2018

Summary of Benefits

VillageHealth (HMO-POS SNP)
Riverside and San Bernardino Counties

January 1, 2018 - December 31, 2018

VillageHealth (HMO-POS SNP) is an HMO plan; and is a Point of Service (POS) plan with a Medicare contract. Enrollment in SCAN Health Plan depends on contract renewal.

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

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VillageHealth
A product of SCAN Health Plan®

SUMMARY OF BENEFITS JANUARY 1, 2018 – DECEMBER 31, 2018

PREMIUM AND BENEFITS	VILLAGEHEALTH		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Monthly Health Plan Premium	You pay $35.50 per month	You pay $35.50 per month	You must continue to pay your Medicare Part B premium.
Deductible	In 2017, the deductible was $183. This amount may change in 2018. In 2018, you pay $370 per year for Part D prescription drugs for Tiers 2-5.	In 2017, the deductible was $183. This amount may change in 2018. In 2018, you pay $370 per year for Part D prescription drugs for Tiers 2-5.	This plan has deductibles for some hospital and medical services, and Part D prescription drugs.
Maximum Out-of-Pocket Responsibility (this does not include prescription drugs)	$6,700 annually	$6,700 annually	The most you pay for copays and coinsurance for Medicare-covered in-network and out-of-network medical services for the year.
Inpatient Hospital Coverage	In 2017, the amounts for each benefit period* were: • $1,316 deductible per benefit period • $0 per day for days 1-60 • $329 copay per day for days 61-90 • $658 copay per day for each "lifetime reserve day" 1-60 These amounts may change for 2018	In 2017, the amounts for each benefit period* were: • $1,316 deductible per benefit period • $0 per day for days 1-60 • $329 copay per day for days 61-90 • $658 copay per day for each "lifetime reserve day" 1-60 These amounts may change for 2018	You are covered for up to 90 days per benefit period.*

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

PREMIUM AND BENEFITS	VILLAGEHEALTH		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Outpatient Hospital Coverage			
• Ambulatory Surgical Center	You pay $0	You pay 20% of the total cost	
• Outpatient Hospital	You pay 20% of the total cost	You pay 20% of the total cost	
Doctor Visits			
• Primary Care	You pay $0	You pay $0	
• Specialists	You pay 20% of the total cost	You pay 20% of the total cost	
Preventive Care	You pay $0	You pay $0	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	You pay 20% of the total cost for up to $80 per visit	You pay 20% of the total cost for up to $80 per visit	The emergency room copay will be waived if you are immediately admitted to the hospital. Not covered outside of the U.S. except under limited circumstances as defined by Medicare.
Urgently Needed Services	You pay $0	You pay $0	Not covered outside of the U.S. except under limited circumstances as defined by Medicare.

PREMIUM AND BENEFITS	VILLAGEHEALTH		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Diagnostic Services/ Labs/ Imaging			
• Lab services	You pay $0	You pay $0	
• Diagnostic tests and procedures	You pay 20% of the total cost	You pay 20% of the total cost	
• Outpatient X-rays	You pay 20% of the total cost	You pay 20% of the total cost	
• Therapeutic radiology	You pay 20% of the total cost	You pay 20% of the total cost	
• Diagnostic radiology (e.g., MRI, CT)	You pay 20% of the total cost	You pay 20% of the total cost	
Hearing Services			
• Medicare-covered diagnostic hearing and balance exam	You pay 20% of the total cost	You pay 20% of the total cost	
• Non-Medicare-covered (routine) hearing exam	You pay $0 for up to 1 visit per year	Not covered out-of-network	You must go to a VillageHealth-contracted provider to obtain a routine hearing exam and hearing aids.
• Non-Medicare-covered (routine) hearing aids	You pay $699 copay per aid for Flyte 770 or $999 copay per aid for Flyte 990 You are covered for up to 2 hearing aids every year	Not covered out-of-network	

PREMIUM AND BENEFITS	VILLAGEHEALTH		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Dental Services			
• Medicare-covered dental services	You pay 20% of the total cost	You pay 20% of the total cost	
• Non-Medicare-covered (routine) cleaning	You pay $0 for up to 2 visits per year	Not covered out-of-network	Routine dental services do not require a prior authorization.
• Non-Medicare-covered (routine) dental fillings	You pay $0	Not covered out-of-network	You must go to a VillageHealth-contracted dentist to obtain routine dental services.
• Non-Medicare-covered (routine) dentures	You pay $0-$350 copay for dentures	Not covered out-of-network	
Vision Services			
• Medicare-covered vision exam to diagnose/treat diseases of the eye	You pay 20% of the total cost	You pay 20% of the total cost	
• Medicare-covered glasses after cataract surgery	You pay 20% of the total cost	You pay 20% of the total cost	
• Non-Medicare-covered (routine) vision exam	You pay $0 for up to 1 visit per year	Not covered out-of-network	Routine vision services do not require a prior authorization.
• Non-Medicare-covered (routine) glasses or contact lenses	You pay $25 copay per pair every 2 years	Not covered out-of-network	You must go to a VillageHealth-contracted vision provider to obtain routine vision services.
• Non-Medicare-covered (routine) vision coverage limit	You are covered for up to $200 for frames or contact lenses every 2 years	Not covered out-of-network	

