## SECTION 2 Use the *Medical Benefits Chart* to find out what is covered for you and how much you will pay

### Section 2.1 Your medical benefits and costs as a member of the plan

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

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart by a footnote.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2016* Handbook. View it online at http://www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2016, either Medicare or our plan will

cover those services.

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

**Medical Benefits Chart**

| Services that are covered for you | **What you must pay** when you get these services |
|---|---|
| **Abdominal aortic aneurysm screening**<br>A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist. | There is no coinsurance, copayment, or deductible for beneficiaries eligible for this preventive screening.<br>**Prior authorization rules apply** |
| **Ambulance services**<br>• Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan.<br>• Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.<br>Paramedic intercept services are covered under limited circumstances as defined by Medicare. | $0 copayment for each one-way trip<br>**Prior authorization rules apply for non-emergency ambulance services** |
| **Annual physical examination***<br>You are covered for one routine physical examination per year. This exam includes screening laboratory services as needed. | $0 copayment for the office visit |
| **Annual wellness visit**<br>If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.<br>**Note**: Your first annual wellness visit can't take place within 12 | There is no coinsurance, copayment, or deductible for the annual wellness visit. |

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

| **Services that are covered for you** | **What you must pay** when you get these services |
|---|---|
| months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months. | |
| **Bone mass measurement**<br>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results. | There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.<br>**Prior authorization rules apply** |
| **Breast cancer screening (mammograms)**<br>Covered services include:<br>• One baseline mammogram between the ages of 35 and 39<br>• One screening mammogram every 12 months for women age 40 and older<br>• Clinical breast exams once every 24 months | There is no coinsurance, copayment, or deductible for covered screening mammograms.<br>You can self-refer within your network for annual mammography screening (1 exam every 12 months).<br>Routine mammography screening does not include MRI.<br>**Prior authorization rules apply** |
| **Cardiac rehabilitation services**<br>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. | $15 copayment for each office visit<br>**Prior authorization rules apply** |
| **Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)** | There is no coinsurance, copayment, or deductible for |

*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 |
|---|---|
| We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating well. | the intensive behavioral therapy cardiovascular disease preventive benefit.<br>**Prior authorization rules apply** |
| **Cardiovascular disease testing**<br>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).<br><br>This benefit does not include genetic testing. | There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.<br>**Prior authorization rules apply** |
| **Cervical and vaginal cancer screening**<br>Covered services include:<br>• For all women: Pap tests and pelvic exams are covered once every 24 months<br>• If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months | There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.<br><br>You may self-refer to an OB/GYN within your medical group for routine preventive care.<br>**Prior authorization rules apply** |
| **Chiropractic services**<br>Covered services include:<br>• We cover only manual manipulation of the spine to correct subluxation<br>Medicare-covered chiropractic services are covered only through your assigned medical group | $15 copayment for each office visit<br>**Prior authorization rules apply** |
| **Routine Chiropractic Services***<br>Routine chiropractic services cover medically-necessary routine care. You are covered up to 20 visits per year for routine chiropractic services. You must use contracted plan providers. This | $15 copayment for each office visit |

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

| **Services that are covered for you** | **What you must pay** when you get these services |
|---|---|
| benefit does not require prior authorization. | |
| **Colorectal cancer screening**<br>For people 50 and older, the following are covered:<br>• Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months<br>• Fecal occult blood test, every 12 months<br>For people at high risk of colorectal cancer, we cover:<br>• Screening colonoscopy (or screening barium enema as an alternative) every 24 months<br>For people not at high risk of colorectal cancer, we cover:<br>• Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy | There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.<br>If during your screening, a diagnostic procedure is required, you will not be responsible for additional copayments.<br>Virtual Colonoscopy is not a covered procedure.<br>**Prior authorization rules apply** |
| **Dental services**<br>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover:<br>• Medically necessary oral surgery that is unrelated to the teeth and supporting structures<br>• Surgery of the jaw or related structures<br>• Setting fractures of the jaw or facial bones<br>• Extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease<br>• Medicare-covered pre-transplant dental services<br>• Treatment of congenital malformations, cysts, and malignancies<br>• Dental services performed if you have an underlying medical condition which requires general anesthesia in a network hospital or surgery center setting<br>**See the "Benefits Not Covered By The Plan (Exclusions)" section later in this chapter for information regarding additional dental procedures that are not covered.** | $15 copayment for each office visit<br>**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 |
|---|---|
| **Depression screening**<br>We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals. | There is no coinsurance, copayment, or deductible for an annual depression screening visit.<br>**Prior authorization rules apply** |
| **Diabetes screening**<br>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.<br>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months. | There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.<br>**Prior authorization rules apply** |
| **Diabetes self-management training, diabetic services and supplies**<br>For all people who have diabetes (insulin and non-insulin users). Covered services include:<br>• Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.<br>• For people with diabetes who have severe diabetic foot disease**: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.<br>• Diabetes self-management training is covered under certain conditions.<br>**As defined by Medicare. | $0 copayment for the supplies to monitor your blood glucose, diabetes self-management training, therapeutic shoes and inserts.<br>Supplies to monitor your blood glucose include coverage of a select manufacturer (Abbott) for glucose monitors, test strips, lancets, and control solutions. (Please contact Member Services for more information).<br>Continuous glucose monitors and related supplies are not covered.<br>**Prior authorization rules apply to diabetes self-management training, therapeutic shoes, and** |

