces, primary or permanent		
D2330	resin-based composite - one surface, anterior		
D2331	resin-based composite - two surfaces, anterior		
D2332	resin-based composite - three surfaces, anterior		
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior or posterior)		
D2390	resin-based composite crown, anterior		
D2391	resin-based composite - one surface, posterior		
D2392	resin-based composite - two surfaces, posterior		
D2393	resin-based composite - three surfaces, posterior		
D2394	resin-based composite - four or more surfaces, posterior		
D2990	resin infiltration of incipient smooth surface lesions		$0
D2510	inlay - metallic - 1 surface	1 of this code group per tooth every 5 years.	$0
D2520	inlay - metallic- 2 surfaces		
D2530	inlay - metallic - 3+ surfaces		
D2542	onlay - metallic - 2 surfaces		

Code	Description	Limitations	Cost-Share
D2543	onlay - metallic - 3 surfaces	1 of this code group per tooth every 5 years. (continued)	$0
D2544	onlay - metallic - 4+ surfaces		
D2610	inlay - porcelain/ceramic - 1 surface		
D2620	inlay - porcelain/ceramic - 2 surfaces		
D2630	inlay - porcelain/ceramic - 3+ surfaces		
D2642	onlay - porcelain/ceramic - 2 surfaces		
D2643	onlay - porcelain/ceramic - 3 surfaces		
D2644	onlay - porcelain/ceramic - 4+ surfaces		
D2650	inlay - composite/resin - 1 surface		
D2651	inlay - composite/resin - 2 surfaces		
D2652	inlay - composite/resin - 3+ surfaces		
D2662	onlay - composite/resin - 2 surfaces		
D2663	onlay - composite/resin - 3 surfaces		
D2664	onlay - composite/resin - 4+ surfaces		
D2710	crown - resin-based composite (indirect)		
D2712	crown - 3/4 resin-based composite (indirect)		
D2720	crown - resin with high noble metal		
D2721	crown - resin with predominantly base metal		
D2722	crown - resin with noble metal		
D2740	crown - porcelain/ceramic		
D2750	crown - porcelain fused to high noble metal		
D2751	crown - porcelain fused to predominantly base metal		
D2752	crown - porcelain fused to noble metal		
D2753	crown - porcelain fused to titanium and titanium alloys		
D2780	crown - 3/4 cast high noble metal		
D2781	crown - 3/4 cast predominantly base metal		
D2782	crown - 3/4 cast noble metal		
D2783	crown - 3/4 porcelain/ceramic		
D2790	crown - full cast high noble metal		

Code	Description	Limitations	Cost-Share
D2791	crown - full cast predominantly base metal	1 of this code group per tooth every 5 years. (continued)	$0
D2792	crown - full cast noble metal		
D2794	crown - titanium		
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	1 of this code group per tooth every 2 years. Only after 6 months of initial placement.	$0
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core		
D2920	re-cement or re-bond crown		
D2940	placement of interim direct restoration	1 per tooth in lifetime.	$0
D2950	core buildup, including any pins when required	1 of this code group per tooth every 5 years. Service will be denied if completed with resin or amalgam restoration.	$0
D2951	pin retention - per tooth, in addition to restoration		
D2952	cast post and core in addition to crown		
D2953	each additional cast post - same tooth		
D2954	prefabricated post and core in addition to crown		
D2980	crown repair, by report	1 per tooth every 2 years. Only after 6 months of initial placement.	$0
Endodontic Services			
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	1 of this code group per tooth in lifetime. Not allowed in conjunction with root canal therapy.	$0
D3221	pulpal debridement, primary and permanent teeth		
D3310	endodontic therapy, anterior tooth (excluding final restoration)	1 of this code group per permanent tooth in lifetime.	$0
D3320	endodontic therapy, premolar tooth (excluding final restoration)		
D3330	endodontic therapy, molar tooth (excluding final restoration)		

Code	Description	Limitations	Cost-Share
D3331	treatment of root canal obstruction; non-surgical access	1 of this code group per permanent tooth in lifetime. (continued)	$0
D3346	retreatment of previous root canal therapy - anterior		
D3347	retreatment of previous root canal therapy - premolar		
D3348	retreatment of previous root canal therapy - molar		
D3410	apicoectomy - anterior		
D3421	apicoectomy - premolar (first root)		
D3425	apicoectomy - molar (first root)		
D3426	apicoectomy (each additional root)		
D3430	retrograde filling - per root		
Periodontal Services (Surgical)			
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	1 of this code group per quadrant every 3 years.	$0
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant		
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	1 of this code group per quadrant every 3 years.	$0
D4241	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant		
D4249	clinical crown lengthening - hard tissue	1 per permanent tooth in lifetime.	$0
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	1 of this code group per quadrant every 3 years.	$0
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant		

Code	Description	Limitations	Cost-Share
Prosthodontic (Removable & Fixed)			
D5110	complete denture - maxillary	1 of this code group every 5 years.	$0
D5130	immediate denture - maxillary		
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)		
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		
D5221	immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)		
D5223	immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		
D5225	maxillary partial denture - flexible base		
D5227	immediate maxillary partial denture - flexible base		
D5863	overdenture - complete maxillary		
D5864	overdenture - partial maxillary		
D5120	complete denture - mandibular	1 of this code group every 5 years.	$0
D5140	immediate denture - mandibular		
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)		
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		
D5222	immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)		

Code	Description	Limitations	Cost-Share
D5224	immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 of this code group every 5 years. (continued)	$0
D5226	mandibular partial denture - flexible base		
D5228	immediate mandibular partial denture - flexible base		
D5865	overdenture - complete mandibular		
D5866	overdenture - partial mandibular		
D5410	adjust complete denture - maxillary	2 of this code group per arch every year. Only after 6 months of initial placement.	$0
D5411	adjust complete denture - mandibular		
D5421	adjust partial denture - maxillary		
D5422	adjust partial denture - mandibular		
D5511	repair broken complete denture base, mandibular	1 of this code group per arch every year. Only after 6 months of initial placement.	$0
D5512	repair broken complete denture base, maxillary		
D5520	replace missing or broken teeth - complete denture - per tooth		
D5611	repair resin denture base, mandibular	1 of this code group per arch every year.	$0
D5612	repair resin denture base, maxillary		
D5621	repair cast framework, mandibular		
D5622	repair cast framework, maxillary		
D5630	repair or replace broken clasp	1 of this code group per tooth every year.	$0
D5640	replace missing or broken teeth - partial denture - per tooth		
D5650	add tooth to existing partial denture - per tooth		
D5660	add clasp to existing partial denture		
D5710	rebase complete maxillary denture	1 of this code group every 3 years. Only after 6 months of initial placement.	$0
D5730	reline complete maxillary denture (chairside)		
D5750	reline complete maxillary denture (laboratory)		

Code	Description	Limitations	Cost-Share
D5711	rebase complete mandibular denture	1 of this code group every 3 years. Only after 6 months of initial placement.	$0
D5731	reline complete mandibular denture (chairside)		
D5751	reline complete mandibular denture (laboratory)		
D5720	rebase maxillary partial denture	1 of this code group every 3 years. Only after 6 months of initial placement.	$0
D5740	reline maxillary partial denture (chairside)		
D5760	reline maxillary partial denture (laboratory)		
D5721	rebase mandibular partial denture	1 of this code group every 3 years. Only after 6 months of initial placement.	$0
D5741	reline mandibular partial denture (chairside)		
D5761	reline mandibular partial denture (laboratory)		
D5725	rebase of hybrid prosthesis	1 per arch every 3 years. Only after 6 months of initial placement.	$0
D5765	soft liner for complete or partial dentures (indirect)		
D5850	tissue conditioning, maxillary	Only allowed in conjunction with fabrication of new denture. Not allowed within 5 years after delivery of denture.	$0
D5851	tissue conditioning, mandibular		
D5876	add metal substructure to acrylic full denture	Only allowed on the same date of service as D5110, D5120, D5130, D5140	$0
D6205	pontic - indirect resin based composite	1 of this code group per tooth every 5 years.	$0
D6210	pontic - cast high noble metal		
D6211	pontic - cast base metal		
D6212	pontic - cast noble metal		
D6214	pontic - titanium		
D6240	pontic - porcelain fused-high noble		
D6241	pontic - porcelain fused to base metal		

Code	Description	Limitations	Cost-Share
D6242	pontic - porcelain fused-noble metal	1 of this code group per tooth every 5 years. (continued)	$0
D6243	pontic - porcelain fused to titanium and titanium alloys		
D6245	prosthodontics fixed, pontic - porcelain/ ceramic		
D6250	pontic - resin with high noble metal		
D6251	pontic - resin with base metal		
D6252	pontic - resin with noble metal		
D6545	retainer - cast metal fixed	1 of this code group per tooth per 60 months.	$0
D6548	prosthodontics fixed, retainer - porcelain/ ceramic for resin bonded fixed prosthodontic		
D6549	resin retainer- resin bonded fixed prosthesis		
D6602	inlay - cast high noble metal, two surfaces		
D6603	inlay - cast high noble metal, three or more surfaces		
D6604	inlay - cast predominantly base metal, two surfaces		
D6605	inlay - cast predominantly base metal, three or more surfaces		
D6606	inlay - cast noble metal, two surfaces		
D6607	inlay - cast noble metal, three or more surfaces		
D6608	onlay - porcelain/ceramic, two surfaces		
D6609	onlay - porcelain/ceramic, three or more surfaces		
D6610	onlay - cast high noble metal, two surfaces		
D6611	onlay - cast high noble metal, three or more surfaces		
D6612	onlay - cast predominantly base metal, two surfaces		
D6613	onlay - cast predominantly base metal, three or more surfaces		
D6614	onlay - cast noble metal, two surfaces		

Code	Description	Limitations	Cost-Share
D6615	onlay - cast noble metal, three or more surfaces	1 of this code group per tooth per 60 months. (continued)	$0
D6624	inlay - titanium		
D6634	onlay - titanium		
D6710	crown - indirect resin-based composite		
D6720	crown - resin with high noble metal		
D6721	crown - resin with base metal		
D6722	crown - resin with noble metal		
D6740	retainer crown - porcelain/ceramic		
D6750	crown - porcelain fused high noble		
D6751	crown - porcelain fused to base metal		
D6752	crown - porcelain fused noble metal		
D6753	retainer crown - porcelain fused to titanium and titanium alloys		
D6780	crown - 3/4 cast high noble metal		
D6781	prosthodontics fixed, crown 3/4 cast predominantly based metal		
D6782	prosthodontics fixed, crown 3/4 cast noble metal		
D6784	retainer crown-3/4-titanium and titanium alloys		
D6790	crown-full cast high noble		
D6791	crown - full cast base metal		
D6792	crown - full cast noble metal		
D6793	provisional retainer crown		
D6794	crown - titanium		
D6930	re-cement or re-bond fixed partial denture	1 every 2 years. Only after 6 months of initial placement.	$0
D6980	fixed partial denture repair	1 every 2 years. Only after 6 months of initial placement.	$0

Code	Description	Limitations	Cost-Share
Oral and Maxillofacial Surgery			
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	1 per tooth in lifetime.	$0
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated		
D7220	removal of impacted tooth-soft tissue		
D7230	removal of impacted tooth-partially bony		
D7240	removal of impacted tooth-completely bony		
D7241	removal of impacted tooth-completely bony, with unusual surgical complications		
D7250	surgical removal of residual tooth roots (cutting procedure)		
D7251	coronectomy - intentional partial tooth removal, impacted teeth only		
D7252	partial extraction for immediate implant placement		
D7259	nerve dissection	1 per quadrant in lifetime.	$0
D7260	oroantral fistula closure	2 per arch in lifetime.	$0
D7261	primary closure of a sinus perforation	2 per arch in lifetime.	$0
D7284	excisional biopsy of minor salivary glands		$0
D7285	incisional biopsy of oral tissue-hard (bone, tooth)		$0
D7286	incisional biopsy of oral tissue-soft		$0
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	1 of this code group per quadrant in lifetime.	$0
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant		

Code	Description	Limitations	Cost-Share
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	1 of this code group per quadrant in lifetime.	$0
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant		
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	1 per arch in lifetime.	$0
D7350	vestibuloplasty - ridge extension		
D7410	radical excision - lesion diameter up to 1.25cm		$0
D7411	excision of benign lesion greater than 1.25cm		$0
D7440	excision of malignant tumor - lesion diameter up to 1.25cm		$0
D7441	excision of malignant tumor - lesion diameter greater than 1.25cm		$0
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm		$0
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm		$0
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm		$0
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm		$0
D7471	removal of exostosis - per site	2 per arch in lifetime.	$0
D7472	removal of torus palatinus	1 in lifetime.	$0
D7473	removal of torus mandibularis	2 in lifetime.	$0
D7485	surgical reduction of osseous tuberosity	2 in lifetime.	$0
D7510	incision and drainage of abscess - intraoral soft tissue	Not allowed in conjunction with extraction on same date of service.	$0
D7520	incision and drainage of abscess - extraoral soft tissue		$0

Code	Description	Limitations	Cost-Share
D7521	incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)		$0
D7961	buccal / labial frenectomy (frenulectomy)	1 of this code group per arch in lifetime.	$0
D7962	lingual frenectomy (frenulectomy)		
D7963	frenuloplasty		
D7970	excision of hyperplastic tissue - per arch	1 per arch in lifetime.	$0
D7971	excision of pericoronal gingiva	1 per tooth in lifetime.	$0
Adjunctive Services			
D9110	palliative treatment of dental pain - per visit	Not allowed with other dental services except for D0140 and x-rays on the same day.	$0
D9222	deep sedation/general anesthesia - first 15 minutes	Up to 60 minutes per date of service. Not allowed with (D9239, D9243) on the same day.	$0
D9223	deep sedation/general anesthesia - each subsequent 15-minute increment		
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	1 per date of service. Not allowed with (D9222, D9223, D9239, D9243, D9248) on the same day.	$0
D9239	intravenous moderation (conscious)	Up to 60 minutes per date of service. Not allowed with (D9222, D9223) on the same day.	$0
D9243	intravenous moderation (conscious)-each subsequent 15-minute increment		

Code	Description	Limitations	Cost-Share
D9248	non-intravenous moderate (conscious) sedation	1 per date of service. Not allowed with (D9222, D9223, D9230, D9239, D9243) on the same day.	$0
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	1 every year.	$0
D9410	house/extended care facility call	1 of this code group per date of service. Limit 6 per year.	$0
D9420	hospital or ambulatory surgical center call		
D9930	treatment of complications (post-surgical)	1 every year.	$0
D9950	occlusion analysis - mounted case	1 of this code group every 5 years.	$0
D9952	occlusal adjustment - complete		
D9951	occlusal adjustment - limited	1 every year.	$0

Please note that page breaks do not affect applicable limitations. A limitation may apply to services or code groups listed on more than one page.

