



Services that are covered for you	What you must pay when you get these services
<p>Inpatient services covered during a non-covered inpatient stay</p> <p>If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy <p>Covered services must be received from contracted, in-network providers.</p>	<p>Physician services: Please refer to “Physician/ Practitioner Services, Including Doctor’s Office Visits” section in this chapter.</p> <p>Diagnostic and radiological services, surgical dressings, and splints: Please refer to “Outpatient Diagnostic Tests and Therapeutic Services and Supplies” section in this chapter.</p> <p>Prosthetics, orthotics, and outpatient medical/ therapeutic supplies: Please refer to “Prosthetic Devices and Related Supplies” section in this chapter.</p> <p>Physical, speech, and occupational therapy services: Please refer to “Outpatient Rehabilitation Services” section in this chapter.</p> <p>Prior authorization rules apply for the above services</p>
<p> Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician’s referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into the next calendar year.</p>	<p>\$0 copayment</p> <p>Prior authorization rules apply</p>

* 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
<p>Medicare Part B prescription drugs</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:</p> <ul style="list-style-type: none"> • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases <p>Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.</p>	<p>\$40 copayment for Part B drugs.</p> <p>Non-Medicare-covered injectable drugs are not covered by SCAN.</p> <p>SCAN covers injectable chemotherapy drugs administered as anti-cancer agents that are covered under Original Medicare.</p> <p>Prior authorization rules apply</p>
<p> Obesity screening and therapy to promote sustained weight loss</p> <p>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.</p>	<p>\$0 copayment</p> <p>Prior authorization rules apply</p>

* 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

Outpatient diagnostic tests and therapeutic services and supplies

Covered services include, but are not limited to:

- X-rays
- Radiation (radium and isotope) therapy including technician materials and supplies
- Surgical supplies, such as dressings
- Splints, casts and other devices used to reduce fractures and dislocations
- Laboratory tests
- Blood. Coverage begins with the first pint of blood that you need. Coverage of storage and administration begins with the first pint of blood that you need.
- Other outpatient diagnostic tests

\$0 copayment for standard, covered laboratory services, diagnostic tests, and x-rays.

\$0 copayment for surgical supplies, splints, casts, and blood.

\$0 copayment for radiological procedures that require specialized equipment beyond normal x-ray equipment and which must be performed by specially trained or certified personnel. These services include, but are not limited to specialized scans such as CT, SPECT, MRI, MRA, Myelogram, Cystogram, Angiogram, ultrasound, and diagnostic nuclear scans.

\$0 copayment for therapeutic radiological procedures, such as Radiation Therapy, Gamma Knife and Cyber Knife procedures.

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

Outpatient hospital services

We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.

Covered services include, but are not limited to:

- Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery
- Laboratory and diagnostic tests billed by the hospital
- Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it
- Chemical dependency care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it
- X-rays and other radiology services billed by the hospital
- Medical supplies such as splints and casts
- Certain screenings and preventive services
- Certain drugs and biologicals that you can't give yourself

Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are 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.

Emergency services:

Please refer to "Emergency Care" section in this chapter.

Outpatient services:

Please refer to "Outpatient Surgery, Including Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers" section in this chapter.

Laboratory and diagnostic tests, x-rays, radiological services, and medical supplies:

Please refer to "Outpatient Diagnostic Tests and Therapeutic Services and Supplies" section in the chapter.

Mental health care and partial hospitalization:

Please refer to "Outpatient Mental Health Care" and "Partial Hospitalization Services" sections in this chapter.

Chemical dependency care:

Please refer to "Outpatient Substance Abuse Services" section in this chapter.

Screenings and preventive services:

Please refer to the applicable sections in this chapter.

Drugs and biologicals that you can't give yourself:

For applicable copayments see "Medicare Part B Prescription Drugs" section in this chapter.

Prior authorization rules apply for the above services

* 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
<p>Outpatient mental health care</p> <p>Covered services include:</p> <p>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	<p>\$15 copayment for each therapy visit in an individual or group setting</p> <p>Prior authorization rules apply</p>
<p>Outpatient rehabilitation services</p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>\$15 copayment</p> <p>Prior authorization rules apply</p>
<p>Outpatient substance abuse services</p> <p>You are covered for services and supplies to treat chemical dependency in an outpatient setting (individual or group therapy).</p>	<p>\$10 copayment for each therapy visit in an individual or group setting</p> <p>Prior authorization rules apply</p>

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Services that are covered for you

What you must pay when you get these services

Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers

You are covered for same-day outpatient services performed in an ambulatory surgical center or an outpatient hospital facility.

Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Ambulatory surgical center

\$0 copayment for each visit for surgical procedures, including but not limited to cardiac catheterizations, endoscopy, epidural injections and non-screening colonoscopies.

\$0 copayment for each visit for non-surgical services, including but not limited to wound care services, anti-coagulation services, and hyperbaric oxygen chamber therapy.

Outpatient hospital facility

\$0 copayment for each visit for surgical procedures, including but not limited to cardiac catheterizations, endoscopy, epidural injections and non-screening colonoscopies.

\$0 copayment for each visit for non-surgical services, including but not limited to wound care services, anti-coagulation services, and hyperbaric oxygen chamber therapy.

Prior authorization rules apply

Partial hospitalization services


"Partial hospitalization" is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.

Partial hospitalization also includes chemical dependency treatment.


\$25 copayment for each partial hospitalization visit

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
<p>Physician/Practitioner services, including doctor's office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP, if your doctor orders it to see if you need medical treatment • Second opinion by another network provider prior to surgery (See "How to Obtain a Second Opinion" later in this chapter) • Non-routine dental care (covered services are limited to 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, or services that would be covered when provided by a physician) • Allergy testing and treatment (performed in a physician's office): Coverage includes allergy serum and injection services. There is no additional copayment. <p>You may receive a home visit in lieu of a physician office visit when medically necessary. Authorization rules apply.</p> <p>Coinsurance payments will apply for Medicare-covered outpatient injectables and intravenous drugs administered in a physician office setting. See "Medicare Part B Prescription Drugs" section in this chapter.</p>	<p>\$15 copayment</p> <p>Prior authorization rules apply</p>
<p>Podiatry services (Medicare-covered)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs 	<p>\$15 copayment</p> <p>Prior authorization rules apply</p>
<p> Prostate cancer screening exams</p> <p>For men age 50 and older, covered services include the following—once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	<p>\$0 copayment</p> <p>Prior authorization rules apply</p>

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Services that are covered for you	What you must pay when you get these services
<p>Prosthetic devices and related supplies</p> <p>Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery—see “Vision Care” later in this section for more detail.</p> <p>Outpatient medical/therapeutic supplies, appliances and devices include: surgical dressings, and splints, casts; leg, arm, back, and neck braces and other devices used for reduction of fractures and dislocations.</p> <p>Repairs and replacements of prosthetics and orthotics are covered due to breakage, wear or a significant change in your physical condition. SCAN Health Plan will repair or replace non-functional prosthetics and orthotics when medically necessary.</p> <p>Prosthetic devices implanted in an inpatient/outpatient setting are covered under the inpatient hospital/outpatient surgery benefit and no additional copayment will apply.</p>	<p>\$0 copayment for each visit</p> <p>Prior authorization rules apply</p>
<p>Pulmonary rehabilitation services</p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</p>	<p>\$15 copayment</p> <p>Prior authorization rules apply</p>
<p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p>	<p>\$0 copayment</p> <p>Prior authorization rules apply</p>

* 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
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.</p>	<p>\$0 copayment</p> <p>Prior authorization rules apply</p>
<p>Services to treat kidney disease and conditions</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) <p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section below, "Medicare Part B prescription drugs."</p> <p>See Chapter 3, Section 2.2 for rules regarding out-of-area dialysis services.</p>	<p>\$0 copayment</p> <p>You pay \$0 for each Medicare-covered dialysis treatment. This includes both professional (Nephrologist dialysis clinic visits) and dialysis facility visits.</p> <p>Prior authorization rules apply</p>

* 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

Skilled nursing facility (SNF) care

(For a definition of “skilled nursing facility care,” see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called “SNFs.”)

You are covered for 100 days per benefit period. No prior hospital stay is required.

A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Covered services include but are not limited to:

- Semiprivate room (or a private room if medically necessary)
- Meals, including special diets
- Skilled nursing services
- Physical therapy, occupational therapy, and speech therapy
- Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.)
- Blood—including storage and administration. Coverage of whole blood and packed red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used.
- Medical and surgical supplies ordinarily provided by SNFs
- Laboratory tests ordinarily provided by SNFs
- X-rays and other radiology services ordinarily provided by SNFs
- Use of appliances such as wheelchairs ordinarily provided by SNFs
- Physician/Practitioner services

Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care).
- A SNF where your spouse is living at the time you leave the hospital.


For skilled nursing facility stays, you pay per benefit period:

\$0 copayment

Your inpatient benefits are based upon the date of admission. If you are admitted to a skilled nursing 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 SNF, 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.

Services that are covered for you	What you must pay when you get these services
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.</p>	<p>\$0 copayment</p> <p>Prior authorization rules apply</p>
<p>Transportation (Routine)*</p> <p>Routine transportation is provided in a passenger vehicle or wheelchair van for non-emergent qualifying medical services. This does not include ambulance transport. See the “Ambulance Services” section earlier in this chapter.</p> <p>Wheelchair transports must meet plan criteria.</p> <p>Rides must be cancelled if you no longer need the transportation. If a ride is not cancelled before the driver has been dispatched to get you, the ride will count and will be deducted from your annual ride limit.</p> <p>Transportation arrangements must be made 24 hours in advance for a passenger vehicle and 48 hours in advance for wheelchair service. SCAN Transportation Department may be contacted to schedule a ride at 1-866-779-0560 (Monday–Friday, 7 A.M.–6 P.M.).</p> <p>Call “Where’s My Ride?” to check the status or to cancel your ride call 1-866-779-0561 (24 hours a day/7 days a week).</p>	<p>\$0 copayment</p> <p>You are covered for unlimited one-way rides per year when using SCAN-contracted transportation providers and only when being transported to SCAN-contracted providers and facilities within the SCAN service area.</p> <p>Prior authorization rules apply</p>

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Services that are covered for you	What you must pay when you get these services
<p>Urgently needed care</p> <p>Urgently needed care is care provided to treat 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.</p> <p>Includes world-wide coverage. For more information, see Chapter 3.</p> <p>When you are in your plan's service area, you must receive urgent care services from an in-network provider, when available.</p> <p>Coinsurance payments will apply for Medicare-covered outpatient injectables and intravenous drugs administered in an urgent care setting. See "Medicare Part B Prescription Drugs" section in this chapter.</p>	<p>\$25 copayment for each visit</p>

* 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

 **Vision care (Medicare-covered)**

Covered services include:

- Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.
- For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year.
- One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.