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| **Services that are covered for you** | **What you must pay** when you get these services |
|---|---|
| | **inserts.** |
| **Durable medical equipment and related supplies**<br>(For a definition of "durable medical equipment," see Chapter 12 of this booklet.)<br>Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.<br>We cover all medically necessary durable medical equipment covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.scanhealthplan.com.<br>DME supplies are limited to equipment and devices which do not duplicate the function of another piece of equipment or device covered by SCAN and are appropriate for use in the home. Coverage does not include items to be used outside of the home, such as travel oxygen, ramps, portable nebulizers, and other equipment.<br>Repairs and replacements of DME are covered due to breakage, wear, or a significant change in your physical condition. Repairs and/or replacements will be made when determined to be necessary by SCAN.<br>Previously authorized services to be provided in-network (such as but not limited to oxygen) are not covered outside of the SCAN service area.<br>For information on nebulizer medication, please see "Medicare Part B prescription drugs" section in this chapter. | $0 copayment<br>**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 |
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| **Emergency care**<br>Emergency care refers to services that are:<br>• Furnished by a provider qualified to furnish emergency services, and<br>• Needed to evaluate or stabilize an emergency medical condition.<br>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.<br>Includes worldwide coverage for services needed to evaluate or stabilize an emergency medical condition. See "Services we do not cover (Exclusions)" later in this chapter for more information.<br>Non-emergency medications obtained outside the United States are not covered.<br>For more information see Chapter 3, Section 3. | $50 copayment for each visit<br>The copayment is waived if you are admitted to the hospital as an inpatient either immediately or after a period of observation.<br>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.<br>If your condition prohibits you from returning to a network hospital, alternative care will be arranged if medically necessary. |
| **Health club membership***<br>SCAN provides a membership at a participating fitness facility. You can select a fitness club or exercise center from SCAN's network of contracted facilities. Please call Member Services for more information. | $0 copayment for membership at participating fitness clubs.<br>Membership includes standard fitness facility services. Any services that typically require an additional fee are not included. |
| **Hearing services (Medicare-covered)**<br>Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. | $15 copayment for each office visit<br>**Prior authorization rules apply** |
| **Hearing services (Routine/Non-Medicare-covered)*** | **Routine hearing test**<br>$15 copayment (one test per |

*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 |
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| Covered services include:<br>• Routine hearing test/screening<br>• Hearing aids<br>• Hearing aid fitting/evaluation<br>You may self-refer to a contracted audiology provider for a hearing screening to determine the need for hearing aids.<br>Hearing aids are covered when determined to be necessary and obtained from a contracted provider.<br>This benefit is provided over a period exceeding one year and is therefore considered a multi-year benefit and may be dropped or modified by SCAN from year-to-year without maintaining obligations to the previous contract year. | year)<br>**Hearing aid fitting/evaluation**<br>$15 copayment (one visit every 2 years)<br>**Hearing aid coverage**<br>You are covered up to $600 for one or two hearing aids every 2 years. You pay any remaining costs beyond what SCAN will cover.<br>**Prior authorization rules apply to routine hearing tests** |
| **HIV screening**<br>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:<br>• One screening exam every 12 months<br>For women who are pregnant, we cover:<br>• Up to three screening exams during a pregnancy | There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered preventive HIV screening.<br>**Prior authorization rules apply** |
| **Home health agency care**<br>Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.<br>Covered services include, but are not limited to:<br>• Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week)<br>• Physical therapy, occupational therapy, and speech therapy<br>• Medical and social services<br>• Medical equipment and supplies | $0 copayment for home health services<br>Coinsurance payments will apply for Medicare-covered outpatient injectables and intravenous drugs administered in a home health setting. See "Medicare Part B Prescription Drugs" section in this chapter.<br>**Prior authorization rules apply** |

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| **Services that are covered for you** | **What you must pay** when you get these services |
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| **Hospice care**<br>You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include:<br>• Drugs for symptom control and pain relief<br>• Short-term respite care<br>• Home care<br>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.<br>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network:<br>• If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services<br>• If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare)<br>For services that are covered by SCAN Employer Group but are not covered by Medicare Part A or B: SCAN Employer Group will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services.<br>For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 (*What if* | When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not SCAN Employer Group. |

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

| **Services that are covered for you** | **What you must pay** when you get these services |
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| **Hospice care (continued)**<br>*you're in Medicare-certified hospice*)<br>**Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services. | |
| **Immunizations**<br>Covered Medicare Part B services include:<br>• Pneumonia vaccine<br>• Flu shots, once a year in the fall or winter<br>• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B<br>• Other vaccines if you are at risk and they meet Medicare Part B coverage rules<br>We also cover some vaccines under our Part D prescription drug benefit. | There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.<br>**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 |
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| **Inpatient hospital care**<br>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.<br>There is no limit to the number of medically necessary hospital days covered by the plan.<br>Covered services include but are not limited to:<br>• Semi-private room (or a private room if medically necessary)<br>• Meals including special diets<br>• Regular nursing services<br>• Costs of special care units (such as intensive care or coronary care units)<br>• Drugs and medications<br>• Lab tests<br>• X-rays and other radiology services<br>• Necessary surgical and medical supplies<br>• Use of appliances, such as wheelchairs<br>• Operating and recovery room costs<br>• Physical, occupational, and speech language therapy<br>• Inpatient substance abuse services (Also see "Inpatient mental health care" later in this section.)<br>• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are at a distant location, you may choose to go locally or distant as long as the local transplant providers are willing to accept the Original Medicare rate. If SCAN Employer Group provides transplant services at a distant location (outside of the service area) and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. **Authorization rules apply.** Contact Member | $100 copayment per admission<br>Your inpatient benefits are based upon the date of admission. If you are admitted to the hospital in 2016 and are not discharged until 2017, the 2016 copayments will apply until you are discharged from the hospital or transferred to a skilled nursing facility.<br>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.<br>**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 |
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| Services for details regarding the plan's policy for transplant travel coverage.<br>• Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used.<br>• Physician services<br>**Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.<br>You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. | |
| **Inpatient mental health care**<br>Covered services include mental health care services that require a hospital stay.<br>You are covered for 90 days per benefit period.<br>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.<br>There is a 190-day lifetime limit for inpatient services in a freestanding psychiatric hospital. The 190-day limit does not apply to mental health services provided in a psychiatric unit of a general hospital. | **For inpatient mental health stays, you pay per benefit period:**<br>$100 copayment per admission<br>Your inpatient benefits are based upon the date of admission. For example, if you are admitted to an inpatient mental health facility in 2016 and are not discharged until 2017, the 2016 copayments will apply until you have not received any inpatient care in an acute hospital, a skilled nursing facility, or an inpatient mental health facility for 60 days in a row.<br>**Prior authorization rules apply** |

