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SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

FROM: Human Resources Department

SUBMITTAL DATE: April 9, 2014

SUBJECT: Retiree Group Health Services Agreement with SCAN Health Plan effective January - December 2014 [District- All] [Total Cost - $56,700] [SOURCE OF FUNDS - N/A]

RECOMMENDED MOTION: That the Board of Supervisors:

1. Ratify and approve the attached Retiree Group Health Services Agreement between the County of Riverside and SCAN Health Plan, effective January 1, 2014 through December 31, 2014 (Attachment A);
2. Authorize the Chairperson to sign four (4) copies of each service agreement; retain one (1) copy of the signed renewal agreement, and return three (3) copies of each service agreement to Human Resources for distribution.

BACKGROUND:

Summary

On October 8, 2013, Item 3.10, the Board of Supervisors approved the 2014 SCAN Health Plan rates for retired employees and their dependents who are Medicare eligible. SCAN Health Plan is a fully insured Medicare Advantage plan with approximately 80 subscribers. SCAN was unable to submit the Service Agreement until the Centers for Medicare and Medicaid Services released their reimbursement rate.

Michael T. Stock
Asst. County Executive Officer/
Human Resources Director

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost:	POLICY/CONSENT (per Exec. Office)
COST	$ 28,350	$ 28,350	$ 56,700	$ 0	Consent ☐ Policy ☒
NET COUNTY COST	$ 0	$ 0	$ 0	$ 0	

SOURCE OF FUNDS: Retiree Health Insurance Premiums and Departmental Budgets

Budget Adjustment: No

For Fiscal Year: 13/14 - 14/15

C.E.O. RECOMMENDATION: APPROVE

BY: Samuel Wong 4/14/14

County Executive Office Signature Samuel Wong

FORM APPROVED COUNTY COUNSEL
BY: NEAL R. KIPNIS DATE 4/14/14

Departmental Concurrence

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Benoit, seconded by Supervisor Tavaglione and duly carried by unanimous vote, IT WAS ORDERED that the above matter is approved as recommended.

Ayes: Jeffries, Tavaglione, Stone, Benoit and Ashley
Nays: None
Absent: None
Date: April 22, 2014
xc: H.R.

Kecia Harper-Ihem
Clerk of the Board
By: Deputy

☐ Positions Added ☐ Change Order
☐ A-30 ☐ 4/5 Vote

Prev. Agn. Ref.: 10/8/2013, 3-10 | **District:** All | **Agenda Number:** 3-25

Impact on Residents and Businesses
There is no direct impact to residents or businessess in the County of Riverside.

SUPPLEMENTAL:
Additional Fiscal Information
The County contribution toward retiree premiums ranges from $25 to $256 per month, approximately $56,700 per year. Retirees pay the remainder of the premiums.

Contract History and Price Reasonableness
The County has contracted with SCAN since 2009. SCAN Health Plan is a fully insured HMO Medicare Advantage plan. Medicare Advantage plans require participants to assign their Medicare Part A and Part B coverage to SCAN in exchange for coverage under the plan.

Retirees may purchase individual SCAN coverage. However, SCAN's individual coverage does not offer prescription drug coverage or plan designs as generous as the group coverage retirees receive through the County.

ATTACHMENTS (if needed, in this order):
A. Retiree Group Health Services Agreement

RETIREE

GROUP HEALTH SERVICES AGREEMENT

BETWEEN

SCAN HEALTH PLAN

AND

COUNTY OF RIVERSIDE, STATE OF CALIFORNIA, A PUBLIC ENTITY

GROUP NUMBER: 117
EFFECTIVE: JANUARY 1, 2014

APR 22 2014 3-25

INTRODUCTION

Under this RETIREE GROUP HEALTH SERVICES AGREEMENT, SCAN Health Plan will arrange for the provision of Benefits to **County of Riverside** Group Retirees and their eligible Dependents ("Members") in accordance with the terms and conditions of this Agreement, the Plan "Combined Evidence of Coverage and Disclosure Information" and the Plan "Employer Group Application," which are all fully incorporated herein by these references, and together constitute the entire "Agreement" between the parties.

RECITALS OF FACTS

SCAN Health Plan ("Plan"), a California not-for-profit corporation, is a health care service plan that arranges for the provision of medical, hospital and preventive medical services to persons enrolled as Members through contracts with associations of licensed physicians, hospitals and other health care providers. County of Riverside ("Contractholder"), a political subdivision of the State of California, is an employer, union, trust organization, or association, which desires to provide such health care services for its eligible Members. Plan desires to contract with Contractorholder to arrange for the provision of such health care services to Members of Contractholder, and Contractholder desires to contract with Plan to arrange for the provision of such services to its Members.

IMPORTANT

There is no vested right to receive Benefits under this Agreement. No Member has the right to receive the Benefits of this Agreement for services or supplies furnished following termination of coverage, except as specifically provided herein. Benefits of this Agreement are available only for services and supplies furnished during the term it is in effect and while the Member claiming Benefits is actually covered by this Agreement. Benefits may be modified during the term of this Agreement under the terms set forth herein, or upon renewal. If Benefits are modified, the revised Benefits (including any reduction in Benefits or the elimination of Benefits) apply for services or supplies furnished on or after the effective date of the modification.

ARTICLE I
DEFINITIONS

1.1 Applicable Law - all federal, state and local statutes, rules, regulations, plans, ordinances, policies and ethical standards applicable to the subject matter of this Agreement or the parties' performance of their duties and obligations hereunder, including but not limited to, those promulgated by the federal Department of Health and Human Services ("DHHS"), the federal Centers for Medicare and Medicaid Services ("CMS"), the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191, enacted August 21, 1996, the Health Information Technology for Economic and Clinical Health Act ("HITECH") provisions of the American Recovery and Reinvestment Act of 2009, Public Law 111-5, enacted February 17, 2009, the California Department of Managed Health Care (DMHC"), California Department of Health Services ("DHS"), Title 28 of the California Code of Regulations, the California Knox-Keene Health Care Service Plan Act of 1975 and its implementing regulations, and all standards, rules and regulations of all accreditation bodies that have jurisdiction over the subject matter of this Agreement or the parties' performance of their duties hereunder.

1.2 Benefits (Covered Services) - those Services, which a Member is entitled to receive pursuant to the terms of this Agreement.

1.3 Calendar Year - a period beginning at 12:01 a.m. on January 1 and ending at 12:01 a.m. on January 1 of the next year.

1.4 Combined Evidence of Coverage and Disclosure Information ("EOC") - the contract between a Member and the Plan under which the Member is entitled to receive certain hospital, medical, and other health and/or social services under the Plan Benefits. The EOC is attached to this Agreement as Exhibit 3 and fully incorporated herein.

1.5 Contracted Medical Group/IPA - A group of Physicians organized to provide medical care. The Contracted Medical Group/IPA has an agreement with the Plan to provide medical services to Members.

1.6 Close Relative - the spouse, child, brother, sister or parent of a subscriber or Dependent.

1.7 Contractholder - the Employer entering into this Agreement for the Benefit of its Retirees.

1.8 Copayment - are fees payable to a health care provider by the Member at the time of provision of services, which are in addition to the Health Plan Premiums paid by the Contractholder. Such fees may be a specific dollar amount or a percentage of total fees as specified herein, depending on the type of services provided.

1.9 Covered Services (Benefits) - those Services which a Member is entitled to receive pursuant to the terms of this Agreement.

1.10 Dependent -

1.10.1 A subscriber's legally married spouse who is not covered for Benefits as a subscriber under another health plan, not legally separated from the subscriber, and is entitled to Benefits under the federal Medicare program, and is eligible to enroll in the Plan.

1.10.2 A subscriber's Domestic Partner, with whom the subscriber has filed a "Declaration of Domestic Partnership" with the California Secretary of State pursuant to California Family Code Section 298, who is not covered for Benefits as a subscriber under another health plan, is entitled to Benefits under the federal Medicare program, and is eligible to enroll in the Plan.

1.10.3 A subscriber's or subscriber's spouse/Domestic Partner's disabled child who is entitled to Benefits under the federal Medicare program and meets all eligibility requirements established by Contractholder.

1.11 Durable Medical Equipment ("DME") - equipment designed for repeated use, which is medically necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. DME includes wheelchairs, hospital beds, respirators, and other items that the Plan determines are DME.

1.12 Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in; 1) Serious jeopardy to the health of the individual; 2) Serious impairment to bodily functions; or 3) Serious dysfunction of any bodily organ or part.

A psychiatric Emergency Medical Condition is a condition where a layperson with an average knowledge of mental health, feels the absence of immediate psychiatric attention would 1) Place the mental or physical health of either the Member or others in serious jeopardy; 2) Cause serious impairment to bodily or mental functions; 3) Cause serious dysfunction of bodily organs; or 4) Result in serious mental dysfunction.

1.13 Emergency Services - Inpatient or outpatient covered Services that are 1) Furnished by a provider qualified to furnish emergency services; and 2) Needed to evaluate or stabilize an Emergency Medical Condition.

1.14 Inpatient - an individual who has been admitted to a hospital or a Skilled Nursing Facility as a registered bed patient and is receiving Services under the direction of a Physician.

1.15 Late Enrollee - an eligible Retiree or Dependent who has declined enrollment in this Plan at the time of the initial enrollment period, and who subsequently requests enrollment in this Plan, provided that the initial enrollment period shall be a period of at least 30 days.

1.16 Medical Group - an organization of Physicians who are generally located in the same facility and provide Benefits to Members.

1.17 Medically Necessary - medical Services or hospital Services which are determined by the Plan to be:

1.17.1 Rendered for the treatment or diagnosis of an injury or illness,

1.17.2 Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards,

1.17.3 Not furnished primarily for the convenience of the Member, the attending physician, or other Contracted Provider of service, and

1.17.4 Furnished in the most economically efficient manner, which may be provided safely and effectively to the Member.

1.17.5 Whether there is "sufficient scientific evidence" shall be determined by the Plan based upon the following: peer-reviewed medical literature; publications, reports, evaluations, and regulations issued by state and federal government agencies, Medicare local carriers, and intermediaries; and such other authoritative medical sources as deemed necessary by the Plan.

1.18 Member – an enrollee, subscriber or Dependent as defined herein.

1.19 Open Enrollment Period - is established annually by the Contractholder during which eligible individuals and their Dependents may transfer from another health benefit plan sponsored by the Contractholder to the Plan.

1.20 Personal Care Physician ("PCP") - a general practitioner, board-certified or eligible family practitioner, internist or obstetrician/gynecologist who has contracted with the Plan as a PCP to provide primary care Benefits to Members and to refer, authorize, supervise and coordinate the provision of all Benefits to Members in accordance with this Agreement.

1.21 Physician Group Service Area - a thirty (30) mile linear radius from any Member's assigned PCP office location.

1.22 Physician - an individual licensed and authorized to engage in the practice of medicine (M.D.) or osteopathic medicine (D.O.).

1.23 Plan - SCAN Health Plan, a California not-for-profit corporation.

1.24 Plan Hospital - a hospital licensed under Applicable Law and contracting with the Plan to provide Benefits to Members of the Plan.

1.25 Plan Provider - a provider who has a contract with the Plan to provide Plan Benefits to Members.

1.26 Plan Service Area - which geographic area served by the Plan.

1.27 Premium - the monthly pre-payment that is made to the Plan on behalf of each Member.

1.28 Provider - a Medical Group or Independent Practice Association ('IPA") and all associated Physicians, Plan Hospitals and ancillary services providers that contract with the Plan to provide Benefits to Members under this Agreement.

1.29 Retiree(s) - any person who was formerly employed by Contractholder and is, thereby, entitled to Benefits under this Agreement.

1.30 Services - includes Medically Necessary health care services as provided for in the EOC, and Medically Necessary supplies furnished incident to those Services.

1.31 Skilled Nursing Facility - a facility licensed by the California Department of Health Services as a "Skilled Nursing Facility."

1.32 Urgently Needed Services - Covered Services provided when the Member needs medical attention right away for an unforeseen illness or injury and it may not be reasonable, given the circumstances, to obtain the medical care from the Member's PCP or Contracted Medical Provider.

ARTICLE II
RETIREE & DEPENDENT ELIGIBILITY

2.1 The following persons are eligible for Benefits under this Agreement:

a. Retirees

b. Dependents as defined herein.

2.2 The date of eligibility for Retirees who declined enrollment in this Plan during the initial enrollment period and later apply for coverage shall be determined as follows:

a. A Late Enrollee who declined enrollment during the initial enrollment period shall be eligible for coverage the earlier of, 12 months from the date of his application for coverage or at the Contractholder's next open enrollment period.

b. A Retiree will not be considered a Late Enrollee if he or his Dependent loses coverage under another employer health benefit plan and shall be eligible for coverage on the date of loss of coverage, provided enrollment is requested within 60 days after termination of that other employer health benefit plan coverage. Retirees will be required to furnish the Contractholder proof of the loss of coverage.

c. A Retiree may add newly acquired Dependents as defined herein.

2.3. The date of eligibility for Dependents of Retirees who are enrolled during the initial enrollment period is the latest to occur of the following:

a. The date of eligibility of the subscriber.

b. The date the subscriber acquires a Dependent.

c. The date the Dependent reaches sixty-five (65) years of age.

2.4. The date of eligibility for Dependents of Retirees who declined enrollment in this Plan during the initial enrollment period or Dependents who do not request enrollment in this Plan within 60 days of eligibility as provided herein, and later apply for coverage, shall be determined as follows:

a. A Dependent who is a Late Enrollee and who has declined coverage during the initial enrollment period, or Dependents who do not request enrollment within 60 days of eligibility as provided herein, shall be eligible for coverage at Contractholder's next open enrollment period.

2.5. NOTIFICATION OF ELIGIBILITY CHANGES. It is the Contractholder's responsibility to notify the Plan within 60 calendar days of all changes in eligibility affecting enrollment in this Plan.

ARTICLE III
EFFECTIVE DATES FOR SUBSCRIBERS AND DEPENDENTS

3.1. INITIAL ENROLLMENT PERIOD. Benefits shall become effective when a completed enrollment application indicating the subscriber's and Dependent's choice of PCP is received before the effective date. Enrollment Applications received later than the first day of eligibility may delay coverage until the first day of the month following the day of receipt. An effective date is always the first day of the month.

a. The Benefits of a subscriber and Dependent who enroll on the effective date of this Agreement and who make a written request for enrollment during the initial enrollment period, shall become effective on the date this Agreement becomes effective for the Contractholder.

b. Coverage for an individual who becomes eligible at a time other than during the original effective date of this Agreement (e.g. new spouse or newly transferred Retiree) will become effective on the first day of the month after eligibility was obtained as provided herein.