Medically necessary eye exams require a referral from a plan physician to a plan specialist to diagnose and treat diseases of the eye including glaucoma and cataracts.

Intraocular lens

You will pay your outpatient surgery copayment for cataract surgery. There is no charge for a standard intraocular lens (IOL). However, for an additional fee, you may request the insertion of a presbyopia-correcting IOL (i.e. Crystalens™, AcrySof RESTOR™, and ReZoom™) in place of a conventional IOL following cataract surgery. You will pay an additional fee for a non-conventional IOL's recommended or directed by your physician. You are responsible for payment of that portion of the charge for the presbyopia-correcting IOL and associated services that exceeds the charge for insertion of a conventional IOL following cataract surgery. You should discuss the extra cost with your ophthalmologist PRIOR to surgery so that you clearly understand the extent of your financial responsibility.

Eyewear after cataract surgery (Medicare-covered)
\$15 copayment

Eye exam (Medicare-covered)
\$15 copayment

An additional facility charge (ambulatory surgical center or hospital facility) will apply for procedures performed on an outpatient basis. This facility charge will apply if your doctor sends you to a hospital or an outpatient facility for procedures such as cataract surgery.

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



“Welcome to Medicare” Preventive Visit

The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.

Important: We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit.

There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.

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

Independent Living Power

SCAN offers unique in-home services designed to keep people on Medicare healthy and Independent. Called Independent Living Power, these services can help you during recovery from a hospital stay or provide support during an acute or long-term illness. For many seniors, these benefits provide the extra help necessary to remain out of a nursing home. Qualifying members are eligible for up to \$500 per month of these additional services. You must qualify for Independent Living Power. Services are only available in Los Angeles, Orange, Riverside and San Bernardino Counties. Contact SCAN Employer Group for details.

Services includes:	SCAN Employer Group pays:
<p>Homemaker Service</p> <p>SCAN Employer Group members are eligible to receive assistance with light cleaning, grocery shopping, laundry and meal preparation.</p>	<p>You pay \$15 per visit.</p>
<p>Home Delivered Meals</p> <p>SCAN Employer Group members are covered for home delivery of meals to meet nutritional needs.</p>	<p>You pay \$0.</p>
<p>Personal Care</p> <p>You are covered for in-home assistance for tasks such as bathing, dressing, eating, getting in and out of bed, moving about/walking, and grooming.</p>	<p>You pay \$15 per visit.</p>
<p>Emergency Response System</p> <p>SCAN Employer Group members are covered for the installation of a personal emergency response device that alerts emergency medical personnel to provide immediate help.</p>	<p>You pay a monthly service fee of \$15 per month.</p>
<p>Enhanced Routine Transportation</p> <p>Members who qualify for Independent Living Power are eligible to receive unlimited rides per year to or from pre-scheduled medical appointments to contracted providers. Call 24 hours in advance 1-866-779-0560 (TTY 711) 7 a.m.–6 p.m., Monday–Friday to arrange a ride.</p>	<p>You pay \$0.</p>
<p>Transportation Escort</p> <p>As a SCAN Employer Group member you are eligible to receive an escort to assist you during transportation to and from medical appointments.</p>	<p>You pay \$15 per visit.</p>

Independent Living Power (cont.)

Services includes:	SCAN Employer Group pays:
<p>Personal Care Coordinator</p> <p>SCAN staff will provide personal assistance to coordinate your Independent Living Power services.</p>	You pay \$0
<p>Inpatient Custodial Care (Custodial Care)</p> <p>You are covered for up to 5 days for post acute or respite support in an in-patient facility such as a skilled nursing facility. You may use this service following a hospital discharge, ER visit, or for respite care purposes.</p>	You pay \$0.
<p>In-Home Caregiver Relief</p> <p>SCAN provides alternative caregiver services in your home when a regular caregiver can't be there.</p>	You pay \$15 per visit.
<p>Adult Day Care</p> <p>SCAN covers adult day care services to provide relief for your regular caregiver while addressing the individual needs of the member for physical, social or intellectual exercises and stimulation.</p>	You pay \$15 per visit.

SECTION 3 WHAT BENEFITS ARE NOT COVERED BY THE PLAN?

SECTION 3.1 BENEFITS WE DO NOT COVER (EXCLUSIONS)

This section tells you what kinds of benefits are “excluded.” Excluded means that the plan doesn’t cover these benefits.

The list below describes some services and items that aren’t covered under any conditions and some that are excluded only under specific conditions.

If you get benefits that are excluded, you must pay for them yourself. We won’t pay for the excluded medical benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare. The only exception: If a benefit on the exclusion list is found upon appeal to be a medical benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this booklet.)

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this *Evidence of Coverage* or *Addenda*, **the following items and services aren’t covered under Original Medicare or by our plan:**

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as covered services.

- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.) Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation. Unless you qualify for Independent Living Power Services.
- Fees charged by your immediate relatives or members of your household.
- Meals delivered to your home. This benefit is offered to select plans, please check Chapter 4 for more details. Unless you qualify for Independent Living Power Services.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine dental care, such as cleanings, fillings or dentures. However, non-routine dental care required to treat illness or injury may be covered as inpatient or outpatient care. Employer Group may have routine dental coverage.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines. Employer Group may offer routine Chiropractic care.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, eyeglasses are covered for people after cataract surgery.

- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Acupuncture.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.

The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

ADDENDA

How to obtain a second opinion?

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

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

If the Medical Group denies your request for a second medical opinion, you have the right to file an appeal with SCAN Health Plan. If you have any questions, contact the Member Services Department. (Please refer to the appeal and grievance procedures in Chapter 9 for information about your right to file an appeal.)

You can request a copy of the time lines for responding to requests for a second opinion from SCAN Health Plan by calling the Member Services Department at 1-800-559-3500, 7 A.M.–8 P.M., seven days a week. TTY Users: call 711.

What do I need to know about compounded drugs and their coverage?

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

Compounded medications are not approved by the Food and Drug Administration (FDA), unlike drugs listed in our formulary. Without the FDA oversight, there is an extra risk factor involved when a compounded product is prepared because it is not tested for purity, stability, safety, effectiveness, or dosage.

Since the quality of compounded products may be compromised, the FDA recommends using an approved product that has undergone vigorous testing instead of a compounded medication when possible.

Our Plan does not cover all compounded medications. In some cases, certain compounded drugs are “excluded” from coverage by Medicare. In other cases, we have decided not to cover a particular compounded drug. To ensure the appropriate utilization of compounded medications, certain rules and restrictions may apply; i.e., Prior Authorization requirements.

Our members are advised to use a compounded medication only when it is medically necessary. If you have questions about compounded medications, please call Member Services (phone numbers are on the cover) or visit our Web site (www.scanhealthplan.com).

ADDITIONAL LIMITATIONS AND EXCLUSIONS

LIMITATIONS

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

1. Covered Services are available only through plan providers in the network you select (unless such care is rendered as emergency services, urgently needed services, or out-of-area renal dialysis services when you are temporarily outside the service area, world-wide emergency services, or is prior authorized). Previously authorized services to be provided in-network (such as but not limited to oxygen, routine blood tests, chemotherapy, and/or non-emergency surgery) are not covered outside the service area.
2. Covered Services provided by non-plan providers are limited to unforeseen urgently-needed services or dialysis services when you are temporarily outside the service area, emergency services and authorized post-stabilization care anywhere in the world, and services for which you have obtained prior authorization. In unusual and extraordinary circumstances, urgently needed services are also covered within the service area when SCAN Health Plan providers are temporarily unavailable or inaccessible. In these circumstances, covered services should be provided by physicians and other practitioners affiliated with Medicare.
3. If you seek routine care or elective medical services from non-plan providers without a SCAN Health Plan-approved referral, neither SCAN Health Plan, Original Medicare, nor most Medicare supplemental insurance policies (e.g., Medigap) will pay for your care and you will be required to pay for the full cost of such services.
4. Biofeedback is excluded, except when Medicare criteria are met.
5. Beneficiaries who have End Stage Renal Disease (ESRD) may not enroll in SCAN Health Plan. Beneficiaries who join SCAN Health Plan and later develop End Stage Renal Disease will continue to be covered by SCAN Health Plan. Note: Individuals with ESRD may re-enroll in another MA Plan if the MA Plan in which the individual was enrolled was terminated after December 31, 1998.
6. Unless stated otherwise, all covered services are provided in accordance with Medicare guidelines.
7. Routine transportation is covered only when authorized by SCAN Health Plan using SCAN Health Plan contracted transportation providers and only when being transported to SCAN Health Plan contracted providers and facilities within the SCAN Health Plan service area.
8. Covered reconstructive and cosmetic surgical services are limited to:
 - Surgery required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member.