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

| **Services that are covered for you** | **What you must pay** when you get these services |
|---|---|
| **Inpatient services covered during a non-covered inpatient stay**<br>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:<br>• Physician services<br>• Diagnostic tests (like lab tests)<br>• X-ray, radium, and isotope therapy including technician materials and services<br>• Surgical dressings<br>• Splints, casts and other devices used to reduce fractures and dislocations<br>• 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<br>• 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<br>• Physical therapy, speech therapy, and occupational therapy<br>Covered services must be received from contracted in-network providers. | **Physician services:**<br>Please refer to "Physician/Practitioner Services, Including Doctor's Office Visits" section in this chapter.<br>**Diagnostic and radiological services, surgical dressings, and splints:**<br>Please refer to "Outpatient Diagnostic Tests and Therapeutic Services and Supplies" section in this chapter.<br>**Prosthetics, orthotics, and outpatient medical/ therapeutic supplies:**<br>Please refer to "Prosthetic Devices and Related Supplies" section in this chapter.<br>**Physical, speech, and occupational therapy services:**<br>Please refer to "Outpatient Rehabilitation Services" section in this chapter.<br>**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 |
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| **Medical nutrition therapy**<br>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor.<br>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. | There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered medical nutrition therapy services.<br>**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 |
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| **Medicare Part B prescription drugs**<br>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:<br>• 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<br>• Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan<br>• Clotting factors you give yourself by injection if you have hemophilia<br>• Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant<br>• 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<br>• Antigens<br>• Certain oral anti-cancer drugs and anti-nausea drugs<br>• 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)<br>• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases<br>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. | You pay a $40 copayment for Part B drugs.<br>Non-Medicare-covered injectable drugs are not covered by SCAN.<br>SCAN covers injectable chemotherapy drugs administered as anti-cancer agents that are covered under Original Medicare.<br>**Prior authorization rules apply** |
| **Obesity screening and therapy to promote sustained weight loss**<br>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 | There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.<br>**Prior authorization rules apply** |