Exclusions

In addition to the frequency limitations and terms outlined within the dental schedule of benefits and SCAN *Evidence of Coverage*, the following items and services are not covered and will be member responsibility.

- Services performed prior to the member's effective date.
- Services completed after the member's termination date and/or the end of the calendar year, including treatment which began prior to that date.
- Services performed by an out-of-network dentist.
- All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
- Any service which is not listed within the schedule of benefits including, but not limited to:
    - Any unspecified procedure by report (DX999).
    - Caries risk assessment.
    - 2D oral or facial photographic images.

  - Veneers.
  - Tooth bleaching, whitening, and/or enamel microabrasion.
  - Orthodontics.
  - Dental splints.
  - Prescription drugs, medication (including toothpaste), and/or antimicrobial agents when dispensed or prescribed.
  - Reconstructive surgery including treatment for congenital or developmental malformations.
  - Surgical or non-surgical services to address temporomandibular joints (TMJ) and/or associated musculature.
  - Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
  - Administration of dermal fillers and/or neuromodulators.
  - Photobiomodulation therapy.
  - Implants, implant-supported dental appliances and attachments, and all other implant related services such as implant placement, maintenance, and removal.
- Charges associated with dental practice administration (e.g. x-ray duplication, missed/cancelled appointments, appt. reminders, claim preparation, completion of forms, equipment sterilization, etc.) rather than direct patient clinical care.
- Services or supplies for sleep apnea.
- Charges to replace lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns, and fixed partial dentures (bridges).
- Charges associated with incomplete, temporary, and/or interim services.
- Charges for services completed outside the United States of America.
- Services determined through professional review to be cosmetic in nature, experimental, and/or to have poor prognosis.
- Service for injuries or conditions covered by workmen's compensation or employer liability laws, and services that are provided without cost to the covered persons by any municipality, county, or other political subdivision.

Notice

- For billing purposes, the "date of service" is defined as the date in which the service is completed or delivered. For example, crowns = seat date, root canal therapy = completion date, and bridges & dentures = delivery date.

- Dental codes and descriptions are set by the American Dental Association (ADA) and may change each year. This document reflects the information available at the time of publication in 2026 and may be updated for 2027.

Important information about the routine transportation benefit

SCAN Classic's routine transportation service is a supplemental benefit and not covered by Original Medicare. The primary purpose of routine transportation is to provide non-emergency transportation to medically necessary services. Each one-way trip may not exceed 50 miles.

Important facts:

- There is no cost for routine transportation services under this benefit.
- Transportation arrangements must be scheduled in advance (excluding weekends):
    - Rideshare (Uber/Lyft): Minimum 24 hours notice
    - Passenger vehicle: Minimum 48 hours notice
    - Wheelchair transport: Minimum 48 hours notice
- Curb-to-curb service: Driver will meet the passenger at the curb outside the home or other location for the ride. This service is what is normally provided unless a different type of service is requested.
- Door-to-door service: Your driver will come to the outside door of your home or scheduled location for limited assistance to and from the vehicle. Please note that drivers are not permitted to enter your home or building. If you require additional assistance beyond the outside door, we encourage you to arrange for a caregiver or escort to be available at the time of your trip. This service must be requested at least 72 hours in advance of the reservation (not including weekends). Medical criteria will apply.
- Standing Orders: Can be scheduled for recurring appointments that are the same time and destination every week.
- "Will-Call" rides can be arranged when going to appointments that may run longer than expected. Members can call the SCAN Classic Transportation Department at 1-844-714-2218 when they are ready to be picked up rather than scheduling a specific return pick-up time. It may take up to an hour after you call for your driver to arrive.
- Shared rides - Drivers may have other passengers in the vehicle going to alternate destinations during your trip.
- An escort may accompany a SCAN Classic member during the ride, but this service must be requested when the reservation is made. The escort must be 18 years of age or older.
- If the driver does not arrive in 10 minutes, you need to call SCAN Classic Transportation at 1-844-714-2218 to dispatch another driver. A new pick-up time will be provided.

- Drivers are only allowed to take passengers to the original destination requested when the reservation is made.
- Rideshare (Lyft or Uber) drivers may be used for routine transportation. If you do not want this form of transportation, you must indicate this when the reservation is made.
- Rides must be canceled if the ride is no longer needed. If a ride is not canceled before the driver has been dispatched, the ride will be applied to and deducted from the member's annual ride limit.

What is NOT covered (exclusions):

- Rides to destinations that are beyond the 50-mile one-way limit.
- Rides that exceed your annual SCAN Classic plan ride limit.
- Rides to non-medical destinations such as grocery stores, health clubs, and senior centers.
- Rides to providers and medical facilities that are not covered by SCAN Classic, such as Veterans Affairs (VA) facilities.
- Specialized equipment or vehicles used to transport members beyond what SCAN Classic's contracted providers can provide.
- Door-to-door service in buildings without an operational elevator.
- Assistance "through" the door or inside of the member's home.
- Reimbursement for transportation arranged by the member is not provided. All transportation must be provided by SCAN-contracted vendors.

SECTION 3 Services that aren't covered by our plan (exclusions)

This section tells you what services are excluded from Medicare coverage and therefore, aren't covered by this plan.

The chart below lists services and items that either aren't covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered, and our plan won't pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3.)

Services not covered by Medicare	Covered only under specific conditions
Any service or material provided by another vision or medical plan or non-contracted provider	Not covered under any condition
Biofeedback	Unless it is medically necessary according to Medicare guidelines and authorized by your plan physician or plan medical director (or designee) or SCAN Health Plan.
Complementary Alternative Medicine (CAM) and/or nonconventional medicine Examples include, but are not limited to homeopathy, yoga, polarity, healing touch therapies, and bioelectromagnetics	Unless it is medically necessary according to Medicare guidelines and authorized by your plan physician or plan medical director (or designee) or SCAN Health Plan.
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance
Custodial care Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing	Not covered under any condition
Dental splints, cosmetic procedures, orthodontics, experimental procedures, lost or stolen appliances, or any treatment related to temporomandibular joint syndrome (TMJ)	Not covered under any condition
Durable Medical Equipment items that do not primarily serve a medical purpose and which are not reasonable and necessary to treat an illness or injury (Go to "Durable Medical Equipment (DME) and Related Supplies" in this chapter.)	Additional durable medical equipment is covered under AHCCCS (Medicaid) if you meet the state nursing facility level of care criteria.

Services not covered by Medicare	Covered only under specific conditions
Experimental medical and surgical procedures, equipment, and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan (Go to Chapter 3, Section 5 for more information on clinical research studies)
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Foreseen services received out of area	Except dialysis within the United States.
Full-time nursing care in your home	Not covered under any condition
Hearing aid accessories, ear molds, warranty claim fees, and hearing aid batteries (beyond the 80 free batteries per non-rechargeable aid purchased)	Not covered under any condition
Home health services	Medicare covers medically necessary part-time or intermittent skilled nursing care.
Immunizations not covered by Medicare (Go to "Immunizations" in this chapter.)	Not covered under any condition
Items purchased by the member either online or at a retail location without prior authorization	Not covered under any condition
Knee scooters	Not covered under any condition
Maintenance therapy	Unless it is medically necessary according to Medicare guidelines and authorized by your plan physician or plan medical director (or designee) or SCAN Health Plan.
Medical and hospital services of a transplant donor when the recipient of an organ transplant is not a SCAN Health Plan member	Not covered under any condition
Medical marijuana	Not covered under any condition
Naturopath services (uses natural or alternative treatments)	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
Non-emergency transportation by ambulance	Unless it is medically necessary according to Medicare guidelines and authorized by your plan physician or plan medical director (or designee) or SCAN Health Plan.
Non-Medicare-covered organ transplants	Not covered under any condition
Nutritional supplements or formulas that are administered orally	Unless it is authorized by your plan physician or plan medical director (or designee) or SCAN Health Plan.
Optional or additional accessories to Durable Medical Equipment, corrective appliances, or prosthetics that are primarily for the comfort or convenience of the member or for use primarily in the community, including home remodeling and vehicle modification	Not covered under any condition
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition
Previously scheduled or planned services and treatments for any known condition and/or elective procedures received while out of the service area	Not covered under any condition
Private room in a hospital	Covered only when medically necessary
Radial keratotomy, LASIK surgery, and other low vision aids	One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens.
Residential treatment services for substance abuse	Not covered under any condition
Reversal of sterilization procedures and or non-prescription contraceptive supplies	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
Routine care or elective medical services from non-plan providers without a SCAN Health Plan-approved referral or prior authorization	Not covered under any condition
Routine foot care	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes)
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition
Services for conditions covered by workers' compensation	Not covered under any condition
Services provided in a local, state, or federal government facility	Except when payment under the plan is expressly required by federal or state law or is in accordance with Medicare guidelines
Services provided in Veterans Affairs (VA) facilities	Emergency room services are covered if medically necessary. (See Emergency Care earlier in this chapter.)
Services received outside of your network if you traveled to such location with the express purpose of obtaining medical services, supplies, and/or drugs, without prior authorization	Not covered under any condition
Services received outside the service area that were previously authorized to be provided in-network (including but not limited to oxygen, routine blood tests, chemotherapy, and/or nonemergency surgery)	Not covered under any condition
Services rendered in excess of visit limits or benefits maximums	Not covered under any condition
Supportive devices for the feet	Orthopedic or therapeutic shoes for people with diabetic foot disease.
Surgical treatment for morbid obesity	Unless it is medically necessary according to Medicare guidelines and authorized by

Services not covered by Medicare	Covered only under specific conditions
	your plan physician or plan medical director (or designee) or SCAN Health Plan.
Treatment for conditions resulting from acts of war (declared or not), or an act of war that occurs after the effective date of your current coverage for hospital insurance benefits or supplementary medical insurance benefits	Not covered under any condition
Vision services and/or materials that are primarily for cosmetic purposes including but not limited to, blended (no-line) bifocal or trifocal lenses, photochromic lenses, tinted lenses, progressive or multifocal lenses, the coating or laminating of the lens or lenses, UV (ultraviolet) lenses, polycarbonate/high index lenses, anti-reflective coating, scratch resistant coating, edge polish and other cosmetic processes, nonstandard or elective contact lenses and plano lenses (nonprescription)	Not covered under any condition
Wigs (any type and their care)	Not covered under any condition

SECTION 4 Addenda

Plan Limitations

The following items, procedures, benefits, services, drugs, supplies, and equipment are limited under the SCAN Classic plan:

- Covered Services are available only through plan providers in the network you select (unless such care is rendered as emergency services, urgently needed services, or out-of-area renal dialysis services when you are temporarily outside the service area, worldwide emergency services, or is prior authorized). Previously authorized or planned services to be provided in-network (such as but not limited to oxygen, routine blood tests, chemotherapy, and/or non-emergency surgery) are not covered outside the service area.
- Covered services provided by non-plan providers are limited to unforeseen urgently-needed services or dialysis services when you are temporarily outside the service area, emergency services and authorized post-stabilization care anywhere in the world, and services for which you have obtained prior authorization. In unusual and extraordinary circumstances, urgently needed services are also covered within the service area when

SCAN Classic providers are temporarily unavailable or inaccessible. In these circumstances, covered services should be provided by physicians and other practitioners affiliated with Medicare.

- If you seek routine care or elective medical services from non-plan providers without a SCAN Classic-approved referral, neither SCAN Classic, Original Medicare, nor most Medicare supplemental insurance policies (e.g., Medigap) will pay for your care and you will be required to pay for the full cost of such services.
- SCAN Classic covers all medical services that are medically necessary, are covered under Medicare, and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or they were obtained out-of-network where not authorized.
- Plan providers may discuss alternative therapy that may not be covered by Medicare or SCAN Classic. Not all alternative therapies discussed may be medically necessary. All treatment requires a prior authorization. Please call Member Services at the phone number listed in Chapter 2.
- Members are fully responsible for all applicable cost-sharing as listed in Chapter 4. Cost-sharing is nonnegotiable.

How to obtain a second opinion?

You have the right to request a second medical opinion about your care from your PCP or specialist if you disagree with the opinion of your physician or you wish for confirmation of a diagnosis, medical necessity or the appropriateness of a medical treatment or procedure. If you wish to request a second medical opinion, simply contact your PCP. Please note that prior authorization for a second opinion must be obtained through your PCP before a second medical opinion can be approved.

The Medical Group will review your request and authorize or deny the second opinion. If your request for a second opinion is approved, your PCP will refer you to a qualified provider within your contracted medical group or IPA. If your condition poses an imminent and serious threat to your health, then the second opinion will be authorized or denied within 72 hours after the contracted provider or SCAN Classic receives the request.

If the Medical Group denies your request for a second medical opinion, you have the right to file an appeal with SCAN Classic. If you have any questions, contact Member Services Department. (Please refer to the appeal and grievance procedures in Chapter 9 for information about your right to file an appeal.) A second opinion is not a treatment plan. Any treatment subsequent to a second opinion must be authorized by your Medical Group.

You can request a copy of the time lines for responding to requests for a second opinion from SCAN Classic by calling Member Services (phone numbers are printed on the back cover of this document).