- Surgery in connection with treatment of severe burns or repair of the face following a serious accident or surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose.
 - Reconstructive surgery and associated procedures
 - Following a mastectomy which resulted from disease, illness, or injury, or
 - For internal breast prosthesis required incidental to a mastectomy or, in the opinion of your physician and surgeon, for the healthy breast to achieve a normal symmetrical appearance with a reconstructed breast.
 - Breast implants that are not medically necessary or that do not meet the above criteria are excluded from your benefit plan.
9. Ambulance services are covered in situations where other means of transportation in the United States would endanger your health. Air ambulance is covered only in emergency situations including ambulance services dispatched through 911, only if transportation in any other vehicle could endanger your health. Air ambulance service is covered only to the nearest facility that is capable of providing the necessary services. If you have questions about ambulance coverage inside or outside of the United States, please call Member Services at 1-800-559-3500, 7 A.M.–8 P.M., seven days a week. TTY Users: call 711.
 10. Home Health Care is skilled nursing care and certain other health care services that a member receives in the member's home for the treatment of an illness or injury. As long as some qualifying skilled nursing services are also included, the home health care can include services from a home health aide. The services from a home health aide must be part of the home plan of care for the illness or injury, and they are not covered unless the member is also receiving a covered skilled service, i.e. intermittent skilled nursing, physical therapy, speech-language pathology services, continued occupational therapy. "Home health services" do not include the services of housekeepers, food service arrangements, or full-time nursing care at home. Home health care is only covered when medically necessary according to Medicare guidelines and authorized by your plan physician or plan medical director (or designee) or SCAN Health Plan.
 11. SCAN Health Plan covers all medical services that are medically necessary, are covered under Medicare, and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or they were obtained out-of-network where not authorized.
 12. Plan providers may discuss alternative therapy that may not be covered by Medicare or SCAN Health Plan. Not all alternative therapies discussed may be medically necessary. All treatment requires a prior authorization. Please call Member Services at the phone number listed in Chapter 2.
 13. Members are fully responsible for all applicable copayments as listed in Chapter 4. Copayments are nonnegotiable.

EXCLUSIONS

The following items, procedures, benefits, services, drugs, supplies, and equipment are excluded from the SCAN Employer Group plan:

1. Any service, procedure, treatment, supply, or medication not specifically included in the Benefits Chart; any service, procedure, treatment, supply, or medication not provided, arranged, or authorized

by your plan provider, SCAN Health Plan, the plan physician's Utilization Review Committee, or your plan medical director or designee (except for emergency services, urgently needed services, or out-of-area dialysis services), or services, procedures, treatments, and supplies obtained prior to a member's effective date of coverage or after termination of coverage. Previously authorized services to be provided in-network (such as but not limited to oxygen, routine blood tests, chemotherapy, and/or non-emergency surgery) are not covered outside the service area.

2. Hospice services provided by a participating Medicare-certified hospice are not paid by SCAN Health Plan, but are reimbursed directly by Medicare when provided by a Medicare-certified hospice. Your doctor can help you arrange for your care in a participating Medicare-certified hospice if you wish to elect such coverage. You remain enrolled in SCAN Health Plan even though you have elected hospice coverage. SCAN Health Plan will be responsible to cover certain benefits not covered by Original Medicare. You may use your SCAN Health Plan contracting doctor as your hospice attending physician.
3. Complementary Alternative Medicine (CAM) and/or non-conventional medicine, except as covered by Medicare criteria for the treatment of an illness or disease. Examples include, but are not limited to: naturopathy, yoga, polarity, massage therapy, healing touch therapies, and bioelectromagnetics.
4. Procedures, services, supplies, and medications until they are reviewed for safety, efficacy, and cost effectiveness and approved by SCAN Health Plan or Medicare.
5. Court-ordered care or evaluation services.
6. Nursing care on a full-time basis in your home.
7. Services rendered in a state or federal hospital.
8. Care for conditions legally required to be treated in a public facility.
9. Conditions resulting from acts of war (declared or not), or an act of war that occurs after the effective date of your current coverage for hospital insurance benefits or supplementary medical insurance benefits.
10. Government treatment for any services provided in a local, state, or federal government facility or agency, except when payment under the plan is expressly required by federal or state law or is in accordance with Medicare guidelines.
11. Optional or additional accessories to Durable Medical Equipment, corrective appliances, or prosthetics that are primarily for the comfort or convenience of the member or for use primarily in the community, including home and car remodeling or modification. Durable Medical Equipment items that do not primarily serve a medical purpose and which are not reasonable and necessary to treat an illness or injury. (See Durable Medical Equipment and Related Supplies in this Chapter).
12. Expenses incurred outside of your network if you traveled to such location with the express purpose of obtaining medical services, supplies, and/or drugs, without prior authorization.
13. Benefits and services not specified as a covered service.
14. Non-Medicare covered organ transplants. Medical and hospital services of a donor when the recipient of an organ transplant is not a SCAN Health Plan member.
15. Immunizations not covered by Medicare (See "Immunizations" under this chapter).
16. Hormone treatments related to gender change surgery.

17. Long-term services beyond those which Medicare would cover, including, but not limited to, skilled nursing and care giver relief.
18. Dental splints, dental prosthesis, or any dental treatment for the teeth, gums, or jaw or dental treatment related to temporomandibular joint syndrome (TMJ).
19. Replacement of lenses and eyeglass frames that are lost or broken, except at the normal intervals when services are otherwise available.
20. Vision services for conditions covered by workers' compensation.
21. Any service or material provided by another vision or medical plan or non-contracting provider.
22. Low vision aids and services except as specifically covered by Medicare guidelines.
23. Cosmetic services and/or materials including but not limited to, blended (no-line) bifocal or trifocal lenses, oversize lenses (62 mm or greater), photochromic lenses, tinted lenses (except pink #1 and #2), progressive or multifocal lenses, the coating or laminating of the lens or lenses, UV (ultraviolet) lenses, polycarbonate/high index lenses, anti-reflective coating, scratch resistant coating, edge polish and other cosmetic processes, nonstandard or elective contact lenses and plano lenses (nonprescription).
24. Disposable supplies such as bandages, IV (intravenous) tubing, and elastic stockings (other than when used in connection with a covered service during a home health care visit, in a hospital, your plan physician's office, outpatient surgery centers, dialysis centers, and skilled nursing facilities).
25. Non-emergency transportation by ambulance unless it is medically necessary according to Medicare guidelines and authorized by your plan physician or plan medical director (or designee) or SCAN.
26. Maintenance Therapy. (See "Maintenance Therapy" in Chapter 12).
27. Incontinence supplies.
28. By law, certain types of drugs or categories of drugs are not covered by Medicare Prescription Drug Plans. These drugs or categories of drugs are called "exclusions" and listed in Chapter 5, Section 7.1 of this EOC. In addition to these "exclusions," SCAN Employer Group does not cover lost or stolen medications.
29. Foreseen services received out of area (except dialysis).
30. Medical marijuana.

CHAPTER 5

USING THE PLAN'S COVERAGE FOR YOUR PART D PRESCRIPTION DRUGS

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SECTION 1 INTRODUCTION

SECTION 1.1 THIS CHAPTER DESCRIBES YOUR COVERAGE FOR PART D DRUGS

This chapter **explains rules for using your coverage for Part D drugs**. The next chapter tells what you pay for Part D drugs (Chapter 6, *What you pay for your Part D prescription drugs*).

In addition to your coverage for Part D drugs, SCAN Employer Group also covers some drugs under the plan's medical benefits:

- The plan covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*) tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*) tells about your benefits and costs for Part B drugs.

The two examples of drugs described above are covered by the plan's medical benefits. The rest of your prescription drugs are covered under the plan's Part D benefits.

SECTION 1.2 BASIC RULES FOR THE PLAN'S PART D DRUG COVERAGE

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

- You must have a network provider (a doctor or other prescriber) write your prescription.
- You must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service*.)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List."*)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

SECTION 2 FILL YOUR PRESCRIPTION AT A NETWORK PHARMACY OR THROUGH THE PLAN'S MAIL-ORDER SERVICE

SECTION 2.1 TO HAVE YOUR PRESCRIPTION COVERED, USE A NETWORK PHARMACY

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

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

SECTION 2.2 FINDING NETWORK PHARMACIES

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our Web site (www.scanhealthplan.com), or call Member Services (phone numbers are printed on the back cover of this booklet). Choose whatever is easiest for you.

You may go to any of our network pharmacies.

If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Member Services (phone numbers are printed on the back cover of this booklet) or use the *Pharmacy Directory*. You can also find information on our Web site at www.scanhealthplan.com.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, please contact Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 2.3 USING THE PLAN'S MAIL-ORDER SERVICES

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. The drugs available through our plan's mail-order service are marked as "**mail-order**" drugs in our Drug List.

Our plan's mail-order service allows you to order **up to a 90-day supply**.

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

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

Our plan's mail-order service provides members with mail-order drugs using an "automatic refill" service. If you used our "automatic refill" service in the past, we automatically sent you a refill of your drugs when our records indicated that you were about to run out. However, starting in January 2014, we will need to get your permission before we can send you a refill by mail. We will not need to get your permission to send your drugs by mail when you ask us for the refill or ask us for a new prescription.

This may be a change for you if you have always used mail order in the past and have not needed to tell us to send a refill of your prescription. But this change helps us to make sure you only get drugs you really need.

So that we can reach you to make sure that you want a refill, please tell us the best way to reach you. The Refill Reminder notification will be sent to you either by email, automated phone call, or by mail, depending on the type of contact information we have for you. If we don't know the best way to reach you, you might miss the chance to tell us whether you want a refill and you could run out of your prescription drugs. Remember, your drugs will not be automatically shipped unless you confirm you still want to receive the order. This new policy won't affect refill reminder programs in which you go in person to pick up the prescription and it won't apply to long-term care pharmacies that give out and deliver prescription drugs.

SECTION 2.4 HOW CAN YOU GET A LONG-TERM SUPPLY OF DRUGS?

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

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Some of these retail pharmacies may agree to accept cost-sharing amount for a long-term supply of maintenance drugs. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).
2. For certain kinds of drugs, you can use the plan's network **mail-order services**. The drugs available through our plan's mail-order service are marked as "**mail-order**" drugs in our Drug List. Our plan's mail-order service allows you to order up to a 90-day supply. See Section 2.3 for more information about using our mail-order services.

SECTION 2.5 WHEN CAN YOU USE A PHARMACY THAT IS NOT IN THE PLAN'S NETWORK?

Your prescription may be covered in certain situations

We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.