PREMIUM AND BENEFITS	VILLAGEHEALTH		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Mental Health Services • Inpatient visit	In 2017, the amounts for each benefit period* were: • $1,316 deductible per benefit period • $0 per day for days 1-60 • $329 copay per day for days 61-90 • $658 copay per day for each "lifetime reserve day" 1-60 These amounts may change for 2018	In 2017, the amounts for each benefit period* were: • $1,316 deductible per benefit period • $0 per day for days 1-60 • $329 copay per day for days 61-90 • $658 copay per day for each "lifetime reserve day" 1-60 These amounts may change for 2018	You are covered for up to 90 days per benefit period.*
• Outpatient individual/group therapy visit	You pay $0	You pay $0	
• Outpatient individual/group therapy visit with a psychiatrist	You pay $0	You pay $0	
Skilled Nursing Facility	In 2017, the amounts for each benefit period* were: • $0 per day for days 1-20 • $164.50 copay per day for days 21-100 These amounts may change for 2018	Not covered out-of-network	You are covered for up to 100 days per benefit period.* No prior hospitalization is required. **Prior Authorization** is required for skilled nursing facility services.

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

PREMIUM AND BENEFITS	VILLAGEHEALTH		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Physical Therapy	You pay $0	You pay $0	
Ambulance	You pay 20% of the total cost per one-way trip	You pay 20% of the total cost per one-way trip	
Transportation (Non-Medicare-covered - routine)	You pay $0 for up to 50 one-way trips per year 75-mile limit applies to each one-way trip	Not covered out-of-network	**Prior Authorization** is required for routine transportation services. Transportation services are covered only within the VillageHealth service area for qualifying medical services such as doctor and dental appointments, pharmacy visits, etc.
Medicare Part B Drugs	You pay $0 for chemotherapy and other Part B drugs received at a pharmacy You pay 20% of the total cost for chemotherapy and other Part B drugs received at any other setting	You pay $0 for chemotherapy and other Part B drugs received at a pharmacy You pay 20% of the total cost for chemotherapy and other Part B drugs received at any other setting	**Prior authorization rules apply** to select drugs.

VILLAGEHEALTH

	Preferred Retail Pharmacy 30-day supply cost-sharing	Standard Retail Pharmacy 30-day supply cost-sharing	Preferred Retail Pharmacy 90-day supply cost-sharing	Standard Retail Pharmacy 90-day supply cost-sharing	Mail-Order Pharmacy 90-day supply cost-sharing
Initial Coverage Stage					
Tier 1 (Preferred Generic)	You pay $0	You pay $3	You pay $0	You pay $9	You pay $0
Tier 2 (Generic)	You pay $6	You pay $11	You pay $18	You pay $33	You pay $18
Tier 3 (Preferred Brand)	You pay 25%	You pay 25%	You pay 25%	You pay 25%	You pay 25%
Tier 4 (Non-Preferred Drug)	You pay 25%	You pay 25%	You pay 25%	You pay 25%	You pay 25%
Tier 5 (Specialty Tier)	You pay 25%	You pay 25%	Not available	Not available	Not available

Coverage Gap Stage	Begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750. You pay 35% of the negotiated price (and a portion of the dispensing fee) for your brand name drugs and 44% of the cost for your generic drugs.
Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs reach $5,000, you pay the greater of: – 5% of the cost, or – $3.35 copay for generic (including brand drugs treated as generic) and a $8.35 copay for all other drugs

Some of our network pharmacies have preferred cost-sharing. You may pay less for certain drugs if you use these pharmacies rather than pharmacies that offer standard cost-sharing.

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

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

Cost-Sharing may change depending on the pharmacy you choose (e.g., Preferred Retail, Standard Retail, Mail-Order, Long Term Care (LTC) or Home infusion, etc.), whether you receive a 30, 60 or 90-day supply, and when you enter another phase of the Part D benefit. For more information, please call our Member Services Department at the number provided in this document or access your Evidence of Coverage online.