CHAPTER 5:
Using plan coverage for Part D drugs

SECTION 1 Basic rules for our plan's Part D coverage

Go to the Medical Benefits Chart in Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

Our plan will generally cover your drugs as long as you follow these rules:

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription, that's valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription (Go to Section 2) or you can fill your prescription through our plan's mail-order service.
- Your drug must be on our plan's Drug List (go to Section 3).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the FDA or supported by certain references. (Go to Section 3 for more information about a medically accepted indication.)
- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 in this chapter for more information.)

SECTION 2 Fill your prescription at a network pharmacy or through our plan's mail-order service

In most cases, your prescriptions are covered *only* if they're filled at our plan's network pharmacies. (Go to Section 2.4 for information about when we cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with our plan to provide your covered drugs. The term "covered drugs" means all the Part D drugs that are on our plan's Drug List.

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your *Provider & Pharmacy Directory*, visit our website (www.scanhealthplan.com/scan-members/member-benefit-materials-and-information/provider-and-pharmacy-directory), and/or call Member Services at 1-855-650-7226 (TTY users call 711).

You may go to any of our network pharmacies. Some network pharmacies provide preferred cost-sharing, which may be lower than the cost-sharing at a pharmacy that offers standard cost-sharing. The *Provider & Pharmacy Directory* will tell you which network pharmacies offer preferred cost-sharing. Contact us to find out more about how your out-of-pocket costs could vary for different drugs.

If your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy in the network. If the pharmacy you use stays in our network but no longer offers preferred cost-sharing, you may want to switch to a different network or preferred pharmacy, if available. To find another pharmacy in your area, get help from Member Services at 1-855-650-7226 (TTY users call 711) or use the *Provider & Pharmacy Directory*. You can also find information on our website at www.scanhealthplan.com/scan-members/member-benefit-materials-and-information/provider-and-pharmacy-directory.

Specialized pharmacies

Some prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, an LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting Part D drugs in an LTC facility, call Member Services at 1-855-650-7226 (TTY users call 711).
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. To locate a specialized pharmacy, go to your *Provider & Pharmacy Directory* www.scanhealthplan.com/scan-members/member-benefit-materials-and-information/provider-and-pharmacy-directory or call Member Services at 1-855-650-7226 (TTY users call 711).

Section 2.2 Our plan's mail-order service

For certain kinds of drugs, you can use the plan's network mail-order service. Generally, the drugs provided through mail-order are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Our plan's mail-order service allows you to order **up to a 100-day supply**.

Our pharmacy network includes mail-order pharmacies that offer standard cost-sharing and preferred cost-sharing. While you can receive your covered prescription drugs at any mail-order network pharmacy, your costs may be less at the mail-order pharmacy with preferred cost-sharing.

To get order forms and information about filling your prescriptions by mail please call Member Services (phone numbers are printed on the back cover of this document).

Usually, a mail-order pharmacy order will be delivered to you in no more than 14 days. If your prescription will take longer than 14 days to process, you may contact Member Services to obtain approval for a local pharmacy refill. Retail pharmacy copayments will apply.

New prescriptions the pharmacy gets directly from your doctor's office.
The pharmacy will automatically fill and deliver new prescriptions it gets from health care providers, without checking with you first, if either:

- You used mail-order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You can ask for automatic delivery of all new prescriptions at any time by calling 1-866-553-4125, 24 hours a day, 7 days a week. TTY users call 711. If you have never used the mail-order services with this plan, the pharmacy will contact you to confirm your order before shipping when a health care provider submits your first prescription directly to the pharmacy. Please make sure to let the pharmacy know the best ways to contact you by calling 1-866-553-4125, 24 hours a day, 7 days a week. TTY users call 711.

If you get a prescription automatically by mail that you don't want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail-order in the past and don't want the pharmacy to automatically fill and ship each new prescription, contact us by calling 1-866-553-4125, 24 hours a day, 7 days a week. TTY users call 711.

If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. It's important to respond each time you're contacted by the pharmacy to let them know whether to ship, delay, or cancel the new prescription.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, contact us by calling 1-866-553-4125, 24 hours a day, 7 days a week. TTY users call 711.

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed.

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, contact your pharmacy 14 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, contact us by calling 1-866-553-4125, 24 hours a day, 7 days a week. TTY users call 711.

If you get a refill automatically by mail that you don't want, you may be eligible for a refund.

Section 2.3 How to get a long-term supply of drugs

When you get a long-term supply of drugs, your cost-sharing may be lower. Our plan offers 2 ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Provider & Pharmacy Directory* (www.scanhealthplan.com/scan-members/member-benefit-materials-and-information/provider-and-pharmacy-directory) tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services at 1-855-650-7226 (TTY users call 711) for more information.
2. You can also get maintenance drugs through our mail-order program. Go to Section 2.2 for more information.

Section 2.4 Using a pharmacy that's not in our plan's network

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you aren't able to use a network pharmacy. We also have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. **Check first with Member Services at 1-855-650-7226 (TTY users call 711)** to see if there's a network pharmacy nearby.

We cover prescriptions filled at an out-of-network pharmacy only in these circumstances:

- If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- If you are trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail or mail-order pharmacy.
- If you are traveling within the US, but outside of the plan's service area, and you become ill or run out of your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules identified within this document and the formulary and if a network pharmacy is not available.
- The out-of-network fills are limited to a 30-day supply and will be evaluated on a case-by-case basis.

If you must use an out-of-network pharmacy, you'll generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Go to Chapter 7, Section 2 for information on how to ask our plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

SECTION 3 Your drugs need to be on our plan's Drug List

Section 3.1 The Drug List tells which Part D drugs are covered

Our plan has a *List of Covered Drugs* (formulary). In this *Evidence of Coverage,* **we call it the Drug List**.

The drugs on this list are selected by our plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare. The Drug List only shows drugs covered under Medicare Part D.

We generally cover a drug on our plan's Drug List as long as you follow the other coverage rules explained in this chapter and use of the drug for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- Approved by the FDA for the diagnosis or condition for which it's being prescribed, or
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

The Drug List includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the Drug List, when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Go to Chapter 12 for definitions of types of drugs that may be on the Drug List.

Drugs that aren't on the Drug List

Our plan doesn't cover all prescription drugs.

- In some cases, the law doesn't allow any Medicare plan to cover certain types of drugs. (For more information, go to Section 7.)
- In other cases, we decided not to include a particular drug on the Drug List.
- In some cases, you may be able to get a drug that's not on the Drug List. (For more information, go to Chapter 9.)

Section 3.2 Five cost-sharing tiers for drugs on the Drug List

Every drug on our plan's Drug List is in one of five cost-sharing tiers. In general, the higher the tier, the higher your cost for the drug:

- Cost-Sharing Tier 1: Preferred Generic. This tier includes generic drugs (the lowest tier).
- Cost-Sharing Tier 2: Generic. This tier includes generic drugs.
- Cost-Sharing Tier 3: Preferred Brand. This tier includes Insulin, other brand drugs and some generic drugs.
- Cost-Sharing Tier 4: Non-Preferred Drug. This tier includes brand drugs and some generic drugs.
- Cost-Sharing Tier 5: Specialty Tier. This tier includes specialty drugs (the highest tier).

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6.

Section 3.3 How to find out if a specific drug is on the Drug List

To find out if a drug is on our Drug List, you have these options:

- Check the most recent Drug List we provided electronically.
- Visit our plan's website (www.scanhealthplan.com/scan-members/member-benefit-materials-and-information/formulary-documents). The Drug List on the website is always the most current.
- Call Member Services at 1-855-650-7226 (TTY users call 711) to find out if a particular drug is on our plan's Drug List or ask for a copy of the list.
- Use our plan's "Real-Time Benefit Tool" www.scanhealthplan.com to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition. You can also call Member Services at 1-855-650-7226 (TTY users call 711).

SECTION 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

For certain prescription drugs, special rules restrict how and when our plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List.

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option.

Note that sometimes a drug may appear more than once on our Drug List. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost-sharing may apply to the different versions of the drug (for example, 10 mg versus 100 mg; one per day versus 2 per day; tablet versus liquid).

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call Member Services at 1-855-650-7226 (TTY users call 711) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you. (Go to Chapter 9.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Member Services at 1-855-650-7226 (TTY users call 711) or on our website www.scanhealthplan.com/scan-members/member-benefit-materials-and-information/formulary-documents.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, our plan may require you to try Drug A first. If Drug A doesn't work for you, our plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**. Our plan's step therapy criteria can be obtained by calling Member Services at 1-855-650-7226 (TTY users call 711) or on our website www.scanhealthplan.com/scan-members/member-benefit-materials-and-information/formulary-documents.

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it's normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

SECTION 5 What you can do if one of your drugs isn't covered the way you'd like

There are situations where a prescription drug you take, or that you and your provider think you should take that isn't on our Drug List has restrictions. For example:

- The drug might not be covered at all. Or a generic version of the drug may be covered but the brand name version you want to take isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage.
- The drug is covered, but in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be.

If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do.

If your drug isn't on the Drug List or is restricted, here are options for what you can do:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can ask for an **exception** and ask our plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, our plan must provide a temporary supply of a drug you're already taking. This temporary supply gives you time to talk with your provider about the change.

To be eligible for a temporary supply, the drug you take **must no longer be on our plan's Drug List OR is now restricted in some way**.

- **If you're a new member,** we'll cover a temporary supply of your drug during the first **90 days** of your membership in our plan.
- **If you were in our plan last year,** we'll cover a temporary supply of your drug during the first **90 days** of the calendar year.
- This temporary supply will be for a maximum of a 30-day supply (for those members who aren't in a long-term care facility) or a 31-day supply (for those members who reside in a long-term care facility). If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum of a 30-day supply (for those members who aren't in a long-term care facility) or a 31-day supply (for those members who

reside in a long-term care facility) of medication. The prescription must be filled at a network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **For members who've been in our plan for more than 90 days and live in a long-term care facility and need a supply right away:** We'll cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- **For those members who are moving from a long-term care (LTC) facility or a hospital stay to home:**

  We'll cover a temporary supply of your drug for a maximum of a 30-day supply, or less if your prescription is written for fewer days.
- **For those members who are moving from home or a hospital stay to a long-term care (LTC) facility:**

  We'll cover a temporary supply of your drug for a maximum of a 31-day supply, or less if your prescription is written for fewer days.

For questions about a temporary supply, call Member Services at 1-855-650-7226 (TTY users call 711).

During the time when you're using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have 2 options:

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call Member Services at 1-855-650-7226 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an exception

You and your provider can ask our plan to make an exception and cover the drug in the way you'd like it covered. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception. For example, you can ask our plan to cover a drug even though it is not on our plan's Drug List. Or you can ask our plan to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, go to Chapter 9, Section 6.4 to learn what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

Section 5.1 What to do if your drug is in a cost-sharing tier you think is too high

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Member Services at 1-855-650-7226 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

You and your provider can ask our plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception to the rule.

If you and your provider want to ask for an exception, go to Chapter 9, Section 6.4 for what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our Tier 5 (Specialty Tier) aren't eligible for this type of exception. We don't lower the cost-sharing amount for drugs in this tier.

SECTION 6 Our Drug List can change during the year

Most changes in drug coverage happen at the beginning of each year (January 1). However, during the year, our plan can make some changes to the Drug List. For example, our plan might:

- **Add or remove drugs from the Drug List**
- **Move a drug to a higher or lower cost-sharing tier**
- **Add or remove a restriction on coverage for a drug**
- **Replace a brand name drug with a generic version of the drug**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product**

We must follow Medicare requirements before we change our plan's Drug List.

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. Sometimes you'll get direct notice if changes are made to a drug that you take.

Changes to drug coverage that affect you during this plan year

- **Adding new drugs to the Drug List and immediately removing or making changes to a like drug on the Drug List.**

- When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
- We'll make these immediate changes only if we add a new generic version of a brand name or add certain new biosimilar versions of an original biological product that was already on the Drug List.
- We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made.

- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List with advance notice.**
  - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
  - We'll make these changes only if we add a new generic version of a brand name drug or add certain new biosimilar versions of an original biological product that was already on the Drug List.
  - We'll tell you at least 30 days before we make the change or tell you about the change and cover a 30-day fill of the version of the drug you're taking.
- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
  - Sometimes a drug can be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you take that drug, we'll tell you after we make the change.
- **Making other changes to drugs on the Drug List.**
  - We may make other changes once the year has started that affect drugs you are taking. For example, we based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - We'll tell you at least 30 days before we make these changes or tell you about the change and cover an additional 30-day fill of the drug you're taking.

If we make changes to any of the drugs you take, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or asking for a coverage decision to satisfy any new restrictions on the drug you take. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you take. For more information on how to ask for a coverage decision, including an exception, go to Chapter 9.

Changes to the Drug List that don't affect you during this plan year

We may make certain changes to the Drug List that aren't described above. In these cases, the change won't apply to you if you're taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that won't affect you during the current plan year are:

- We move your drug into a higher cost-sharing tier.
- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you take (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We won't tell you about these types of changes directly during the current plan year. You'll need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to drugs you take that will impact you during the next plan year.

SECTION 7 Types of drugs we don't cover

Some kinds of prescription drugs are *excluded*. This means Medicare doesn't pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself (except for certain excluded drugs covered under our enhanced drug coverage). If you appeal and the requested drug is found not to be excluded under Part D, we'll pay for or cover it. (For information about appealing a decision, go to Chapter 9.)

Here are 3 general rules about drugs that Medicare drug plans won't cover under Part D:

- Our plan's Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B.
- Our plan can't cover a drug purchased outside the United States or its territories.
- Our plan can't cover *off-label* use of a drug when the use isn't supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label* use is any use of the drug other than those indicated on a drug's label as approved by the FDA.

In addition, by law, the following categories of drugs aren't covered by Medicare drug plans: (Our plan covers certain drugs listed below through our enhanced drug coverage, for which you may have cost-sharing.)