Newly added Dependents are subject to all other provisions of this Agreement.

3.2. OUTSIDE OF INITIAL OR OPEN ENROLLMENT PERIOD:

a. The Benefits of a subscriber or Dependent who is not a Late Enrollee shall become effective on the date of loss of coverage under another employer health benefit plan, provided enrollment is requested within 60 days of the loss of that other employer health benefit plan coverage. The subscriber will be required to furnish the Contractholder proof of the loss of coverage.

b. A subscriber requesting reinstatement of his Benefits or Dependent Benefits after they have been discontinued due to voluntary cancellation would not be eligible for Benefits until the Retiree's former employer's next open enrollment period.

3.3 EXCEPTIONS TO LATE ENROLLEE STATUS. The following individuals are not considered Late Enrollees:

a. The Retiree or Dependent was covered under another employer health benefit plan at the time of initial eligibility;

b. The Contractholder offers multiple health benefit plans and the Retiree elects a different plan during an Open Enrollment Period;

c. If a Retiree declines enrollment during the initial enrollment period and subsequently requests enrollment for him and eligible Dependent due to a mid-year qualifying event, the Retiree and Dependent coverage will be effective on the first day of the month following receipt of request for enrollment;

d. If the Member is receiving Inpatient care at a non-Plan facility when coverage becomes effective. The Plan will provide Benefits only for as long as the Member's medical condition prevents transfer to a Plan facility in the Member's PCP Service Area, as approved by the Plan. Unauthorized continuing or follow-up care in a non-Plan facility or by non-Plan Providers is not a Covered Service.

ARTICLE IV
DISCONTINUANCE OF SUBSCRIBER AND/OR DEPENDENT BENEFITS

4.1 Except as specifically provided herein, there is no right of either a subscriber or his Dependents to receive Benefits following termination of this Agreement, or any part of it. The Benefits for each cease on the first of the following to occur, with respect to the subscriber and/or Dependent, as applicable:

a. The date of discontinuance of any part of this Agreement providing Benefits;

b. The date of discontinuance of this Agreement;

c. The end of the last period for which the subscriber has made his contribution for Dependent Benefits

d. The date of termination of the subscriber's coverage;

e. The date the Agreement is amended to terminate the eligibility of any class of Retirees of which the subscriber is a member.

f. The last day of the month in which the Dependent ceases to qualify as a Dependent as defined herein, including a spouse following the entry of a final decree of annulment or dissolution of marriage from the subscriber, unless a different date on which the Dependent no longer meets the requirements for eligibility has been agreed to between the Plan and the Contractholder;

g. A subscriber or subscriber's Domestic Partner files with the California Secretary of State a, "Notice of Termination of Domestic Partnership" pursuant to California Family Code Section 298.

ARTICLE V
PREMIUM RATES ("PREMIUMS")

5.1 PREMIUMS - Effective: January 1, 2014 through December 31, 2014

Retiree Only	$257.93
Retiree & Spouse	$515.86
Retiree, Spouse & Disabled Child	$773.79

5.2 WHEN AND WHERE PAYABLE:

a. The first month's Premiums must be paid to the Plan by the effective date of this Agreement and subsequent Premiums shall be prepaid in full by the same date of each succeeding month. No Member will be covered under this Agreement until the first month's Premiums payment has been received by the Plan.

b. Premiums for Retirees and/or Dependents who become eligible on a date other than the bill date are waived for the month during which eligibility for covered Benefits is attained. Premiums for Retirees and/or Dependents whose eligibility for covered Benefits terminates on a date other than the bill date are due in full for the month during which eligibility is terminated.

c. All Premiums are payable by the Contractholder to the Plan. The payment of any Premiums shall not maintain the Benefits under this Agreement in force beyond the date immediately preceding the next transmittal date.

5.3 GRACE PERIOD FOR PAYMENT. A grace period of 60 calendar days will be granted for the payment of Premiums accruing, other than those due on the effective date of this Agreement, during which period this Agreement shall continue in force. The Contractholder shall be liable to the Plan for the payment of all Premiums accruing during the period the Agreement continues in force.

5.4 CHANGES TO BENEFIT AMOUNTS OR PREMIUMS. The Benefit amounts or the Premiums payable may be changed from time to time as set forth herein.

a. If a state or any other taxing authority imposes upon the Plan a tax or license fee that is levied upon or measured by the base Premiums or by the gross receipts of the Plan, or any portion of either, then the Plan may amend the Agreement to increase the base Premiums by an amount sufficient to cover all such taxes or license

fees rounded to the nearest cent, provided that Contractholder receives 60 days of written notice and approves of such increase in base Premiums. If Contractholder approves of the increase in base Premiums, the effective date of such increase shall be the date indicated in the mutual written Amendment executed by Contractholder and Plan and shall not be earlier than the date of the imposition of such tax or license fee imposed by the state or taxing authority.

b. If Benefit amounts are changed pursuant to a mutual written Amendment executed by Contractholder and Plan, the Premiums charged therefore may be made, or the Premiums credit therefore may be given, as of the date indicated in such mutual written Amendment.

ARTICLE VI
INDEPENDENT CONTRACTORS

6.1 Plan Providers are neither agents nor employees of the Plan, but are independent contractors. In no instance shall the Plan be liable for the negligence, wrongful acts or omissions of any person receiving or providing Services, including any Physician, Plan Hospital, or other provider or their employees, subject to the Managed Health Care Insurance Accountability Act of 1999 (California Civil Code Section 3428).

6.2 The relationship between Contractholder and Plan is an independent contractor relationship. Neither party nor its employees and/or agents shall be considered to be an employee and/or agent of the other party. None of the provisions of this Agreement shall be construed to create a relationship of agency, representation, joint venture, ownership, control or employment between the parties other than that of independent parties contacting for the purposes of effectuating this Agreement.

ARTICLE VII
PLAN SERVICE AREA

7.1 The Service Area of this Plan is as described in the EOC that the Plan distributes to all Members.

7.2 Within the Physician Group Service Area, Members will be entitled to receive all Covered Services specified in the EOC. The Plan will not pay for Covered Services that are not provided by, referred by and authorized by the Member's PCP and/or the Plan, where applicable. The Member will be required to pay for the cost of any services that are not approved by the PCP or the Plan, including services that the Member receives from non-contracting providers, except for Emergency Services or Urgently Needed Services. Procedures for obtaining Emergency Services and Urgently Needed Services are described in the EOC.

ARTICLE VIII
COORDINATION OF BENEFITS

8.1 If a Member is covered under one or more other health insurance plans, the Benefits of this Plan will be coordinated with the benefits payable by those other health insurance plans in accordance with the following provisions.

a. PLAN IS PRIMARY - If a Member possesses health benefits coverage through another policy, which is secondary to the Plan under applicable coordination of Benefits rules, including the Medicare secondary payer program, the Plan will determine its Benefit coverage obligations before the other policy, including applicable Copayments.

b. PLAN IS SECONDARY - If a Member possesses health benefits coverage through another policy which is primary to the Plan under applicable coordination of Benefits rules, including the Medicare secondary payer program, or if the Member is entitled to payment under a Workers' Compensation policy, the Plan will determine its Benefit coverage obligations after the other policy or Workers' Compensation policy, consistent with Applicable Laws and regulations. In such event, the Benefit coverage under the Plan will not exceed the amount of the out-of-pocket expenses (i.e. coinsurance, Copayments and deductibles) that the Member would incur in the absence of Member's secondary coverage.

ARTICLE IX
DISPUTES BETWEEN THE PLAN AND CONTRACTHOLDER

9.1 Plan and Contractholder agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement, prior to the filing of a claim under the Government Claims Act (Government Code Section 900 et. seq.), and prior to the initiation of any litigation by either party.

9.2 CURE PERIOD PROVISIONS - In the event that either party defaults in the performance of any duties or obligations under this Agreement, the non-breaching party shall serve written notice of breach of contract on the breaching party. The breaching party shall have thirty (30) days from receipt of the notice of breach to cure said breach. If the breach is not cured within this timeframe, the non-breaching party has sole discretion to extend such cure period. If the breach is not cured within this timeframe, as may be extended at non-breaching party's sole discretion, this Agreement may thereafter be terminated as provided herein.

These cure period provisions shall not be applicable when the breach is of a nature where Plan has failed to provide services, or the safety, health and/or welfare of Members is at risk, at the sole determination of the Contractholder.

9.3 ADVERSE GOVERNMENT ACTION - In the event any action of any department, branch or bureau of the federal, state, or local government has a material adverse effect on either party in the performance of their obligations hereunder, then that party shall notify the other of the nature of this action, including in the notice a copy of the adverse action. The parties shall meet within thirty (30) days and shall, in good faith, attempt to negotiate a modification to this Agreement that minimizes the adverse effect. Notwithstanding the provisions herein, if the parties fail to reach a negotiated modification concerning the adverse action, then the affected party may terminate this Agreement by giving at least ninety (90) days notice or may terminate sooner if agreed to by both parties.

ARTICLE X
MEMBER GRIEVANCE AND APPEALS PROCEDURES

10.1 ADMINISTRATION - The Plan shall be responsible for establishing and administering the Appeal and Grievance Procedures as described in the EOC.

10.2 PARTICIPATION BY CONTRACTHOLDER - Contractholder agrees to cooperate fully, participate in, and provide assistance and information to the Plan as may be necessary or helpful to the Plan in administering such Appeal and Grievance Procedures, including participation in any independent external review of coverage decisions.

10.3 BINDING ARBITRATION - In the event any grievance or appeal of a Member cannot be settled through the grievance mechanism described herein, such matter may be submitted to binding arbitration in accordance with the terms of the EOC. In such event, Contractholder shall cooperate and, when necessary, participate, in any arbitration proceedings arising there from, subject to either party's right to seek judicial review thereof in accordance with the terms of the EOC.

10.4 APPEALS - Appeals of claims denials and/or referral for service denials by Members shall be resolved according to the appeals and reconsideration procedures established by CMS as outlined in the EOC or in applicable CMS regulations, policies, or letters or instructions, which documents shall supersede the provisions outlined in the EOC.

ARTICLE XI
INDEMNIFICATION, ACTS AND OMISSIONS, LIABILITY AND INSURANCE

11.1 INDEMNIFICATION - Plan shall indemnify and hold harmless the Contractholder, its Agencies, Districts, Special Districts and Departments, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives from any liability whatsoever, based or asserted upon the conduct of Plan, its officers, employees, subcontractors, agents or representatives in connection with performing its obligations under this Agreement, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever arising from the performance of Plan, its officers, agents, employees, subcontractors, agents or representatives from this Agreement; Plan shall defend, at its sole expense, all costs and fees including but not limited to attorney fees, cost of investigation, defense and settlements or awards, the Contractholder, its Agencies, Districts, Special Districts and Departments, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives in any claim or action based upon such alleged acts or omissions.

With respect to any action or claim subject to indemnification herein by Plan, Plan shall, at their sole cost, have the right to use counsel of their own choice and shall have the right to adjust, settle, or compromise any such action or claim without the prior consent of Contractholder; provided, however, that any such adjustment, settlement or compromise in no manner whatsoever limits or circumscribes Plan's indemnification to Contractholder as set forth herein.

Plan's obligation hereunder shall be satisfied when Plan has provided to Contractholder the appropriate form of dismissal relieving Contractholder from any liability for the action or claim involved.

The specified insurance limits required in this Agreement shall in no way limit or circumscribe Plan's obligations to indemnify and hold harmless the Contractholder herein from third party claims.

In the event there is conflict between this clause and California Civil Code Section 2782, this clause shall be interpreted to comply with Civil Code 2782. Such interpretation shall not relieve the Plan from indemnifying the Contractholder to the fullest extent allowed by law.

11.2 CONTRACTHOLDER ACTS OR OMISSIONS - Contractholder agrees to defend, indemnify, and hold harmless Plan and its officers, directors, agents, and employees from and against any and all fines, claims, demands, suits, actions, and costs (including, without limitation, reasonable attorney's fees) of any kind and nature arising by reasons of the acts or omissions of Contractholder, or of its officers, directors, agents, and employees in connection with the obligations imposed by this Agreement.

11.3 LIABILITY FOR OBLIGATIONS - Nothing contained in this Agreement shall cause either party to be liable or responsible for any debt, liability, or obligation of the other party, or any third party, unless such liability or responsibility is expressly assumed by the party sought to be charged therewith. Each party shall be solely responsible for and shall indemnify and hold the other party harmless against any obligation for the payment of wages, salaries or other compensation (including all state, federal and local taxes and mandatory employee benefits), insurance and voluntary employment related or other contractual or fringe benefits as may be due or payable by the party to or on behalf of such party's employees, agents and representatives.

11.4 INSURANCE - Without limiting or diminishing the Plan's obligation to indemnify or hold the Contractholder harmless, Plan shall procure and maintain or cause to be maintained, at its sole cost and expense, the following insurance coverage's during the term of this Agreement.

a. Workers' Compensation:
If the Plan has employees as defined by the State of California, the Plan shall maintain statutory Workers' Compensation Insurance (Coverage A) as prescribed by the laws of the State of California. Policy shall include Employers' Liability (Coverage B) including Occupational Disease with limits not less than $1,000,000 per person per accident. This policy shall be endorsed to waive subrogation against the Contractholder for claims arising from this Agreement.

b. Commercial General Liability:
Commercial General Liability insurance coverage, including but not limited to, premises liability, contractual liability, products and completed operations liability, personal and advertising injury, and cross liability coverage, covering claims which may arise from or out of Plan's performance of its obligations hereunder. Policy shall name the Contractholder, its Agencies, Districts, Special Districts, and Departments, their respective directors, officers, Board of Supervisors, employees, elected or appointed officials, agents or representatives as Additional Insured's. Policy's limit of liability shall not be less than $1,000,000 per occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this agreement or be no less than two (2) times the occurrence limit.

c. Vehicle Liability:
If vehicles or mobile equipment is used in the performance of the obligations under this Agreement, then Plan shall maintain liability insurance for all owned, non-owned or hired vehicles so used in an amount not less than $1,000,000 per occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this agreement or be no less than two (2) times the occurrence limit.

d. Professional Liability Insurance:
Plan shall maintain Professional Liability Insurance providing coverage for the Plan's performance of work included within this Agreement, with a limit of liability of not less than $1,000,000 per occurrence and $2,000,000 annual aggregate. If Plan's Professional Liability Insurance is written on a claims made basis rather than an occurrence basis, such insurance shall continue through the term of this Agreement and Plan shall purchase at his sole expense either 1) an Extended Reporting Endorsement (also known as Tail Coverage); or 2) Prior Dates Coverage from new insurer with a retroactive date back to the date of, or prior to, the inception of this Agreement; or 3) demonstrate through Certificates of Insurance that Plan has Maintained continuous coverage with the same or original insurer. Coverage provided under items; 1), 2) or 3) will continue for a period of five (5) years beyond the termination of this Agreement.

e. General Insurance Provisions - All lines:

1) Any insurance carrier providing insurance coverage hereunder shall be admitted to do business in the United States and have an A M BEST rating of not less than A-: VII (A-:7) unless such requirements are waived, in writing, by the Contractholder Risk Manager. If the Contractholder's Risk Manager waives a requirement for a particular insurer, such waiver is only valid for that specific insurer and only for one policy term.

