2017

Summary of Benefits

Scripps Classic offered by SCAN Health Plan (HMO)
Scripps Signature offered by SCAN Health Plan (HMO)
San Diego County

January 1, 2017 - December 31, 2017

Scripps Classic offered by SCAN Health Plan (HMO) and Scripps Signature offered by SCAN Health Plan (HMO) are HMO plans with a Medicare contract. Enrollment in SCAN Health Plan depends on contract renewal.

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

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scan HEALTH PLAN®

SUMMARY OF BENEFITS JANUARY 1, 2017 – DECEMBER 31, 2017

PREMIUM AND BENEFITS	SCRIPPS CLASSIC OFFERED BY SCAN HEALTH PLAN	SCRIPPS SIGNATURE OFFERED BY SCAN HEALTH PLAN	WHAT YOU SHOULD KNOW
Monthly Health Plan Premium	You pay $0	You pay $74 per month	You must continue to pay your Medicare Part B premium.
Deductible	You pay $0	You pay $0	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (this does not include prescription drugs)	$3,400 annually	$4,000 annually	The most you pay for copays and coinsurance for **Medicare-covered medical services** for the year.
Inpatient Hospital Coverage	You pay $295 copay per day for days 1-7 You pay $0 per day for days 8-90 and beyond	You pay $150 copay per day for days 1-5 You pay $0 per day for days 6-90 and beyond	Our plan covers an unlimited number of days for an inpatient hospital stay. **Prior authorization rules apply.**
Doctor Visits • Primary Care • Specialists	 You pay $10 copay per visit You pay $35 copay per visit	 You pay $10 copay per visit You pay $25 copay per visit	**Prior authorization** is required for specialist visits.
Preventive Care	You pay $0	You pay $0	Any additional preventive services approved by Medicare during the contract year will be covered. **Prior authorization rules apply.**
Emergency Care	You pay $75 copay per visit	You pay $75 copay per visit	The emergency room copay will be waived if you are immediately admitted to the hospital. You are covered for worldwide emergency services.
Urgently Needed Services	You pay $40 copay per visit	You pay $25 copay per visit	You are covered for worldwide urgent care services.

PREMIUM AND BENEFITS	SCRIPPS CLASSIC OFFERED BY SCAN HEALTH PLAN	SCRIPPS SIGNATURE OFFERED BY SCAN HEALTH PLAN	WHAT YOU SHOULD KNOW
Diagnostic Services/Labs/ Imaging			**Prior authorization** is required for diagnostic, lab, and imaging services.
• Lab services	You pay $0	You pay $0	
• Diagnostic tests and procedures	You pay $0	You pay $0	
• Outpatient x-rays	You pay $0	You pay $0	
• Therapeutic radiology	You pay 20% of the cost	You pay 20% of the cost	
• Diagnostic radiology (e.g., MRI, CT)	You pay 20% of the cost	You pay 20% of the cost	
Hearing Services			**Prior authorization** is required for Medicare-covered diagnostic hearing and balance exams. You must go to a SCAN-contracted provider to obtain a routine hearing exam and hearing aids.
• Medicare-covered diagnostic hearing and balance exam	You pay $10 copay per visit	You pay $10 copay per visit	
• Non-Medicare-covered (routine) hearing exam	You pay $0 for up to 1 visit per year	You pay $0 for up to 1 visit per year	
• Non-Medicare-covered (routine) hearing aids	You pay $699 copay per aid for Flyte 700 or $999 copay per aid for Flyte 900 You are covered for up to 2 hearing aids every year	You pay $699 copay per aid for Flyte 700 or $999 copay per aid for Flyte 900 You are covered for up to 2 hearing aids every year	
Dental Services			**Prior authorization** is required for Medicare-covered dental services. SCAN offers dental benefits for an additional cost. See "Optional Supplemental Benefits" at the end of this document.
• Medicare-covered dental services	You pay $10 copay per visit	You pay $10 copay per visit	
• Non-Medicare-covered (routine) oral exam and cleaning	Not covered	Not covered	
• Non-Medicare-covered (routine) dental x-rays	Not covered	Not covered	

