

## SCAN Health Plan

### January 1, 2027

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| Annual Maximum Out of Pocket for Medical Copays                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | \$3,000 per member                                                                                |
| <ul style="list-style-type: none"> <li><b>Tier 1 &amp; 2 Generic Drugs</b> on the Prescription Drug List</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                    | \$10 copay per prescription<br>(\$5 when using preferred pharmacy)                                |
| <ul style="list-style-type: none"> <li><b>Tier 2 Preferred Brand</b> Medically Necessary Name Brand Drugs designated as preferred on the Prescription Drug List, with no Generic Equivalent</li> </ul>                                                                                                                                                                                                                                                                                                                                                                 | \$20 copay per prescription                                                                       |
| <ul style="list-style-type: none"> <li><b>Tier 3 Non-Preferred Brand</b> Non-Medically Necessary Name Brand Drugs on the Prescription Drug List with a Generic Equivalent and drugs designated non-preferred on the Prescription Drug List</li> </ul>                                                                                                                                                                                                                                                                                                                  | \$20 copay per prescription                                                                       |
| <ul style="list-style-type: none"> <li><b>Tier 4 Specialty Drugs</b></li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 25% coinsurance                                                                                   |
| Pharmacy Initial Coverage Stage until your total out-of-pocket cost reaches \$2,100. You then move to Catastrophic Coverage Stage. You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$2,100 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.<br>During this payment stage, the plan pays the full cost for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit. You pay nothing. | \$0                                                                                               |
| 100-days supply available at retail pharmacy or mail order through ESI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Two copays for 100-days supply                                                                    |
| Inpatient Hospital Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | \$100 copay per admission                                                                         |
| Outpatient Facility Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | \$0 copay                                                                                         |
| Hospital Emergency Room or Outpatient Facility                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | \$50 copay per visit, waived if admitted                                                          |
| Urgent Care Facility                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | \$15 copay per visit                                                                              |
| Rehabilitative Therapy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | \$15 copay per visit                                                                              |
| Primary Care and Specialist Physician Office Visits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | \$15 copay per visit                                                                              |
| Preventive Services:<br>Annual Physical Exam Well Woman Exam                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | \$0 copay per visit<br>\$0 copay per visit                                                        |
| Chiropractic Service: For the diagnosis and treatment of disorders neuromusculoskeletal system                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | \$15 copay per visit; up to 20-self-referred visits                                               |
| Vision Care: Eye Exam                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | \$15 copay per visit                                                                              |
| Vision Care: One Pair                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | \$100 allowance towards glasses; \$0 copay for lenses' \$130 contact allowance in lieu of glasses |
| Hearing Exam Hearing Aids                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | \$15 copay<br>\$2,000 maximum allowance for one or two aids every two calendar years              |
| Durable Medical Equipment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | \$0 copay                                                                                         |
| External Prosthetic Appliances                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | \$0 copay                                                                                         |
| Home Health Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | \$0 copay                                                                                         |
| Hospice Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | \$0 copay                                                                                         |
| Skilled Nursing and Rehabilitation Facilities                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | \$0 copay                                                                                         |
| Laboratory and Radiology Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | \$0 copay                                                                                         |
| Mental Health Inpatient Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | \$100 copay per admission                                                                         |
| Mental Health Outpatient Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | \$15 copay per visit                                                                              |
| Substance Abuse Detoxification Inpatient Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | \$100 copay per admission                                                                         |
| Substance Abuse Detoxification Outpatient Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | \$10 copay per visit                                                                              |
| Gym Membership – One Pass Fitness<br>Telehealth<br>Behavior Health Telehealth<br>Transportation unlimited rides; 75 miles maximum per ride<br>Nurse Advice Line<br>SCAN Technical Support                                                                                                                                                                                                                                                                                                                                                                              | \$0 copay<br>\$0 copay<br>\$0 copay<br>\$0 copay<br>\$0 copay<br>\$0 copay                        |

**Additional Services & Programs offered:**

Prospective members please contact SCAN Health Plan at 1-877-212-7654. SCAN is available to assist you in reviewing SCAN benefits, primary care selection, prescription drug formulary, and coordination of service for pre-arrangement procedures. For member related questions, please contact Member Services at 1-800-559-3500.

**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 during recovery from a hospital stay or provide support during an acute or long-term illness. For many retirees, these benefits provide the extra help necessary to remain out of a nursing home. Qualifying members are eligible for up to \$1,200 monthly allowance for these additional services. Retirees must qualify for Independent Living Power. Services are only available in Los Angeles, Orange, Riverside, San Bernardino, and San Diego Counties.

**Personal Care Coordinator**

\$0 copay

SCAN staff will provide personal assistance to coordinate your Independent Living Power services or other services within SCAN and refer members to community resources.

**Home Delivered Meals**

\$0 copay

SCAN members are covered for home delivery of meals to meet nutritional needs.

**Personal Care**

\$15 copay/visit

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.

**Emergency Response System**

\$0 copay

SCAN 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.

**Routine Transportation**

\$0 copay

Unlimited rides per year to or from pre-scheduled medical appointments to contracted providers. 75 miles maximum per ride.

**Transportation Escort**

\$15 copay

As a SCAN member you are eligible to receive an escort to assist you during transportation to and from medical appointments.

**Homemaker Service**

\$15 copay/visit

SCAN members are eligible to receive assistance with light cleaning, grocery shopping, laundry, and meal preparation.

**Inpatient Custodial Level Care**

\$0 copay

You are covered for up to five 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.

**In-Home Caregiver Relief**

\$15 copay/visit

SCAN provides alternative caregiver services in your home when a regular caregiver can't be there.

**Adult Day Care**

\$15 copay

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.

**Incontinence supplies/Hygiene supplies**

\$0 copay

SCAN covers incontinence supply if members are living in Assisted Living Facility or Board and Care or at Home when they are wheelchair bound or bedbound.

**Select Bathroom Safety Equipment**

\$0 copay