2) Plan shall cause Plan's insurance carrier(s) to furnish the Contractholder with either 1) a properly executed Certificate(s) of Insurance and copies of Endorsements effecting coverage as required herein, and 2) if requested to do so in writing by the Contractholder Risk Manager, provide copies of policies including all Endorsements and all attachments thereto, showing such insurance is in full force and effect. Further, said Certificate(s) and policies of insurance shall provide for not. In the event of a, cancellation, this Agreement shall terminate forthwith, unless the Contractholder receives another properly executed Certificate of Insurance and copies of endorsements or policies, including all endorsements and attachments thereto evidencing coverage's set forth herein and the insurance required herein is in full force and effect. *Plan shall not commence operations until the Contractholder has been furnished Certificate (s) of Insurance and copies of endorsements and if requested, policies of insurance including all endorsements and any and all other attachments as required in this Section.*

4) It is understood and agreed to by the parties hereto that the Certificate(s) of Insurance and policies shall so covenant and shall be construed as primary insurance, and the Contractholder's insurance

and/or deductibles and/or self-insured retention's or self-insured programs shall not be construed as contributory.

5) The Contractholder's Reserved Rights--Insurance. If, during the term of this Agreement or any extension thereof, there is a material change in the scope of services; or, there is a material change in the equipment to be used in the performance of the scope of work which will add to additional exposures (such as the use of aircraft, watercraft, cranes, etc.) the Contractholder reserves the right to adjust the types of insurance required under this Agreement and the monetary limits of liability for the insurance coverage's currently required herein, if; in the Contractholder Risk Manager's reasonable judgment, the amount or type of insurance carried by the Plan has become inadequate.

6) The insurance requirements contained in this Agreement may be met with a program(s) of self-insurance acceptable to the Contractholder.

ARTICLE XII
CANCELLATION

12.1 CANCELLATION WITHOUT CAUSE – Either party may cancel this Agreement without cause at any time by providing sixty (60) days' prior written notice to the other party. If the Agreement is cancelled on or after the 15th of the month, the Contractholder is liable for a full month's payment of Premiums. If the Agreement is cancelled prior to the 15th of the month, then Premiums payment will be waived and refunded to the Contractholder. In the event of such cancellation by either the Plan or the Contractholder, the Contractholder shall promptly pay any earned Premiums that have not previously been paid, and the Plan shall within 30 days:

a. return to the Contractholder the amount of prepaid Premiums, if any, that the Plan determines will not have been earned as of such cancellation date;

b. be responsible for Benefits for which charges were incurred prior to such cancellation date.

12.2 CANCELLATION FOR CAUSE – Either party may cancel this Agreement immediately for cause as set forth herein upon written notice of termination stating the actions of the other party constituting cause for termination.

a. CANCELLATION BY PLAN. The following shall constitute cause for immediate cancellation of this Agreement by Plan:

1. Contractholder's breach of any material term, covenant, or condition of this Agreement and subsequent failure to cure such breach within thirty (30) days following written notice of such breach, including:

   i. Failure of the Contractholder to pay any Premiums in accordance with the conditions of this Agreement; or

   ii. Failure of the Contractholder to abide by and enforce the conditions of enrollment as set forth in this Agreement and in the "Employer Group Application."

2. Insolvency of Contractholder, including the filing of bankruptcy by Contractholder.

3. A change in ownership of Contractholder.

4. A change in Contractholder-Retiree relationship.

b. CANCELLATION BY CONTRACTORHOLDER. The following shall constitute cause for immediate cancellation of this Agreement by Contractholder:

1. Plan's breach of any material term, covenant, or condition and subsequent failure to cure such breach within thirty (30) days following written notice of such breach.

2. Failure of Plan to provide services to Members as authorized in this Agreement.

3. Reasonable determination by Contractholder that the safety, health and/or welfare of Members are placed in danger by Plan.

4. Failure of Plan to secure and maintain the necessary governmental licenses, permits, accreditation or certification required for the performance of duties hereunder.

5. Failure by Plan to maintain adequate general and professional liability insurance coverage, as provided in this Agreement.

6. Insolvency of Plan, including the filing of bankruptcy by Plan.

12.3 Either party may cancel this Agreement for cause in accordance with Section 9.2 (Cure Period Provision), Section 9.3 (Adverse Government Action) or Section 16.4 (Limitation on Severability).

12.4 NOTIFICATION OF CANCELLATION TO SUBSCRIBERS - If this Agreement is rescinded, or cancelled by either party, the Contractholder shall be responsible for providing written notification of rescission or cancellation to the subscriber. The Contractholder shall promptly mail a legible, true copy of the Plan's notice of the rescission or cancellation to each subscriber at the subscriber's current address and shall promptly provide proof of such mailing and the date thereof to the Plan.

12.5 CANCELLATION OF INDIVIDUAL MEMBERS FOR CAUSE - The Plan may terminate coverage of a Member and his/her Dependent(s) for cause immediately upon notice to the Member for any of the reasons set forth in the EOC.

ARTICLE XIII
HIPAA AND HITECH

HIPAA AND HITECH COMPLIANCE

13.1 Plan and Contractholder shall comply with all applicable requirements of HIPAA and HITECH, including the laws and regulations promulgated and in full force and effect thereunder, upon the compliance dates set forth in the rules and regulations promulgated pursuant to HIPAA and HITECH. For purposes of this Agreement, HIPAA and HITECH rules, regulations and/or requirements include, but are not limited to, all rules and regulations promulgated by the Department of Health and Human Services, or any office, administration or division thereof, pursuant to HIPAA and HITECH. The Parties shall be in compliance and shall remain in compliance with the requirements of HIPAA and HITECH, and the laws and regulations promulgated subsequent thereto, as may be amended from time to time.

HIPAA BUSINESS ASSOCIATE AGREEMENT

13.2 The Parties shall adhere to all terms and conditions as outlined and specified in Exhibit 1 – Business Associate Agreement ("BAA") Addendum attached hereto and by this reference incorporated herein. The Parties agree to cooperate in accordance with the terms and intent of this Agreement and the BAA Addendum for implementation of relevant laws and/or regulations promulgated under HIPAA and HITECH, as may be amended from time to time.

ARTICLE XIV
Term and Termination

14.1 The term of this Agreement shall become effective on January 1, 2014, and shall terminate on December 31, 2014, unless this Agreement is terminated as provided

in **ARTICLE XII CANCELLATION** herein. Wherever this Agreement provides for a date of commencement or termination of any part or all of this Agreement, commencement or termination shall be effective as of 12:01 A.M. Pacific Standard Time of that date.

ARTICLE XV
IDENTIFICATION OF OFFICERS, OWNERS, STOCKHOLDERS, CREDITORS

15.1 On annual basis, Contractholder shall identify the names of the following persons by listing them on Exhibit 2 of this Agreement, attached hereto and incorporated herein by this reference.

A. Contractholder officers;
B. Contractholder owners, including parent corporation(s);
C. Stockholders owning greater than 10% of any stock issued by Contractor;
D. Major creditors holding more than 10% of any debts owed by Contractor.

ARTICLE XVI
GENERAL PROVISIONS

16.1 USE OF MASCULINE PRONOUN - Whenever a masculine pronoun is used in this Agreement, it shall include the feminine gender unless the context clearly indicates otherwise.

16.2 ASSIGNMENT AND DELEGATION - This Agreement and the rights, interests, and benefits hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by Plan or Contractholder, and shall not be subject to execution, attachment or similar process, nor shall the duties imposed herein be subcontracted or delegated without the prior written consent of the other party. Any assignment or delegation of this Agreement by Plan to a third party shall be void unless prior written approval is obtained from Contractholder.

16.3 INVALIDITY AND SEVERABILITY - If any provision of this Agreement is found to be invalid or unenforceable by any court or becomes invalid or unenforceable by Act of Congress, statute passes by the California Legislature, local ordinance, or any regulation duly promulgated by officers of the United States or of the State of California acting in accordance with law, such provision shall be in effect only to the extent that it is not in contravention of applicable laws without invalidating the remaining provisions hereof.

16.4 LIMITATIONS OF SEVERABILITY - In the event the removal of any provision rendered invalid or unenforceable pursuant to Section 16.3 has the effect of

materially altering the obligations of either party in such manner as to cause serious financial hardship to such party, the parties shall make all reasonable efforts to negotiate amendments to this Agreement to abrogate the effects of such removal and to avoid, to the extent possible under the circumstances, interruption of the delivery of services, or interference with the business activities of the parties. In the event the parties cannot reach mutual agreement on any amendments, the affected party shall have the right to terminate this Agreement upon providing thirty (30) days prior written notice to the other party.

16.5 CAPTIONS - Captions in this Agreement are descriptive only and do not affect the intent or interpretation of the Agreement.

16.6 ENTIRE AGREEMENT - This Agreement (together with all attachments hereto), and any requirements promulgated by Contractholder, shall constitute the entire agreement between the parties related to the rights herein granted and the obligations herein assumed. It is the express intention of Plan and Contractholder that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Agreement that are not expressly set forth herein, or are not promulgated by Contractholder, shall be of no further force, effect or legal consequence after the effective date hereunder.

16.7 AMENDMENT - This Agreement may be amended or modified only by mutual written consent of the parties.

16.8 ATTORNEYS FEES - If any action at law or in equity is necessary to enforce the terms of this Agreement, the prevailing party shall be entitled to reasonable attorney's fees and reasonable costs, in addition to any other relief to which such party may be entitled.

16.9 TIME IS OF THE ESSENCE - Time shall be of the essence of each and every term, obligation, and condition of this Agreement.

16.10 GOVERNING LAW - Contractholder, Plan and this Agreement are subject to the laws of the State of California and the United States of America, and regulations promulgated thereto. Any provision required to be in this Agreement by any Applicable Law, and regulations thereto shall bind Contractholder and Plan, whether or not expressly provided in this Agreement. Any provision of this Agreement which is in conflict with, or does not conform with Applicable Law as applied to the Plan shall be amended automatically to conform to the requirements of such Applicable Law.

16.11 VENUE - All actions and proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the state and federal (if permitted by law and a party elects to file an action in federal court) courts located in the County of Riverside, State of California.

16.12 GOVERNMENT CLAIMS ACT - The provisions of the Government Claims Act (Government Code section 900 et. seq.) must be followed first for any disputes arising under this Agreement.

16.13 CONFLICT OF INTEREST - The parties hereto and their respective employees or agents shall have no interest, and shall not acquire any interest, direct or indirect, which shall conflict in any manner or degree with the performance of services required under this Agreement.

16.14 EXHIBITS - All exhibits attached to this Agreement, and referenced herein, are incorporated into and made part of this Agreement.

16.15 FORCE MAJEURE - Neither party shall be liable to the other party or be deemed to have breached this Agreement for any failure or delay in the performance of all or any portion of its obligations under this Agreement if such failure or delay is due to any contingency beyond its reasonable control (a 'force majeure"). Without limiting the generality of the foregoing, such contingency includes, but is not limited to, acts of God, fires, floods, pandemics, storms, earthquakes, riots, boycotts, strikes, lock-outs, acts of terror, wars and war operations, restraints of government, power or communication line failure or other circumstance beyond such party's reasonable control, or by reason of a judgment, ruling or order of any court or agency of competent jurisdiction or change of law or regulation subsequent to the execution of this Agreement. Both parties are obligated to provide reasonable back-up capability to avoid the potential interruptions described above. If a force majeure occurs, the party delayed or unable to perform shall give immediate notice to the other party. Plan acknowledges and agrees that in the event Contractholder is unable to make timely payments due to causes beyond its reasonable control, Contractoholder shall not be held liable to Plan for such delay in payment, including any interest for untimely payments.

16.16 APPROVAL OF DMHC/DHS/CMS - All amendments, including but not limited to renewals of this Agreement, and any proposed amendments governing premiums, Covered Services, or the term hereof, shall be submitted by Plan to applicable/appropriate regulatory agencies for prior approval at least thirty (30) days before their effective date. No such amendment between Contractholder and the Plan shall be effective unless the appropriate approval from the regulatory agencies have been obtained.

16.17 NOTICE - Written notice required under this Agreement shall be delivered personally, or sent by United States registered certified mail or express mail, postage prepaid and return receipt requested, and shall be deemed given when so delivered by hand or if mailed, on the date of delivery shown on the receipt and addressed or delivered to each of the parties at the following address (or such other address as may hereafter be designated by a party by written notice thereof to the other party):

Plan: SCAN Health Plan
3800 Kilroy Airport Way, Suite 100
Long Beach, California 90801-5616
Attn: Gil Miller, Senior Vice President

Contractholder: County of Riverside, Human Resources
P.O. Box 1569
Riverside, CA 92502
Attn: Stacey Beale, Human Resources Division Manager

16.18 RECORDS AND INFORMATION TO BE FURNISHED - The Contractholder shall furnish the Plan such information as the Plan may require enabling it to administer this Plan, to determine the Premiums and to enable it to perform its obligations under the Agreement. All of the Contractholder's records that relate to eligibility and Benefits of this Plan shall be made available for inspection by the Plan when and so often as reasonably required.

16.19 LIMITATION OF LIABILITY - Members shall not be responsible to Plan Providers for payment for Services to the extent they are a Benefit of this Plan. When a Plan Provider renders Covered Services, the Member is responsible only for the applicable Copayments, and for non-benefit items. Members are responsible for the full charges for any non-covered services they obtain.

16.20 PAYMENT OF PROVIDERS - The Plan generally Contracts with groups of Physicians to provide Services to Members. A fixed, monthly fee is generally paid to the groups of Physicians for each Member whose PCP is in the group. This payment system, capitation, includes incentives to the group of Physicians to manage all Services provided to Members in an appropriate manner consistent with this Agreement. Members may request additional information about this payment system by contacting the Plan's Member Services Department or the Member's Plan Provider.