PREMIUM AND BENEFITS	SCRIPPS CLASSIC OFFERED BY SCAN HEALTH PLAN	SCRIPPS SIGNATURE OFFERED BY SCAN HEALTH PLAN	WHAT YOU SHOULD KNOW
Vision Services			**Prior authorization** is required for Medicare-covered vision exams and glasses after cataract surgery. Routine vision services do not require prior authorization. You must go to a SCAN-contracted vision provider to obtain routine vision services.
• Medicare-covered vision exam to diagnose/treat diseases of the eye	You pay $10 copay per visit	You pay $10 copay per visit	
• Medicare-covered glasses after cataract surgery	You pay $10 copay per pair	You pay $10 copay per pair	
• Non-Medicare-covered (routine) vision exam	You pay $0 for up to 1 visit per year	You pay $0 for up to 1 visit per year	
• Non-Medicare-covered (routine) glasses or contact lenses	You pay $0 per pair every 2 years	You pay $30 copay per pair every 2 years	
• Non-Medicare-covered (routine) vision coverage limit	You are covered for up to $130 for frames or contact lenses every 2 years	You are covered for up to $175 for frames or contact lenses every 2 years	
Mental Health Services			**Prior authorization** is required for inpatient mental health hospitalization. You are covered for up to 90 days per benefit period.*
• Inpatient visit	You pay $250 copay per day for days 1-7 You pay $0 per day for days 8-90	You pay $150 copay per day for days 1-5 You pay $0 per day for days 6-90	
• Outpatient individual/ group therapy visit	You pay $25 copay per visit	You pay $25 copay per visit	**Prior authorization** is required for outpatient mental health services.
Skilled Nursing Facility	You pay $0 per day for days 1-20 You pay $150 copay per day for days 21-100	You pay $0 per day for days 1-20 You pay $50 copay per day for days 21-100	**Prior authorization** is required for skilled nursing facility services. You are covered for up to 100 days per benefit period.* No prior hospitalization is required

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

PREMIUM AND BENEFITS	SCRIPPS CLASSIC OFFERED BY SCAN HEALTH PLAN	SCRIPPS SIGNATURE OFFERED BY SCAN HEALTH PLAN	WHAT YOU SHOULD KNOW
Rehabilitation Services • Occupational, Physical and Speech Therapy visit	You pay $40 copay per visit	You pay $25 copay per visit	**Prior authorization** is required for outpatient rehabilitation services.
Ambulance	You pay $250 copay per one-way trip	You pay $100 copay per one-way trip	
Transportation (Non-Medicare-covered - routine)	You pay $0 for up to 12 one-way trips per year	You pay $0 for up to 12 one-way trips per year	**Prior authorization** is required for routine transportation services. You must use a SCAN-contracted provider to obtain routine transportation services.
Foot Care (podiatry services) • Medicare-covered foot exam and treatment • Non-Medicare-covered (routine) foot care	You pay $25 copay per visit Not covered	You pay $25 copay per visit Not covered	**Prior authorization** is required for Medicare-covered foot care.
Medical Equipment/Supplies • Durable Medical Equipment (e.g., wheelchairs, oxygen) • Prosthetics (e.g., braces, artificial limbs) • Diabetic supplies	You pay 20% of the cost You pay 20% of the cost You pay $0	You pay 20% of the cost You pay 20% of the cost You pay $0	**Prior authorization** is required for covered durable medical equipment, prosthetic devices, and certain diabetic supplies. SCAN covers diabetic supplies such as glucose monitors, test strips, and control solution from a select manufacturer. Lancets are also covered and are available from all manufacturers.
Wellness Programs • Health club membership	You pay $0	You pay $0	You are covered for SCAN-contracted health clubs in your area.
Medicare Part B Drugs	You pay 20% of the cost for chemotherapy and other Part B drugs	You pay 20% of the cost for chemotherapy and other Part B drugs	**Prior authorization rules apply** to select drugs.

OUTPATIENT PRESCRIPTION DRUGS

You pay the following:

SCRIPPS CLASSIC OFFERED BY SCAN HEALTH PLAN

	Preferred Retail Pharmacy 30-day supply cost-sharing	Standard Retail Pharmacy 30-day supply cost-sharing	Preferred Retail Pharmacy 90-day supply cost-sharing	Standard Retail Pharmacy 90-day supply cost-sharing	Mail-Order Pharmacy 90-day supply cost-sharing
Initial Coverage Stage					
Tier 1 (Preferred Generic)	You pay $0	You pay $5	You pay $0	You pay $10	You pay $0
Tier 2 (Generic)	You pay $5	You pay $10	You pay $10	You pay $20	You pay $10
Tier 3 (Preferred Brand)	You pay $42	You pay $47	You pay $116	You pay $131	You pay $116
Tier 4 (Non-Preferred Drug)	You pay $95	You pay $100	You pay $275	You pay $290	You pay $275
Tier 5 (Specialty Tier)	You pay 33%	You pay 33%	Not available	Not available	Not available
Tier 6 (Select Care Drugs)	You pay $11	You pay $11	You pay $23	You pay $23	You pay $23

Coverage Gap Stage	Begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,700. You pay 40% of the negotiated price (and a portion of the dispensing fee) for your brand name drugs and 51% of the cost for your generic drugs.

Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs reach $4,950, you pay the greater of: – 5% of the cost, or – $3.30 copay for generic (including brand drugs treated as generic) and a $8.25 copay for all other drugs

Some of our network pharmacies have preferred cost-sharing. You may pay less for certain drugs if you use these pharmacies. Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information, please call our Member Services Department at the number provided in this document or access our Evidence of Coverage online.

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

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

For information about the costs for additional day supplies that are available to you, please visit your Evidence of Coverage online.