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| **Services that are covered for you** | **What you must pay** when you get these services |
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| doctor or practitioner to find out more. | |
| **Outpatient diagnostic tests and therapeutic services and supplies**<br>Covered services include, but are not limited to:<br>• X-rays<br>• Radiation (radium and isotope) therapy including technician materials and supplies<br>• Surgical supplies, such as dressings<br>• Splints, casts and other devices used to reduce fractures and dislocations<br>• Laboratory tests<br>• Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used.<br>• Other outpatient diagnostic tests | $0 copayment<br>**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**<br>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.<br>Covered services include, but are not limited to:<br>• Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery<br>• Laboratory and diagnostic tests billed by the hospital<br>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it<br>• Chemical dependency care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it<br>• X-rays and other radiology services billed by the hospital<br>• Medical supplies such as splints and casts<br>• Certain screenings and preventive services<br>• Certain drugs and biologicals that you can't give yourself<br>**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.<br>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.<br>Coinsurance payments will apply for Medicare-covered outpatient injectables and intravenous drugs administered in an outpatient setting. See "Medicare Part B Prescription Drugs" section in this chapter. | **Emergency services:**<br>Please refer to "Emergency Care" section in this chapter.<br>**Outpatient surgery:**<br>Please refer to "Outpatient Surgery, Including Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers" section in this chapter.<br>**Laboratory and diagnostic tests, x-rays, radiological services, and medical supplies:**<br>Please refer to "Outpatient Diagnostic Tests and Therapeutic Services and Supplies" section in the chapter.<br>**Mental health care and partial hospitalization:** Please refer to Outpatient Mental Health Care" and "Partial Hospitalization Services" sections in this chapter.<br>**Chemical dependency care:**<br>Please refer to "Outpatient Substance Abuse Services" section in this chapter.<br>**Screenings and preventive services:**<br>Please refer to the applicable sections in this chapter.<br>**Drugs and biologicals that you can't give yourself:**<br>For applicable copayments see "Medicare Part B Prescription Drugs" section in this chapter.<br>**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 |
|---|---|
| **Outpatient mental health care**<br>Covered services include:<br>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.<br>Services must be received from a contracted network provider unless prior authorized. | $15 copayment for each therapy visit in a group or individual setting.<br>**Prior authorization rules apply** |
| **Outpatient rehabilitation services**<br>Covered services include: physical therapy, occupational therapy, and speech language therapy.<br>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). | $15 copayment for each office or clinic visit<br>**Prior authorization rules apply** |
| **Outpatient substance abuse services**<br>You are covered for services to treat chemical dependency in an outpatient setting (group or individual therapy). | $10 copayment for each therapy visit in a group or individual setting.<br>**Prior authorization rules apply** |
| **Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers**<br>You are covered for outpatient services performed in an ambulatory surgical center or an outpatient hospital facility.<br>**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."<br>For radiological services received in an outpatient hospital facility, see "Outpatient Diagnostic Tests and Therapeutic Services and Supplies" section in this chapter. | $0 copayment for each visit<br>**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 |
|---|---|
| **Partial hospitalization services**<br>"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.<br>Partial hospitalization also includes chemical dependency treatment. | $25 copayment for each partial hospitalization visit.<br>**Prior authorization rules apply** |
| **Physician/Practitioner services, including doctor's office visits**<br>Covered services include:<br>• Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location<br>• Consultation, diagnosis, and treatment by a specialist<br>• Basic hearing and balance exams performed by your PCP, if your doctor orders it to see if you need medical treatment<br>• Second opinion by another network provider prior to surgery (See "How to Obtain a Second Opinion" later in this chapter)<br>• 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)<br>• Allergy testing and treatment (performed in a physician's office): Coverage includes allergy serum and injection services.<br>Members may receive a home visit in lieu of a physician office visit when medically necessary. **Authorization rules apply.**<br>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. | You pay the following for PCP office visits:<br>$15 copayment for each office visit<br>You pay the following for Specialist office visits:<br>$15 copayment for each office visit<br>**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 |
|---|---|
| **Podiatry services**<br>Covered services include:<br>• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).<br>• Routine foot care for members with certain medical conditions affecting the lower limbs as defined by Medicare | $15 copayment for each office visit<br>**Prior authorization rules apply** |
| **Prostate cancer screening exams**<br>For men age 50 and older, covered services include the following - once every 12 months:<br>• Digital rectal exam<br>• Prostate Specific Antigen (PSA) test | There is no coinsurance, copayment, or deductible for an annual PSA test or digital rectal exam.<br>**Prior authorization rules apply** |
| **Prosthetic devices and related supplies**<br>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.<br>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.<br>Repairs and replacements of prosthetics and orthotics are covered due to breakage, wear, or a significant change in your physical condition. Repairs and/or replacements will be made when determined to be necessary by SCAN.<br>Prosthetic devices implanted in an inpatient/outpatient setting are covered under the inpatient hospital/outpatient surgery benefit and no additional copay will apply. | $0 copayment<br>**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 |
|---|---|
| **Pulmonary rehabilitation services**<br>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. | $15 copayment for each office visit<br>**Prior authorization rules apply** |
| **Screening and counseling to reduce alcohol misuse**<br>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent.<br>If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting. | There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.<br>**Prior authorization rules apply** |
| **Screening for sexually transmitted infections (STIs) and counseling to prevent STIs**<br>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.<br>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. | There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling to prevent STIs preventive benefit.<br>**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 |
|---|---|
| **Services to treat kidney disease and conditions**<br>Covered services include:<br>• 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.<br>• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3)<br>• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)<br>• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)<br>• Home dialysis equipment and supplies<br>• 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)<br>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."<br>See Chapter 3, Section 2.2 for rules regarding out-of-area dialysis services. | $0 copayment for kidney disease services<br>You pay $0 for each Medicare-covered dialysis treatment. This includes both professional (nephrologist dialysis clinic visits) and dialysis facility visits.<br>Dialysis received as a hospital inpatient will be covered under your hospital inpatient benefit.<br>**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 |
|---|---|
| **Skilled nursing facility (SNF) care**<br>(For a definition of "skilled nursing facility care," see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called "SNFs.")<br>You are covered for 100 days per benefit period. No prior hospital stay is required.<br>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.<br>Covered services include but are not limited to:<br>• Semiprivate room (or a private room if medically necessary)<br>• Meals, including special diets<br>• Skilled nursing services<br>• Physical therapy, occupational therapy, and speech therapy<br>• 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.)<br>• Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used.<br>• Medical and surgical supplies ordinarily provided by SNFs<br>• Laboratory tests ordinarily provided by SNFs<br>• X-rays and other radiology services ordinarily provided by SNFs<br>• Use of appliances such as wheelchairs ordinarily provided by SNFs<br>• Physician/Practitioner services<br>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to get your care from a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.<br>• 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).<br>• A SNF where your spouse is living at the time you leave the hospital. | **For skilled nursing facility stays, you pay per benefit period:**<br>$0 copayment per admission<br>Your skilled nursing facility benefits are based upon the date of admission. If you are admitted to a skilled nursing facility in 2016 and are not discharged until 2017, the 2016 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.<br>**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 |
|---|---|
| **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)**<br>If you use tobacco, but do not have signs or symptoms of tobacco-related disease: 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.<br>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: 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. | There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.<br>**Prior authorization rules apply** |
| **Transportation (Routine)***<br>Routine transportation is provided in a taxi or wheelchair van for non-emergent qualifying medical services. This does not include ambulance transport. See the "Ambulance Services" section earlier in this chapter.<br>Wheelchair transports must meet plan criteria.<br>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.<br>Transportation arrangements should be made 24 hours in advance for a passenger vehicle and 48 hours in advance for wheelchair service. The SCAN Transportation Department may be contacted to schedule a ride. Please call the number on your SCAN Transportation card or contact Member Services at 1-800-559-3500. | $0 copayment for each one-way ride<br>You are covered for an unlimited number of 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.<br>**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 |
|---|---|
| **Urgently needed services**<br>Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.<br>Includes worldwide coverage for services needed to evaluate or stabilize an urgent medical condition. For more information, see Chapter 3, Section 3.<br>When you are in your plan's service area, you must receive urgent care services from an in-network provider, when available.<br>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. | $25 copayment for each visit |