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

We offer additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan. These drugs (prescription vitamins and erectile dysfunction medication) are covered under tier 1. For a list of these additional drugs that we cover and any restrictions that may apply, please refer to your Drug List under the section "Additional Covered Drugs." For more information about these drugs, visit our plan's website (www.scanhealthplan.com) or call Member Services. The amount you pay for these drugs doesn't count towards qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 6, Section 6.)

If you **get Extra Help from Medicare** to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. (Go to our plan's Drug List or call Member Services at 1-855-650-7226 (TTY users call 711) for more information.) If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 How to fill a prescription

To fill your prescription, provide our plan membership information (which can be found on your membership card) at the network pharmacy you choose. The network pharmacy will automatically bill our plan for *our* share of your drug cost. You need to pay the pharmacy *your* share of the cost when you pick up your prescription.

If you don't have our plan membership information with you, you or the pharmacy can call our plan to get the information, or you can ask the pharmacy to look up our plan enrollment information.

If the pharmacy can't get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** You can then **ask us to reimburse you** for our share. Go to Chapter 7, Section 2 for information about how to ask our plan for reimbursement.

SECTION 9 Part D drug coverage in special situations

Section 9.1 In a hospital or a skilled nursing facility for a stay covered by our plan

If you're admitted to a hospital or to a skilled nursing facility for a stay covered by our plan, we'll generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, our plan will cover your prescription drugs as long as the drugs meet all our rules for coverage described in this chapter.

Section 9.2 As a resident in a long-term care (LTC) facility

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy or uses a pharmacy that supplies drugs for all its residents. If you're a resident of an LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it's part of our network.

Check your *Provider & Pharmacy Directory* www.scanhealthplan.com/scan-members/member-benefit-materials-and-information/provider-and-pharmacy-directory to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Member Services at 1-855-650-7226 (TTY users call 711). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

If you're a resident in an LTC facility and need a drug that's not on our Drug List or restricted in some way, go to Section 5 for information about getting a temporary or emergency supply.

Section 9.3 If you also have drug coverage from an employer or retiree group plan

If you have other drug coverage through your (or your spouse or domestic partner's) employer or retiree group, contact **that group's benefits administrator.** They can help you understand how your current drug coverage will work with our plan.

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage pays first.

Special note about creditable coverage:

Each year your employer or retiree group should send you a notice that tells you if your drug coverage for the next calendar year is creditable.

If the coverage from the group plan is creditable, it means that your plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard drug coverage.

Keep any notices about creditable coverage because you may need these notices later to show that you maintained creditable coverage. If you didn't get a creditable coverage notice, ask for a copy from your employer or retiree plan's benefits administrator or the employer or union.

Section 9.4 If you're in a Medicare-certified hospice

Hospice and our plan don't cover the same drug at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in getting these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

We conduct drug use reviews to help make sure our members get safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems like:

- Possible medication errors
- Drugs that may not be necessary because you take another similar drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you're allergic to
- Possible errors in the amount (dosage) of a drug you take
- Unsafe amounts of opioid pain medications

If we see a possible problem with your use of medications, we'll work with your provider to correct the problem.

Section 10.1 Drug Management Program (DMP) to help members safely use opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we'll cover for you

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You'll have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your request about the limitations that apply to your access to medications, we'll automatically send your case to an independent reviewer outside of our plan. Go to Chapter 9 for information about how to ask for an appeal.

You won't be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you're getting hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.2 Medication Therapy Management (MTM) program to help members manage medications

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help them use opioids safely may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other

health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will get information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program, call Member Services at 1-855-650-7226 (TTY users call 711).

CHAPTER 6: What you pay for Part D drugs

SECTION 1 What you pay for Part D drugs

If you're in a program that helps pay for your drugs, **some information in this** *Evidence of Coverage* **about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, call Member Services at 1-855-650-7226 (TTY users call 711) and ask for the *LIS Rider*.

We use "drug" in this chapter to mean a Part D prescription drug. Not all drugs are Part D drugs. Some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5 explains these rules. When you use our plan's "Real-Time Benefit Tool" to look up drug coverage (www.scanhealthplan.com), the cost you see shows an estimate of the out-of-pocket costs you're expected to pay. You can also get information provided by the "Real-Time Benefit Tool" by calling Member Services at 1-855-650-7226 (TTY users call 711).

Section 1.1 Types of out-of-pocket costs you may pay for covered drugs

There are 3 different types of out-of-pocket costs for covered Part D drugs that you may be asked to pay:

- **Deductible** is the amount you pay for drugs before our plan starts to pay our share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost you pay each time you fill a prescription.

Section 1.2 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what doesn't count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments are included in your out-of-pocket costs

Your out-of-pocket costs **include** the payments listed below (as long as they are for covered Part D drugs, and you followed the rules for drug coverage explained in Chapter 5):

- The amount you pay for drugs when you're in the following drug payment stages:
  - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare drug plan before you joined our plan
- Any payments for your drugs made by family or friends
- Any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, and most charities

Moving to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $2,400 in out-of-pocket costs within the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments aren't included in your out-of-pocket costs

Your out-of-pocket costs **don't include** any of these types of payments:

- Drugs you buy outside the United States and its territories
- Drugs that aren't covered by our plan
- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage
- Prescription drugs and vaccines covered by Part A or Part B
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Drug Plan
- Payments you make toward drugs not normally covered in a Medicare Drug Plan
- Payments for your drugs made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder: If any other organization like the ones listed above pays part or all your out-of-pocket costs for drugs, you're required to tell our plan by calling Member Services at 1-855-650-7226 (TTY users call 711).

Tracking your out-of-pocket total costs

- The *Part D Explanation of Benefits* (EOB) you get includes the current total of your out-of-pocket costs. When this amount reaches $2,400, the *Part D EOB* will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up to date.

SECTION 2 Drug payment stages for SCAN Classic members

There are **3 drug payment stages** for your drug coverage under SCAN Classic. How much you pay for each prescription depends on what stage you're in when you get a prescription filled or refilled. Details of each stage are explained in this chapter. The stages are:

- **Stage 1: Yearly Deductible Stage**
- **Stage 2: Initial Coverage Stage**
- **Stage 3: Catastrophic Coverage Stage**

SECTION 3 Your *Part D Explanation of Benefits (EOB)* explains which payment stage you're in

Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track 2 types of costs:

- **Out-of-Pocket Costs:** this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- **Total Drug Costs:** this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you filled one or more prescriptions through our plan during the previous month, we'll send you a *Part D EOB*. The *Part D EOB* includes:

- **Information for that month.** This report gives payment details about prescriptions you filled during the previous month. It shows the total drug costs, what our plan paid, and what you and others paid on your behalf.
- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.

- **Drug price information.** This displays the total drug price, and information about changes in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This shows information about other available drugs with lower cost-sharing for each prescription claim, if applicable.

Section 3.1 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here's how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we won't automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
    - When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit.
    - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
    - Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
    - If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you get the *Part D EOB*, look it over to be sure the information is complete and correct. If you think something is missing or you have questions, call Member Services at 1-855-650-7226 (TTY users call 711). You may access electronic Part D EOB statements by logging in at **Express-Scripts.com**, and go to **Select Communication Preferences** under **My Account**. Click on **Edit preferences** and then choose to get your printed materials online. Then you'll receive your Medicare Part D EOB statements online rather than by mail. There's no cost and you can switch back to paper EOBs anytime. First-time visitors will need to register with their SCAN Health Plan member ID number. Be sure to keep these reports.

SECTION 4 There is no deductible for SCAN Classic

There is no deductible for SCAN Classic. You begin in the Initial Coverage Stage when you fill your first prescription of the year. Go to Section 5 for information about your coverage in the Initial Coverage Stage.

SECTION 5 The Initial Coverage Stage

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, our plan pays its share of the cost of your covered drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

Our plan has five cost-sharing tiers

Every drug on our plan's Drug List is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Cost-Sharing Tier 1: Preferred Generic. This tier includes generic drugs (the lowest tier).
- Cost-Sharing Tier 2: Generic. This tier includes generic drugs.
- Cost-Sharing Tier 3: Preferred Brand. This tier includes Insulin, other brand drugs and some generic drugs.
    - You pay $35 per month supply of each covered insulin product on this tier.
- Cost-Sharing Tier 4: Non-Preferred Drug. This tier includes brand drugs and some generic drugs.
- Cost-Sharing Tier 5: Specialty Tier. This tier includes specialty drugs (the highest tier).

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy that offers standard cost-sharing. Costs may be less at pharmacies that offer preferred cost-sharing
- A network retail pharmacy that offers preferred cost-sharing
- A pharmacy that isn't in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 5, Section 2.4 to find out when we'll cover a prescription filled at an out-of-network pharmacy.
- Our plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 5 and our plan's *Provider & Pharmacy Directory* www.scanhealthplan.com/scan-members/member-benefit-materials-and-information/provider-and-pharmacy-directory.

Section 5.2 Your costs for a *one-month* supply of a covered drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

The amount of the copayment or coinsurance depends on the cost-sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your costs for a *one-month* supply of a covered Part D drug:

Tier		Standard retail in-network cost-sharing (up to a 30-day supply)	Preferred retail in-network cost-sharing (up to a 30-day supply)	Standard Mail-order cost-sharing (up to a 30-day supply)	Preferred Mail-order cost-sharing (up to a 30-day supply)	Long-term care (LTC) cost-sharing (up to a 31-day supply)	Out-of-network cost-sharing* (Coverage is limited to certain situations; go to Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Preferred Generic)		$7 copay	$0 copay	$7 copay	$0 copay	$7 copay	$7 copay
Cost-Sharing Tier 2 (Generic)		$15 copay	$0 copay	$15 copay	$0 copay	$15 copay	$15 copay
Cost-Sharing Tier 3 (Preferred Brand)	**Insulin**	$35 copay	$35 copay	$35 copay	$35 copay	$35 copay	$35 copay
	Other drugs	$47 copay	$42 copay	$47 copay	$42 copay	$47 copay	$47 copay
Cost-Sharing Tier 4 (Non-Preferred Drug)		35% of the total cost	35% of the total cost	35% of the total cost	35% of the total cost	35% of the total cost	35% of the total cost
Cost-Sharing Tier 5 (Specialty Tier)		33% of the total cost	33% of the total cost	33% of the total cost	33% of the total cost	33% of the total cost	33% of the total cost

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

You won’t pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Go to Section 8 of this chapter for more information on cost-sharing for Part D vaccines.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you're trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense less than a full month's supply, if this will help you plan refill dates better.

If you get less than a full month's supply of certain drugs, you won't have to pay for the full month's supply.

- If you're responsible for coinsurance, you pay a percentage of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you're responsible for a copayment for the drug, you only pay for the number of days of the drug that you get instead of a whole month. We calculate the amount you pay per day for your drug (the daily cost-sharing rate) and multiply it by the number of days of the drug you get.

Section 5.4 Your costs for a *long-term* (100-day) supply of a covered Part D drug

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is a 100-day supply.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your costs for a *long-term* (100-day) supply of a covered Part D drug:

Tier		Standard retail cost-sharing (in-network) (100-day supply)	Preferred retail cost-sharing (in-network) (100-day supply)	Standard Mail-order cost-sharing (100-day supply)	Preferred Mail-order cost-sharing (100-day supply)
Cost-Sharing Tier 1 (Preferred Generic)		$14 copay	$0 copay	$14 copay	$0 copay
Cost-Sharing Tier 2 (Generic)		$30 copay	$0 copay	$30 copay	$0 copay
Cost-Sharing Tier 3 (Preferred Brand)	**Insulin**	$85 copay	$85 copay	$85 copay	$85 copay
	Other drugs	$141 copay	$126 copay	$141 copay	$126 copay
Cost-Sharing Tier 4 (Non-Preferred Drug)		35% of the total cost	35% of the total cost	35% of the total cost	35% of the total cost
Cost-Sharing Tier 5 (Specialty Tier)		A long-term supply is not available for drugs in tier 5	A long-term supply is not available for drugs in tier 5	A long-term supply is not available for drugs in tier 5	A long-term supply is not available for drugs in tier 5

You won't pay more than $70 for up to a 2-month supply or $85 for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier. You won't pay more than $70 for a 2-month supply or $105 for up to a 3-month supply of each insulin product covered through a coverage determination, appeal, or transition.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2,400

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,400. You then move to the Catastrophic Coverage Stage.

We offer additional coverage on some prescription drugs that aren't normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs won't count towards your total out-of-pocket costs.

The *Part D EOB* you get will help you keep track of how much you, our plan, and any third parties have spent on your behalf during the year. Not all members will reach the $2,400 out-of-pocket limit in a year.

We'll let you know if you reach this amount. Go to Section 1.2 for more information on how Medicare calculates your out-of-pocket costs.

SECTION 6 The Catastrophic Coverage Stage

In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the $2,400 limit for the calendar year. Once you're in the Catastrophic Coverage Stage, you'll stay in this payment stage until the end of the calendar year.

- During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs covered under our enhanced benefit.

SECTION 7 Additional benefits information

Compounded drugs and their coverage:

Compounded drugs are produced by mixing or altering the existing prescription medications for a variety of reasons. Sometimes, an individual cannot use the standard version of the product because of an allergy to one of its ingredients. In other cases, the right dosage form is not readily available, so the commercially offered drug products need to be transformed into a different form. For people who can't swallow tablets or capsules, compounding procedures can customize a drug into a powder, liquid, lozenge, suppository, or another form.

Compounded medications are not approved by the Food and Drug Administration (FDA), unlike drugs listed in our formulary. Without the FDA oversight, there is an extra risk factor involved when a compounded product is prepared because it is not tested for purity, stability, safety, effectiveness, or dosage. Since the quality of compounded products may be compromised, the FDA recommends using an approved product that has undergone rigorous testing instead of a compounded medication when possible.

Our plan does not cover all compounded medications. In some cases, certain compounded products are "excluded" from coverage by Medicare. In other cases, we have decided not to cover a particular compounded product. To ensure the appropriate utilization of compounded medications, certain rules and restrictions may apply e.g., Prior Authorization and Quantity Limit requirements, etc.