16.21 PLAN INTERPRETATION - For the purpose of providing Benefits to Members, the Plan shall have the power and discretionary authority to construe and interpret the provisions of this Agreement to determine the Benefits of this Agreement and determine eligibility to receive Benefits under this Agreement. The Plan shall exercise this authority for the benefit of all Members entitled to receive Benefits under this Agreement.

16.22 CONDITIONS PRECEDENT TO THE EFFECTIVENESS OF THIS AGREEMENT:

a. SERVICE DELIVERY SYSTEM COMPLETION - This Agreement is contingent upon execution of contracts by the Plan with hospitals, physicians, and ancillary service providers who collectively constitute the Plan-Contracted Network. The Plan shall pursue these agreements in good faith, but does not covenant that such agreements can be reached.

b. GOVERNMENTAL APPROVAL - This Agreement is contingent upon the Plan receiving approval from the appropriate local, state, and federal governmental or quasi-governmental agencies, which have regulatory or quasi-regulatory powers over the Plan or its programs. Such agencies include, but are not limited to DMHC, DHS, CMS and any other relevant state, federal and local agencies. Additionally, this Agreement is contingent upon approval by DMHC in writing, or by operation of law.

16.23 CONTRACTHOLDER NOTICE OBLIGATIONS - It is Contractholder's obligation to advise enrollees and/or their dependents of any rights they may have under the Employee Retirement Income Security Act of 1974 ("ERISA"), the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and Cal-COBRA, to the extent applicable.

16.24 CERTIFICATION OF AUTHORITY TO EXECUTE THIS AGREEMENT - Plan certifies that the individual signing herein has authority to execute this Agreement on behalf of Plan, and may legally bind Plan to the terms and conditions of this Agreement, and any attachments hereto.

[The remainder of this page was intentionally left blank]

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Agreement:

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By: _____
Deputy

Date: APR 22 2014

COUNTY OF RIVERSIDE:

By: _____
Chairman, Board of Supervisors
JEFF STONE

Date: APR 22 2014

Approved as to form:

Pamela J. Walls
County Counsel

By: _____
Deputy County Counsel

SCAN HEALTH PLAN,
a California not-for-profit corporation

By: _____

Printed Name: CHRIS WING

Title: CEO

Date: 3/21/2014

EXHIBIT 1

HIPAA Business Associate Agreement

Addendum to Contract

Between the County of Riverside and SCAN Health Plan

This HIPAA Business Associate Agreement (the "Addendum") supplements, and is made part of the Retiree Group Health Services Agreement (the "Underlying Agreement") between the County of Riverside ("County") and SCAN Health Plan ("Contractor") and shall be effective as of the date the Underlying Agreement is approved by both Parties (the "Effective Date").

RECITALS

WHEREAS, County and Contractor entered into the Underlying Agreement pursuant to which the Contractor provides services to County, and in conjunction with the provision of such services certain protected health information ("PHI") and/or certain electronic protected health information ("ePHI") may be created by or made available to Contractor for the purposes of carrying out its obligations under the Underlying Agreement; and,

WHEREAS, the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191 enacted August 21, 1996, and the Health Information Technology for Economic and Clinical Health Act ("HITECH") of the American Recovery and Reinvestment Act of 2009, Public Law 111-5 enacted February 17, 2009, and the laws and regulations promulgated subsequent thereto, as may be amended from time to time, are applicable to the protection of any use or disclosure of PHI and/or ePHI pursuant to the Underlying Agreement; and,

WHEREAS, County is a covered entity, as defined in the Privacy Rule; and,

WHEREAS, to the extent County discloses PHI and/or ePHI to Contractor or Contractor creates, receives, maintains, transmits, or has access to PHI and/or ePHI of County, Contractor is a business associate, as defined in the Privacy Rule; and,

WHEREAS, pursuant to 42 USC §17931 and §17934, certain provisions of the Security Rule and Privacy Rule apply to a business associate of a covered entity in the same manner that they apply to the covered entity, the additional security and privacy requirements of HITECH are applicable to business associates and must be incorporated into the business associate agreement, and a business associate is liable for civil and criminal penalties for failure to comply with these security and/or privacy provisions; and,

WHEREAS, the parties mutually agree that any use or disclosure of PHI and/or ePHI must be in compliance with the Privacy Rule, Security Rule, HIPAA, HITECH and any other applicable law; and,

WHEREAS, the parties intend to enter into this Addendum to address the requirements and obligations set forth in the Privacy Rule, Security Rule, HITECH and HIPAA as they apply to

Contractor as a business associate of County, including the establishment of permitted and required uses and disclosures of PHI and/or ePHI created or received by Contractor during the course of performing functions, services and activities on behalf of County, and appropriate limitations and conditions on such uses and disclosures;

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

1. **Definitions.** Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in HITECH, HIPAA, Security Rule and/or Privacy Rule, as may be amended from time to time.

A. "Breach" when used in connection with PHI means the acquisition, access, use or disclosure of PHI in a manner not permitted under subpart E of the Privacy Rule which compromises the security or privacy of the PHI, and shall have the meaning given such term in 45 CFR §164.402.

(1) Except as provided below in Paragraph (2) of this definition, acquisition, access, use, or disclosure of PHI in a manner not permitted by subpart E of the Privacy Rule is presumed to be a breach unless Contractor demonstrates that there is a low probability that the PHI has been compromised based on a risk assessment of at least the following four factors:
(a) The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;
(b) The unauthorized person who used the PHI or to whom the disclosure was made;
(c) Whether the PHI was actually acquired or viewed; and

(d) The extent to which the risk to the PHI has been mitigated.

(2) Breach excludes:

(a) Any unintentional acquisition, access or use of PHI by a workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under subpart E of the Privacy Rule.

(b) Any inadvertent disclosure by a person who is authorized to access PHI at a covered entity or business associate to another person authorized to access PHI at the same covered entity, business associate, or organized health care arrangement in which County participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted by subpart E of the Privacy Rule.

(c) A disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

B. "Business associate" has the meaning given such term in 45 CFR §164.501, including but not limited to a subcontractor that creates, receives, maintains, transmits or accesses PHI on behalf of the business associate.

C. "Data aggregation" has the meaning given such term in 45 CFR §164.501.

D. "Designated record set" as defined in 45 CFR §164.501 means a group of records maintained by or for a covered entity that may include: the medical records and billing records about individuals maintained by or for a covered health care provider; the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or, used, in whole or in part, by or for the covered entity to make decisions about individuals.

E. "Electronic protected health information" ("ePHI") as defined in 45 CFR §160.103 means protected health information transmitted by or maintained in electronic media.

F. "Electronic health record" means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff, and shall have the meaning given such term in 42 USC §17921(5).

G. "Health care operations" has the meaning given such term in 45 CFR §164.501.

H. "Individual" as defined in 45 CFR §160.103 means the person who is the subject of protected health information.

I. "Person" as defined in 45 CFR §160.103 means a natural person, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private.

J. "Privacy Rule" means the HIPAA regulations codified at 45 CFR Parts 160 and 164, Subparts A and E.

K. "Protected health information" ("PHI") has the meaning given such term in 45 CFR §160.103, which includes ePHI.

L. "Required by law" has the meaning given such term in 45 CFR §164.103.

M. "Secretary" means the Secretary of the U.S. Department of Health and Human Services ("HHS").

N. "Security incident" as defined in 45 CFR §164.304 means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

O. "Security Rule" means the HIPAA Regulations codified at 45 CFR Parts 160 and 164, Subparts A and C.

P. "Subcontractor" as defined in 45 CFR §160.103 means a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate.

Q. "Unsecured protected health information" and "unsecured PHI" as defined in 45 CFR §164.402 means PHI not rendered unusable, unreadable, or indecipherable to unauthorized persons through use of a technology or methodology specified by the Secretary in the guidance issued under 42 USC §17932(h)(2).

2. **Scope of Use and Disclosure by Contractor of County's PHI and/or ePHI.**

A. Except as otherwise provided in this Addendum, Contractor may use, disclose, or access PHI and/or ePHI as necessary to perform any and all obligations of Contractor under the Underlying Agreement or to perform functions, activities or services for, or on behalf of, County as specified in this Addendum, if such use or disclosure does not violate HIPAA, HITECH, the Privacy Rule and/or Security Rule.

B. Unless otherwise limited herein, in addition to any other uses and/or disclosures permitted or authorized by this Addendum or required by law, in accordance with 45 CFR §164.504(e)(2), Contractor may:

(1) Use PHI and/or ePHI if necessary for Contractor's proper management and administration and to carry out its legal responsibilities; and,

(2) Disclose PHI and/or ePHI for the purpose of Contractor's proper management and administration or to carry out its legal responsibilities, only if:

(a) The disclosure is required by law; or,

(b) Contractor obtains reasonable assurances, in writing, from the person to whom Contractor will disclose such PHI and/or ePHI that the person will:

(i) Hold such PHI and/or ePHI in confidence and use or further disclose it only for the purpose for which Contractor disclosed it to the person, or as required by law; and,

(ii) Notify Contractor of any instances of which it becomes aware in which the confidentiality of the information has been breached; and,

(3) Use PHI to provide data aggregation services relating to the health care operations of County pursuant to the Underlying Agreement or as requested by County; and,

(4) De-identify all PHI and/or ePHI of County received by Contractor under this Addendum provided that the de-identification conforms to the requirements of the Privacy Rule and/or Security Rule and does not preclude timely payment and/or claims processing and receipt.

C. Notwithstanding the foregoing, in any instance where applicable state and/or federal laws and/or regulations are more stringent in their requirements than the provisions of HIPAA, including, but not limited to, prohibiting disclosure of mental health and/or substance abuse records, the applicable state and/or federal laws and/or regulations shall control the disclosure of records.

3. **Prohibited Uses and Disclosures.**

A. Contractor may neither use, disclose, nor access PHI and/or ePHI in a manner not authorized by the Underlying Agreement or this Addendum without patient authorization or de-identification of the PHI and/or ePHI and as authorized in writing from County.

B. Contractor may neither use, disclose, nor access PHI and/or ePHI it receives from County or from another business associate of County, except as permitted or required by this Addendum, or as required by law.

C. Contractor agrees not to make any disclosure of PHI and/or ePHI that County would be prohibited from making.

D. Contractor shall not use or disclose PHI for any purpose prohibited by the Privacy Rule, Security Rule, HIPAA and/or HITECH, including, but not limited to 42 USC §17935 and §17936. Contractor agrees:

(1) Not to use or disclose PHI for fundraising, unless pursuant to the Underlying Agreement and only if permitted by and in compliance with the requirements of 45 CFR §164.514(f) or 45 CFR §164.508;

(2) Not to use or disclose PHI for marketing, as defined in 45 CFR §164.501, unless pursuant to the Underlying Agreement and only if permitted by and in compliance with the requirements of 45 CFR §164.508(a)(3);

(3) Not to disclose PHI, except as otherwise required by law, to a health plan for purposes of carrying out payment or health care operations, if the individual has requested this restriction pursuant to 42 USC §17935(a) and 45 CFR §164.522, and has paid out of pocket in full for the health care item or service to which the PHI solely relates; and,

(4) Not to receive, directly or indirectly, remuneration in exchange for PHI, or engage in any act that would constitute a sale of PHI, as defined in 45 CFR §164.502(a)(5)(ii), unless permitted by the Underlying Agreement and in compliance with the requirements of a valid authorization under 45 CFR §164.508(a)(4). This prohibition shall not apply to payment by County to Contractor for services provided pursuant to the Underlying Agreement.

4. **Obligations of County.**

A. County agrees to make its best efforts to notify Contractor promptly in writing of any restrictions on the use or disclosure of PHI and/or ePHI agreed to by County that may affect Contractor's ability to perform its obligations under the Underlying Agreement, or this Addendum.

B. County agrees to make its best efforts to promptly notify Contractor in writing of any changes in, or revocation of, permission by any individual to use or disclose PHI and/or ePHI, if such changes or revocation may affect Contractor's ability to perform its obligations under the Underlying Agreement, or this Addendum.

C. County agrees to make its best efforts to promptly notify Contractor in writing of any known limitation(s) in its notice of privacy practices to the extent that such limitation may affect Contractor's use or disclosure of PHI and/or ePHI.

D. County agrees not to request Contractor to use or disclose PHI and/or ePHI in any manner that would not be permissible under HITECH, HIPAA, the Privacy Rule, and/or Security Rule.

E. County agrees to obtain any authorizations necessary for the use or disclosure of PHI and/or ePHI, so that Contractor can perform its obligations under this Addendum and/or Underlying Agreement.

5. **Obligations of Contractor.** In connection with the use or disclosure of PHI and/or ePHI, Contractor agrees to:

A. Use or disclose PHI only if such use or disclosure complies with each applicable requirement of 45 CFR §164.504(e). Contractor shall also comply with the additional privacy requirements that are applicable to covered entities in HITECH, as may be amended from time to time.

B. Not use or further disclose PHI and/or ePHI other than as permitted or required by this Addendum or as required by law. Contractor shall promptly notify County if Contractor is required by law to disclose PHI and/or ePHI.

C. Use appropriate safeguards and comply, where applicable, with the Security Rule with respect to ePHI, to prevent use or disclosure of PHI and/or ePHI other than as provided for by this Addendum.

D. Mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of PHI and/or ePHI by Contractor in violation of this Addendum.

E. Report to County any use or disclosure of PHI and/or ePHI not provided for by this Addendum or otherwise in violation of HITECH, HIPAA, the Privacy Rule, and/or Security Rule of which Contractor becomes aware, including breaches of unsecured PHI as required by 45 CFR §164.410.

F. In accordance with 45 CFR §164.502(e)(1)(ii), require that any subcontractors that create, receive, maintain, transmit or access PHI on behalf of the Contractor agree through contract to the same restrictions and conditions that apply to Contractor with respect to such PHI and/or ePHI, including the restrictions and conditions pursuant to this Addendum.

G. Make available to County or the Secretary, in the time and manner designated by County or Secretary, Contractor's internal practices, books and records relating to the use, disclosure and privacy protection of PHI received from County, or created or received by Contractor on behalf of County, for purposes of determining, investigating or auditing Contractor's and/or County's compliance with the Privacy Rule.

H. Request, use or disclose only the minimum amount of PHI necessary to accomplish the intended purpose of the request, use or disclosure in accordance with 42 USC §17935(b) and 45 CFR §164.502(b)(1).

I. Comply with requirements of satisfactory assurances under 45 CFR §164.512 relating to notice or qualified protective order in response to a third party's subpoena, discovery request, or other lawful process for the disclosure of PHI, which Contractor shall promptly notify County upon Contractor's receipt of such request from a third party.