ADDITIONAL BENEFITS

PREMIUM AND BENEFITS	VILLAGEHEALTH		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Medical Equipment/ Supplies • Durable Medical Equipment (e.g., wheelchairs, oxygen)	You pay 0%-20% of the total cost	You pay 0%-20% of the total cost	**Prior authorization** is required for covered durable medical equipment, prosthetic devices, and certain diabetic supplies. VillageHealth covers diabetic supplies such as glucose monitors, test strips, and control solution from a select manufacturer. Lancets are also covered and are available from all manufacturers.
• Prosthetics (e.g., braces, artificial limbs)	You pay 0%-20% of the total cost	You pay 0%-20% of the total cost	
• Diabetic supplies	You pay $0	You pay $0	
Wellness Programs • Health club membership	You pay $0	Not covered out-of-network	You are covered for VillageHealth-contracted health clubs in your area.

ABOUT VILLAGEHEALTH	
Who can join?	**You must:** - have both Medicare Part A and Part B - live in the plan service area (Riverside and San Bernardino counties, California) - be diagnosed with End-stage renal disease or be a post-transplant patient
Phone Number (Members)	**1-800-399-7226**
Phone Number (Non-Members)	**1-877-916-1234** (Calling this number will direct you to a licensed insurance agent)
TTY	**711**
Hours of Operation	**October 1 to February 14:** 8:00 am to 8:00 pm, 7 days a week **February 15 to September 30:** 8:00 am to 8:00 pm, Monday through Friday (messages received on holidays and outside of our business hours will be returned within one business day)
Website	http://www.villagehealthca.com
Provider & Pharmacy Directory link	http://www.villagehealthca.com
Formulary link	http://www.villagehealthca.com
Link to Evidence of Coverage	http://www.villagehealthca.com

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

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. Other providers are available in our network. You must continue to pay your Medicare Part B premium. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. Premium, copays, coinsurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.

You can get prescription drugs shipped to your home through our network mail-order delivery program. Typically, you should expect to receive your prescription drugs within 14 days from the time that the mail-order pharmacy receives the order. If you do not receive your prescription drug(s) within this time, please contact VillageHealth Member Services at 1-800-399-7226, 8 A.M. to 8 P.M., 7 days a week from October 1 to February 14. From February 15 to September 30, hours are 8 A.M. to 8 P.M. Monday through Friday (messages received on holidays and outside of our business hours will be returned within one business day). TTY users call 711.

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SCAN Health Plan complies with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of, or because of, race, color, national origin, age, disability, or sex.

SCAN Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).

SCAN Health Plan provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact SCAN Member Services.

If you believe that SCAN Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by phone, mail, or fax, at:

SCAN Member Services
Attention: Grievance and Appeals Department
P.O. Box 22616, Long Beach, CA 90801-5616
1-800-559-3500 (TTY: 711)
FAX: 1-562-989-5181

Or by filling out the “File a Grievance” form on our website at:
https://www.scanhealthplan.com/contact-us/file-a-grievance

If you need help filing a grievance, SCAN Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 (TTY: 1-800-537-7697)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

Multi-language Interpreter Services

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-559-3500. (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-559-3500. (TTY: 711).

Chinese Traditional: 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-800-559-3500。(TTY: 711)。

Chinese Simplified: 注意：如果您使用中文，您可以免费获得语言援助服务，请致电 1-800-559-3500。(TTY: 711)。

Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin vui lòng gọi số 1-800-559-3500. (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-559-3500. (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-559-3500 번으로 연락해 주십시오. (TTY: 711).

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա Ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարե՛ք 1-800-559-3500 հեռախոսահամարով: Հեռատիպի համարն է՝ 711:

Persian: **توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با شماره 1-800-559-3500 تماس بگیرید. (TTY: 711).

Russian: ВНИМАНИЕ! Если вы говорите по-русски, вы можете бесплатно получить услуги перевод;а. Звоните по телефону 1-800-559-3500 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。お問合せ先 1-800-559-3500. (TTY: 711).

Arabic: ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-559-3500. (الهاتف النصي: 711).

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-559-3500 ਉੱਤੇ ਕਾਲ ਕਰੋ। (TTY: 711)।

Mon-Khmer, Cambodian: សូមយកចិត្តទុកដាក់៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ អាចមានសំរាប់បំរើអ្នក។ សូមទូរស័ព្ទទៅលេខ 1-800-559-3500 ។ (TTY: 711) ។

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob (Ntawv Suav - Hmoob), muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-559-3500. (TTY: 711).

Hindi: **ध्यान दें**: **यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।** **कॉल करें** 1-800-559-3500, (TTY: 711)।

Thai: โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-559-3500 (TTY: 711)