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

| Services that are covered for you | **What you must pay** when you get these services |
|---|---|
| **Vision care**<br>Covered services include:<br>• 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.<br>• 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.<br>• 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.)<br>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.<br>**Intraocular lens**<br>There is no charge for a standard intra-ocular lens (IOL). However, for an additional fee, you may request the insertion of a presbyopia-correcting IOL (e.g. Crystalens™, AcrySof RESTOR™, and ReZoom™) in place of a conventional IOL following cataract surgery. You will pay an additional fee for non-conventional 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 exceed the charge for insertion of a conventional IOL following cataract surgery. You should discuss the extra cost with your ophthalmologist PRIOR to surgery so that you clearly understand the extent of your financial responsibility. | **Eyewear after cataract surgery (Medicare-covered):**<br>$15 copayment<br>**Eye Exam (Medicare-covered):**<br>$15 copayment for each office visit<br>**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**<br>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.<br>**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. |

| **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. | |
| **Homemaker Service**<br>SCAN Employer Group members are eligible to receive assistance with light cleaning, grocery shopping, laundry and meal preparation. | You pay $15 per visit. |
| **Home Delivered Meals**<br>SCAN Employer Group members are covered for home delivery of meals to meet nutritional needs. | You pay $0. |
| **Personal Care**<br>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. | You pay $15 per visit. |

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

| **Independent Living Power** | |
|---|---|
| **Emergency Response System**<br>SCAN Employer Group members are covered for the installation of a personal emergency response device that alerts emergency medical personnel to provide immediate help. There is no cost for installation. | You pay a monthly service fee of $15 per month. |
| **Enhanced Routine Transportation**<br>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. | You pay $0. |
| **Transportation Escort**<br>As a SCAN Employer Group member you are eligible to receive an escort to assist you during transportation to and from medical appointments. | You pay $15 per visit. |
| **Personal Care Coordinator**<br>SCAN staff will provide personal assistance to coordinate your Independent Living Power services. | You pay $0. |
| **Inpatient Custodial Care (Custodial Care)**<br>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. | You pay $0. |
| **In-Home Caregiver Relief**<br>SCAN provides alternative caregiver services in your home when a regular caregiver can't be there. | You pay $15 per visit. |
| **Adult Day Care**<br>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. | You pay $15 per visit. |

# SECTION 3 What services are not covered by the plan?

## Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are "excluded" from Medicare coverage and therefore, are not covered by this plan. If a service is "excluded," it means that this plan doesn't cover the service.

The chart below lists services and items that either are not covered under any conditions or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself. We won't pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this booklet.)

All exclusions or limitations on services are described in the Benefits Chart or in the chart below.

Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

| Services not covered by Medicare | Not covered under any condition | Covered only under specific conditions |
|---|---|---|
| Services considered not reasonable and necessary, according to the standards of Original Medicare | ✓ | |
| Experimental medical and surgical procedures, equipment and medications.<br><br>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. | | ✓<br>May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan.<br><br>(See Chapter 3, Section 5 for more information on clinical research studies.) |
| Private room in a hospital. | | ✓<br>Covered only when medically necessary. |
| Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a | ✓ | |

| Services not covered by Medicare | Not covered under any condition | Covered only under specific conditions |
|---|---|---|
| television. | | |
| Full-time nursing care in your home. | ✓ | |
| Fees charged for care by your immediate relatives or members of your household. | ✓ | |
| Cosmetic surgery or procedures | | ✓<br>• Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member.<br>• Covered for all stages of reconstruction 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. | ✓ | |
| Non-routine dental care. | | ✓<br>Dental care required to treat illness or injury may be covered as inpatient or outpatient care. |
| Routine foot care | | ✓<br>Some limited covereage provided according to Medicare guidelines, e.g., if you have diabetes |
| Orthopedic shoes | | ✓<br>If 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 | | ✓<br>Orthopedic or therapeutic shoes for people with diabetic foot disease. |

| Services not covered by Medicare | Not covered under any condition | Covered only under specific conditions |
|---|---|---|
| Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, vision therapy and other low vision aids. | | ✓ Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. |
| Reversal of sterilization procedures and or non-prescription contraceptive supplies. | ✓ | |
| Acupuncture | ✓ | |
| Naturopath services (uses natural or alternative treatments). | ✓ | |
| Services provided in Veterans Affairs (VA) facilities. | | ✓ Emergency room services are covered if medically necessary. (See Emergency Care earlier in this chapter) |
| Services received outside the service area that were previously authorized to be provided in-network (including but not limited to oxygen, routine blood tests, chemotherapy, and/or non-emergency surgery) | ✓ | |
| Complementary Alternative Medicine (CAM) and/or non-conventional medicine. Examples include, but are not limited to: homeopathy, yoga, polarity, massage therapy, healing touch therapies, and bioelectromagnetics. | | ✓ Unless it is medically necessary according to Medicare guidelines and authorized by your plan physician or plan medical director (or designee) or SCAN. |
| Court-ordered care or evaluation services. | ✓ | |
| Treatment for conditions resulting from acts of war (declared or not), or an act of war that occurs after the effective date of your current coverage for hospital insurance benefits or supplementary medical insurance benefits. | ✓ | |

| Services not covered by Medicare | Not covered under any condition | Covered only under specific conditions |
|---|---|---|
| Services provided in a local, state, or federal government facility. | | ✓ Except when payment under the plan is expressly required by federal or state law or is in accordance with Medicare guidelines. |
| 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.) | ✓ | |
| Services received outside of your network if you traveled to such location with the express purpose of obtaining medical services, supplies, and/or drugs, without prior authorization. | ✓ | |
| Non-Medicare covered organ transplants. | ✓ | |
| Medical and hospital services of a transplant donor when the recipient of an organ transplant is not a SCAN Health Plan member. | ✓ | |
| Immunizations not covered by Medicare. (See "Immunizations" under this chapter.) | ✓ | |
| Gender reassignment surgery and related hormone therapy. | | ✓ Unless it is medically necessary according to Medicare guidelines and authorized by your plan |