J. Not require an individual to provide patient authorization for use or disclosure of PHI as a condition for treatment, payment, enrollment in any health plan (including the health plan administered by County), or eligibility of benefits, unless otherwise excepted under 45 CFR §164.508(b)(4) and authorized in writing by County.

K. Use appropriate administrative, technical and physical safeguards to prevent inappropriate use, disclosure, or access of PHI and/or ePHI.

L. Obtain and maintain knowledge of applicable laws and regulations related to HIPAA and HITECH, as may be amended from time to time.

M. Comply with the requirements of the Privacy Rule that apply to the County to the extent Contractor is to carry out County's obligations under the Privacy Rule.

N. Take reasonable steps to cure or end any pattern of activity or practice of its subcontractor of which Contractor becomes aware that constitute a material breach or violation of the subcontractor's obligations under the business associate contract with Contractor, and if such steps are unsuccessful, Contractor agrees to terminate its contract with the subcontractor if feasible.

6. **Access to PHI, Amendment and Disclosure Accounting.** Contractor agrees to:

A. **Access to PHI, including ePHI.** Provide access to PHI, including ePHI if maintained electronically, in a designated record set to County or an individual as directed by County, within five (5) days of request from County, to satisfy the requirements of 45 CFR §164.524.

B. **Amendment of PHI.** Make PHI available for amendment and incorporate amendments to PHI in a designated record set County directs or agrees to at the request of an individual, within fifteen (15) days of receiving a written request from County, in accordance with 45 CFR §164.526.

C. **Accounting of disclosures of PHI and electronic health record.** Assist County to fulfill its obligations to provide accounting of disclosures of PHI under 45 CFR §164.528 and, where applicable, electronic health records under 42 USC §17935(c) if Contractor uses or maintains electronic health records. Contractor shall:

(1) Document such disclosures of PHI and/or electronic health records, and information related to such disclosures, as would be required for County to respond to a request by an individual for an accounting of disclosures of PHI and/or electronic health record in accordance with 45 CFR §164.528.

(2) Within fifteen (15) days of receiving a written request from County, provide to County or any individual as directed by County information collected in accordance with this section to permit County to respond to a request by an individual for an accounting of disclosures of PHI and/or electronic health record.

(3) Make available for County information required by this Section 6.C for six (6) years preceding the individual's request for accounting of disclosures of PHI, and for three (3) years preceding the individual's request for accounting of disclosures of electronic health record.

7. **Security of ePHI.** In the event County discloses ePHI to Contractor or Contractor needs to create, receive, maintain, transmit or have access to County ePHI, in accordance with 42 USC §17931 and 45 CFR §164.314(a)(2)(i), and §164.306, Contractor shall:

A. Comply with the applicable requirements of the Security Rule, and implement administrative, physical,and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI that Contractor creates, receives, maintains, or transmits on behalf of County in accordance with 45 CFR §164.308, §164.310, and §164.312;

B. Comply with each of the requirements of 45 CFR §164.316 relating to the implementation of policies, procedures and documentation requirements with respect to ePHI;

C. Protect against any reasonably anticipated threats or hazards to the security or integrity of ePHI;

D. Protect against any reasonably anticipated uses or disclosures of ePHI that are not permitted or required under the Privacy Rule;

E. Ensure compliance with the Security Rule by Contractor's workforce;

F. In accordance with 45 CFR §164.308(b)(2), require that any subcontractors that create, receive, maintain, transmit, or access ePHI on behalf of Contractor agree through contract to the same restrictions and requirements contained in this Addendum and comply with the applicable requirements of the Security Rule;

G. Report to County any security incident of which Contractor becomes aware, including breaches of unsecured PHI as required by 45 CFR §164.410; and,

H. Comply with any additional security requirements that are applicable to covered entities in Title 42 (Public Health and Welfare) of the United States Code, as may be amended from time to time, including but not limited to HITECH.

8. **Breach of Unsecured PHI.** In the case of breach of unsecured PHI, Contractor shall comply with the applicable provisions of 42 USC §17932 and 45 CFR Part 164, Subpart D, including but not limited to 45 CFR §164.410.

A. **Discovery and notification.** Following the discovery of a breach of unsecured PHI, Contractor shall notify County in writing of such breach without unreasonable delay and in no case later than 60 calendar days after discovery of a breach, except as provided in 45 CFR §164.412.

(1) **Breaches treated as discovered.** A breach is treated as discovered by Contractor as of the first day on which such breach is known to Contractor or, by exercising reasonable diligence, would have been known to Contractor, which includes any person, other than the person committing the breach, who is an employee, officer, or other agent of Contractor (determined in accordance with the federal common law of agency).

(2) **Content of notification.** The written notification to County relating to breach of unsecured PHI shall include, to the extent possible, the following information if known (or can be reasonably obtained) by Contractor:

(a) The identification of each individual whose unsecured PHI has been, or is reasonably believed by Contractor to have been accessed, acquired, used or disclosed during the breach;

(b) A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;

(c) A description of the types of unsecured PHI involved in the breach, such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved;

(d) Any steps individuals should take to protect themselves from potential harm resulting from the breach;

(e) A brief description of what Contractor is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches; and,

(f) Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, web site, or postal address.

B. **Cooperation.** With respect to any breach of unsecured PHI reported by Contractor, Contractor shall cooperate with County and shall provide County with any information requested by County to enable County to fulfill in a timely manner its own reporting and notification obligations, including but not limited to providing notice to individuals, prominent media outlets and the Secretary in accordance with 42 USC §17932 and 45 CFR §164.404, §164.406 and §164.408.

C. **Breach log.** To the extent breach of unsecured PHI involves less than 500 individuals, Contractor shall maintain a log or other documentation of such breaches and provide such log or other documentation on an annual basis to County not later than fifteen (15) days after the end of each calendar year for submission to the Secretary.

D. **Delay of notification authorized by law enforcement.** If Contractor delays notification of breach of unsecured PHI pursuant to a law enforcement official's statement that required notification, notice or posting would impede a criminal investigation or cause damage to national security, Contractor shall maintain documentation sufficient to demonstrate its compliance with the requirements of 45 CFR §164.412.

E. **Payment of costs.** With respect to any breach of unsecured PHI caused solely by the Contractor's failure to comply with one or more of its obligations under this Addendum and/or the provisions of HITECH, HIPAA, the Privacy Rule or the Security Rule, Contractor agrees to pay any and all costs associated with providing all legally required notifications to individuals, media outlets, and the Secretary. This provision shall not be construed to limit or diminish Contractor's obligations to indemnify, defend and hold harmless County under Section 9 of this Addendum.

F. **Documentation.** Pursuant to 45 CFR §164.414(b), in the event Contractor's use or disclosure of PHI and/or ePHI violates the Privacy Rule, Contractor shall maintain documentation sufficient to demonstrate that all notifications were made by Contractor as required by 45 CFR Part 164, Subpart D, or that such use or disclosure did not constitute a breach, including Contractor's completed risk assessment and investigation documentation.

G. **Additional State Reporting Requirements.** The parties agree that this Section 8.G applies only if and/or when County, in its capacity as a licensed clinic, health facility, home health agency, or hospice, is required to report unlawful or unauthorized access, use, or disclosure of medical information under the more stringent requirements of California Health & Safety Code §1280.15. For purposes of this Section 8.G, "unauthorized" has the meaning given such term in California Health & Safety Code §1280.15(j)(2).

(1) Contractor agrees to assist County to fulfill its reporting obligations to affected patients and to the California Department of Public Health ("CDPH") in a timely manner under the California Health & Safety Code §1280.15.

(2) Contractor agrees to report to County any unlawful or unauthorized access, use, or disclosure of patient's medical information without unreasonable delay and no later than two (2) business days after Contractor detects such incident. Contractor further agrees such report shall be made in writing, and shall include substantially the same types of information listed above in Section 8.A.2 (Content of Notification) as applicable to the unlawful or unauthorized access, use, or disclosure as defined above in this section, understanding and acknowledging that the term "breach" as used in Section 8.A.2 does not apply to California Health & Safety Code §1280.15.

9. **Hold Harmless/Indemnification.**

A. Contractor agrees to indemnify and hold harmless County, all Agencies, Districts, Special Districts and Departments of County, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives from any liability whatsoever, based or asserted upon any services of Contractor, its officers, employees, subcontractors, agents or representatives arising out of or in any way relating to this Addendum, including but not limited to property damage, bodily injury, death, or any other element of any kind or nature whatsoever arising from the performance of Contractor, its officers, agents, employees, subcontractors, agents or representatives from this Addendum. Contractor shall defend, at its sole expense, all costs and fees, including but not limited to attorney fees, cost of investigation, defense and settlements or awards, of County, all Agencies, Districts, Special Districts and Departments of County, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents or representatives in any claim or action based upon such alleged acts or omissions.

B. With respect to any action or claim subject to indemnification herein by Contractor, Contractor shall, at their sole cost, have the right to use counsel of their choice, subject to the approval of County, which shall not be unreasonably withheld, and shall have the right to adjust, settle, or compromise any such action or claim without the prior consent of County; provided, however, that any such adjustment, settlement or compromise in no manner whatsoever limits or circumscribes Contractor's indemnification to County as set forth herein. Contractor's obligation to defend, indemnify and hold harmless County shall be subject to County having given Contractor written notice within a reasonable period of time of the claim or of the commencement of the related action, as the case may be, and information and reasonable assistance, at Contractor's expense, for the defense or settlement thereof. Contractor's obligation hereunder shall be satisfied when Contractor has provided to County the appropriate form of dismissal relieving County from any liability for the action or claim involved.

C. The specified insurance limits required in the Underlying Agreement of this Addendum shall in no way limit or circumscribe Contractor's obligations to indemnify and hold harmless County herein from third party claims arising from issues of this Addendum.

D. In the event there is conflict between this clause and California Civil Code §2782, this clause shall be interpreted to comply with Civil Code §2782. Such interpretation shall not relieve the Contractor from indemnifying County to the fullest extent allowed by law.

E. In the event there is a conflict between this indemnification clause and an indemnification clause contained in the Underlying Agreement of this Addendum, this indemnification shall only apply to the subject issues included within this Addendum.

10. **Term.** This Addendum shall commence upon the Effective Date and shall terminate when all PHI and/or ePHI provided by County to Contractor, or created or received by Contractor on behalf of County, is destroyed or returned to County, or, if it is infeasible to return or destroy PHI and/ePHI, protections are extended to such information, in accordance with section 11.B of this Addendum.

11. **Termination.**

A. **Termination for Breach of Contract.** A breach of any provision of this Addendum by either party shall constitute a material breach of the Underlying Agreement and will provide grounds for terminating this Addendum and the Underlying Agreement with or without an opportunity to cure the breach, notwithstanding any provision in the Underlying Agreement to the contrary. Either party, upon written notice to the other party describing the breach, may take any of the following actions:

(1) Terminate the Underlying Agreement and this Addendum, effective immediately, if the other party breaches a material provision of this Addendum.

(2) Provide the other party with an opportunity to cure the alleged material breach and in the event the other party fails to cure the breach to the satisfaction of the non-breaching party in a timely manner, the non-breaching party has the right to immediately terminate the Underlying Agreement and this Addendum.

(3) If termination of the Underlying Agreement is not feasible, the breaching party, upon the request of the non-breaching party, shall implement, at its own expense, a plan to cure the breach and report regularly on its compliance with such plan to the non-breaching party.

B. **Effect of Termination.**

(1) Upon termination of this Addendum, for any reason, Contractor shall return or, if agreed to in writing by County, destroy all PHI and/or ePHI received from County, or created or received by the Contractor on behalf of County, and, in the event of destruction, Contractor shall certify such destruction, in writing, to County. This provision shall apply to all PHI and/or ePHI which are in the possession of subcontractors or agents of Contractor. Contractor shall retain no copies of PHI and/or ePHI, except as provided below in paragraph (2) of this section.

(2) In the event that Contractor determines that returning or destroying the PHI and/or ePHI is not feasible, Contractor shall provide written notification to County of the conditions that make such return or destruction not feasible. Upon determination by Contractor that return or destruction of PHI and/or ePHI is not feasible, Contractor shall extend the protections of this Addendum to such PHI and/or ePHI and limit further uses and disclosures of such PHI and/or ePHI to those purposes which make the return or destruction not feasible, for so long as Contractor maintains such PHI and/or ePHI.

12. **General Provisions.**

A. **Retention Period.** Whenever Contractor is required to document or maintain documentation pursuant to the terms of this Addendum, Contractor shall retain such documentation for 6 years from the date of its creation or as otherwise prescribed by law, whichever is later.

B. **Amendment.** The parties agree to take such action as is necessary to amend this Addendum from time to time as is necessary for County to comply with HITECH, the Privacy Rule, Security Rule, and HIPAA generally.

C. **Survival.** The obligations of Contractor under Sections 3, 5, 6, 7, 8, 9, 11.B and 12.A of this Addendum shall survive the termination or expiration of this Addendum.

D. **Regulatory and Statutory References.** A reference in this Addendum to a section in HITECH, HIPAA, the Privacy Rule and/or Security Rule means the section(s) as in effect or as amended.

E. **Conflicts.** The provisions of this Addendum shall prevail over any provisions in the Underlying Agreement that conflict or appear inconsistent with any provision in this Addendum.

F. **Interpretation of Addendum.**

(1) This Addendum shall be construed to be part of the Underlying Agreement as one document. The purpose is to supplement the Underlying Agreement to include the requirements of the Privacy Rule, Security Rule, HIPAA and HITECH.

(2) Any ambiguity between this Addendum and the Underlying Agreement shall be resolved to permit County to comply with the Privacy Rule, Security Rule, HIPAA and HITECH generally.

G. **Notices to County.** All notifications required to be given by Contractor to County pursuant to the terms of this Addendum shall be made in writing and delivered to the County both by fax and to both of the addresses listed below by either registered or certified mail return receipt requested or guaranteed overnight mail with tracing capability, or at such other address as County may hereafter designate. All notices to County provided by Contractor pursuant to this Section shall be deemed given or made when received by County.