Our members are advised to use a compounded medication only when it is medically necessary. If you have questions about compounded medications and their coverage, please call Member Services (phone numbers are printed on the back cover of this document) or visit our website (www.scanhealthplan.com).

SECTION 8 What you pay for Part D vaccines

Important message about what you pay for vaccines – Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs.

You can find these vaccines listed in our plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you. Go to our plan's Drug List or call Member Services at 1-855-650-7226 (TTY users call 711) for coverage and cost-sharing details about specific vaccines.

There are 2 parts to our coverage of Part D vaccines:

- The first part is the cost of **the vaccine itself.**
- The second part is for the cost of **giving you the vaccine.** (This is sometimes called the administration of the vaccine.)

Your costs for a Part D vaccine depend on 3 things:

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
   - Most adult Part D vaccines are recommended by ACIP and cost you nothing.
2. **Where you get the vaccine.**
   - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine.**
   - A pharmacist or another provider may give the vaccine in the pharmacy. Or a provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccine can vary depending on the circumstances and what **drug payment stage** you're in.

- When you get a vaccine, you may have to pay the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you'll be reimbursed the entire cost you paid.
- Other times when you get a vaccine, you pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you pay nothing.

Below are 3 examples of ways you might get a Part D vaccine.

Situation 1: You get the Part D vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states don't allow pharmacies to give certain vaccines.)

- For most adult Part D vaccines, you pay nothing.
- For other Part D vaccines, you pay the pharmacy your coinsurance or copayment for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccine at your doctor's office.

- When you get the vaccine, you may have to pay the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any coinsurance or copayment for the vaccine (including administration), and less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we'll reimburse you for this difference.)

Situation 3: You buy the Part D vaccine itself at the network pharmacy and take it to your doctor's office where they give you the vaccine.

- For most adult Part D vaccines, you pay nothing for the vaccine itself.
- For other Part D vaccines, you pay the pharmacy your copayment or coinsurance for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid.

Select doctor's offices may be able to process the Part D vaccine, and/or the administrative fee, electronically.

CHAPTER 7: Asking us to pay our share of a bill for covered medical services or drugs

SECTION 1 Situations when you should ask us to pay our share for covered services or drugs

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost. Other times, you may find you pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you got or for more than your share of cost-sharing. First, try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll notify the provider. You should never pay more than plan-allowed cost-sharing. If this provider is contracted, you still have the right to treatment.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

1. **When you got emergency or urgently needed medical care from a provider who's not in our plan's network**

   Outside the service area, you can get emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases,

   - You're only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care.
   - If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.
   - You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
     - If the provider is owed anything, we'll pay the provider directly.
     - If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill you think you shouldn't pay

Network providers should always bill our plan directly and ask you only for your share of the cost. But sometimes they make mistakes and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get covered services. We don't allow providers to add additional separate charges, called **balance billing**. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a network provider you think is more than you should pay, send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you already paid a bill to a network provider, but feel you paid too much, send us the bill along with documentation of any payment you made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

3. If you're retroactively enrolled in our plan

Sometimes a person's enrollment in our plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out of pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You need to submit paperwork, such as receipts and bills, for us to handle the reimbursement.

4. When you use an out-of-network pharmacy to fill a prescription

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. Go to Chapter 5, Section 2.4 to learn about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount we'd pay at an in-network pharmacy.

5. When you pay the full cost for a prescription because you don't have our plan membership card with you

If you don't have our plan membership card with you, you can ask the pharmacy to call our plan or look up our plan enrollment information. If the pharmacy can't get the

enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find the drug isn't covered for some reason.

- For example, the drug may not be on our plan's Drug List, or it could have a requirement or restriction you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or pay a bill you got

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within 12 months for Medical claims and 36 months for Prescription Drug claims** of the date you got the service, item, or drug.

To make sure you're giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it'll help us process the information faster.
- Download a copy of the form from our website (www.scanhealthplan.com) or call Member Services at 1-855-650-7226 (TTY users call 711) and ask for the form.

For Medical Claims, mail your request for payment together with any itemized bills, medical records, and proof of payment/receipts to us at this address:

SCAN Health Plan
ATTN: Claims Department
P.O. Box 21543
Eagan, MN 55121

For Prescription Drug Claims, mail your request for payment together with any bills or paid receipts to us at this address:

Express Scripts
ATTN: Medicare Part D
P.O. Box 52023
Phoenix, AZ 85072

SECTION 3 We'll consider your request for payment and say yes or no

When we get your request for payment, we'll let you know if we need any additional information from you. Otherwise, we'll consider your request and make a coverage decision.

- If we decide the medical care or drug is covered and you followed all the rules, we'll pay for our share of the cost. Our share of the cost might not be the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you already paid for the service or drug, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service or drug yet, we'll mail the payment directly to the provider.
- If we decide the medical care or drug is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your right to appeal that decision.

Section 3.1 If we tell you that we won't pay for all or part of the medical care or drug, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9.

CHAPTER 8: Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, braille, large print, or other alternate formats, etc.)

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how our plan can meet these accessibility requirements include but aren't limited to, provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in languages other than English including Spanish and braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Services at 1-855-650-7226 (TTY users call 711).

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in our plan's network for a specialty aren't available, it's our plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you'll only pay in-network cost-sharing. If you find yourself in a situation where there are no specialists in our plan's network that cover a service you need, call our plan for information on where to go to get this service at in-network cost-sharing.

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Member Services at 1-855-650-7226. You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Debemos proporcionarle información de una manera que sea conveniente para usted (en otros idiomas que no sean el inglés, en braille, grabación de audio, letra grande u otros formatos alternativos, etc.)

Nuestro plan debe garantizar que todos los servicios, tanto clínicos como no clínicos, se brinden de manera culturalmente competente y sean accesibles para todas las personas

inscritas, incluyendo aquellas con dominio limitado del inglés, habilidades de lectura limitadas, discapacidad auditiva o aquellos con distintos orígenes culturales y étnicos. Ejemplos de cómo nuestro plan puede cumplir con estos requisitos de accesibilidad incluyen, entre otros, la prestación de servicios de traductores, servicios de interpretación, teletipos o conexión TTY (teléfono de texto o teléfono de teletipo).

Nuestro plan cuenta con servicios de interpretación gratuitos para responder preguntas de los miembros que no hablan inglés. También podemos proporcionarle información en otros idiomas además del inglés, incluidos español y braille, en letra grande u otros formatos alternativos, sin costo alguno, si lo necesita. Debemos proporcionarle información sobre los beneficios de nuestro plan en un formato que sea accesible y adecuado para usted. Para obtener información nuestra de una manera que le resulte más conveniente, llame a Member Services al 1-855-650-7226 (los usuarios de TTY deben llamar al 711).

Nuestro plan debe brindar a las mujeres inscritas la opción de acceso directo a un especialista en salud de la mujer dentro de la red para servicios de atención médica preventiva y de rutina para mujeres.

Si los proveedores de la red de nuestro plan para una especialidad no están disponibles, es responsabilidad de nuestro plan encontrar proveedores especializados fuera de la red que le brinden la atención necesaria. En este caso, solo pagará el gasto compartido dentro de la red. Si se encuentra en una situación en la que no hay especialistas en la red de nuestro plan que cubran un servicio que necesita, llame a nuestro plan para obtener información sobre dónde puede recibir este servicio con el mismo gasto compartido que en la red.

Si tiene problemas para obtener información de nuestro plan en un formato que sea accesible y adecuado para usted, consultar a un especialista en salud de la mujer o encontrar un especialista de la red, llame para presentar un reclamo ante Member Services al 1-855-650-7226. También puede presentar una queja ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles al 1-800-368-1019 o por TTY al 1-800-537-7697.

Section 1.2 We must ensure you get timely access to covered services and drugs

You have the right to choose a primary care provider (PCP) in our plan’s network to provide and arrange for your covered services. You also have the right to go to a women’s health specialist (such as a gynecologist) without a referral.

You have the right to get appointments and covered services from our plan’s network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think you aren’t getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your personal health information includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practice*, that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first*.
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
    - We're required to release health information to government agencies that are checking on quality of care.
    - Because you're a member of our plan through Medicare, we're required to give Medicare your health information including information about your Part D drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it's been shared with others

You have the right to look at your medical records held by our plan, and to get a copy of your records. We're allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we'll work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that aren't routine.

If you have questions or concerns about the privacy of your personal health information, call Member Services at 1-855-650-7226 (TTY users call 711).

SCAN NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is for participants enrolled in all SCAN Health Plans, including SCAN Health Plan (CA, WA, OR nonprofit corporations), SCAN Desert Health Plan, Inc. (an AZ nonprofit corporation), SCAN Health Plan Nevada, Inc. (a NV nonprofit corporation), and SCAN Health Plan Texas, Inc. (a TX nonprofit corporation) (collectively, "SCAN").

SCAN is part of the SCAN Affiliated Covered Entity ("SCAN's ACE"), a designation for purposes of the Health Insurance Portability and Accountability Act. For the full list of SCAN's ACE members, refer to **Attachment A**.

When you are both enrolled in a SCAN product and a patient of a SCAN ACE medical provider, SCAN and the provider may use and disclose your information as permitted under HIPAA and applicable state law. Any disclosure of medical information beyond what is permitted by law is prohibited.

SCAN must follow the privacy practices described in this Notice while it is in effect. This Notice took effect May 14, 2013, and was most recently reviewed on May 4, 2026. This Notice is subject to change and will remain in effect until we replace or modify it.

FEDERAL AND STATE LAW

Federal and state laws require SCAN's ACE to protect your health information, and federal law requires us to describe to you how we handle your information. When state privacy law offers stronger protections or greater access than federal law, SCAN follows stricter state law.

Oregon: Oregon law may provide additional protections for certain health information, including information relating to mental health treatment, HIV/AIDS, genetic testing or genetic information, biological specimens, and substance use disorder diagnosis, treatment, or referral. We will use and disclose this information in accordance with applicable Oregon and federal law and will obtain your authorization when required. Oregon law may also provide additional rights regarding the confidentiality of health-related communications and additional protections concerning the use, disclosure, retention or research use of genetic information and biological specimens. To the extent Oregon law provides greater privacy protections or additional rights with respect to your health information, we will comply with those requirements.

PROTECTING YOUR PRIVACY

At SCAN, we understand the importance of keeping your health information confidential and we are committed to use of your health information that is consistent with state and federal law. This Notice explains how we use your health information and describes how we may share your health information with others involved in your health care. This Notice also lists your rights concerning your health information and how you may exercise those rights.

PROTECTED HEALTH INFORMATION

For the purposes of this Notice, "health information" or "information" refers to Protected Health Information or PHI. Protected Health Information is defined as information that identifies who you are and relates to your past, present, or future physical or mental health or condition, provision of care, or payment for care.

HOW WE USE YOUR HEALTH INFORMATION

SCAN uses and shares your health information for the purposes of treatment, payment, health care operations, and other uses permitted or required by federal, state, or local law.

TREATMENT

SCAN may use or disclose your health information to health care providers (doctors, hospitals, pharmacies, and other caregivers) who request it in connection with your treatment without your written authorization. Please be aware that your medical records are stored at your physician's office. Here are some examples of how SCAN may share your information:

- We may share information with your physician or medical group when necessary for you to receive treatment.
- We may share information about you to a hospital so that you receive appropriate care.
- We may share information about you with plan providers involved in the delivery of your health care services. This includes sharing your health information as part of a local, state or national Health Information Exchange or "HIE".

PAYMENT

SCAN may use and disclose your health information for the purposes of payment of the health care services you receive, without your written authorization. This may include claims payment, eligibility, utilization management, and care management activities. For example:

- We may provide your eligibility information to your medical group, so they are paid accurately and timely.
- We may share information about you to a hospital to ensure that claims are billed properly.
- We may provide your information to a third-party entity to ensure that your doctor or hospital is paid accurately and timely.

HEALTH CARE OPERATIONS

SCAN may use and disclose your health information to support various business activities without your written authorization. Health care operations are activities related to the normal business functions of SCAN. For example, we may share information with others for any of the following purposes:

- Quality management and improvement activities, such as credentialing activities and peer reviews,
- Contracting activities with plan providers and vendors,
- Research and studies, such as member satisfaction surveys,
- Compliance and regulatory activities,
- Risk management activities,
- Population and disease management studies and programs, and
- Grievance and appeals activities.

SCAN may not use or disclose your genetic health information for underwriting purposes.

OTHER PERMITTED USES AND DISCLOSURES

SCAN may use or disclose your health information without your written authorization, for the following purposes under limited circumstances:

- To state and federal agencies that have the legal right to receive data, such as to make sure SCAN is making proper payments and to assist Federal/State Medicaid programs,
- For public health activities, such as reporting disease outbreaks or disaster relief,
- For government healthcare oversight activities, such as fraud and abuse investigations or the Food and Drug Administration (FDA),
- For judicial, arbitration, and administrative proceedings, such as in response to a court order, subpoena, or search warrant,
- To a probate court investigator to determine the need for conservatorship or guardianship,
- For law enforcement purposes, such as providing limited information to locate a missing person,
- For research studies that meet all privacy law requirements, such as research related to the prevention of disease or disability,
- To avoid a serious and imminent threat to health or safety,
- To contact you about new or changed benefits under Medicare and/or SCAN,
- To contact you to remind you of visits/deliveries,
- To create a collection of information that can no longer be traced back to you,
- For purposes when issues concern child or elder abuse and neglect,
- In cases of death, such as a coroner, medical examiner, funeral director or organ procurement organization,
- For specialized government functions, such as providing information for national security and military activities,
- To workers' compensation claims or authorities as required by state workers' compensation laws,
- To the plan sponsor of a group health plan or employee welfare benefit plan,
- To law enforcement officials if you are an inmate or under custody. These would be permitted if needed to provide medical services to you or for the protection and safety of others,
- To friends or family members to the extent necessary to assist with your health care or payment for your healthcare, if you are unavailable to agree to disclosure, such as in a medical emergency,
- As required otherwise by federal, state, or local law.