| Services not covered by Medicare | Not covered under any condition | Covered only under specific conditions |
|---|---|---|
| | | physician or plan medical director (or designee) or SCAN. |
| Dental splints, dental prosthesis, or any dental treatment for the teeth, gums, or jaw or dental treatment related to temporomandibular joint syndrome (TMJ). | ✓ | |
| Services for conditions covered by workers' compensation. | ✓ | |
| Any service or material provided by another vision or medical plan or non-contracting provider. | ✓ | |
| Cosmetic services and/or materials including but not limited to, blended (no-line) bifocal or trifocal lenses, photochromic lenses, tinted lenses, progressive or multifocal lenses, the coating or laminating of the lens or lenses, UV (ultraviolet) lenses, polycarbonate/high index lenses, anti-reflective coating, scratch resistant coating, edge polish and other cosmetic processes, nonstandard or elective contact lenses and plano lenses (nonprescription). | ✓ | |
| Disposable supplies such as bandages, IV (intravenous) tubing, and elastic stockings obtained through a non-contracted provider. | ✓ | |
| 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. |
| Foreseen services received out of | | ✓ Except dialysis within the United |

| Services not covered by Medicare | Not covered under any condition | Covered only under specific conditions |
|---|---|---|
| area. | | States |
| Medical marijuana. | ✓ | |
| Biofeedback | | ✓ Unless it is medically necessary according to Medicare guidelines and authorized by your plan physician or plan medical director (or designee) or SCAN. |
| Residential treatment services for substance abuse. | ✓ | |
| Routine care or elective medical services from non-plan providers without a SCAN Health Plan-approved referral or prior authorization. | ✓ | |
| Maintenance therapy | | ✓ Unless it is medically necessary according to Medicare guidelines and authorized by your plan physician or plan medical director (or designee) or SCAN. |
| Over-the-Counter purchases | ✓ | |
| Services rendered in excess of visit limits or benefits maximums. | ✓ | |
| Surgical treatment for morbid obesity | | ✓ Unless it is medically necessary according to Medicare guidelines and authorized by your plan physician or plan medical director (or designee) or SCAN. |

*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.

## Addenda

### Plan Limitations

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

- Covered Services are available only through plan providers in the network you select (unless such care is rendered as emergency services, urgently needed services, or out-of-area renal dialysis services when you are temporarily outside the service area, worldwide emergency services, or is prior authorized). Previously authorized services to be provided in-network (such as but not limited to oxygen, routine blood tests, chemotherapy, and/or non-emergency surgery) are not covered outside the service area.

- Covered services provided by non-plan providers are limited to unforeseen urgently-needed services or dialysis services when you are temporarily outside the service area, emergency services and authorized post-stabilization care anywhere in the world, and services for which you have obtained prior authorization. In unusual and extraordinary circumstances, urgently needed services are also covered within the service area when SCAN Health Plan providers are temporarily unavailable or inaccessible. In these circumstances, covered services should be provided by physicians and other practitioners affiliated with Medicare.

- If you seek routine care or elective medical services from non-plan providers without a SCAN 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.

- 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.

- 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.

- Members are fully responsible for all applicable copayments as listed in Chapter 4. Copayments are nonnegotiable.

- Supplemental benefit usage (e.g. routine dental, routine transportation, etc.) is applied to your new plan when you switch to another SCAN plan within the same calendar year.

**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 Member Services Department. (Please refer to the appeal and grievance procedures in Chapter 9 for information about your right to file an appeal.) A second opinion is not a treatment plan. Any treatment subsequent to a second opinion must be authorized by your Medical Group.

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

# CHAPTER 5

## *Using the plan's coverage for your Part D prescription drugs*

# Chapter 5. Using the plan's coverage for your Part D prescription drugs


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HEALTH PLAN®

### 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 drugs 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 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. Through its coverage of Medicare A benefits, our plan generally covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Through its coverage of Medicare Part B benefits, our plan covers drugs including 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 drugs during a covered hospital or skilled nursing facility stay, as well as your benefits and costs for Part B drugs.

Your drugs may be covered by Original Medicare if you are in Medicare hospice. Our plan only covers Medicare Parts A, B, and D services and drugs that are unrelated to your terminal prognosis and related conditions and therefore not covered under the Medicare hospice benefit. For more information, please see Section 9.4 *(What if you're in Medicare-certified hospice)*. For information on hospice coverage, see the hospice section of Chapter 4 *(Medical Benefits Chart, what is covered and what you pay)*.

The following sections discuss coverage of your drugs under the plan's Part D benefit rules. Section 9, *Part D drug coverage in special situations* includes more information on your Part D coverage and Original Medicare.

## 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 provider (a doctor, dentist or other prescriber) write your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.
- You generally 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 *Provider & Pharmacy Directory*, visit our website (www.scanhealthplan.com), or call Member Services (phone numbers are printed on the back cover of this booklet).

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 *Provider & Pharmacy Directory*. You can also find information on our website 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 (LTC) facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in and LTC facility, 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 *Provider & 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 provided 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.

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

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

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

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

If you have never used our mail order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

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

**Refills on mail order prescriptions.** For refills, please contact your pharmacy 21 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you by calling 1-866-553-4125, 24 hours a day, 7 days a week. TTY users call 711.

## 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 (also called an "extended supply") of "maintenance" drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.) You may order this supply through mail order (see Section 2.3) or you may go to a retail pharmacy.

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 *Provider & 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

Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. If you cannot 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.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

### 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) at the time 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; the USPDI or its successor; and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or their successors.)

### 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 Generic Drugs
- Cost-Sharing Tier 3 includes Preferred Brand Drugs (it may also include some generic drugs)
- Cost-Sharing Tier 4 includes Non-Preferred Brand Drugs
- Cost-Sharing Tier 5 includes Specialty Tier 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 website (www.scanhealthplan.com).The Drug List on the website 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.)