County HIPAA Privacy Officer: HIPAA Privacy Manager

County HIPAA Privacy Officer Address: P.O. Box 1569
Riverside, CA 92502

County HIPAA Privacy Officer Fax Number: (951) 955-HIPAA or (951) 955-4472

— — — — — — — TO BE COMPLETED BY COUNTY PERSONNEL ONLY— — — — —

County Departmental Officer: Susan Birch

County Departmental Officer Title: Human Resources Services Manager

County Department Address: 4080 Lemon St. 7th floor, Riverside, CA 92502

County Department Fax Number: (951) 955-4472

EXHIBIT 2

Name of Business: SCAN Health Plan

OWNERSHIP INFORMATION

Check one:

Corporation		
Partnership		
Sole Proprietorship		
Other	X	Not-For-Profit Corporation

Board of Directors:

Colleen Cain, Co-Founder and former CEO, Benova, Inc
Michael L. Noel, Chairman, Noel Consulting Company
Tom Higgins, The Laurel Company
Tom McDaniel, Edison International (retired)
Kim L. Hunter, LA Grant Communications
Pat Seaver, Lathan & Watkins (retired)
Andrew Allocco, Aetna Inc. (retired)

Officers and Executives:

Chris Wing, Chief Executive Officer
Randy Stone, Chief Financial Officer
Bill Roth, Chief Operating Officer
Douglas A. Jaques, Esq., Senior Vice President, General Counsel and Secretary
Gil Miller, Senior Vice President of National Sales
Andrew Whitelock, Vice President Compliance
Peter Begans, Senior Vice President, Public and Government Affairs

Additional Shareholders:

County of Riverside

SCAN Employer Group (HMO)
offered by **SCAN Health Plan**

Evidence of Coverage for 2014

Y0057_SCAN_8119_2013 IA 08302013 G8161 08/13

scan HEALTH PLAN®

APR 22 2014 3-25

JANUARY 1–DECEMBER 31, 2014

Evidence of Coverage:

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

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1–December 31, 2014. It explains how to get coverage for the health care services and prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

This plan, SCAN Employer Group, is offered by 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 Employer Group.)

SCAN Employer Group (HMO) is an HMO plan with a Medicare contract. Enrollment in SCAN Health Plan depends on contract renewal.

This information is available for free in other languages. Please contact our Member Services number at 1-800-559-3500 for additional information. (TTY users should call 711). Hours are 7 A.M.–8 P.M., seven days a week. Member Services also has free language interpreter services available for non-English speakers.

Esta información está disponible gratuitamente en otros idiomas. Comuníquese con nuestro Departamento de Servicios para Miembros al 1-800-559-3500 para obtener más información. (Los usuarios de TTY deben llamar al 711). El horario de atención es de 7 A.M. a 8 P.M., los siete días de la semana. Servicios para Miembros también cuenta con personal y servicios gratuitos de interpretación.

We can also give you information for free in large print, audio recording, or other alternate formats if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

Benefits, formulary, pharmacy network, premium, deductible, and/or copayments/coinsurance may change on January 1, 2015.

Y0057_SCAN_8119_2013 IA 08302013

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

CHAPTER 1 GETTING STARTED AS A MEMBER

SECTION 1 INTRODUCTION

SECTION 1.1 YOU ARE ENROLLED IN SCAN EMPLOYER GROUP, WHICH IS A MEDICARE HMO

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, SCAN Employer Group.

There are different types of Medicare health plans. SCAN Employer Group is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization). Like all Medicare health plans, this Medicare HMO is approved by Medicare and run by a private company.

SECTION 1.2 WHAT IS THE *EVIDENCE OF COVERAGE* BOOKLET ABOUT?

This *Evidence of Coverage* booklet tells you how to get your Medicare medical care and prescription drugs covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

This plan, SCAN Employer Group is offered by 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 Employer Group.)

The word "coverage" and "covered services" refers to the medical care and services and the prescription drugs available to you as a member of SCAN Employer Group.

SECTION 1.3 WHAT DOES THIS CHAPTER TELL YOU?

Look through Chapter 1 of this *Evidence of Coverage* to learn:

- What makes you eligible to be a plan member?
- What is your plan's service area?
- What materials will you get from us?
- What is your plan premium and how can you pay it?
- How do you keep the information in your membership record up to date?

SECTION 1.4 WHAT IF YOU ARE NEW TO SCAN EMPLOYER GROUP?

If you are a new member, then it's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact our plan's Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 1.5 LEGAL INFORMATION ABOUT THE *EVIDENCE OF COVERAGE*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how SCAN Employer Group covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive 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 months in which you are enrolled in SCAN Employer Group between January 1, 2014 and December 31, 2014.

Medicare must approve our plan each year

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

SECTION 2 WHAT MAKES YOU ELIGIBLE TO BE A PLAN MEMBER?

SECTION 2.1 YOUR ELIGIBILITY REQUIREMENTS

You are eligible for membership in our plan as long as:

- You live in our geographic service area (section 2.3 below describes our service area)
- —*and*— you have both Medicare Part A and Medicare Part B
- —*and*— you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.

SECTION 2.2 WHAT ARE MEDICARE PART A AND MEDICARE PART B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services furnished by institutional providers such as hospitals (for inpatient services), skilled nursing facilities, or home health agencies.
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment and supplies).

SECTION 2.3 HERE IS THE PLAN SERVICE AREA FOR SCAN EMPLOYER GROUP

Although Medicare is a Federal program, SCAN Employer Group is available only to individuals who live in our plan service area. To remain a member of our plan, you must keep living in this service area. The service area is described below.

Los Angeles County Service Area Zip Codes - All zip codes included

Orange County - All zip codes included

Riverside County - All zip codes included

San Bernardino County - All zip codes included

San Diego County - All zip codes included

Ventura County - All zip codes included

Contra Costa County - All zip codes included

Santa Clara County - All zip codes included

San Francisco County - All zip codes included

Marin County - All zip codes included

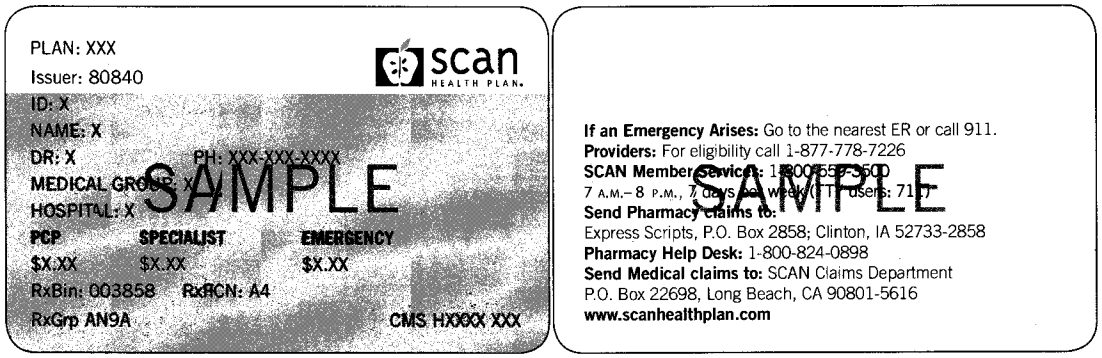
If you plan to move out of the service area, please contact Member Services (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

SECTION 3 WHAT OTHER MATERIALS WILL YOU GET FROM US?

SECTION 3.1 YOUR PLAN MEMBERSHIP CARD—USE IT TO GET ALL COVERED CARE AND PRESCRIPTION DRUGS

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. Here's a sample membership card to show you what yours will look like:



Front of Card Back of Card

As long as you are a member of our plan **you must not use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). Keep your red, white, and blue Medicare card in a safe place in case you need it later.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your SCAN Employer Group membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. (Phone numbers for Member Services are printed on the back cover of this booklet.)

SECTION 3.2 THE *PROVIDER DIRECTORY & PHARMACY DIRECTORY*: YOUR GUIDE TO ALL PROVIDERS AND PHARMACIES IN THE PLAN'S NETWORK

The *Provider Directory & Pharmacy Directory* lists our network providers and pharmacies.

What are "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. We have arranged for these providers to deliver covered services to members in our plan.

Why do you need to know which providers are part of our network?

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed care when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which SCAN Employer Group authorizes use of out-of-network providers. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage.

If you don't have your copy of the *Provider Directory*, you can request a copy from Member Services (phone numbers are printed on the back cover of this booklet). You may ask Member Services for more information about our network providers, including their qualifications. You can also see a listing of providers at www.scanhealthplan.com. Both Member Services and the Web site can give you the most up-to-date information about changes in our network providers.

What are "network pharmacies"?

Our *Pharmacy Directory* gives you a complete list of our network pharmacies—that means all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the *Pharmacy Directory* to find the network pharmacy you want to use. This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our plan to cover (help you pay for) them.

If you don't have the *Pharmacy Directory*, you can get a copy from Member Services (phone numbers are printed on the back cover of this booklet). At any time, you can call Member Services to get up-to-date information about changes in the pharmacy network. You can also find this information on our Web site at www.scanhealthplan.com.

SECTION 3.3 THE PLAN'S LIST OF COVERED DRUGS (FORMULARY)

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered by SCAN Employer Group. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the SCAN Employer Group Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will send you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's Web site (www.scanhealthplan.com) or call Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 3.4 THE *EXPLANATION OF BENEFITS* (THE "EOB"): REPORTS WITH A SUMMARY OF PAYMENTS MADE FOR YOUR PART D PRESCRIPTION DRUGS

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Explanation of Benefits* (or the "EOB").

The *Explanation of Benefits* tells you the total amount you have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 (What you pay for your Part D prescription drugs) gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

An *Explanation of Benefits* summary is also available upon request. To get a copy, please contact Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 4 YOUR MONTHLY PREMIUM FOR SCAN EMPLOYER GROUP

SECTION 4.1 HOW MUCH IS YOUR PLAN PREMIUM?

You must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

In some situations, your plan premium could be <u>more</u>

In some situations, your plan premium could be more than the amount listed above in Section 4.1. These situations are described below.

- Some members are required to pay a **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) For these members, the late enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their late enrollment penalty.
    - If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 6, Section 10 explains the late enrollment penalty.

- If you have a late enrollment penalty and do not pay it, you could be disenrolled from the plan.

Many members are required to pay other Medicare premiums

Many members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. And most plan members pay a premium for Medicare Part B. **You must continue paying your Medicare premiums to remain a member of the plan.**

Some people pay an extra amount for Part D because of their yearly income. If your income is $85,000 or above for an individual (or married individuals filing separately) or $170,000 or above for married couples, **you must pay an extra amount directly to the government (not the Medicare plan)** for your Medicare Part D coverage.

- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.**
- If you have to pay an extra amount, Social Security, **not your Medicare plan**, will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, go to Chapter 4, Section 11 of this booklet. You can also visit http://www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of *Medicare & You 2014* gives information about the Medicare premiums in the section called "2014 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2014* from the Medicare Web site (http://www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

SECTION 4.2 IF YOU PAY A PART D LATE ENROLLMENT PENALTY, THERE ARE SEVERAL WAYS YOU CAN PAY YOUR PENALTY

May not be applicable to Employer Group members. For premium information contact your former Employer Group Benefits Administrator.

If you pay a Part D late enrollment penalty, there are four ways you can pay the penalty. You can indicate your payment option by selecting the appropriate box on your enrollment form or by completing an AutoPay form. Contact Member Services if you want to change your payment option.

If you decide to change the way you pay your late enrollment penalty, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your late enrollment penalty is paid on time.

Option 1: You can pay by check

You will receive a SCAN 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. Your payment will be due the 1st of each month and will be considered delinquent if payment is not received by the 5th of the same month. Please make the check payable to "SCAN Health Plan", not CMS or HHS.

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

You can have your 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, you need to complete an AutoPay form and send it to us in the envelope provided. Contact Member Services to request an AutoPay form.

Option 3: You can have the late enrollment penalty taken out of your monthly Social Security check

You can have the late enrollment penalty taken out of your monthly Social Security check. Contact Member Services for more information on how to pay your monthly penalty this way. We will be happy to help you set this up. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Option 4: You can pay your late enrollment penalty by credit or debit card

You can have the late enrollment penalty charged to your credit or debit card each month. To choose this option, you need to complete the AutoPay form and send it to us in the envelope provided. Contact Member Services to request an AutoPay form.

What to do if you are having trouble paying your late enrollment penalty

Your late enrollment penalty is due in our office by the 1st of each month. If we have not received your penalty by the 5th of each month, we will send you a notice telling you that your plan membership will end if we do not receive your late enrollment penalty within three calendar months.

If you are having trouble paying your late enrollment penalty on time, please contact Member Services to see if we can direct you to programs that will help with your penalty. (Phone numbers for Member Services are printed on the back cover of this booklet.)

If we end your membership with the plan because you did not pay your late enrollment penalty, then you may not be able to receive Part D coverage until the following year if you enroll in a new plan during the annual enrollment period. During the annual enrollment period, you may either join a stand-alone prescription drug plan or a health plan that also provides drug coverage. (If you go without "creditable" drug coverage for more than 63 days, you may have to pay a late enrollment penalty for as long as you have Part D coverage.)

If we end your membership because you did not pay your late enrollment penalty, you will have health coverage under Original Medicare.

At the time we end your membership, you may still owe us for the penalty you have not paid. We have the right to pursue collection of the penalty amount you owe. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the amount you owe before you can enroll.

If you think we have wrongfully ended your membership, you have a right to ask us to reconsider this decision by making a complaint. Chapter 9, Section 10 of this booklet tells how to make a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your premiums within our grace period, you can ask Medicare to reconsider this decision 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.

SECTION 4.3 CAN WE CHANGE YOUR MONTHLY PLAN PREMIUM DURING THE YEAR?

No. We are not allowed to begin charging a monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

However, in some cases, you may need to start paying or may be able to stop paying a late enrollment penalty. (The late enrollment penalty may apply if you had a continuous period of 63 days or more when you didn't have "creditable" prescription drug coverage.) This could happen if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year:

- If you currently pay the late enrollment penalty and become eligible for "Extra Help" during the year, you would be able to stop paying your penalty.
- If the "Extra Help" program is currently paying your late enrollment penalty and you lose your eligibility during the year, you would need to start paying your penalty.

You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 5 PLEASE KEEP YOUR PLAN MEMBERSHIP RECORD UP TO DATE

SECTION 5.1 HOW TO HELP MAKE SURE THAT WE HAVE ACCURATE INFORMATION ABOUT YOU

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider (PCP) and Medical Group or IPA.

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

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive 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 are participating in a clinical research study

If any of this information changes, please let us know by calling Member Services (phone numbers are printed on the back cover of this booklet).

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 6 WE PROTECT THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION

SECTION 6.1 WE MAKE SURE THAT YOUR HEALTH INFORMATION IS PROTECTED

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.

For more information about how we protect your personal health information, please go to Chapter 8, Section 1.4 of this booklet.

SECTION 7 HOW OTHER INSURANCE WORKS WITH OUR PLAN

SECTION 7.1 WHICH PLAN PAYS FIRST WHEN YOU HAVE OTHER INSURANCE?

