VillageHealth
A product of SCAN Health Plan®

VillageHealth (HMO-POS SNP) offered by SCAN Health Plan

Annual Notice of Changes for 2020

You are currently enrolled as a member of VillageHealth. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. **ASK:** Which changes apply to you

❏ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.1 and 1.5 for information about benefit and cost changes for our plan.

❏ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost-sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2020 Drug List and look in Section 1.6 for information about changes to our drug coverage.

- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit https://go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

❏ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our *Provider & Pharmacy Directory*.

❏ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

❏ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

❏ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click “Find health & drug plans.”
- Review the list in the back of your Medicare & You handbook.
- Look in Section 2.2 to learn more about your choices.

❏ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan’s website.

3. CHOOSE: Decide whether you want to change your plan

- If you want to **keep** VillageHealth, you don’t need to do anything. You will stay in VillageHealth.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2019**

- If you don't join another plan by **December 7, 2019**, you will stay in VillageHealth.
- If you join another plan by **December 7, 2019**, your new coverage will start on **January 1, 2020**.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-800-399-7226 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., 7 days a week from October 1 to March 31. From April 1 to September 30 hours are 8 a.m. to 8 p.m., Monday through Friday. We are closed on most federal holidays. When we are closed you have an option to leave a message. Messages received on holidays and outside of our business hours will be returned within one business day.
- We can also give you information for free in large print, Braille, audio recording, or other alternate formats if you need it.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About VillageHealth

- VillageHealth (HMO-POS SNP) is an HMO plan with a Medicare contract. Enrollment in SCAN Health Plan depends on contract renewal. Point of Service (POS) is a Medicare Managed Care Plan option that allows you the option of receiving specified services outside of the plan's provider network. In some instances, there may be additional cost for services.
- When this booklet says "we," "us," or "our," it means SCAN Health Plan. When it says "plan" or "our plan," it means VillageHealth.

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Summary of Important Costs for 2020

The table below compares the 2019 costs and 2020 costs for VillageHealth in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at www.villagehealthca.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Cost	2019 (this year)	2020 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$34.80	$32
Deductible	$185	$185 This is a 2019 deductible amount and may change for 2020.
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	**In and Out-of-Network** $6,700	**In and Out-of-Network** $6,700
Doctor office visits	**In-Network** **Primary care visits:** $0 per visit **Specialist visits:** $0 for nephrology visits. 20% of the total cost for all other specialist services per visit. **Out-of-Network** **Primary care visits:** 20% of the total cost per visit.	**In-Network** **Primary care visits:** $0 per visit **Specialist visits:** $0 for nephrology visits. 20% of the total cost for all other specialist services per visit. **Out-of-Network** **Primary care visits:** 20% of the total cost per visit.

Cost	2019 (this year)	2020 (next year)
Doctor office visits (continued)	**Specialist visits:** $0 for nephrology visits. 20% of the total cost for all other specialist services per visit.	**Specialist visits:** $0 for nephrology visits. 20% of the total cost for all other specialist services per visit.
Inpatient hospital stays 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.	You pay a $1,364 deductible for days 1-60, a $341 copayment per day for days 61-90, and a $682 copayment per day for lifetime reserve days (up to 60 days per lifetime) per benefit period.	You pay a $1,364 deductible for days 1-60, a $341 copayment per day for days 61-90, and a $682 copayment per day for lifetime reserve days (up to 60 days per lifetime) per benefit period. These are 2019 cost-sharing amounts and may change for 2020.
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $415 Copayment/Coinsurance during the Initial Coverage Stage: • **Drug Tier 1:** $3 per prescription (*Standard cost-sharing* 30-day supply) $0 per prescription (*Preferred cost-sharing* 30-day supply)	Deductible: $435 Copayment/Coinsurance during the Initial Coverage Stage: • **Drug Tier 1:** $3 per prescription (*Standard cost-sharing* 30-day supply) $0 per prescription (*Preferred cost-sharing* 30-day supply)