Please note that sometimes a drug may appear more than once in our drug list. This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

### 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 by limiting 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 website (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

We hope that your drug coverage will work well for you. But it's possible that there could be a prescription drug you are currently taking, or one that you and your provider think you should be taking that is not on our formulary or is on our formulary with restrictions. 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.
- 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.
- 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 are new or who were in the plan last year and aren't in a long-term care (LTC) facility:**

  We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you were new and during the first 90 days of the calendar year if you were in the plan last year**. This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy.

- **For those members who are new or who were in the plan last year and reside in a long-term care (LTC) facility:**

  We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you are new and during the first 90 days of the calendar year if you were in the plan last year.** The total supply will be for a maximum of at least a 91-day supply and may be up to a 98-day supply depending on the dispensing increment. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of at least a 91-day supply and may be up to a 98-day supply of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

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

  We will cover one 31-day supply of a particular drug, 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 moving from a long-term care (LTC) facility or a hospital stay to home:**

  We will cover a temporary supply of your drug for a maximum of a 30-day supply, or less if your prescription is written for fewer days.

- **For those members who are moving from home or a hospital stay to a long-term care (LTC) facility:**

  We 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 3: Preferred Brand Drugs (select drugs only) 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 our Tier 5 (Specialty Tier Drugs) are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this 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 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, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology, or their successors. 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 (LTC) facility?

Usually, a long-term care (LTC) 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 (LTC) 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 total supply will be for a maximum of at least a 91-day supply and may be up to a 98-day supply depending on the dispensing increment, or less if your prescription is written for fewer days. (Please note that the long-term care (LTC) pharmacy may provide the drug in smaller amounts at a time to prevent waste.) 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 9.4 What if you're in Medicare-certified hospice?

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that tell about the rules for getting drug coverage under Part D Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay.

## 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 Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs. For example, some members have several medical conditions, take different drugs at the same time, and have high drug costs.

This program is voluntary and free to members. A team of pharmacists and doctors developed the program for us. This program can help make sure that our members get the most benefit from the drugs they take. Our program is called a Medication Therapy Management (MTM) program. Some members who take medications for different medical conditions may be able to get services through a MTM program. 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, and any problems or questions you have about your prescription and over-the-counter medications. 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.

It's a good idea to have your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we 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).

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# CHAPTER 6

## *What you pay for your Part D prescription drugs*

# 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 drugs 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 website at www.scanhealthplan.com. The Drug List on the website 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.

| **Stage 1**<br>*Yearly Deductible Stage* | **Stage 2**<br>*Initial Coverage Stage* | **Stage 3**<br>*Coverage Gap Stage* | **Stage 4**<br>*Catastrophic Coverage Stage* |
|---|---|---|---|
| Because there is no deductible for the plan, this payment stage does not apply to you. | You begin in this stage when you fill your first prescription of the year.<br><br>During this stage, the plan pays its share of the cost of your drugs **and you pay your share of the cost.**<br><br>You stay in this stage until your year-to-date **"out-of-pocket costs"** (your payments) reach $4,850.<br><br>(Details are in Section 5 of this chapter.) | Because there is no coverage gap for the plan, this payment stage does not apply to you.<br><br>(Details are in Section 6 of this chapter.) | During this stage, **the plan will pay most of the cost** of your drugs for the rest of the calendar year (through December 31, 2016).<br><br>(Details are in Section 7 of this chapter.) |

## 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 "Part D Explanation of Benefits" (the "Part D 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 *Part D Explanation of Benefits* (it is sometimes called the "Part D 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 (ADAP), 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 *Part D Explanation of Benefits* (a "Part D 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 Generic Drugs
- Cost-Sharing Tier 3 includes Preferred Brand Drugs (it may also include some generic drugs)
- Cost-Sharing Tier 4 includes Non-Preferred Brand Drugs
- Cost-Sharing Tier 5 includes Specialty Tier 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 *Provider & 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.

- **"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 table 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.

**County of Riverside**

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

| Tier | Standard Mail Order & Retail cost-sharing (in-network) (up to a 30-day supply) | Long-term care (LTC) cost-sharing (up to a 31-day supply) | Out-of-network cost-sharing* (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply) |
|---|---|---|---|
| **Cost-Sharing Tier 1 (Preferred Generic Drugs)** | $10 copayment | $10 copayment | $20 copayment |
| **Cost-Sharing Tier 2 (Generic Drugs)** | $10 copayment | $10 copayment | $20 copayment |
| **Cost-Sharing Tier 3 (Preferred Brand Drugs)** | $20 copayment | $20 copayment | $30 copayment |
| **Cost-Sharing Tier 4 (Non-Preferred Brand Drugs)** | $20 copayment | $20 copayment | $30 copayment |
| **Cost-Sharing Tier 5 (Specialty Tier Drugs)** | 25% coinsurance | 25% coinsurance | 25% coinsurance |
| **Cost-Sharing Tier 6 (Select Care Drugs)** | $20 copayment | $20 copayment | $30 copayment |

*For out-of-network fills, you will be responsible for the in-network cost-sharing plus a differential between the out-of-network billed amount and the in-network allowable.

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

Typically, the amount you pay for a prescription drug covers 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 prescribes less than a full month's supply, 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.

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply. You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of a drug or drugs, if this will help you better plan refill date for different prescriptions so that you can take fewer trips to the pharmacy. The amount you pay will depend upon the days' supply you receive.