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

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 size of the 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 is still working, your 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 is still working, the 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.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

CHAPTER 2 IMPORTANT PHONE NUMBERS AND RESOURCES

SECTION 1 SCAN EMPLOYER GROUP CONTACTS (HOW TO CONTACT US, INCLUDING HOW TO REACH MEMBER SERVICES AT THE PLAN)

How to contact our plan's Member Services

For assistance with claims, billing or member card questions, please call or write to SCAN Employer Group Member Services. We will be happy to help you.

MEMBER SERVICES	
CALL	**1-800-559-3500** Calls to this number are free. A representative is available to speak with you 7 A.M.–8 P.M., seven days a week. Assistance with Part D Pharmacy questions or issues is available 24 hours a day, 365 days a year. We are closed on most major holidays. You may leave a recorded message and a representative will return your call within 1 business day. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. A representative is available to speak with you 7 A.M.–8 P.M., seven days a week. Assistance with Part D Pharmacy questions or issues is available 24 hours a day, 365 days a year. We are closed on most major holidays. You may leave a recorded message and a representative will return your call within 1 business day.
FAX	**1-562-989-5181**
WRITE	**SCAN Health Plan** Attention: Member Services Department P.O. Box 22616, Long Beach, CA 90801-5616 MemberServices@scanhealthplan.com
WEB SITE	www.scanhealthplan.com

How to contact us when you are asking for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

You may call us if you have questions about our coverage decision process.

COVERAGE DECISIONS FOR MEDICAL CARE	
CALL	**1-800-559-3500** Calls to this number are free. A representative is available to speak with you 7 A.M.–8 P.M., seven days a week. We are closed on most major holidays. You may leave a recorded message and a representative will return your call within 1 business day.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. A representative is available to speak with you 7 A.M.–8 P.M., seven days a week. We are closed on most major holidays. You may leave a recorded message and a representative will return your call within 1 business day.
FAX	**1-562-989-5181**
WRITE	**SCAN Health Plan** Attention: Member Services Department P.O. Box 22616, Long Beach, CA 90801-5616
WEB SITE	www.scanhealthplan.com

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

APPEALS FOR MEDICAL CARE	
CALL	**1-800-559-3500** Calls to this number are free. A representative is available to speak with you 7 A.M.–8 P.M., seven days a week. We are closed on most major holidays. You may leave a recorded message and a representative will return your call within 1 business day.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. A representative is available to speak with you 7 A.M.–8 P.M., seven days a week. We are closed on most major holidays. You may leave a recorded message and a representative will return your call within 1 business day.
FAX	**1-562-989-0958**
WRITE	**SCAN Health Plan** Attention: Grievances and Appeals Department P.O. Box 22644, Long Beach, CA 90801-5644
WEB SITE	www.scanhealthplan.com

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

COMPLAINTS ABOUT MEDICAL CARE	
CALL	**1-800-559-3500** Calls to this number are free. A representative is available to speak with you 7 A.M.–8 P.M., seven days a week. We are closed on most major holidays. You may leave a recorded message and a representative will return your call within 1 business day.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. A representative is available to speak with you 7 A.M.–8 P.M., seven days a week. We are closed on most major holidays. You may leave a recorded message and a representative will return your call within 1 business day.
FAX	**1-562-989-0958**
WRITE	**SCAN Health Plan** Attention: Grievances and Appeals Department P.O. Box 22644, Long Beach, CA 90801-5644
MEDICARE WEB SITE	You can submit a complaint about SCAN Employer Group directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your Part D prescription drugs. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

COVERAGE DECISIONS FOR PART D PRESCRIPTION DRUGS	
CALL	**1-800-417-8164** Calls to this number are free. A representative is available 24 hours a day, seven days a week.
TTY	**1-800-899-2114** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. A representative is available 24 hours a day, seven days a week.
FAX	**1-877-837-5922**
WRITE	**Express Scripts, Inc.** Attention: Prior Authorization Department—Part D Mail Stop B401-03, 8640 Evans Road, St. Louis, MO 63134
WEB SITE	www.scanhealthplan.com

How to contact us when you are making an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

APPEALS FOR PART D PRESCRIPTION DRUGS	
CALL	**1-800-559-3500** Calls to this number are free. A representative is available to speak with you 7 A.M.–8 P.M., seven days a week. We are closed on most major holidays. You may leave a recorded message and a representative will return your call within 1 business day.
TTY	**711** Calls to this number are free. A representative is available to speak with you 7 A.M.–8 P.M., seven days a week. We are closed on most major holidays. You may leave a recorded message and a representative will return your call within 1 business day.
FAX	**1-562-989-0958**
WRITE	**SCAN Health Plan** Attention: Grievances and Appeals Department P.O. Box 22644, Long Beach, CA 90801-5644
WEB SITE	www.scanhealthplan.com

How to contact us when you are making a complaint about your Part D prescription drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

COMPLAINTS ABOUT PART D PRESCRIPTION DRUGS	
CALL	**1-800-559-3500** Calls to this number are free. A representative is available to speak with you 7 A.M.–8 P.M., seven days a week. We are closed on most major holidays. You may leave a recorded message and a representative will return your call within 1 business day.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. A representative is available to speak with you 7 A.M.–8 P.M., seven days a week. We are closed on most major holidays. You may leave a recorded message and a representative will return your call within 1 business day.
FAX	**1-562-989-0958**
WRITE	**SCAN Health Plan** Attention: Grievances and Appeals Department P.O. Box 22644, Long Beach, CA 90801-5644
MEDICARE WEB SITE	You can submit a complaint about SCAN Employer Group directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

PAYMENT REQUESTS	
CALL	**1-800-559-3500** Calls to this number are free. A representative is available to speak with you 7 A.M.–8 P.M., seven days a week. We are closed on most major holidays. You may leave a recorded message and a representative will return your call within 1 business day.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. A representative is available to speak with you 7 A.M.–8 P.M., seven days a week. We are closed on most major holidays. You may leave a recorded message and a representative will return your call within 1 business day.
FAX	**1-562-989-5181**
WRITE	**SCAN Health Plan** Attention: Member Services Department P.O. Box 22616, Long Beach, CA 90801-5616
WEB SITE	www.scanhealthplan.com

SECTION 2 MEDICARE (HOW TO GET HELP AND INFORMATION DIRECTLY FROM THE FEDERAL MEDICARE PROGRAM)

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 (sometimes called "CMS"). This agency contracts with Medicare Advantage organizations including us.

MEDICARE	
CALL	**1-800-MEDICARE**, or **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 with hearing or speaking. Calls to this number are free.
WEB SITE	http://www.medicare.gov This is the official government Web site for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare Web site also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the Web site to tell Medicare about any complaints you have about SCAN Employer Group: • **Tell Medicare about your complaint:** You can submit a complaint about SCAN Employer Group directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this Web site using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the Web site, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

SECTION 3 STATE HEALTH INSURANCE ASSISTANCE PROGRAM (FREE HELP, INFORMATION, AND ANSWERS TO YOUR QUESTIONS ABOUT MEDICARE)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In California, the SHIP is called Health Insurance and Advocacy Program (HICAP).

Health Insurance and Advocacy Program (HICAP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

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

HEALTH INSURANCE AND ADVOCACY PROGRAM (HICAP) (CALIFORNIA SHIP)	
CALL	**1-800-434-0222**
WRITE	**HICAP** **Los Angeles County** 520 S. La Fayette Park Pl, Ste 214, Los Angeles, CA 90057 **Orange County** 1971 E. 4th St, Ste 200, Santa Ana, CA 92705 **Riverside and San Bernardino Counties** 9121 Haven Ave, Ste 120, Rancho Cucamonga, CA 91739

SECTION 4 QUALITY IMPROVEMENT ORGANIZATION (PAID BY MEDICARE TO CHECK ON THE QUALITY OF CARE FOR PEOPLE WITH MEDICARE)

There is a Quality Improvement Organization for each state. For California, the Quality Improvement Organization is called Health Services Advisory Group (HSAG).

Health Services Advisory Group (HSAG) has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. Health Services Advisory Group (HSAG) is an independent organization. It is not connected with our plan.

You should contact Health Services Advisory Group (HSAG) in any of these situations:

- You have a complaint about the quality of care you have received.
- 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 are ending too soon.

HEALTH SERVICES ADVISORY GROUP (HSAG) (CALIFORNIA'S QUALITY IMPROVEMENT ORGANIZATION)	
CALL	**1-800-841-1602**
TTY	**1-800-881-5980** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**HSAG** Attention: Beneficiary Protection 700 North Brand Boulevard, Suite 370 Glendale, CA 91203
WEB SITE	www.hsag.com

SECTION 5 SOCIAL SECURITY

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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 a reconsideration.

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

SOCIAL SECURITY	
CALL	**1-800-772-1213** Calls to this number are free. Available 7 A.M. to 7 P.M., Monday through Friday. You can 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 7 A.M. to 7 P.M., Monday through Friday.
WEB SITE	http://www.ssa.gov

SECTION 6 MEDICAID (A JOINT FEDERAL AND STATE PROGRAM THAT HELPS WITH MEDICAL COSTS FOR SOME PEOPLE WITH LIMITED INCOME AND RESOURCES)

Medi-Cal (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 Medi-Cal (Medicaid).

In addition, there are programs offered through Medi-Cal (Medicaid) that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **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 Medi-Cal (Medicaid) benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medi-Cal (Medicaid) benefits (SLMB+).)
- **Qualified Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medi-Cal (Medicaid) and its programs, contact the California Department Health Care Services (DHCS).

CALIFORNIA DEPARTMENT HEALTH CARE SERVICES (DHCS)	
CALL	The Office of the Ombudsman **1-888-452-8609** Monday through Friday, 8 A.M. to 5 P.M. PST; excluding state holidays.
WRITE	**California Department of Health Care Services** 1501 Capitol Avenue P.O. Box 997413 Sacramento, CA 95899-7413 MMCDOmbudsmanOffice@dhcs.ca.gov
WEB SITE	www.dhcs.ca.gov

SECTION 7 INFORMATION ABOUT PROGRAMS TO HELP PEOPLE PAY FOR THEIR PRESCRIPTION DRUGS

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This "Extra Help" also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for "Extra Help." Some people automatically qualify for "Extra Help" and don't need to apply. Medicare mails a letter to people who automatically qualify for "Extra Help."

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

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 A.M. and 7 P.M., Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office. (See Section 6 of this chapter for contact information.)

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- If you would like to request assistance with obtaining best available evidence and for providing this evidence, please contact Member Services.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions (phone numbers are printed on the back cover of this booklet).

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program is available nationwide. Because SCAN Employer Group offers additional gap coverage during the Coverage Gap Stage, your out-of-pocket costs will sometimes be lower than the costs described here. Please go to Chapter 6, Section 6 for more information about your coverage during the Coverage Gap Stage.

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap and are not already receiving "Extra Help." A 50% copayment discount on your brand drugs.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your *Explanation of Benefits* (EOB) will show any discount provided. Both the amount

you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than "Extra Help"), you still get the 50% discount on covered brand name drugs. Also, the plan pays 2.5% of the costs of brand drugs in the coverage gap. The 50% discount and the 2.5% paid by the plan is applied to the price of the drug before any SPAP or other coverage.

What if you get "Extra Help" from Medicare to help pay your prescription drug costs? Can you get the discounts?

No. If you get "Extra Help," you already get coverage for your prescription drug costs during the coverage gap.

What if you don't get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next *Explanation of Benefits* (EOB) notice. If the discount doesn't appear on your *Explanation of Benefits*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this Chapter) or 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.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, or medical condition. Each state has different rules to provide drug coverage to its members.

These programs provide limited income and medically needy seniors and individuals with disabilities financial help for prescription drugs. In California, the State Pharmaceutical Assistance Program is Genetically Handicapped Persons Program (GHPP).

GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP) (CALIFORNIA'S STATE PHARMACEUTICAL ASSISTANCE PROGRAM)	
CALL	**1-800-639-0597**
WRITE	**Genetically Handicapped Persons Program** MS 8100, P.O. Box 997413 Sacramento, CA 95899-7413
WEB SITE	http://www.dhcs.ca.gov

SECTION 8 HOW TO CONTACT THE RAILROAD RETIREMENT BOARD

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 have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

RAILROAD RETIREMENT BOARD	
CALL	**1-877-772-5772** Calls to this number are free. Available 9 A.M. to 3:30 P.M., Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 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 with hearing or speaking. Calls to this number are *not* free.
WEB SITE	http://www.rrb.gov

SECTION 9 DO YOU HAVE "GROUP INSURANCE" OR OTHER HEALTH INSURANCE FROM AN EMPLOYER?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group, call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the back cover of this booklet.)

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

CHAPTER 3 USING THE PLAN'S COVERAGE FOR YOUR MEDICAL SERVICES

SECTION 1 THINGS TO KNOW ABOUT GETTING YOUR MEDICAL CARE COVERED AS A MEMBER OF OUR PLAN

This chapter explains what you need to know about using the plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

SECTION 1.1 WHAT ARE "NETWORK PROVIDERS" AND "COVERED SERVICES"?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **"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 have arranged for these providers to deliver covered services to members in our plan. The providers in our network generally bill us directly for care they give you. When you see a network provider, you usually pay only your share of the cost for their services.
- **"Covered services"** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

SECTION 1.2 BASIC RULES FOR GETTING YOUR MEDICAL CARE COVERED BY THE PLAN

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

SCAN Employer Group will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered 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.
- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
    - In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.3 of this chapter.

- Referrals from your PCP are not required for emergency care or urgently needed care. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).

- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. *Here are three exceptions:*

  - The plan covers emergency care or urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, see Section 3 in this chapter.

  - If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. You must obtain authorization before seeking care. Your PCP can assist you with obtaining authorization. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.

  - Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

SECTION 2 USE PROVIDERS IN THE PLAN'S NETWORK TO GET YOUR 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 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 doctors 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 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. 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 do you choose your PCP?

To view a list of available PCPs, please review our *Provider Directory* or visit our Web site at http://www.scanhealthplan.com. After you have reviewed the list of available providers in your area, please call our Member Services Department at 1-800-559-3500 (TTY Users 711) to select your PCP.

Please note: If you do not select a PCP within 30 days of your enrollment, SCAN 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 120 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.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP.

If you wish to change your PCP within your contracted medical group or 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 Department, 7 A.M.–8 P.M., at 1-800-559-3500, seven days a week. TTY Users: call 711.