Other uses and disclosures not described in this Notice will only be made with your written authorization. For instance, SCAN needs your authorization before we disclose your PHI for the following: (1) most uses and disclosures of psychotherapy notes; (2) uses and disclosures for marketing purposes; and (3) uses and disclosures that involve the sale of PHI. You may revoke your authorization at any time as long as the request to revoke is in writing and the plan has not relied on your authorization to take a specific action.

SUBSTANCE USE DISORDER

We will use and disclose protected health information (PHI) related to your substance use disorder treatment that is subject to 42 CFR Part 2 ("SUD health information") only with your written consent.

Notwithstanding anything to the contrary, we will not use or disclose any SUD health information (or testify about its contents) for civil, criminal, administrative, or legislative proceedings unless: (i) you provide consent; or (ii) disclosure is compelled by a court order that complies with 42 CFR Part 2 and provides notice and an opportunity to be heard, as required by law. Any such disclosure must be accompanied by the qualifying court order and a subpoena or other legal mandate.

For uses and disclosures of your PHI for treatment, payment, and healthcare operations purposes, you may provide a single consent. You may revoke your written consent as provided by 42 CFR §§ 2.31 and 2.35.

PHI disclosed to a Part 2 program, covered entity, or business associate pursuant to your written consent for treatment, payment, and healthcare operations may be further disclosed by that Part 2 program, covered entity, or business associate without your written consent, to the extent permitted by the HIPAA regulations.

SHARING YOUR HEALTH INFORMATION WITH OTHERS

As part of normal business, SCAN shares your information with contracted plan providers (e.g., medical groups, hospitals, pharmacy benefit management companies, social service providers, etc.). We will also share your PHI with other companies and business associates that perform different kinds of activities for our health plan. We may also use your PHI to give you reminders about your appointments. We may use your PHI to give you information about other treatments, or other health-related benefits and In-services.

SCAN also works to ensure that your PHI is readily available to you by complying with the Information Blocking Rule established by the 21st Century Cures Act.

In addition, we may use and share your PHI directly or indirectly with Health Information Exchanges (HIEs) for payment, health care operations and treatment. In all cases where your health information is shared with plan providers, we have a written contract that contains language designed to protect the privacy of your health information. Our plan providers are required to keep your health information confidential and protect the privacy of your information in accordance with state and federal law, similar to how SCAN protects your health information.

YOUR RIGHTS INVOLVING YOUR HEALTH INFORMATION

You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. However, your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

RIGHT TO REQUEST RESTRICTIONS

You have the right to ask us to restrict how we use and disclose your information for treatment, payment, or health care operations as described in the Notice. You also have the right to ask us to restrict information that we have been asked to give to family members or to others who are involved in your health care. However, we are not required to agree to these restrictions. If we deny your request, we will notify you in writing with the specific reason(s) the request was denied. If we do agree to your request to restrict health information, we may not use or disclose your protected health information for that purpose, except as needed to provide treatment in an emergency. Please refer to the definition of “emergency” in your *Evidence of Coverage*. We also do not have to honor your restriction if we are required by law to disclose the information or when the information is needed for your treatment.

You also have the right to terminate a request for restriction that we have granted. You may do this by calling or writing us. We also have the right to terminate the restriction if you agree to it or if we inform you in writing that we are terminating it. If we do this, it will only apply to medical information that we create or receive after we have informed you.

Your request for a restriction must be in writing and must provide us with specific information needed to fulfill your request. This would include the information you wish to be restricted and to whom you want the limits to apply.

RIGHT TO INSPECT AND COPY

You have a right to review and get a copy of your health information held by us. This may include records used in making coverage, claims and other decisions as a SCAN member. *Important Note: We do not have complete copies of your medical records. If you want to look at, get a copy of, or change your medical records, please contact your provider.*

> Your request must be in writing and must include specific information needed to fulfill your request. If you call Member Services Department, we will send you a form to use to do this; (phone numbers are listed below in this notice). Or if you prefer, you may send your written request to:
>
> **SCAN Health Plan**
> Attention: Member Services (Request to Inspect and Copy)
> PO Box 22616
> Long Beach, CA 90801

If we maintain an electronic health record containing your health information you have the right to request that we send a copy of your health information to you or a third party that you identify. We may charge a reasonable fee for the cost of producing the electronic copy of your health information and for postage if applicable. You must pay this fee before we give you the copies. You may also request that we provide you with summary information about your

Protected Health Information instead of all the information. If so, you must pay us the cost of preparing this summary information before we give it to you.

In certain situations, we may deny your request to inspect or obtain a copy of your health information. If we deny your request, we will notify you in writing with the specific reason(s) the request was denied. Our letter to you will also include information about how you may request a review of our denial if you are entitled to such a review. You are entitled to request a review of our denial in three instances only. These three instances involve situations where a licensed health care professional has determined that such access would endanger the life or physical safety of you or of another person. Our letter will also tell you about any other rights you have to file a complaint. These are the same rights described in this Notice.

RIGHT TO REQUEST AN AMENDMENT OF PHI

You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. Your request should be sent to our Member Services Department at the address listed in the “Complaints” section of this Notice.

We will deny your request if you fail to submit it in writing or if you fail to include the reasons for your request. We may also deny your request if you ask us to amend information that is (1) accurate and complete, (2) not part of the medical information that SCAN keeps, (3) not part of the information that you would be entitled to inspect and copy, or (4) not created by SCAN, unless the creator of the information is not available to amend it.

If we deny your request, we will provide you a written explanation. This letter will tell you how you can file a complaint with us or with the Secretary of the Department of Health and Human Services. It will also tell you about the right you have to file a statement disagreeing with our denial and other rights you may have.

If we accept your request to amend the information, we will make the changes requested in your amendment. But first we will contact you to identify the persons you want notified and to get your approval for us to do so. We will make reasonable efforts to inform others of the amendment and to include the changes in any future disclosures of that information.

RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS

You have the right to request that we communicate with you in confidence about your health information by alternative means or to an alternative location (e.g., mail to a post office box address or fax to a designated number). Your request must be made in writing and must clearly state that if the request is not granted it could endanger you. SCAN will accommodate reasonable requests.

RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES

You have the right to receive an accounting of disclosures regarding your health information. Typically, the accounting would include disclosures found in the section titled “Other Permitted Uses and Disclosures”. The accounting will not cover those disclosures made for the purposes of treatment, payment, and health care operations, and ones that you have authorized.

All requests for an accounting must be in writing and must include specific information needed to fulfill your request. This accounting requirement applies for six years from the date of the disclosure, beginning with disclosures occurring after April 14, 2003, unless you request a lesser period of time. If you request this accounting more than once in a 12-month period, we may charge you a reasonable fee to produce the accounting of disclosures. Before doing so, we will notify you of the fee, and give you an opportunity to withdraw or limit your request in order to reduce the fee.

RIGHT TO RECEIVE NOTICE OF A BREACH OF PROTECTED HEALTH INFORMATION

You have the right to receive a notice of the unauthorized acquisition, access, or disclosure of your health information. SCAN will provide any legally required notices of any unauthorized use acquisition, access, or disclosure of your health information.

RIGHT TO COPIES OF THIS NOTICE

You have the right to receive an additional copy of this Notice at any time.

If you have any questions about our Notice of Privacy Practices or would like to request an additional copy of the Notice, please contact Member Services at the telephone numbers listed below in this notice: Or, you can write to:

SCAN Health Plan
Attention: Privacy Office
PO BOX 22616
Long Beach, CA 90801

Or email the Privacy Office at PrivacyOffice@scanhealthplan.com, or fax to 1-562-308-1365.

You may also visit our website online and download a printable version of the Notice at www.scanhealthplan.com.

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you believe SCAN has violated your privacy rights, or you disagree with a decision we made about access to your health information you may submit a written complaint to the SCAN Privacy Office.

COMPLAINTS TO SCAN

If you want to file a complaint with us, write to:

SCAN Health Plan
Attention: Privacy Office
PO BOX 22616
Long Beach, CA 90801

Or email PrivacyOffice@scanhealthplan.com, or fax to 1-562-308-1365.

If you need assistance with filing a complaint you can call the SCAN Member Services at the telephone numbers listed below in this notice.

COMPLAINTS TO THE FEDERAL GOVERNMENT

You may also notify the Secretary of the US Department of Health and Human Services to file a complaint with the federal government.

SCAN supports your right to protect the privacy of your personal and health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. Filing a complaint will not affect your benefits under SCAN or Medicare.

File a complaint with the federal government here:

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

Complaint forms are available at https://www.hhs.gov/hipaa/filing-a-complaint/index.html.

COMPLAINTS TO THE STATE (DUALLY ELIGIBLE MEMBERS FOR CALIFORNIA ONLY)

For members enrolled in dual Medicare and Medi-Cal (Medicaid) health plans, you may also contact:

DHCS Privacy Office
c/o: Office of HIPAA Compliance
California Department of Health Care Services
P.O. Box 997413, MS 0010
Sacramento, CA 95899-7413
Telephone: 1-916-445-4646 (Voice) (877) 735-2929 (TTY/TDD)
Email: incidents@dhcs.ca.gov

CHANGES TO THIS NOTICE

The terms of this Notice apply to all records containing your health information that are created or retained by SCAN. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to the Notice will be effective for all of your records that we have created or maintained in the past. Such revision or amendment shall also be effective for any of your records that we may create or maintain in the future. If we do revise this Notice, you will receive a copy.

SCAN complies with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, age (40 or older), disability and genetic information (including family medical history).

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

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

If you need these services, contact SCAN Member Services at the phone numbers below for the corresponding State Health Plans.

If you believe that SCAN has failed to provide these services or discriminated in another way on the basis of race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, age (40 or older), disability and genetic information (including family medical history), you can file a grievance in person, by phone, mail, or fax, at:

SCAN Member Services
Attention: Grievance and Appeals Department
P.O. Box 22644
Long Beach, CA 90801-5644

Phone: for CA Members:1-800-559-3500; for NV Members:1-855-827-7226; for TX Members: 1-855-844-7226; for AZ Members: 1-855-650-7226; for WA Members: 1-833-944-7226 (TTY: 711); for OR Members: 1-877-746-4712 (TTY: 711).

FAX: 1-562-989-0958

Or by filling out the “File a Grievance” form on our website at: https://www.scanhealthplan.com/Help-Center/Contact-Us/File-A-Grievance.

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

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

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

Complaint forms are available at https://www.hhs.gov/civil-rights/filing-a-complaint/index.html.

ATTACHMENT A

Scan Health Plan (CA)

SCAN Desert Health Plan, Inc.

SCAN Health Plan Nevada, Inc.

SCAN Health Plan (OR)

SCAN Health Plan Texas, Inc.

SCAN Health Plan (WA)

Healthcare in Action, Inc.

Healthcare in Action Medical Group

Welcome Health Medical Group

myPlace Great LA PACE, Inc.

myPlace South LA PACE, Inc.

myPlace Transport CA LLC

myPlace Care Partners, P.C

Section 1.4 We must give you information about our plan, our network of providers, and your covered services

As a member of SCAN Classic, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Member Services at 1-855-650-7226 (TTY users call 711):

- **Information about our plan.** This includes, for example, information about our plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug isn't covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 You have the right to know your treatment options and participate in decisions about your care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. If you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what's to be done if you can't make medical decisions for yourself

For additional Advanced Directive information, you can access https://azsos.gov/services/advance-directives

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you're in this situation. This means, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

Legal documents you can use to give directions in advance of these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you're going to be hospitalized, and you signed an advance directive, **take a copy with you to the hospital**.

- The hospital will ask whether you signed an advance directive form and whether you have it with you.
- If you didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

Filling out an advance directive is your choice (including whether you want to sign one if you're in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you signed an advance directive.

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the Arizona Attorney General.

Section 1.6 You have the right to make complaints and ask us to reconsider decisions we made

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—**we're required to treat you fairly.**

Section 1.7 If you believe you're being treated unfairly, or your rights aren't being respected

If you believe you've been treated unfairly or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY users call 1-800-537-7697), or call your local Office for Civil Rights.

If you believe you've been treated unfairly or your rights haven't been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you're having from these places:

- **Call Member Services at 1-855-650-7226 (TTY users call 711)**
- **Call your local SHIP** at 1-800-432-4040
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call our plan's Member Services at 1-855-650-7226 (TTY users call 711)**
- **Call your local SHIP** at 1-800-432-4040
- **Contact Medicare**
    - Visit Medicare.gov to read the publication *Medicare Rights & Protections* (available at: Medicare Rights & Protections)
    - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Member Services at 1-855-650-7226 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give details about medical services.
  - Chapters 5 and 6 give details about Part D drug coverage.
- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get medical care or Part D drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
  - You must continue to pay a premium for your Medicare Part B to stay a member of our plan.
  - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug.
  - If you're required to pay a late enrollment penalty, you must pay the penalty to keep your drug coverage.
  - If you're required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to stay a member of our plan.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 9: If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

This chapter explains 2 types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints** (also called grievances).

Both processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The information in this chapter will help you identify the right process to use and what to do.

Section 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services at 1-855-650-7226 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help you are:

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

Medicare

You can also contact Medicare for help.

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Visit Medicare.gov.

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B drugs) are covered or not, the way they are covered, and problems related to payment for medical care.

Yes.

Go to **Section 4**, **A guide to coverage decisions and appeals.**

No.

Go to **Section 10**, **How to make a complaint about quality of care**, **waiting times**, **customer service or other concerns.**

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

Coverage decisions and appeals deal with problems about your benefits and coverage for your medical care (services, items, and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B drugs as **medical care**. You may use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuse to provide medical care you think you need.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide whether medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we properly followed the rules. When we complete the review, we will give you our decision.

In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go to a Level 2 appeal conducted by an independent review organization not connected to us.