- If you are trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail or mail order pharmacy.
- If you are traveling within the US, but outside of the plan's service area, and you become ill or run out of your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules identified within this document and the formulary and if a network pharmacy is not available.
- The out-of-network fills will be evaluated on a case by case basis.

In these situations, **please check first with Member Services** to see if there is a network pharmacy nearby. (Phone numbers for Member Services are printed on the back cover of this booklet.)

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

SECTION 3 YOUR DRUGS NEED TO BE ON THE PLAN'S "DRUG LIST"

SECTION 3.1 THE "DRUG LIST" TELLS WHICH PART D DRUGS ARE COVERED

The plan has a "*List of Covered Drugs (Formulary)*." In this *Evidence of Coverage*, we call it the "**Drug List**" for short.

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 plan's Drug List.

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs).

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

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- —or— supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

The Drug List includes both brand name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the Drug List.

SECTION 3.2 THERE ARE SIX "COST-SHARING TIERS" FOR DRUGS ON THE DRUG LIST

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

- Cost-Sharing Tier 1 includes Preferred Generic Drugs (the lowest tier)
- Cost-Sharing Tier 2 includes Non-Preferred Generic Drugs
- Cost-Sharing Tier 3 includes Preferred Brand Drugs
- Cost-Sharing Tier 4 includes Non-Preferred Brand Drugs
- Cost-Sharing Tier 5 includes Specialty Drugs (the highest tier)
- Cost-Sharing Tier 6 includes Select Care Drugs

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

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6 (*What you pay for your Part D prescription drugs*).

SECTION 3.3 HOW CAN YOU FIND OUT IF A SPECIFIC DRUG IS ON THE DRUG LIST?

You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail.
2. Visit the plan's Web site (www.scanhealthplan.com). The Drug List on the Web site is always the most current.
3. Call Member Services to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. (Phone numbers for Member Services are printed on the back cover of this booklet.)

SECTION 4 THERE ARE RESTRICTIONS ON COVERAGE FOR SOME DRUGS

SECTION 4.1 WHY DO SOME DRUGS HAVE RESTRICTIONS?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2 for information about asking for exceptions.)

SECTION 4.2 WHAT KINDS OF RESTRICTIONS?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Restricting brand name drugs when a generic version is available

Generally, a “generic” drug works the same as a brand name drug and usually costs less. **When a generic version of a brand name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called “**prior authorization.**” Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called “**step therapy.**”

Quantity limits

For certain drugs, we limit the amount of the drug that you can have. For example, the plan might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

SECTION 4.3 DO ANY OF THESE RESTRICTIONS APPLY TO YOUR DRUGS?

The plan’s Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services (phone numbers are printed on the back cover of this booklet) or check our Web site (www.scanhealthplan.com).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to

make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2 for information about asking for exceptions.)

SECTION 5 WHAT IF ONE OF YOUR DRUGS IS NOT COVERED IN THE WAY YOU'D LIKE IT TO BE COVERED?

SECTION 5.1 THERE ARE THINGS YOU CAN DO IF YOUR DRUG IS NOT COVERED IN THE WAY YOU'D LIKE IT TO BE COVERED

Suppose there is a prescription drug you are currently taking, or one that you and your provider think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. For example:

- **What if the drug you want to take is not covered by the plan?** For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- **What if the drug is covered, but there are extra rules or restrictions on coverage for that drug?** As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you. For example, you might want us to cover a certain drug for you without having to try other drugs first. Or you may want us to cover more of a drug (number of pills, etc.) than we normally will cover.
- **What if the drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be?** The plan puts each covered drug into one of six different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

SECTION 5.2 WHAT CAN YOU DO IF YOUR DRUG IS NOT ON THE DRUG LIST OR IF THE DRUG IS RESTRICTED IN SOME WAY?

If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.

- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer on the plan's Drug List**.
- —or— the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- **For those members who were in the plan last year and aren't in a long-term care facility:**

We will cover a temporary supply of your drug **during the first 90 days of the calendar year**. This temporary supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and aren't in a long-term care facility:**

We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. This temporary supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and reside in a long-term care facility:**

We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. The first supply will be for a maximum of a 98-day supply, or less if your prescription is written for fewer days. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.) If needed, we will cover additional refills during your first 90 days in the plan.

- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**

We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

- **For those members who are current members transitioning to a different level of care (changing from one treatment setting to another):**

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

To ask for a temporary supply, call Member Services (phone numbers are printed on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by

the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Member Services are printed on the back cover of this booklet.)

You can ask for an exception

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

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

SECTION 5.3 WHAT CAN YOU DO IF YOUR DRUG IS IN A COST-SHARING TIER YOU THINK IS TOO HIGH?

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

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Member Services are printed on the back cover of this booklet.)

You can ask for an exception

For drugs in Tier 4 (Non-Preferred Brand Drugs Tier) or in Tier 2 (Non-Preferred Generic Drugs Tier), you and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

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

Drugs in some of our cost-sharing tiers are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in Tier 5 (Specialty Drugs Tier).

SECTION 6

WHAT IF YOUR COVERAGE CHANGES FOR ONE OF YOUR DRUGS?

SECTION 6.1 THE DRUG LIST CAN CHANGE DURING THE YEAR

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

- **Add or remove drugs from the Drug List.** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand name drug with a generic drug.**

In almost all cases, we must get approval from Medicare for changes we make to the plan's Drug List.

SECTION 6.2 WHAT HAPPENS IF COVERAGE CHANGES FOR A DRUG YOU ARE TAKING?

How will you find out if your drug's coverage has been changed?

If there is a change to coverage *for a drug you are taking*, the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time.**

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away. Your provider will also know about this change, and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happens for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a **brand name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand name drug at a network pharmacy.
 - During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.
 - Or you and your provider can ask the plan to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
 - Your provider will also know about this change, and can work with you to find another drug for your condition.

SECTION 7

WHAT TYPES OF DRUGS ARE *NOT* COVERED BY THE PLAN?

SECTION 7.1

TYPES OF DRUGS WE DO NOT COVER

This section tells you what kinds of prescription drugs are “excluded.” This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 6.5 in this booklet.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. “Off-label use” is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
 - Generally, coverage for “off-label use” is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its “off-label use.”

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms

- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

If you receive “Extra Help” paying for your drugs, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 SHOW YOUR PLAN MEMBERSHIP CARD WHEN YOU FILL A PRESCRIPTION

SECTION 8.1 SHOW YOUR MEMBERSHIP CARD

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

SECTION 8.2 WHAT IF YOU DON'T HAVE YOUR MEMBERSHIP CARD WITH YOU?

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then **ask us to reimburse you** for our share. See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9 PART D DRUG COVERAGE IN SPECIAL SITUATIONS

SECTION 9.1 WHAT IF YOU'RE IN A HOSPITAL OR A SKILLED NURSING FACILITY FOR A STAY THAT IS COVERED BY THE PLAN?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay.

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a Special Enrollment Period. During this time period, you can switch plans or change your coverage. (Chapter 10, *Ending your membership in the plan*, tells when you can leave our plan and join a different Medicare plan.)

SECTION 9.2 WHAT IF YOU'RE A RESIDENT IN A LONG-TERM CARE FACILITY?

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

Check your *Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Member Services (phone numbers are printed on the back cover of this booklet).

What if you're a resident in a long-term care facility and become a new member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The first supply will be for a maximum of a 98-day supply, or less if your prescription is written for fewer days. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.) If needed, we will cover additional refills during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do.

SECTION 9.3 WHAT IF YOU'RE ALSO GETTING DRUG COVERAGE FROM AN EMPLOYER OR RETIREE GROUP PLAN?

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

In general, if you are currently employed, the prescription drug coverage you get from us will be *secondary* to your employer or retiree group coverage. That means your group coverage would pay first.

Special note about 'creditable coverage':

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

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

Keep these notices about creditable coverage, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained

creditable coverage. If you didn't get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from your employer or retiree plan's benefits administrator or the employer or union.

SECTION 10 PROGRAMS ON DRUG SAFETY AND MANAGING MEDICATIONS

SECTION 10.1 PROGRAMS TO HELP MEMBERS USE DRUGS SAFELY

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

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

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking.

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

SECTION 10.2 PROGRAMS TO HELP MEMBERS MANAGE THEIR MEDICATIONS

We have programs that can help our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, or they could have very high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members are using the drugs that work best to treat their medical conditions and help us identify possible medication errors.

One program is called a Medication Therapy Management (MTM) program. Some members who take several medications for different medical conditions may qualify. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs, or any problems you're having. You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Member Services (phone numbers are printed on the back cover of this booklet).

CHAPTER 6

WHAT YOU PAY FOR YOUR PART D PRESCRIPTION DRUGS

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Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include “Extra Help” and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drug may not apply to you.** We send you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “LIS Rider.” (Phone numbers for Member Services are printed on the back cover of this booklet.)

SECTION 1 INTRODUCTION

SECTION 1.1 USE THIS CHAPTER TOGETHER WITH OTHER MATERIALS THAT EXPLAIN YOUR DRUG COVERAGE

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use “drug” in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **The plan’s *List of Covered Drugs (Formulary)*.** To keep things simple, we call this the “Drug List.”
 - This Drug List tells which drugs are covered for you.
 - It also tells which of the six “cost-sharing tiers” the drug is in and whether there are any restrictions on your coverage for the drug.
 - If you need a copy of the Drug List, call Member Services (phone numbers are printed on the back cover of this booklet). You can also find the Drug List on our Web site at www.scanhealthplan.com. The Drug List on the Web site is always the most current.
- **Chapter 5 of this booklet.** Chapter 5 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells which types of prescription drugs are not covered by our plan.
- **The plan’s *Provider/Pharmacy Directory*.** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The *Provider/Pharmacy Directory* has a list of pharmacies in the plan’s network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month’s supply).

SECTION 1.2 TYPES OF OUT-OF-POCKET COSTS YOU MAY PAY FOR COVERED DRUGS

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. The amount that you pay for a drug is called “cost-sharing,” and there are three ways you may be asked to pay.