When you call, be sure to tell Member Services if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Member Services will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. 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 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 WHAT KINDS OF MEDICAL CARE CAN YOU GET WITHOUT GETTING APPROVAL IN ADVANCE FROM YOUR PCP?

You can get services such as those listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes 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 and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed care from in-network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, e.g., when you are temporarily outside of the plan's service area.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away. Phone numbers for Member Services are printed on the back cover of this booklet.)

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. Here are a few examples:

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

For some types of referrals, your PCP may need to get approval in advance from SCAN (this is called getting "prior authorization").

It is very important to get a 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 referral (approval in advance) before you get services from a specialist, you may have to pay for these services yourself.

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 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.

What if a specialist or another network provider leaves our plan?

Sometimes a specialist, clinic, hospital, or other network provider you are using might leave the plan.

If this happens, you will have to switch to another provider who is part of the SCAN network. Your medical group or IPA will notify you of this change in the network and will offer alternative providers.

If you are in the middle of care with a provider who leaves the plan, your PCP will assist you with transitioning your care.

SECTION 2.4 HOW TO GET CARE FROM OUT-OF-NETWORK PROVIDERS

SCAN Health Plan does not cover out-of-network services

SECTION 3 HOW TO GET COVERED SERVICES WHEN YOU HAVE AN EMERGENCY OR URGENT NEED FOR CARE

SECTION 3.1 GETTING CARE IF YOU HAVE A MEDICAL EMERGENCY

What is a "medical emergency" and what should you do if you have one?

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, 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 is 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 do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that 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. Please call our plan's Member Services at the telephone number listed on the back of your membership card. You should also have someone call your PCP at the telephone number listed on your membership card as soon as reasonably possible.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

In addition, our plan also covers emergency care 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.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

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 was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- —*or*— the additional care you get is considered "urgently needed care" and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

SECTION 3.2 GETTING CARE WHEN YOU HAVE AN URGENT NEED FOR CARE

What is "urgently needed care"?

"Urgently needed care" is a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan's service area when you have an urgent need for care?

In most situations, if you are in the plan's service area, we will cover urgently needed care *only* if you get this care from a network provider and follow the other rules described earlier in this chapter. However, if the circumstances are unusual or extraordinary, and network providers are temporarily unavailable or inaccessible, we will cover urgently needed care that you get from an out-of-network provider.

For information on how to access urgently needed services in-network please contact your PCP at the telephone number listed on your membership card. Please call our plan's Member Services at the telephone number listed on the back of your membership card if you need additional assistance.

What if you are outside the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed care that you get from any provider.

Our plan covers urgently needed care worldwide as long as the reason for receiving care meets the definition of "urgently needed care" that is given above. Please refer to Chapter 4 for more information.

SECTION 4 WHAT IF YOU ARE BILLED DIRECTLY FOR THE FULL COST OF YOUR COVERED SERVICES?

SECTION 4.1 YOU CAN ASK US TO PAY OUR SHARE OF THE COST OF COVERED SERVICES

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do.

SECTION 4.2 IF SERVICES ARE NOT COVERED BY OUR PLAN, YOU MUST PAY THE FULL COST

SCAN Employer Group covers all medical services that are medically necessary, are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), 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 and were not authorized.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services to get more information about how to do this (phone numbers are printed on the back cover of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. Once a covered benefit limit is reached, your additional expenses will not count toward the 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 HOW ARE YOUR MEDICAL SERVICES COVERED WHEN YOU ARE 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. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study.*

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study**. Here is why you need to tell us:

1. We can let you know whether the clinical research study is Medicare-approved.
2. We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan on participating in a clinical research study, contact Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 5.2 WHEN YOU PARTICIPATE IN A CLINICAL RESEARCH STUDY, WHO PAYS FOR WHAT?

Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive 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 is part of the research study.
- Treatment of side effects and complications of the new care.

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost sharing in Original Medicare and your cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.

> *Here's an example of how the cost sharing works:* Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and we would pay another $10. This means that you would pay $10, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 7 for more information about submitting requests for payment.

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

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare Web site (http://www.medicare.gov). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 6 RULES FOR GETTING CARE COVERED IN A "RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTION"

SECTION 6.1 WHAT IS 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 care. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

SECTION 6.2 WHAT CARE FROM A RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTION IS COVERED BY OUR PLAN?

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

- "Non-excepted" medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- "Excepted" medical treatment is medical care or treatment that you get that is *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's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in your home, our plan will cover these services only if your condition would ordinarily meet the conditions for coverage of services given by home health agencies that are not religious non-medical health care institutions.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - —*and*— you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

There is unlimited coverage for Inpatient Hospital Care. Please refer to the benefit chart in Chapter 4.

SECTION 7 RULES FOR OWNERSHIP OF DURABLE MEDICAL EQUIPMENT

SECTION 7.1 WILL YOU OWN THE DURABLE MEDICAL EQUIPMENT AFTER MAKING A CERTAIN NUMBER OF PAYMENTS UNDER OUR PLAN?

Durable medical equipment includes items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a provider for use in the home. Certain items, such as prosthetics, are always owned by the member. In this section, we discuss other types of durable medical equipment that must be rented.

In Original Medicare, people who rent certain types of durable medical equipment own the equipment after paying copayments for the item for 13 months. As a member of SCAN Employer Group, however, you usually will not acquire ownership of rented durable medical equipment items no matter how many copayments you make for the item while a member of our plan. Under certain limited circumstances and depending on the type of DME, we will transfer ownership of the durable medical equipment item. Call Member Services (phone numbers are printed on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

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

If you switch to Original Medicare after being a member of our plan: If you did not acquire ownership of the durable medical equipment item while in our plan, you will have to make 13 new consecutive payments for the item while in Original Medicare in order to acquire ownership of the item. Your previous payments while in our plan do not count toward these 13 consecutive payments.

If you made payments for the durable medical equipment item under Original Medicare *before* you joined our plan, these previous Original Medicare payments also do not count toward the 13 consecutive payments. You will have to make 13 consecutive payments for the item under Original Medicare in order to acquire ownership. There are no exceptions to this case when you return to Original Medicare.

CHAPTER 4 MEDICAL BENEFITS CHART (WHAT IS COVERED AND WHAT YOU PAY)

SECTION 1 UNDERSTANDING YOUR OUT-OF-POCKET COSTS FOR COVERED SERVICES

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of SCAN Employer Group. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

(See the Addenda in Section 3 of this chapter for additional information on limitations and exclusions).

SECTION 1.1 TYPES OF OUT-OF-POCKET COSTS YOU MAY PAY FOR YOUR COVERED SERVICES

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **"Coinsurance"** is 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 in Section 2 tells you more about your coinsurance.)

SECTION 1.2 WHAT IS THE MOST YOU WILL PAY FOR MEDICARE PART A AND PART B COVERED MEDICAL SERVICES?

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of SCAN Employer Group, the most you will have to pay out-of-pocket for in-network covered Part A and Part B services in 2014 is $6,700. 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 Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not 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 $6,700, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medi-Cal (Medicaid) or another third party).

SECTION 1.3 OUR PLAN DOES NOT ALLOW PROVIDERS TO "BALANCE BILL" YOU

As a member of SCAN Employer Group, an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. We do not 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 is a dispute and we don't pay certain provider charges.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), then 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), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you receive the 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. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)

SECTION 2 USE THE *MEDICAL BENEFITS CHART* TO FIND OUT WHAT IS COVERED FOR YOU AND HOW MUCH YOU WILL PAY

SECTION 2.1 YOUR MEDICAL BENEFITS AND COSTS AS A MEMBER OF THE PLAN

The Medical Benefits Chart on the following pages lists the services SCAN Employer Group covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *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.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. 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*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2014* Handbook. View it online at http://www.medicare.gov or ask for 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.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2014, either Medicare or our plan will cover those services.

 You will see this apple next to the preventive services in the benefits chart.

MEDICAL BENEFITS CHART

Services that are covered for you	**What you must pay** when you get these services
 **Abdominal aortic aneurysm screening** A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" preventive visit.	$0 copayment **Prior authorization rules apply**

* These benefits do not apply to your maximum out-of-pocket amount.

Services that are covered for you	**What you must pay** when you get these services
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health) or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required. 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. (Urgent care and doctors' offices are not considered facilities for the purpose of this benefit.) Paramedic intercept services are not covered except under limited circumstances.	$0 copayment for each one-way trip **Prior authorization rules apply**
Annual physical examination* You are covered for one routine physical examination per year. This exam includes screening laboratory services as needed.	$15 copayment
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" visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.

* These benefits do not apply to your maximum out-of-pocket amount.

Services that are covered for you	**What you must pay** when you get these services
Bone mass measurement For qualified individuals (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.	$0 copayment **Prior authorization rules apply**
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 age 40 and older • Clinical breast exams once every 24 months	$0 copayment You can self-refer within your network for annual mammography screening (1 exam every 12 months). **Prior authorization rules 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. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	$15 copayment **Prior authorization rules apply**
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover 1 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 well.	$0 copayment **Prior authorization rules apply**
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	$0 copayment **Prior authorization rules apply**
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months	$0 copayment You may self-refer to an OB/GYN within the network for routine preventive care. **Prior authorization rules apply**

* These benefits do not apply to your maximum out-of-pocket amount.

Services that are covered for you	**What you must pay** when you get these services
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation	$15 copayment **Prior authorization rules apply**
Chiropractic Services (Routine)* Routine chiropractic services cover medically-necessary routine care. You are covered up to 20 visits per year for routine chiropractic services. You must use contracted plan providers. This benefit does not require prior authorization.	$15 copayment for each office visit
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Fecal occult blood test, every 12 months For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	$0 copayment If, during a screening, a diagnostic procedure is required, you will not be responsible for additional copayments. Virtual Colonoscopy is not a covered procedure. **Prior authorization rules apply**
Covered Compounded Drugs* See Chapter 12 and Addenda for additional information	See Chapter 6 for Tier 5 Specialty drug copayment
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover: • Surgery of the jaw or related structures • Setting fractures of the jaw or facial bones • Extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease	$15 copayment **Prior authorization rules apply**
Depression screening We cover 1 screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.	$0 copayment **Prior authorization rules apply**

* These benefits do not apply to your maximum out-of-pocket amount.

Services that are covered for you	**What you must pay** when you get these services
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following 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. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	$0 copayment **Prior authorization rules 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 two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. ** As defined by Medicare.	$0 copayment Includes coverage of a select manufacturer (Abbott) for glucose monitors, test strips, lancets, and control solutions. (Please contact Member Services for more information). **Prior authorization rules apply to diabetes self-management training, therapeutic shoes, and inserts.**

* These benefits do not apply to your maximum out-of-pocket amount.

Services that are covered for you	**What you must pay** when you get these services
Durable medical equipment and related supplies (For a definition of "durable medical equipment," see Chapter 12 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. We cover all medically necessary durable medical equipment covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. DME supplies are limited to equipment and devices which do not duplicate the function of another piece of equipment or device covered by SCAN and are appropriate for use in the home. Coverage does not include items to be used outside of the home, such as travel oxygen, ramps, portable nebulizers, and other equipment. Repair and replacement of DME are covered due to breakage, wear or a significant change in your physical condition. SCAN Health Plan will repair or replace non-functional DME when medically necessary. Previously authorized services to be provided in-network (such as but not limited to oxygen) are not covered outside of the service area. DME copayments apply to each individual item and are based upon the cost of the item regardless of whether it is purchased or rented.	$0 copayment based on the Medicare-approved amount **Prior authorization rules apply**

* These benefits do not apply to your maximum out-of-pocket amount.

Services that are covered for you	**What you must pay** when you get these services
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • 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, 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 is quickly getting worse. Includes world-wide coverage. Non-emergency medications obtained outside the United States are not covered. For more information see Chapter 3.	$50 copayment for each The copayment is waived if you are admitted to the hospital as an inpatient either immediately or after a period of observation. If you receive 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 the plan and your cost is the cost sharing you would pay at a network hospital. If your condition prohibits you from returning to a network hospital, alternative care will be arranged if medically necessary.
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 furnished by a physician, audiologist, or other qualified provider.	$15 copayment **Prior authorization rules apply**
Hearing services (Routine)* Covered services include: • Routine hearing test • Hearing aids You may self-refer to a contracted 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. This benefit is provided over a period exceeding one year and is therefore considered a multi-year benefit and may be dropped or modified by SCAN from year-to-year without maintaining obligations to the previous contract year.	**Routine hearing test** $15 copayment (one test per year) **Hearing aid fitting/evaluation** $15 copayment (one visit every 2 years) **Hearing aid coverage** $600 coverage limit for one or two hearing aids every 2 years. You pay any remaining costs beyond what SCAN will cover. **Prior authorization rules apply to routine hearing tests**

* These benefits do not apply to your maximum out-of-pocket amount.

Services that are covered for you	**What you must pay** when you get these services
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	$0 copayment **Prior authorization rules apply**
Home health agency care Prior to receiving home health services, a doctor must 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 are not 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 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 chapter.	$0 copayment **Prior authorization rules apply**

* These benefits do not apply to your maximum out-of-pocket amount.

Services that are covered for you	**What you must pay** when you get these services
Hospice care You may receive care from any Medicare-certified hospice program. 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 For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal condition: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal condition: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal condition, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare) For services that are covered by SCAN Employer Group but are not covered by Medicare Part A or B: SCAN Employer Group will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal condition. You pay your plan cost sharing amount for these services. **Note:** If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not SCAN Employer Group.

* These benefits do not apply to your maximum out-of-pocket amount.

Services that are covered for you	**What you must pay** when you get these services
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit. Travel vaccinations are not covered.	$0 copayment **Prior authorization rules apply**

* These benefits do not apply to your maximum out-of-pocket amount.

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital care There is no limit to the number of medically necessary hospital days covered by the plan. Covered services include but are not 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" section in this chapter) • 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 will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Original Medicare rate, then you can choose to obtain your transplant services locally or at a distant location offered by the plan. If SCAN Employer Group provides transplant services at a distant location (outside of the service area) and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Authorization rules apply. Contact Member Services for details regarding the plan's policy for transplant travel coverage. (Continued)	$100 copayment Your inpatient benefits are based upon the date of admission. If you are admitted to the hospital in 2014 and are not discharged until 2015, the 2014 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 apply**

* These benefits do not apply to your maximum out-of-pocket amount.

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital care (continued) • Blood—including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • 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 are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare—Ask!" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Inpatient mental health care • 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 free-standing 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: $100 copayment per admission Your inpatient benefits are based upon the date of admission. If you are admitted to an inpatient mental health facility in 2014 and are not discharged until 2015, the 2014 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 apply**

* These benefits do not apply to your maximum out-of-pocket amount.