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 5.4** for more information about Level 2 appeals for medical care.
- Part D appeals are discussed further in Section 6.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.1 Get help asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **Call Member Services at 1-855-650-7226 (TTY users call 711)**
- **Get free help** from your State Health Insurance Assistance Program
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services at 1-855-650-7226 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.scanhealthplan.com/appointment-of-representative-form.)
    - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
    - For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
    - If you want a friend, relative, or other person to be your representative, call Member Services at 1-855-650-7226 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.scanhealthplan.com/appointment-of-representative-form.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
    - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for different situations

There are 4 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations:

- **Section 5:** Medical care: How to ask for a coverage decision or make an appeal

- **Section 6:** Part D drugs: How to ask for a coverage decision or make an appeal
- **Section 7:** How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- **Section 8:** How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services:* home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call Member Services at 1-855-650-7226 (TTY users call 711). You can also get help or information from your SHIP.

SECTION 5 Medical care: How to ask for a coverage decision or make an appeal

Section 5.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe this is covered by our plan. **Ask for a coverage decision. Section 5.2**.
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2**.
3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an appeal. Section 5.3**.
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5**.
5. You're told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3**.

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 7 and 8. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms:

A coverage decision that involves your medical care is called an **organization determination.**

A fast coverage decision is called an **expedited determination.**

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:

- You may *only ask* for coverage for medical items and/or services (not requests for payment for items and/or services you already got).
- You can get a fast coverage decision *only* if using the standard deadlines could cause serious harm to your health or hurt your ability to regain function.

If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.

If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision. If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
- Explains you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an

answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get your request.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 10 for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll answer within 24 hours.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. (Go to Section 10 for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you're going on to Level 1 of the appeals process.

Section 5.3 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a medical care coverage decision is called a plan **reconsideration.**

A fast appeal is also called an **expedited reconsideration.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.2.

Step 2: Ask our plan for an appeal or a fast appeal

- **If you're asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

Step 3: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take a careful look at all the information. We check to see if we followed all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
    - If you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
    - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.

- **If our answer is no to part or all of what you asked for,** we'll automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we receive your appeal. We'll give you our decision sooner if your health condition requires us to.
    - If you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
    - If you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 10 of this chapter for information on complaints.)
    - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal,** we'll automatically send your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Section 5.4 The Level 2 appeal process

Legal Term:

The formal name for the independent review organization is the **Independent Review Entity.** It's sometimes called the **IRE.**

The **independent review organization is an independent organization hired by Medicare.** It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file.**

- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all the information about your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2.

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.** If they take extra days, they will notify you in writing. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2.

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.** If they take extra days, they will notify you in writing. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

Step 2: The independent review organization gives you its answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the independent review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within **72 hours** or provide the service within 14 calendar days after we get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we get the decision from the independent review organization.
- **If this organization says no to part or all of your appeal,** it means it agrees with us that your request (or part of your request) for coverage for medical care shouldn't be

approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:

- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
- Tells you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 explains the Level 3, 4, and 5 appeals processes.

Section 5.5 If you're asking us to pay for our share of a bill you got for medical care

Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed the rules for using your coverage for medical care.

- **If we say yes to your request**: If the medical care is covered and you followed the rules, we'll send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.
- **If we say no to your request**: If the medical care is *not* covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

If you don't agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you're asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals in Section 5.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the provider within 60 calendar days.

SECTION 6 Part D drugs: How to ask for a coverage decision or make an appeal

Section 6.1 What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs go to Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term Drug List instead of *List of Covered Drugs* or formulary.

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it.
- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term:

An initial coverage decision about your Part D drugs is called a **coverage determination.**

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your drugs. This section tells what you can do if you're in any of the following situations:

- Asking to cover a Part D drug that's not on our plan's Drug List. **Ask for an exception. Section 6.2**

- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first). **Ask for an exception. Section 6.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 6.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

If you disagree with a coverage decision we made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to ask for an appeal.

Section 6.2 Asking for an exception

Legal Terms:

Asking for coverage of a drug that's not on the Drug List is a **formulary exception.**

Asking for removal of a restriction on coverage for a drug is a **formulary exception.**

Asking to pay a lower price for a covered non-preferred drug is a **tiering exception.**

If a drug isn't covered in the way you'd like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are 3 examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug that's not on our Drug List.** If we agree to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to drugs in Tier 4 (Non-Preferred Drug). You can't ask for an exception to the cost-sharing amount we require you to pay for the drug when we agree to cover a drug not on the Drug list.
2. **Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the cost-sharing amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of five cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you pay as your share of the cost of the drug.
    - If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).

- If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.
- If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
- If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- You can't ask us to change the cost-sharing tier for any drug in Tier 5: Specialty Tier.
- If we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons you're asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List typically includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you're asking for and wouldn't cause more side effects or other health problems, we generally won't approve your request for an exception. If you ask us for a tiering exception, we generally *won't* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of our plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 6.4 How to ask for a coverage decision, including an exception

Legal Term:

A fast coverage decision is called an **expedited coverage determination.**

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

Standard coverage decisions are made within **72 hours** after we get your request. **Fast coverage decisions** are made within **24 hours** after we get your request.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet 2 requirements:**

- You must be asking for a drug you didn't get yet. (You can't ask for a fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we'll automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
  - Explains that we'll use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
  - Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We'll answer your complaint within 24 hours of receipt.

Step 2: Ask for a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form* or on our plan's form, which are available on our website www.scanhealthplan.com. Chapter 2 has contact information. **A request can be submitted through our website via email to:** medicarepartdparequests@express-scripts.com. To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

You, your doctor (or other prescriber), or your representative can do this. You can also have a lawyer act on your behalf. Section 4 tells how you can give written permission to someone else to act as your representative.

- **If you're asking for an exception, provide the supporting statement** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

Step 3: We consider your request and give you our answer.

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we get your request.
  - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you didn't get yet

- We must generally give you our answer **within 72 hours** after we get your request.
  - For exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it'll be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for,** we must **provide the coverage** we agreed to **within 72 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we get your request.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.

- **If our answer is yes to part or all of what you asked for,** we're also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you're going to Level 1 of the appeals process.

Section 6.5 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a Part D drug coverage decision is called a plan **redetermination.**

A fast appeal is called an **expedited redetermination.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.

- If you're appealing a decision we made about a drug you didn't get yet, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.4 of this chapter.

Step 2: You, your representative, doctor, or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal.

- **For standard appeals, submit a written request or call us at 1-855-650-7226**. Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at 1-855-650-7226**. Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the *CMS Model Redetermination Request Form*, which is available on our website (www.scanhealthplan.com). Include your name, contact information, and information about your claim to help us process your request.
- **Members and Providers can submit appeal requests electronically** to the below website address: www.scanhealthplan.com/help-center/report-an-issue/file-an-appeal/medicare-part-d-prescription-benefits-redetermination-appeal.

- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

Step 3: We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
    - If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
    - If we don't give you a decision within 7 calendar days, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you already bought

- We must give you our answer **within 14 calendar days** after we get your request.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for,** we're also required to make payment to you within **30 calendar** days after we get your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 6.6 How to make a Level 2 appeal

Legal Term:

The formal name for the independent review organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

The independent review organization is an independent organization hired by Medicare. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the independent review organization.
- **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE. We'll let you know in writing if your request has been sent to the independent review organization.
- We'll send the information about your appeal to the independent review organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**.

- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all the information about your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.
- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for standard appeal

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

Step 3: The independent review organization gives you its answer.

For fast appeals:

- **If the independent review organization says yes to part or all of what you asked for,** we must provide the drug coverage that was approved by the independent review organization **within 24 hours** after we get the decision from the independent review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the independent review organization **within 72 hours** after we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we're required to **send payment to you within 30 calendar days** after we get the decision from the independent review organization.

What if the independent review organization says no to your appeal?

If this organization says no to **part or all of** your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It's also called **turning down your appeal**.) In this case, the independent review organization will send you a letter that:

- Explains the decision.

- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.
- Tells you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal).
- If you want to go on to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay, and your request will be considered.

Section 7.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at 1-855-650-7226 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
    - Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.

- Your right to be involved in any decisions about your hospital stay.
- Where to report any concerns you have about the quality of your hospital care.
- Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.

2. **You'll be asked to sign the written notice to show that you got it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.
3. **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
   - To look at a copy of this notice in advance, call Member Services at 1-855-650-7226 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 7.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process**
- **Meet the deadlines**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at 1-855-650-7226 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals who are paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you got (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
  - **If you meet this deadline,** you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
  - **If you don't meet this deadline, contact us**. If you decide to stay in the hospital after your planned discharge date, *you may have to pay the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at 1-855-650-7226 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. Or you can get a sample notice online at CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the independent review organization says *no*, they're saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you are going on to *Level 2* of the appeals process.

Section 7.3 How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date your coverage for the care ends.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information about your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.

If the independent review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you got since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal. This is called upholding the decision.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further by going to Level 3.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care.*

If you think we're ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 8.1 We'll tell you in advance when your coverage will be ending

Legal Term:

Notice of Medicare Non-Coverage. It tells you how you can ask for a **fast-track appeal.** Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
   - The date when we'll stop covering the care for you.
   - How to ask for a fast-track appeal to ask us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got it.** Signing the notice shows *only* that you have got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

Section 8.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you'll need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at 1-855-650-7226 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts who are paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

How can you contact this organization?

- The written notice you got (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the *Notice of Medicare Non-Coverage*.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the *Notice of Medicare Non-Coverage*. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Term:

Detailed Explanation of Non-Coverage. Notice that gives details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers tell us of your appeal, you'll get the *Detailed Explanation of Non-Coverage* from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need; the reviewers will tell you it's decision.

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it's medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, **you'll have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 8.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information about your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the independent review organization says yes?

- **We must reimburse you** for our share of the costs of care you got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it's medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the independent review organization says no?

- It means they agree with the decision made to your Level 1 appeal.

- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you'll need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Levels 3, 4, and 5

Section 9.1 Appeal Levels 3, 4, and 5 for Medical Service Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the item or medical service you appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

An **Administrative Law Judge** or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
    - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
    - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.

- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
  - If you decide to accept the decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
  - If we decide to appeal the decision, we'll let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 9.2 Appeal Levels 3, 4, and 5 for Part D Drug Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

An **Administrative Law Judge** or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
    - If you decide to accept the decision that turns down your appeal, the appeals process is over.
    - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
    - If you decide to accept the decision that turns down your appeal, the appeals process is over.
    - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Making complaints

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 10.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems about quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you're being encouraged to leave our plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at our plan? ◦ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all about the *timeliness* of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal,* and we said no; you can make a complaint.

Complaint	Example
	• You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 10.2 How to make a complaint

Legal Terms:

A **complaint** is also called a **grievance.**

Making a complaint is called **filing a grievance.**

Using the process for complaints is called **using the process for filing a grievance.**

A **fast complaint** is called an **expedited grievance.**

Step 1: Contact us promptly – either by phone or in writing.

- **Calling Member Services at 1-855-650-7226 (TTY users call 711) is usually the first step.** If there's anything else you need to do, Member Services will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- Member Services can be reached at 1-855-650-7226, TTY 711. Contact us from 8 a.m. to 8 p.m., seven days a week from October 1 to March 31. From April 1 to September 30, hours are 8 a.m. to 8 p.m., Monday through Friday. Messages received on holidays and outside of our business hours will be returned within one business day
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we'll answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, **we can take up to 14 more calendar days** (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.

- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours**.
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 10.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

  Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 10.4 You can also tell Medicare about your complaint

You can submit a complaint about SCAN Classic directly to Medicare. To submit a complaint to Medicare, go to Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

CHAPTER 10:
Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in SCAN Classic may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care and prescription drugs, and you'll continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You can end your membership during the Open Enrollment Period

You can end your membership in our plan during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Open Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year**. If you decide to change to a new plan, you can choose any of the following types of coverage:
    - Another Medicare health plan, with or without drug coverage,
    - Original Medicare *with* a separate Medicare drug plan, or
    - Original Medicare *without* a separate Medicare drug plan.
        - If you choose this option and receive Extra Help, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Note: If you disenroll from Medicare drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- **Your membership will end in our plan** when your new plan's coverage starts on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without drug coverage.
  - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan, or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of SCAN Classic may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply. These are just examples. For the full list you can contact our plan, call Medicare, or visit Medicare.gov.

- Usually, when you move
- If you have AHCCCS (Medicaid)
- If you're eligible for Extra Help paying for Medicare drug coverage
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE)
- **Note:** If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end

your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without drug coverage,
- Original Medicare *with* a separate Medicare drug plan, or
- Original Medicare *without* a separate Medicare drug plan.

Note: If you disenroll from Medicare drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- **Your membership will usually end** on the first day of the month after we get your request to change your plan.
- **If you get Extra Help from Medicare to pay your drugs coverage costs:** If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Section 2.4 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Member Services at 1-855-650-7226 (TTY users call 711)**
- Find the information in the ***Medicare & You 2027*** handbook
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048

SECTION 3 How to end your membership in our plan

The table below explains how you can end your membership in our plan.

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from SCAN Classic when your new plan's coverage starts.
Original Medicare *with* a separate Medicare drug plan	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from SCAN Classic when your new drug plan's coverage starts.
Original Medicare *without* a separate Medicare drug plan	• **Send us a written request to disenroll**. Call Member Services at 1-855-650-7226 (TTY users call 711) if you need more information on how to do this.

To switch from our plan to:	Here's what to do:
	• You can also call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from SCAN Classic when your coverage in Original Medicare starts.

SECTION 4 Until your membership ends, you must keep getting your medical items, services, and drugs through our plan

Until your membership ends, and your new Medicare coverage starts, you must continue to get your medical services, items, and prescription drugs through our plan.