- The “**deductible**” is the amount you must pay for drugs before our plan begins to pay its share.
- “**Copayment**” means that you pay a fixed amount each time you fill a prescription.
- “**Coinsurance**” means that you pay a percent of the total cost of the drug each time you fill a prescription.

SECTION 2

WHAT YOU PAY FOR A DRUG DEPENDS ON WHICH "DRUG PAYMENT STAGE" YOU ARE IN WHEN YOU GET THE DRUG

SECTION 2.1

WHAT ARE THE DRUG PAYMENT STAGES FOR SCAN EMPLOYER GROUP MEMBERS?

As shown in the table below, there are "drug payment stages" for your prescription drug coverage under SCAN Employer Group. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled.

Employer Group members do not have a coverage gap; benefits are unlimited. The illustration is only for non-Employer Group members.

STAGE 1 <i>Yearly Deductible Stage</i>	STAGE 2 <i>Initial Coverage Stage</i>	STAGE 3 <i>Coverage Gap Stage</i>	STAGE 4 <i>Catastrophic Coverage Stage</i>
Because there is no deductible for the plan, this payment stage does not apply to you.	<p>You begin in this stage when you fill your first prescription of the year.</p> <p>During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.</p> <p>You stay in this stage until your year-to-date "total drug costs" (your payments plus any Part D plan's payments) total \$2,850.</p> <p>(Details are in Section 5 of this chapter.)</p>	<p>During this stage, you receive coverage by the plan on certain drugs. You pay 50% of your brand name drug copayment.</p> <p>You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of \$4,550. This amount and rules for counting costs toward this amount have been set by Medicare.</p> <p>(Details are in Section 6 of this chapter.)</p>	<p>During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2014).</p> <p>(Details are in Section 7 of this chapter.)</p>

SECTION 3

WE SEND YOU REPORTS THAT EXPLAIN PAYMENTS FOR YOUR DRUGS AND WHICH PAYMENT STAGE YOU ARE IN

SECTION 3.1

WE SEND YOU A MONTHLY REPORT CALLED THE "EXPLANATION OF BENEFITS" (THE "EOB")

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **“out-of-pocket”** cost.
- We keep track of your **“total drug costs.”** This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the *Explanation of Benefits* (it is sometimes called the “EOB”) when you have had one or more prescriptions filled through the plan during the previous month. It includes:

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

SECTION 3.2 HELP US KEEP OUR INFORMATION ABOUT YOUR DRUG PAYMENTS UP TO DATE

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

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
 - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan’s benefit.
 - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
 - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive an *Explanation of Benefits* (an EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Member Services (phone numbers are printed on the back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 THERE IS NO DEDUCTIBLE FOR SCAN EMPLOYER GROUP

SECTION 4.1 YOU DO NOT PAY A DEDUCTIBLE FOR YOUR PART D DRUGS

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

SECTION 5 DURING THE INITIAL COVERAGE STAGE, THE PLAN PAYS ITS SHARE OF YOUR DRUG COSTS AND YOU PAY YOUR SHARE

SECTION 5.1 WHAT YOU PAY FOR A DRUG DEPENDS ON THE DRUG AND WHERE YOU FILL YOUR PRESCRIPTION

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

The plan has six cost-sharing tiers

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

- Cost-Sharing Tier 1 includes Preferred Generic Drugs (the lowest tier)
- Cost-Sharing Tier 2 includes Non-Preferred Generic Drugs
- Cost-Sharing Tier 3 includes Preferred Brand Drugs
- Cost-Sharing Tier 4 includes Non-Preferred Brand Drugs
- Cost-Sharing Tier 5 includes Specialty Drugs (the highest tier)
- Cost-Sharing Tier 6 includes Select Care Drugs

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

Your pharmacy choices

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

- A retail pharmacy that is in our plan's network
- A pharmacy that is not in the plan's network
- The plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 in this booklet and the plan's *Pharmacy Directory*.

SECTION 5.2 A TABLE THAT SHOWS YOUR COSTS FOR A ONE-MONTH SUPPLY OF A DRUG

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance. **Employer Group members have unlimited prescription drug coverage.**

- **“Copayment”** means that you pay a fixed amount each time you fill a prescription.
- **“Coinsurance”** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the tables below, the amount of the copayment or coinsurance depends on which cost-sharing tier your drug is in. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

SCAN Employer Group: County of Riverside

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug from:

	NETWORK PHARMACY (up to a 31-day supply)	THE PLAN'S MAIL-ORDER SERVICE (up to a 31-day supply)	NETWORK LONG-TERM CARE PHARMACY (up to a 31-day supply)	OUT-OF-NETWORK PHARMACY* (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 31-day supply)
Cost-Sharing Tier 1 (Preferred Generic Drugs)	\$10 copayment	\$10 copayment	\$10 copayment	\$20 copayment
Cost-Sharing Tier 2 (Non-Preferred Generic Drugs)	\$10 copayment	\$10 copayment	\$10 copayment	\$20 copayment
Cost-Sharing Tier 3 (Preferred Brand Drugs)	\$20 copayment	\$20 copayment	\$20 copayment	\$30 copayment
Cost-Sharing Tier 4 (Non-Preferred Brand Drugs)	\$20 copayment	\$20 copayment	\$20 copayment	\$30 copayment
Cost-Sharing Tier 5 (Specialty Drugs)	\$40 copayment	\$40 copayment	\$40 copayment	\$45 copayment
Cost-Sharing Tier 6 (Select Care Drugs)	\$20 copayment	\$20 copayment	\$20 copayment	\$30 copayment

SECTION 5.3 IF YOUR DOCTOR PRESCRIBES LESS THAN A FULL MONTH'S SUPPLY, YOU MAY NOT HAVE TO PAY THE COST OF THE ENTIRE MONTH'S SUPPLY

Typically, you pay a copay to cover a full month's supply of a covered drug. However your doctor can prescribe less than a month's supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor agrees, you will not have to pay for the full month's supply for certain drugs.

The amount you pay when you get less than a full month's supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount).

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month's supply, the *amount* you pay will be less.
- If you are responsible for a copayment for the drug, your copay will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.
 - Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is \$30. This means that the amount you pay per day for your drug is \$1. If you receive a 7 days' supply of the drug, your payment will be \$1 per day multiplied by 7 days, for a total payment of \$7.
 - You should not have to pay more per day just because you begin with less than a month's supply. Let's go back to the example above. Let's say you and your doctor agree that the drug is working well and that you should continue taking the drug after your 7 days' supply runs out. If you receive a second prescription for the rest of the month, or 23 days more of the drug, you will still pay \$1 per day, or \$23. Your total cost for the month will be \$7 for your first prescription and \$23 for your second prescription, for a total of \$30—the same as your copay would be for a full month's supply.

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply.

SECTION 5.4 A TABLE THAT SHOWS YOUR COSTS FOR A LONG-TERM (UP TO A 90-DAY) SUPPLY OF A DRUG

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5, Section 2.4.)

The tables below show what you pay when you get a long-term (up to a 90-day) supply of a drug.

- Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

SCAN Employer Group: County of Riverside

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug from:

	NETWORK PHARMACY (up to a 90-day supply)	THE PLAN'S MAIL-ORDER SERVICE (up to a 90-day supply)
Cost-Sharing Tier 1 (Preferred Generic Drugs)	\$20 copayment	\$20 copayment
Cost-Sharing Tier 2 (Non-Preferred Generic Drugs)	\$20 copayment	\$20 copayment
Cost-Sharing Tier 3 (Preferred Brand Drugs)	\$40 copayment	\$40 copayment
Cost-Sharing Tier 4 (Non-Preferred Brand Drugs)	\$40 copayment	\$40 copayment
Cost-Sharing Tier 5 (Specialty Drugs)	A long-term supply is not available for drugs in tier 5	A long-term supply is not available for drugs in tier 5
Cost-Sharing Tier 6 (Select Care Drugs)	\$40 copayment	\$40 copayment

SECTION 5.5 YOU STAY IN THE INITIAL COVERAGE STAGE UNTIL YOUR TOTAL DRUG COSTS FOR THE YEAR REACH \$2,850

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **\$2,850 limit for the Initial Coverage Stage. Employer Group members have unlimited Part D coverage.**

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
 - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What the plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2014, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

The *Explanation of Benefits* (EOB) that we send to you will help you keep track of how much you and the plan have spent for your drugs during the year. Many people do not reach the \$2,850 limit in a year.

We will let you know if you reach this \$2,850 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

SECTION 6 DURING THE COVERAGE GAP STAGE, THE PLAN PROVIDES SOME DRUG COVERAGE

SECTION 6.1 YOU STAY IN THE COVERAGE GAP STAGE UNTIL YOUR OUT-OF-POCKET COSTS REACH \$4,550

Employer Group members have unlimited Part D coverage.

During the Coverage Gap Stage, you receive some coverage by the plan on certain drugs. Drugs in the cost-sharing tiers 1 and 2 continue to be provided for a copayment.

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides discounts on brand name drugs. You pay 50% of the brand name drug copayment.

You continue receiving coverage by the plan on certain drugs and paying the discounted price for brand name drugs and no more than 72% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2014, that amount is \$4,550.

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. When you reach an out-of-pocket limit of \$4,550, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

SECTION 6.2 HOW MEDICARE CALCULATES YOUR OUT-OF-POCKET COSTS FOR PRESCRIPTION DRUGS

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

THESE PAYMENTS ARE INCLUDED IN YOUR OUT-OF-POCKET COSTS

When you add up your out-of-pocket costs, **you can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):

- The amount you pay for drugs when you are in any of the following drug payment stages:
 - The Initial Coverage Stage.
 - The Coverage Gap Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$4,550 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

THESE PAYMENTS ARE NOT INCLUDED IN YOUR OUT-OF-POCKET COSTS

When you add up your out-of-pocket costs, you are **not allowed to include** any of these types of payments for prescription drugs:

- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veteran's Administration.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker's Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Member Services to let us know (phone numbers are printed on the back cover of this booklet).

How can you keep track of your out-of-pocket total?