SCRIPPS SIGNATURE OFFERED BY SCAN HEALTH PLAN

	Preferred Retail Pharmacy 30-day supply cost-sharing	Standard Retail Pharmacy 30-day supply cost-sharing	Preferred Retail Pharmacy 90-day supply cost-sharing	Standard Retail Pharmacy 90-day supply cost-sharing	Mail-Order Pharmacy 90-day supply cost-sharing
Initial Coverage Stage					
Tier 1 (Preferred Generic)	You pay $0	You pay $5	You pay $0	You pay $10	You pay $0
Tier 2 (Generic)	You pay $3	You pay $8	You pay $6	You pay $16	You pay $6
Tier 3 (Preferred Brand)	You pay $42	You pay $47	You pay $116	You pay $131	You pay $116
Tier 4 (Non-Preferred Drug)	You pay $95	You pay $100	You pay $275	You pay $290	You pay $275
Tier 5 (Specialty Tier)	You pay 33%	You pay 33%	Not available	Not available	Not available
Tier 6 (Select Care Drugs)	You pay $11	You pay $11	You pay $23	You pay $23	You pay $23

Coverage Gap Stage	Begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,700. You pay the same copays as in the Initial Coverage Stage for Tier 1 and Tier 2 drugs. For drugs in other tiers, you pay 40% of the negotiated price (and a portion of the dispensing fee) for your brand name drugs and 51% of the cost for your generic drugs.
Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs reach $4,950, you pay the greater of: – 5% of the cost, or – $3.30 copay for generic (including brand drugs treated as generic) and a $8.25 copay for all other drugs

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

For information about the costs for additional day supplies that are available to you, please visit your Evidence of Coverage online.

OPTIONAL SUPPLEMENTAL BENEFITS

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

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

Scripps Classic offered by SCAN Health Plan and Scripps Signature offered by SCAN Health Plan have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

ABOUT SCAN	
Who can join?	**You must:** - have both Medicare Part A and Part B - live in the plan service area (San Diego County, California) - not be medically determined to have End-Stage Renal Disease (ESRD)
Phone Number (Members)	**800-559-3500**
Phone Number (Non-Members)	**800-915-7226** (Calling this number will direct you to a licensed insurance agent)
TTY	**711**
Hours of Operation	**October 1 to February 14:** 8:00 am to 8:00 pm - 7 days a week **February 15 to September 30:** 8:00 am to 8:00 pm - Monday through Friday 9:00 am to 4:00 pm on Saturday (messages received on holidays and outside of our business hours will be returned within one business day)
Website	http://www.scanhealthplan.com
Provider and Pharmacy directory link	http://www.scanhealthplan.com
Formulary link	http://www.scanhealthplan.com
Link to Evidence of Coverage	http://www.scanhealthplan.com

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

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This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year. Other providers are available in our network. You must continue to pay your Medicare Part B premium.

You can get prescription drugs shipped to your home through our network mail order delivery program. Typically, you should expect to receive your prescription drugs within 14 days from the time that the mail-order pharmacy receives the order. If you do not receive your prescription drug(s) within this time, please contact SCAN Health Plan's Member Services at 1-800-559-3500, 8 A.M. to 8 P.M., 7 days a week from October 1 to February 14. From February 15 to September 30, hours are 8 A.M. to 8 P.M. Monday through Friday, and 9 A.M. to 4 P.M. on Saturday (messages received on holidays and outside of our business hours will be returned within one business day). TTY users call 711.

This information is available for free in other languages. Please call our Member Services number at 1-800-559-3500, 8 A.M. to 8 P.M., 7 days a week from October 1 to February 14. From February 15 to September 30, hours are 8 A.M. to 8 P.M. Monday through Friday, and 9 A.M. to 4 P.M. on Saturday (messages received on holidays and outside of our business hours will be returned within one business day). TTY users call 711.

Esta información está disponible gratuitamente en otros idiomas. Llame nuestro número de Servicios para Miembros al 1-800-559-3500, de 8 A.M. a 8 P.M., los siete días de la semana del 1 de octubre al 14 de febrero. Del 15 de febrero al 30 de septiembre el horario es de 8 A.M. a 8 P.M. de lunes a viernes, y de 9 A.M. a 4 P.M. el sábado (los mensajes recibidos en días festivos o fuera de nuestras horas de oficina serán contestados dentro de un día hábil). Los usuarios de TTY llamen al 711.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-559-3500. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-559-3500. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-559-3500。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-559-3500。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-559-3500. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-559-3500. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-559-3500 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-559-3500. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-559-3500번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-559-3500. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:
إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم بمساعدتك. هذه خدمة فوري، ليس عليك سوى الاتصال بنا على 1-800-559-3500. سيقوم شخص ما يتحدث العربية مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-559-3500 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-559-3500. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-559-3500. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-559-3500. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-559-3500. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-559-3500にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。