- **Continue to use our network providers to get medical care.**
- **Continue to use our network pharmacies or mail-order to get your prescriptions filled**.
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

SECTION 5 SCAN Classic must end your plan membership in certain situations

SCAN Classic must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B
- If you move out of our service area
- If you're away from our service area for more than 6 months
  - If you move or take a long trip, call Member Services at 1-855-650-7226 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or national, or an eligible noncitizen
- If you lie or withhold information about other insurance, you have that provides prescription drug coverage
- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)

- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General
- If you're required to pay the extra Part D amount because of your income and you don't pay it, Medicare will disenroll you from our plan and you'll lose drug coverage

If you have questions or want more information on when we can end your membership, call Member Services at 1-855-650-7226 (TTY users call 711).

Section 5.1 We can't ask you to leave our plan for any health-related reason

SCAN Classic isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 11: Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage Plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, call Member Services at 1-855-650-7226 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, SCAN Classic, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

SECTION 4 Binding Arbitration

New members who enroll with SCAN Health Plan with an effective date that falls on or after March 1, 2008, receive within their post-enrollment materials an Arbitration Opt-Out Card that

they may use to opt out of binding arbitration. These members have one opportunity to opt out of binding arbitration by returning the Arbitration Opt-Out Card to SCAN Health Plan within 60-days of their SCAN Health Plan enrollment application date, according to the instructions provided on the card.

The following description of binding arbitration applies to the following members:

- All members enrolled in SCAN Health Plan who enrolled with an effective date prior to 3/1/08; and
- All members enrolled in SCAN Health Plan with an effective date of 3/1/08 or after who have not expressly opted out of the binding arbitration process by submitting the Arbitration Opt-Out Card that was included within their post-enrollment materials at the time of enrollment.
- For all claims subject to this "Binding Arbitration" provision, both Claimants and Respondents (as defined below) give up the right to a jury or court trial and accept the use of binding arbitration. Insofar as this "Binding Arbitration" provision applies to claims asserted by SCAN Health Plan Parties (as defined below), it shall apply retroactively to all unresolved claims that accrued before the effective date of this *Evidence of Coverage*. Such retroactive application shall be binding only on the SCAN Health Plan Parties.

Scope of Arbitration

Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this Evidence of Coverage or a Member Party's (as defined below) relationship to SCAN Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services, irrespective of the legal theories upon which the claim is asserted.
- The claim is asserted by one or more Member Parties against one or more SCAN Health Plan Parties or by one or more SCAN Health Plan Parties against one or more Member Parties.
- The claim is not within the jurisdiction of the small claims court.
- The claim is not subject to a Medicare appeal procedure.

As referred to in this "Binding Arbitration" provision, "Member Parties" include:

- A member.
- A member's heir, relative, or personal representative.
- Any person claiming that a duty to him or her arises from a member's relationship to one or more SCAN Health Plan Parties.

"SCAN Health Plan Parties" include:

- SCAN Health Plan.
- SCAN Group and any of its subsidiaries.
- Any employee or agent of any of the foregoing.

"Claimant" refers to a Member Party or a SCAN Health Plan Party who asserts a claim as described above. "Respondent" refers to a Member Party or a SCAN Health Plan Party against whom a claim is asserted.

Arbitration Administered By JAMS

Claimants shall submit any dispute subject to binding arbitration to JAMS (an organization that provides arbitration services) for resolution by final and binding arbitration before a single arbitrator. Any such dispute will not be resolved by a lawsuit or resort to court process, except as Arizona law provides for judicial review of arbitration proceedings.

Claimants shall initiate arbitration by submitting a demand for arbitration to JAMS. Please contact JAMS at the telephone number or email address provided below in order to submit a demand for arbitration.

The demand for arbitration shall include the basis of the claim against the Respondents; the amount of damages Claimants seek in the arbitration; the names, addresses, and telephone numbers of the Claimants and their attorneys, if any; and the names of all Respondents. Claimants shall include all claims against Respondents that are based on the same incident, transaction, or related circumstances in the demand for arbitration.

Administration of the arbitration will be performed by JAMS in accordance with the JAMS Comprehensive Arbitration Rules and Procedures. Claimants and Respondents will endeavor to mutually agree to the appointment of the arbitrator. But if an agreement cannot be reached within thirty (30) days following the date that demand for arbitration is made, the arbitrator appointment procedures in the JAMS Comprehensive Rules and Procedures will be used.

Arbitration hearings will be held in Maricopa County, Arizona or at another location that Claimants and Respondents agree to in writing. Civil discovery may be taken in the arbitration as provided by Arizona law. The arbitrator selected will have the power to control the time, scope, and manner of the taking of discovery. The arbitrator will also have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of Arizona, including but not limited to, imposing sanctions. The arbitrator will have the power to grant all remedies provided by Arizona law.

The arbitrator will prepare in writing an award that includes the legal and factual reasons for the decision. The award will include the allocation of the proceeding's fee and expenses between parties. The requirement of binding arbitration will not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction. However, any and all other claims or causes of action, including but not

limited to, those seeking damages, will be subject to binding arbitration as provided herein. The Federal Arbitration Act, 9 U.S.C. §§ 1–16, will apply to the arbitration.

Should you have any questions regarding initiating binding arbitration, please contact JAMS at 1-800-352-5267, or on the Internet at www.jamsadr.com.

CHAPTER 12: Definitions

AHCCCS (Medicaid) (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State AHCCCS (Medicaid) programs vary, but most health care costs are covered if you qualify for both Medicare and AHCCCS (Medicaid).

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center doesn't exceed 24 hours.

Annual Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of SCAN Classic, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to **balance bill** or otherwise charge you more than the amount of cost-sharing our plan says you must pay.

Benefit Period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (Go to "**Original Biological Product**" and "**Biosimilar**").

Biosimilar – A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (go to "**Interchangeable Biosimilar**").

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same

active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $2,400 for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

Chronic-Care Special Needs Plan (C-SNP) – C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs.

Complaint – The formal name for making a complaint is **filing a grievance.** The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Compound Medication/Compounding – In general, compounding is a practice in which a licensed pharmacist, a licensed physician, or, in the case of an outsourcing facility, a person under the supervision of a licensed pharmacist, combines, mixes, or alters ingredients of a drug to create a medication tailored to the needs of an individual patient.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example $10), rather than a percentage.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are gotten. Cost-sharing includes any combination of the following 3 types of payments: 1) any deductible amount a plan may impose before services or drugs are covered; 2) any fixed copayment amount that a plan requires when a specific service or drug is gotten; or 3) any coinsurance amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is gotten.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you're required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under our plan, that isn't a coverage determination. You need to call or write to our plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

Covered Drugs – The term we use to mean all the prescription drugs covered by our plan.

Covered Services – The term we use to mean all the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Daily cost-sharing rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in our plan is 30 days, then your daily cost-sharing rate is $1 per day.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and the person's eligibility.

Dually Eligible Individual – A person who is eligible for Medicare and Medicaid coverage.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include: walkers, wheelchairs, crutches, powered

mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that's approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

Grievance – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Home Health Aide – A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people won't pay a higher premium.

Independent Physician Association (IPA) – an independent group of physicians and other healthcare providers under contract to provide services to members of SCAN Health Plan.

Initial Coverage Stage – This is the stage after you pay your deductible (if you have one) and before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Institutional-Equivalent Special Needs Plan (IE-SNP) – An IE-SNP restricts enrollment to MA eligible people who live in the community but need the level of care a facility offers.

Institutional Special Needs Plan (I-SNP) – I-SNPs restrict enrollment to MA eligible people who live in the community but need the level of care a facility offers, or who live (or are expected to live) for at least 90 days straight in certain long-term facilities. I-SNPs include the following types of plans: Institutional-equivalent SNPs (IE-SNPs) Hybrid Institutional SNPs (HI-SNPs), and Facility-based Institutional SNPs (FI-SNPs).

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (formulary or Drug List) – A list of prescription drugs covered by our plan.

Low Income Subsidy (LIS) – Go to Extra Help.

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

Maximum Out-of-Pocket Amount – The most that you pay out of pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your prescription drugs don't count toward the maximum out-of-pocket amount.

Medical Group – A group of doctors, hospitals, pharmacies, and other health care experts hired by a health plan to take care of its members. See Chapter 3, Section 1.1 for more information.

Medically Accepted Indication – A use of a drug that is either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person is first eligible for Medicare.

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our

plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill *gaps* in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network – A group of doctors, hospitals, pharmacies, and other health care experts hired by a health plan to take care of its members. See Chapter 3, Section 1.1 for more information.

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – **Provider** is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers**.

Open Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Biological Product – A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (**Traditional Medicare or Fee-for-Service Medicare**) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies aren't covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost-sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs gotten is also referred to as the member's out-of-pocket cost requirement.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and AHCCCS (Medicaid) benefits through our plan.

Part C – Go to Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly plan premium for Medicare drug coverage if you go without creditable coverage (coverage that's expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D plan.

Preferred Cost-Sharing – Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits

whether they're received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are gotten from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services gotten from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive services – Health care services that help you stay healthy, detect health problems early, determine the most effective treatments, and prevent certain diseases. Preventive services include exams, shots, lab tests, and screenings. They also include programs for health monitoring, and counseling and education to help you take care of your own health.

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services and/or certain drugs based on specific criteria. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

Prosthetics and Orthotics – Medical devices including, but not limited to: arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

Quantity Limits – A management tool that is designed to limit the use of a drug for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

"Real-Time Benefit Tool" – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. Our plan must disenroll you if you permanently move out of our plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor. Skilled care is nursing and therapy care that can only be safely and effectively performed by, or under the supervision of, professionals or technical personnel. It's health care given when you need skilled nursing or skilled therapy to treat, manage, and observe your condition, and evaluate your care.

Special Enrollment Period – A set time when members can change their health or drug plan or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you're getting Extra Help with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and AHCCCS (Medicaid), who live in a nursing home, or who have certain chronic medical conditions.

Standard Cost-Sharing – Standard cost-sharing is cost-sharing other than preferred cost-sharing offered at a network pharmacy.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we'll cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

Notice of Non-Discrimination and Accessibility

Discrimination is against the law

SCAN Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (as defined in 45 CFR § 92.101(a)(2)). **SCAN Health Plan** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCAN Health Plan:

- Provides reasonable modifications and free aids and services to people with disabilities to ensure effective communication with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact SCAN Health Plan Member Services between 8 am to 8 pm, 7 days a week from October 1 to March 31. From April 1 to September 30, hours are 8 am to 8 pm Monday through Friday (messages received on holidays and outside of our business hours will be returned within one business day) by calling a number listed below.

SCAN Member Services	
SCAN Health Plan (California)	1-800-559-3500
SCAN Health Plan (Arizona)	1-855-650-7226
SCAN Health Plan (Nevada)	1-855-827-7226
SCAN Health Plan (Oregon)	1-988-746-4712
SCAN Health Plan (Texas)	1-855-844-7226
SCAN Health Plan (Washington)	1-833-944-7226
TTY: 711	

Filing a complaint

If you believe that SCAN Health Plan has not provided these services or has otherwise discriminated on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: **Peter Yanez, Civil Rights Coordinator, Attn: Grievance and Appeals Department, P.O. Box 22644, Long Beach, CA 90801-5644, 562) 989-5140, or FAX (562) 989-0958.** You can file a grievance in person or by mail, or fax. If you need help filing a grievance, **Peter Yanez, Civil Rights Coordinator**, is available to help you.

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

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

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

English - ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-650-7226 (TTY: 711) or speak to your provider.

Spanish - ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-855-650-7226 (TTY: 711) o hable con su proveedor.

Simplified Chinese - 中文 - 注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-855-650-7226（文本电话：711）或咨询您的服务提供商。

Traditional Chinese - 台語

注意：如果您說台語，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-855-650-7226（TTY：711）或與您的提供者討論。」

Korean – 한국어 - 주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-855-650-7226(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

Vietnamese - Việt - LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-855-650-7226 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Arabic

العربية

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-855-650-7226 (711) أو تحدث إلى مقدم الخدمة.

French - ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-650-7226 (TTY: 711) ou parlez à votre fournisseur.

Tagalog - PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-650-7226 (TTY: 711) o makipag-usap sa iyong provider.

German - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-855-650-7226 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Hindi - हिंदी - ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-650-7226 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Japanese - 日本語 - 注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-855-650-7226（TTY：711）までお電話ください。または、ご利用の事業者にご相談ください。

Farsi

فارسي

توجه: اگر وارد کردن زبان صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1-855-650-7266 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.

Russian – РУССКИЙ - ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-650-7226 (TTY: 711) или обратитесь к своему поставщику услуг.

Telugu – తెలుగు - సావధానం: మీరు తెలుగు మాట్లాడితే, మీకు ఉచిత భాషా సహాయ సేవలు అందుబాటులో ఉంటాయి. యాక్సెస్ చేయగల ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక సహాయాలు మరియు సేవలు కూడా ఉచితంగా అందుబాటులో ఉంటాయి. 1-855-650-7226 (TTY: 711)కి కాల్ చేయండి లేదా మీ ప్రొవైడర్‌తో మాట్లాడండి.

Portuguese - ATENÇÃO: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-855-650-7226
(TTY: 711) ou fale com seu provedor.

This page is intentionally blank.

This page is intentionally blank.

This page is intentionally blank.

SCAN Classic (HMO) Member Services

Member Services – Contact Information	
Call	**1-855-650-7226** Calls to this number are free. 8 a.m. - 8 p.m., 7 days a week Oct. 1-March 31, Monday-Friday Apr. 1-Sept. 30. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 8 a.m. - 8 p.m., 7 days a week Oct. 1-March 31, Monday-Friday Apr. 1-Sept. 30.
Fax	**1-562-989-5181**
Write	**SCAN Health Plan** Attention: Member Services Department P.O. Box 22616 Long Beach, CA 90801-5616
Website	www.scanhealthplan.com

Arizona State Health Insurance Assistance Program (SHIP): Arizona's SHIP

SHIP is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Arizona State Health Insurance Assistance Program (SHIP) – Contact Information	
Call	1-800-432-4040
Write	Division of Aging and Adult Services Arizona Department of Economic Security 1789 West Jefferson, Site Code 950A Phoenix AZ 85007
Website	azship.org

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*