- **We will help you.** The *Explanation of Benefits* (EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of \$4,550 in out-of-pocket costs for the year, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 7 DURING THE CATASTROPHIC COVERAGE STAGE, THE PLAN PAYS MOST OF THE COST FOR YOUR DRUGS

SECTION 7.1 ONCE YOU ARE IN THE CATASTROPHIC COVERAGE STAGE, YOU WILL STAY IN THIS STAGE FOR THE REST OF THE YEAR

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$4,550 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:
 - —*either*— coinsurance of 5% of the cost of the drug
 - —*or*— \$2.55 for a generic drug or a drug that is treated like a generic and \$6.35 for all other drugs.
- **Our plan pays the rest** of the cost.

SECTION 8 ADDITIONAL BENEFITS INFORMATION

SECTION 8.1 OUR PLAN OFFERS ADDITIONAL BENEFITS

Not Applicable.

SECTION 9 WHAT YOU PAY FOR VACCINATIONS COVERED BY PART D DEPENDS ON HOW AND WHERE YOU GET THEM

SECTION 9.1 OUR PLAN HAS SEPARATE COVERAGE FOR THE PART D VACCINE MEDICATION ITSELF AND FOR THE COST OF GIVING YOU THE VACCINATION SHOT

Our plan provides coverage of a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the Medical Benefits Chart in Chapter 4, Section 2.1.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine medication itself**. The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the vaccination shot**. (This is sometimes called the “administration” of the vaccine.)

What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
 - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to Chapter 4, *Medical Benefits Chart (What is covered and what you pay)*.
 - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary)*.
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccination shot.**

What you pay at the time you get the Part D vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccination shot, you will have to pay the entire cost for both the vaccine medication and for getting the vaccination shot. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccination shot, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccination shot. Remember you are responsible for all of the costs associated with vaccines (including their administration) during the Coverage Gap Stage of your benefit.

Situation 1:

You buy the Part D vaccine at the pharmacy and you get your vaccination shot at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
- Our plan will pay for the cost of giving you the vaccination shot.

Situation 2:

You get the Part D vaccination at your doctor's office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).
- You will be reimbursed the amount you paid less your normal copayment for the vaccine (including administration) less any difference between the amounts the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

Situation 3:

You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccination shot.

- You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7 of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the vaccine less any difference between the amounts the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

Select doctor's offices may be able to process the Part D vaccine, and/or the administrative fee, electronically. In this instance, you pay your applicable copayment for the vaccine to your provider. Remember you are responsible for all of the costs associated with vaccines (including their administration) during the Coverage Gap Stage of your benefit.

SECTION 9.2 YOU MAY WANT TO CALL US AT MEMBER SERVICES BEFORE YOU GET A VACCINATION

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Member Services whenever you are planning to get a vaccination. (Phone numbers for Member Services are printed on the back cover of this booklet.)

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

SECTION 10 DO YOU HAVE TO PAY THE PART D "LATE ENROLLMENT PENALTY"?

SECTION 10.1 WHAT IS THE PART D "LATE ENROLLMENT PENALTY"?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, the late enrollment penalty rules do not apply to you. You will not pay a late enrollment penalty, even if you go without "creditable" prescription drug coverage.

You may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage or you experienced a continuous period of 63 days or more when you didn't have creditable prescription drug coverage. ("Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

When you first enroll in SCAN Employer Group, we let you know the amount of the penalty. Your late enrollment penalty is considered your plan premium. If you do not pay your late enrollment penalty, you could be disenrolled from the plan.

SECTION 10.2 HOW MUCH IS THE PART D LATE ENROLLMENT PENALTY?

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2013, this average premium amount was \$31.17. This amount may change for 2014.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times

\$31.17, which equals \$4.36. This rounds to \$4.40 This amount would be added **to the monthly premium for someone with a late enrollment penalty.**

There are three important things to note about this monthly late enrollment penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.
- Third, if you are under 65 and currently receiving Medicare benefits, the late enrollment penalty will reset when you turn 65. After age 65, your late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

SECTION 10.3 IN SOME SITUATIONS, YOU CAN ENROLL LATE AND NOT HAVE TO PAY THE PENALTY

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the late enrollment penalty.

You will not have to pay a penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "**creditable drug coverage.**"
Please note:
 - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
 - Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
 - The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount Web sites.
 - For additional information about creditable coverage, please look in your *Medicare & You 2014 Handbook* or call Medicare at 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.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

SECTION 10.4 WHAT CAN YOU DO IF YOU DISAGREE ABOUT YOUR LATE ENROLLMENT PENALTY?

If you disagree about your late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review **within 60 days** from the date on the letter you receive stating you have to pay a late enrollment penalty. Call Member Services to find out more about how to do this (phone numbers are printed on the back cover of this booklet).

Important: Do not stop paying your late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

SECTION 11 DO YOU HAVE TO PAY AN EXTRA PART D AMOUNT BECAUSE OF YOUR INCOME?

SECTION 11.1 WHO PAYS AN EXTRA PART D AMOUNT BECAUSE OF INCOME?

Most people pay a standard monthly Part D premium. However, some people pay an extra amount 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 for your Medicare Part D 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 and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium.**

SECTION 11.2 HOW MUCH IS THE EXTRA PART D AMOUNT?

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium.

The chart below shows the extra amount based on your income.

If you filed an individual tax return and your income in 2012 was:	If you were married but filed a separate tax return and your income in 2012 was:	If you filed a joint tax return and your income in 2012 was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)
Equal to or less than \$85,000	Equal to or less than \$85,000	Equal to or less than \$170,000	\$0
Greater than \$85,000 and less than or equal to \$107,000		Greater than \$170,000 and less than or equal to \$214,000	\$12.10
Greater than \$107,000 and less than or equal to \$160,000		Greater than \$214,000 and less than or equal to \$320,000	\$31.10
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$85,000 and less than or equal to \$129,000	Greater than \$320,000 and less than or equal to \$428,000	\$50.20
Greater than \$214,000	Greater than \$129,000	Greater than \$428,000	\$69.30

SECTION 11.3 WHAT CAN YOU DO IF YOU DISAGREE ABOUT PAYING AN EXTRA PART D AMOUNT?

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

SECTION 11.4 WHAT HAPPENS IF YOU DO NOT PAY THE EXTRA PART D AMOUNT?

The extra amount is paid directly to the government (not your 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.

CHAPTER 7

ASKING US TO PAY OUR SHARE OF A BILL YOU HAVE RECEIVED FOR COVERED MEDICAL SERVICES OR DRUGS

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SECTION 1

SITUATIONS IN WHICH YOU SHOULD ASK US TO PAY OUR SHARE OF THE COST OF YOUR COVERED SERVICES OR DRUGS

SECTION 1.1

IF YOU PAY OUR PLAN'S SHARE OF THE COST OF YOUR COVERED SERVICES OR DRUGS, OR IF YOU RECEIVE A BILL, YOU CAN ASK US FOR PAYMENT

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our plan whenever you’ve paid more than your share of the cost for medical services or drugs that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

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

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed care from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill the plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
 - If the provider is owed anything, we will pay the provider directly.
 - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill you think you should not pay

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

- You only have to pay your cost-sharing amount when you get 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. For more information about “balance billing,” go to Chapter 4, Section 1.3.

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

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

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

- Please call Member Services for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Member Services are printed on the back cover of this booklet.)

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

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Section 2.5 to learn more.)

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

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

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

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

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

SECTION 2 HOW TO ASK US TO PAY YOU BACK OR TO PAY A BILL YOU HAVE RECEIVED

SECTION 2.1 HOW AND WHERE TO SEND US YOUR REQUEST FOR PAYMENT

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

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

SCAN Health Plan
Attention: Member Services
PO Box 22616 Long Beach, CA 90801-5616

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

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our Web site (www.scanhealthplan.com) or call Member Services and ask for the form. (Phone numbers for Member Services are printed on the back cover of this booklet.)

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

Express Scripts, Inc.
P.O. Box 66752
St. Louis, MO 63166-6752
ATTN: MED-D Accounts

You must submit your claim to us within 365 days of the date you received the drug.

Contact Member Services if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3 WE WILL CONSIDER YOUR REQUEST FOR PAYMENT AND SAY YES OR NO

SECTION 3.1 WE CHECK TO SEE WHETHER WE SHOULD COVER THE SERVICE OR DRUG AND HOW MUCH WE OWE

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

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

SECTION 3.2 IF WE TELL YOU THAT WE WILL NOT PAY FOR ALL OR PART OF THE MEDICAL CARE OR DRUG, YOU CAN MAKE AN APPEAL

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 9. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to the section in Chapter 9 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 5.3 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 6.5 of Chapter 9.

SECTION 4 OTHER SITUATIONS IN WHICH YOU SHOULD SAVE YOUR RECEIPTS AND SEND COPIES TO US

SECTION 4.1 IN SOME CASES, YOU SHOULD SEND COPIES OF YOUR RECEIPTS TO US TO HELP US TRACK YOUR OUT-OF-POCKET DRUG COSTS

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. When you buy the drug for a price that is lower than our price

Sometimes when you are in the Coverage Gap Stage, you can buy your drug **at a network pharmacy** for a price that is lower than our price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** If you are in the Coverage Gap Stage, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

2. When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

CHAPTER 8

YOUR RIGHTS AND RESPONSIBILITIES

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SECTION 1

OUR PLAN MUST HONOR YOUR RIGHTS AS A MEMBER OF THE PLAN

SECTION 1.1 WE MUST PROVIDE INFORMATION IN A WAY THAT WORKS FOR YOU (IN SPANISH, IN BRAILLE, IN LARGE PRINT, OR OTHER ALTERNATE FORMATS, ETC.)

To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet).

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. Written materials are available in English and Spanish. We can also give you information in Braille, in large print, 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.

If you have any trouble getting information from our plan because of problems related to language or a disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

Debemos brindar información de manera que la pueda entender (en español, en Braille, en letra grande u otros formatos alternativos, etc.)