## 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 table below shows 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.*

**County of Riverside**

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

| Tier | Standard Mail-Order & Retail cost-sharing (in-network) (up to a 90-day supply) |
|---|---|
| **Cost-Sharing Tier 1 (Preferred Generic Drugs)** | $20 copayment |
| **Cost-Sharing Tier 2 (Generic Drugs)** | $20 copayment |
| **Cost-Sharing Tier 3 (Preferred Brand Drugs)** | $40 copayment |
| **Cost-Sharing Tier 4 (Non-Preferred Brand Drugs)** | $40 copayment |
| **Cost-Sharing Tier 5 (Specialty Tier Drugs)** | A long-term supply is not available for drugs in tier 5 |
| **Cost-Sharing Tier 6 (Select Care Drugs)** | $40 copayment |

## Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $4,850

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $4,850. Medicare has rules about what counts and what does not count as your out-of-pocket costs. (See Section 5.6 for information about how Medicare counts your out-of-pocket costs.) When you reach an out-of-pocket limit of $4,850, you leave the Initial Coverage Gap and move on to the Catastrophic Coverage Stage.

The *Part D Explanation of Benefits* (Part D EOB) that we send to you will help you keep track of how much you and the plan, as well as any third parties, have spent on your behalf during the year. Many people do not reach the $4,850 limit in a year.

We will let you know if you reach this $4,850 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

## Section 5.6 How Medicare calculates your out-of-pocket costs for prescription drugs

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 $4,850, you leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

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

### These payments <u>are included</u> in your out-of-pocket costs

When you add up your out-of-pocket costs, **<u>you can include</u>** 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.
- 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.
- Payments for your drugs that are made by group health plans including employer

**Moving on to the Catastrophic Coverage Stage:**

When you (or those paying on your behalf) have spent a total of **$4,850** in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

### These payments <u>are not included</u> in your out-of-pocket costs

When you add up your out-of-pocket costs, you **are <u>not</u> 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.
- Drugs covered by Medicaid only.
- 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 for your drugs that are made by certain insurance plans and governmentfunded 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).

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

- **We will help you.** The Part D Explanation of Benefits (Part D 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 $4,850 in out-of-pocket costs for the year, this report will tell you that you have left the Initial Coverage 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 6 There is no Coverage Gap for SCAN Employer Group

### Section 6.1 You do not have a Coverage Gap for your Part D drugs

There is no Coverage Gap for **SCAN Employer Group.** Once you leave the Initial Coverage Stage, you move on to the Catastrophic Coverage Stage. See Section 7 for information about your coverage in the Catastrophic Coverage Stage.

## 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 $4,850 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* – $2.95 for a generic drug or a drug that is treated like a generic and $7.40 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

**Compounded drugs and their coverage**:

For covered compounded drugs that contain all generic products, you will pay the cost-sharing amount that applies to drugs in Tier 2: Generic Drugs. If a compounded drug contains any brand name products, you will pay the cost-sharing amount that applies to drugs in Tier 4: Non-Preferred Brand Drugs.

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

can't swallow tablets or capsules, compounding procedures can customize a drug into a powder, liquid, lozenge, suppository, or another form.

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

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

Our Plan does not cover all compounded medications. In some cases, certain compounded 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 printed on the back cover of this booklet) or visit our website (www.scanhealthplan.com).

## SECTION 9 What you pay for vaccinations covered by Part D depends on how and where you get them

### Section 9.1 Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine

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 vaccine**. (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 vaccine?**

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 vaccine, you will have to pay the entire cost for both the vaccine medication and for getting the vaccine. 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 vaccine, 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 vaccine.

*Situation 1:* You buy the Part D vaccine at the pharmacy and you get your vaccine 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 and the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

*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 amount 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 vaccine.

- You will have to pay the pharmacy the amount of your copayment for the vaccine itself.

- When your doctor gives you the vaccine, 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.

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 doctor.

### 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, you will not pay a late enrollment penalty.

The late enrollment penalty is an amount that is added to you Part D premium. You may owe a late enrollment penalty if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other 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 lose your prescription drug benefits.

## 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 2015, this average premium amount was $33.13. This amount may change for 2016.
- 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 $33.13, which equals $4.64. This rounds to $4.60. 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 websites.
- For additional information about creditable coverage, please look in your *Medicare & You 2016* 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 2014 was: | If you were married but filed a separate tax return and your income in 2014 was: | If you filed a joint tax return and your income in 2014 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 | $0.00 |
| Greater than $85,000 and less than or equal to $107,000 | | Greater than $170,000 and less than or equal to $214,000 | $12.70 |
| Greater than $107,000 and less than or equal to $160,000 | | Greater than $214,000 and less than or equal to $320,000 | $32.80 |
| 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 | $52.80 |
| Greater than $214,000 | Greater than $129,000 | Greater than $428,000 | $72.90 |

## 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*

# 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 services 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.

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 website (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 medical claims, mail your request for payment together with any bills or receipts to us at this address:

**SCAN Health Plan**
Attention: Member Services
P.O. Box 22616
Long Beach, CA 90801-5616

For prescription drug claims, mail your request for payment together with any bills or receipts to us at this address:

**Express Scripts**
ATTN: Medicare Part D
P.O. Box 14718
Lexington, KY 40512-4718

**You must submit your claim to us within 36 months** 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 situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

**1. 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*

# Chapter 8. Your rights and responsibilities

## 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 languages other than English, in audio recording, 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 audio recording, 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. 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).

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 idiomas que no sean el inglés, por grabación en audio, en letra grande u otros formatos alternativos, etc.)**

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

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 Member Services Department we will send you a form to use to do this; (phone numbers are printed on the back cover if this booklet). Or if you prefer, you may send your written request.
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> **SCAN Health Plan**
> Attention: Member Services (Request to Inspect and Copy)
> 3800 Kilroy Airport Way, P.O. Box 22616
> Long Beach, CA 90801-5616

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.