Para que le brindemos información en una forma que funcione para usted, llame a Servicios para Miembros (los números de teléfono aparecen en la cubierta posterior de este folleto).

Nuestro plan cuenta con personal y servicios gratuitos de interpretación para responder a las preguntas de los miembros que no hablan inglés. Los materiales impresos se encuentran disponibles en inglés y español. También podemos brindarle información en Braille, en letra grande u otro formato alternativo si lo necesita. Si usted es elegible para Medicare debido a una discapacidad, es nuestra obligación brindarle información sobre los beneficios del plan que sea accesible y adecuada para usted.

Si tiene problemas obteniendo información de nuestro plan debido a problemas relacionados con el idioma o una discapacidad, llame a Medicare al 1-800-MEDICARE (1-800-633-4227), las 24 horas del día, los 7 días de la semana, e infórmeles que desea presentar una queja. Los usuarios TTY deben comunicarse al 1-877-486-2048.

SECTION 1.2 WE MUST TREAT YOU WITH FAIRNESS AND RESPECT AT ALL TIMES

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Services (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 1.3 WE MUST ENSURE THAT YOU GET TIMELY ACCESS TO YOUR COVERED SERVICES AND DRUGS

As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

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

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 10 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 4 tells what you can do.)

SECTION 1.4 WE MUST PROTECT THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first*. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - For example, we are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are printed on the back cover of this booklet).

SCAN HEALTH PLAN NOTICE OF PRIVACY PRACTICES

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

SCAN Health Plan is required by law to maintain the privacy of your health information and to provide you this Notice about our legal duties and privacy practices. We must follow the privacy practices described in this Notice while it is in effect. This Notice takes effect May 14, 2013, and will remain in effect until we replace or modify it.

Protecting Your Privacy

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

Protected Health Information

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

How We Use Your Health Information

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

Treatment

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

- We may share information with your physician or medical group when necessary for you to receive treatment.
- We may share information about you to a hospital so that you receive appropriate care.
- We may share information about you with plan providers involved in the delivery of your health care services.

Payment

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

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

Health Care Operations

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

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

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

Other Permitted Uses and Disclosures

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

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

Other uses and disclosures not described in this Notice will only be made with your written authorization. You may revoke your authorization at any time as long as the request to revoke is in writing and the plan has not relied on your authorization to take a specific action.

Sharing Your Health Information with Others

As part of normal business, SCAN Health Plan shares your information with contracted plan providers (e.g., medical groups, hospitals, pharmacy benefit management companies, social service providers, etc.). In all cases where your health information is shared with plan providers, we have a written contract that contains language designed to protect the privacy of your health information. Our plan providers are required to keep

your health information confidential, and protect the privacy of your information in accordance with state and federal law.

Your Rights Involving Your Health Information

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

The following are your rights with respect to your health information. If you would like to exercise any of the following rights, please refer to the section below titled "How to Obtain Additional Information About This Notice".

Right to Request Restrictions

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

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

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

Right to Inspect and Copy

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

Your request must be in writing and must include specific information needed to fulfill your request. If you call the Member Services Department we will send you a form to use to do this; 1-800-559-3500, between the hours of 7 A.M.–8 P.M., seven days a week. TTY users call: 711. Or if you prefer, you may send your written request:

SCAN Health Plan

Attention: Member Services (Request to Inspect and Copy)
3800 Kilroy Airport Way, P.O. Box 22616
Long Beach, CA 90801-9826

If we maintain an electronic health record containing your health information you have the right to request that we send a copy of your health information to you or a third party that you identify. We may charge a reasonable fee for the cost of producing the electronic copy of your health information and for postage if

applicable. You must pay this fee before we give you the copies. You may also request that we provide you with summary information about your Protected Health Information instead of all the information. If so, you must pay us the cost of preparing this summary information before we give it to you.

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

Right to Request an Amendment

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

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

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

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

Right to Receive Confidential Communications

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

Right to Receive an Accounting of Disclosures

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

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

Right to Receive Notice of a Breach of Protected Health Information

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

Right to Copies of this Notice

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

If you have any questions about our Notice of Privacy Practices or would like to request an additional copy of the Notice, please contact the Privacy Office at 1-562-997-3134 or 1-855-895-7226, TTY users call: 711. Or, you can write to:

SCAN Health Plan

Attention: Privacy Office
3800 Kilroy Airport Way, P.O. Box 22616
Long Beach, CA 90801-9826

Or email the Privacy Office at PrivacyOffice@scanhealthplan.com, or fax to 1-562-308-3689.

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

How to Complain About Our Privacy Practices

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

Complaints to SCAN Health Plan

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

SCAN Health Plan

Attention: Privacy Officer
3800 Kilroy Airport Way, P.O. Box 22616
Long Beach, CA 90801-9826

Or email PrivacyOffice@scanhealthplan.com, or fax to 1-562-308-3689.

If you need assistance with filing a complaint you can call the SCAN Health Plan Privacy Officer at 1-562-997-3134 or 1-855-895-7226.

Complaints to the Federal Government

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

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

How to Obtain Additional Information About this Notice

If you have any questions about our Notice of Privacy Practices or would like to request an additional copy of the Notice, please contact the Privacy Officer 1-855-895-7226, 8 A.M.–5 P.M. Pacific Standard Time, Monday through Friday. TTY users call: 711.

Changes to this Notice

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

SECTION 1.5 WE MUST GIVE YOU INFORMATION ABOUT THE PLAN, ITS NETWORK OF PROVIDERS, AND YOUR COVERED SERVICES

As a member of SCAN Employer Group, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in Spanish, and in large print or audio recording.)

If you want any of the following kinds of information, please call Member Services (phone numbers are printed on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers including our network pharmacies.**
 - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
 - For a list of the providers and pharmacies in the plan's network, see the *Provider/Pharmacy Directory*.
 - For more detailed information about our providers or pharmacies, you can call Member Services (phone numbers are printed on the back cover of this booklet) or visit our Web site at www.scanhealthplan.com.
- **Information about your coverage and the rules you must follow when using your coverage.**
 - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
 - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *List of Covered Drugs (Formulary)*. These chapters, together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
 - If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the back cover of this booklet).

- **Information about why something is not covered and what you can do about it.**
 - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
 - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
 - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

SECTION 1.6 WE MUST SUPPORT YOUR RIGHT TO MAKE DECISIONS ABOUT YOUR CARE

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

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

For additional Advanced Directive information you can access http://oag.ca.gov/consumers/general/adv_hc_dir.

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

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

The legal documents that you can use to give your directions in advance in these situations are called “**advance directives**.” There are different types of advance directives and different names for them. Documents called “**living will**” and “**power of attorney for health care**” are examples of advance directives.

If you want to use an “advance directive” to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms (phone numbers are printed on the back cover of this booklet).
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

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

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the California Department of Health Care Services.

SECTION 1.7 YOU HAVE THE RIGHT TO MAKE COMPLAINTS AND TO ASK US TO RECONSIDER DECISIONS WE HAVE MADE

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 9, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to

change a coverage decision, or make a complaint. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—we are required to treat you fairly.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 1.8 WHAT CAN YOU DO IF YOU BELIEVE YOU ARE BEING TREATED UNFAIRLY OR YOUR RIGHTS ARE NOT BEING RESPECTED?

If it is about discrimination, call the Office for Civil Rights

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

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and it's not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **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 1.9 HOW TO GET MORE INFORMATION ABOUT YOUR RIGHTS

There are several places where you can get more information about your rights:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
 - You can visit the Medicare Web site to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: <http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf>.)
 - Or, you can 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 2.1 WHAT ARE YOUR RESPONSIBILITIES?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services (phone numbers are printed on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
 - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).
 - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “**coordination of benefits**” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.

- For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.
- If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
 - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
- If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
- If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.
- ***Tell us if you move.*** *If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are printed on the back cover of this booklet).*
 - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
 - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
 - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- ***Call Member Services for help if you have questions or concerns.*** *We also welcome any suggestions you may have for improving our plan.*
 - Phone numbers and calling hours for Member Services are printed on the back cover of this booklet.
 - For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 9

WHAT TO DO IF YOU HAVE A PROBLEM OR COMPLAINT (COVERAGE DECISIONS, APPEALS, COMPLAINTS)

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BACKGROUND

SECTION 1 INTRODUCTION

SECTION 1.1 WHAT TO DO IF YOU HAVE A PROBLEM OR CONCERN

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

- For some types of problems, you need to use the **process for coverage decisions and appeals**.
- For other types of problems, you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

SECTION 1.2 WHAT ABOUT THE LEGAL TERMS?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination” or “coverage determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful—and sometimes quite important—for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 YOU CAN GET HELP FROM GOVERNMENT ORGANIZATIONS THAT ARE NOT CONNECTED WITH US

SECTION 2.1 WHERE TO GET MORE INFORMATION AND PERSONALIZED ASSISTANCE

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

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

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare Web site (<http://www.medicare.gov>).

SECTION 3 TO DEAL WITH YOUR PROBLEM, WHICH PROCESS SHOULD YOU USE?

SECTION 3.1 SHOULD YOU USE THE PROCESS FOR COVERAGE DECISIONS AND APPEALS? OR SHOULD YOU USE THE PROCESS FOR MAKING COMPLAINTS?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

TO FIGURE OUT WHICH PART OF THIS CHAPTER WILL HELP WITH YOUR SPECIFIC PROBLEM OR CONCERN, START HERE

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes.	No.
My problem is about benefits or coverage. Go on to the next section of this chapter, Section 4, "A guide to the basics of coverage decisions and making appeals."	My problem is <u>not</u> about benefits or coverage. Skip ahead to Section 10 at the end of this chapter: "How to make a complaint about quality of care, waiting times, customer service or other concerns."

COVERAGE DECISIONS AND APPEALS

SECTION 4 A GUIDE TO THE BASICS OF COVERAGE DECISIONS AND APPEALS

SECTION 4.1 ASKING FOR COVERAGE DECISIONS AND MAKING APPEALS: THE BIG PICTURE

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for medical services and prescription drugs, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases we might decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

SECTION 4.2 HOW TO GET HELP WHEN YOU ARE ASKING FOR A COVERAGE DECISION OR MAKING AN APPEAL

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call us at Member Services** (phone numbers are printed on the back cover of this booklet).
- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).

- **Your doctor can make a request for you.**
 - For medical care, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.
 - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - There may be someone who is already legally authorized to act as your representative under State law.
 - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s Web site at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf> or on our Web site at www.scanhealthplan.com.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

SECTION 4.3 WHICH SECTION OF THIS CHAPTER GIVES THE DETAILS FOR YOUR SITUATION?

There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: “Your medical care: How to ask for a coverage decision or make an appeal”
- **Section 6** of this chapter: “Your Part D prescription drugs: How to ask for a coverage decision or make an appeal”
- **Section 7** of this chapter: “How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon”
- **Section 8** of this chapter: “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (*Applies to these services only:* home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you’re not sure which section you should be using, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

SECTION 5

YOUR MEDICAL CARE: HOW TO ASK FOR A COVERAGE DECISION OR MAKE AN APPEAL



Have you read Section 4 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

SECTION 5.1

THIS SECTION TELLS WHAT TO DO IF YOU HAVE PROBLEMS GETTING COVERAGE FOR MEDICAL CARE OR IF YOU WANT US TO PAY YOU BACK FOR OUR SHARE OF THE COST OF YOUR CARE

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*. To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
 - **NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services,** you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:
 - Chapter 9, Section 7: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*
 - Chapter 9, Section 8: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
 - For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

WHICH OF THESE SITUATIONS ARE YOU IN?

If you are in this situation:	This is what you can do:
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you. Go to the next section of this chapter, Section 5.2 .
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an appeal . (This means you are asking us to reconsider.) Skip ahead to Section 5.3 of this chapter.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill. Skip ahead to Section 5.5 of this chapter.

SECTION 5.2 STEP-BY-STEP: HOW TO ASK FOR A COVERAGE DECISION (HOW TO ASK OUR PLAN TO AUTHORIZE OR PROVIDE THE MEDICAL CARE COVERAGE YOU WANT)

LEGAL TERMS

When a coverage decision involves your medical care, it is called an **“organization determination.”**

Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a **“fast coverage decision.”**

LEGAL TERMS

A “fast coverage decision” is called an **“expedited determination.”**

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your medical care.*

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. **A standard coverage decision means we will give you an answer within 14 days** after we receive your request.

- **However, we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint

within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

If your health requires it, ask us to give you a “fast coverage decision”

- **A fast coverage decision means we will answer within 72 hours.**
 - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
 - You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)
 - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision.
 - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
 - The letter will also tell how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a “fast” coverage decision

- Generally, for a fast coverage decision, we will give you our answer **within 72 hours**.
 - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

- If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a detailed written explanation as to why we said no.

Deadlines for a “standard” coverage decision

- Generally, for a standard coverage decision, we will give you our answer **within 14 days of receiving your request**.
 - We can take up to 14 more calendar days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
 - If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our coverage decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If we say no, you have the right to ask us to reconsider—and perhaps change—this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

SECTION 5.3 STEP-BY-STEP: HOW TO MAKE A LEVEL 1 APPEAL (HOW TO ASK FOR A REVIEW OF A MEDICAL CARE COVERAGE DECISION MADE BY OUR PLAN)

LEGAL TERMS

An appeal to the plan about a medical care coverage decision is called a plan “reconsideration.”

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a “fast appeal.”

What to do

- **To start an appeal you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for section called, *How to contact us when you are making an appeal about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.**
 - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. It is also available on Medicare’s Web site at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf> or on our Web site at www.scanhealthplan.com.) While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form within 44 days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be sent to the Independent Review Organization for dismissal.
- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal:**
 - You have the right to ask us for a copy of the information regarding your appeal.
 - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal” (you can make a request by calling us)

**LEGAL
TERMS**

A “fast appeal” is also called an **“expedited reconsideration.”**

- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.”
- The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast coverage decision.” To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.

Step 2: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a “fast” appeal

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing.
 - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
 - If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If our plan says no to part or all of your appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

SECTION 5.4 STEP-BY-STEP: HOW A LEVEL 2 APPEAL IS DONE

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

LEGAL TERMS

The formal name for the “Independent Review Organization” is the “**Independent Review Entity.**” It is sometimes called the “**IRE.**”

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

If you had a “fast” appeal at Level 1, you will also have a “fast” appeal at Level 2

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

If you had a “standard” appeal at Level 1, you will also have a “standard” appeal at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of what you requested**, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
 - There is a certain dollar value that must be in dispute to continue with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 5.5 WHAT IF YOU ARE ASKING US TO PAY YOU FOR OUR SHARE OF A BILL YOU HAVE RECEIVED FOR MEDICAL CARE?

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Medical Benefits Chart (What is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan’s coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven’t paid for the services, we will send the payment directly to the provider. (When we send the payment, it’s the same as saying yes to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in

detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in part 5.3 of this section. Go to this part for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 YOUR PART D PRESCRIPTION DRUGS: HOW TO ASK FOR A COVERAGE DECISION OR MAKE AN APPEAL



Have you read Section 4 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

SECTION 6.1 THIS SECTION TELLS YOU WHAT TO DO IF YOU HAVE PROBLEMS GETTING A PART D DRUG OR YOU WANT US TO PAY YOU BACK FOR A PART D DRUG

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our plan's *List of Covered Drugs (Formulary)*. To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the *List of Covered Drugs (Formulary)*, rules and restrictions on coverage, and cost information, see Chapter 5 (*Using our plan's coverage for your Part D prescription drugs*) and Chapter 6 (*What you pay for your Part D prescription drugs*).

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

**LEGAL
TERMS**

An initial coverage decision about your Part D drugs is called a “**coverage determination.**”

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
 - Asking us to cover a Part D drug that is not on the plan’s *List of Covered Drugs (Formulary)*
 - Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
 - Asking to pay a lower cost-sharing amount for a covered non-preferred drug
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan’s *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)
 - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

WHICH OF THESE SITUATIONS ARE YOU IN?			
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you have already received and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.) Start with Section 6.2 of this chapter.	You can ask us for a coverage decision. Skip ahead to Section 6.4 of this chapter.	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to Section 6.4 of this chapter.	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to Section 6.5 of this chapter.

SECTION 6.2 WHAT IS AN EXCEPTION?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an “exception.” An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our *List of Covered Drugs (Formulary)*.** (We call it the “Drug List” for short.)

LEGAL TERMS

Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a “**formulary exception.**”

- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 4 (Non-Preferred Generic Drugs Tier) for brand name drugs or Tier 2 (Non-Preferred Generic Drugs Tier) for generic drugs. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
2. **Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (for more information, go to Chapter 5 and look for Section 4).

LEGAL TERMS

Asking for removal of a restriction on coverage for a drug is sometimes called asking for a “**formulary exception.**”

- The extra rules and restrictions on coverage for certain drugs include:
 - *Being required to use the generic version* of a drug instead of the brand name drug.
 - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
 - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
 - *Quantity limits.* For some drugs, there are restrictions on the amount of the drug you can have.
 - If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of six cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

LEGAL TERMS

Asking to pay a lower preferred price for a covered non-preferred drug is sometimes called asking for a “**tiering exception.**”

- If your drug is in Tier 4 (Non-Preferred Brand Drugs Tier), you can ask us to cover it at the cost-sharing amount that applies to drugs in Tier 3 (Preferred Brand Drugs Tier). This would lower your share of the cost for the drug.
- If your drug is in Tier 2 (Non-Preferred Generic Drugs Tier), you can ask us to cover it at the cost-sharing amount that applies to drugs in Tier 1 (Preferred Generic Drugs Tier). This would lower your share of the cost for the drug.
- You cannot ask us to change the cost-sharing tier for any drug in Tier 5 (Specialty Drugs Tier).

SECTION 6.3 IMPORTANT THINGS TO KNOW ABOUT ASKING FOR EXCEPTIONS

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

SECTION 6.4 STEP-BY-STEP: HOW TO ASK FOR A COVERAGE DECISION, INCLUDING AN EXCEPTION

Step 1: You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a “fast coverage decision.” You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our Web site. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called, *Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received*.

- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug**, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the “supporting statement.”** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the “supporting statement.”) Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our Web site.

If your health requires it, ask us to give you a “fast coverage decision”

LEGAL TERMS

A “fast coverage decision” is called an **“expedited coverage determination.”**

- When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor’s statement. A fast coverage decision means we will answer within 24 hours.
- **To get a fast coverage decision, you must meet two requirements:**
 - You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
 - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor or other prescriber tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own (without your doctor’s or other prescriber’s support), we will decide whether your health requires that we give you a fast coverage decision.
 - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
 - The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a “fast” complaint, which means you would get our answer to your complaint within 24 hours. (The

process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 10 of this chapter.)

Step 2: We consider your request and we give you our answer.

Deadlines for a “fast” coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
 - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor’s statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a “standard” coverage decision about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.
 - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested—**
 - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor’s statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a “standard” coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Step 3: If we say no to your coverage request, you decide if you want to make an appeal.

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider—and possibly change—the decision we made.

SECTION 6.5 STEP-BY-STEP: HOW TO MAKE A LEVEL 1 APPEAL (HOW TO ASK FOR A REVIEW OF A COVERAGE DECISION MADE BY OUR PLAN)

LEGAL TERMS

An appeal to the plan about a Part D drug coverage decision is called a plan “redetermination.”

Step 1: You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a “fast appeal.”

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
 - For details on how to reach us by phone, fax, or mail, or on our Web site, for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, *How to contact us when you are making an appeal about your Part D prescription drugs.*
- **If you are asking for a standard appeal, make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** (*How to contact us when you are making an appeal about your part D prescription drugs*).
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our Web site.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
 - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
 - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal”

A “fast appeal” is also called an “**expedited redetermination.**”

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 6.4 of this chapter.

Step 2: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a “fast” appeal

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires it.
 - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for “fast” appeal.
 - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested—**
 - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
 - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.