Cost	2019 (this year)	2020 (next year)
	• **Drug Tier 2:** 25% of the total cost (*Standard cost-sharing* 30-day supply) 25% of the total cost (*Preferred cost-sharing* 30-day supply) • **Drug Tier 3:** 25% of the total cost (*Standard cost-sharing* 30-day supply) 25% of the total cost (*Preferred cost-sharing* 30-day supply) • **Drug Tier 4:** 25% of the total cost (*Standard cost-sharing* 30-day supply) 25% of the total cost (*Preferred cost-sharing* 30-day supply) • **Drug Tier 5:** 25% of the total cost (*Standard cost-sharing* 30-day supply) 25% of the total cost (*Preferred cost-sharing* 30-day supply)	• **Drug Tier 2:** 25% of the total cost (*Standard cost-sharing* 30-day supply) 25% of the total cost (*Preferred cost-sharing* 30-day supply) • **Drug Tier 3:** 25% of the total cost (*Standard cost-sharing* 30-day supply) 25% of the total cost (*Preferred cost-sharing* 30-day supply) • **Drug Tier 4:** 25% of the total cost (*Standard cost-sharing* 30-day supply) 25% of the total cost (*Preferred cost-sharing* 30-day supply) • **Drug Tier 5:** 25% of the total cost (*Standard cost-sharing* 30-day supply) 25% of the total cost (*Preferred cost-sharing* 30-day supply)

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2019 (this year)	2020 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$34.80	$32

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2019 (this year)	2020 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	**In and Out-of-Network** $6,700	**In and Out-of-Network** $6,700 Once you have paid $6,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider & Pharmacy Directory* is located on our website at www.villagehealthca.com. You may also call Member Services for updated provider information or to ask us to mail you a *Provider & Pharmacy Directory*. **Please review the 2020 *Provider & Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated *Provider & Pharmacy Directory* is located on our website at www.villagehealthca.com. You may also call Member Services for updated provider information or to ask us to mail you a *Provider & Pharmacy Directory*. **Please review the 2020 *Provider & Pharmacy Directory* to see which pharmacies are in our network.**

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2020 Evidence of Coverage.*

Cost	2019 (this year)	2020 (next year)
Inpatient hospital care	**In and Out-of-Network** You pay a $1,364 deductible for days 1-60, a $341 copayment per day for days 61-90, and a $682 copayment per day for lifetime reserve days (up to 60 days per lifetime) per benefit period.	**In and Out-of-Network** You pay a $1,364 deductible for days 1-60, a $341 copayment per day for days 61-90, and a $682 copayment per day for lifetime reserve days (up to 60 days per lifetime) per benefit period. These are 2019 cost sharing amounts and may change for 2020.
Inpatient mental health care	**In and Out-of-Network** You pay a $1,364 deductible for days 1-60, a $341 copayment per day for days 61-90, and a $682 copayment per day for lifetime reserve days (up to 60 days per lifetime) per benefit period.	**In and Out-of-Network** You pay a $1,364 deductible for days 1-60, a $341 copayment per day for days 61-90, and a $682 copayment per day for lifetime reserve days (up to 60 days per lifetime) per benefit period. These are 2019 cost sharing amounts and may change for 2020.
Opioid treatment services	**In and Out-of-Network** Opioid treatment services are not covered.	**In and Out-of-Network** You pay 20% of the total cost for Medicare-covered opioid treatment services.

Cost	2019 (this year)	2020 (next year)
Over-the-counter (OTC) products	**In and Out-of-Network** Over-the-counter products are not covered.	**In Network** You are covered for up to $50 of over-the-counter products available through the VillageHealth OTC mail-order catalog every quarter. **Out-of-Network** Over-the-counter products are not covered out-of-network.
Personal emergency response system	**In and Out-of-Network** A personal emergency response system is not covered.	**In Network** You pay $0 per month for a personal emergency response system. **Out-of-Network** Personal emergency response system is not covered out-of-network.
Skilled nursing facility (SNF)	**In Network** You pay $0 per day for days 1-20 and You pay a $170.50 copayment per day for days 21-100.	**In Network** You pay $0 per day for days 1-20 and You pay a $170.50 copayment per day for days 21-100. These are 2019 cost-sharing amounts and may change for 2020.
Transportation (Routine)	**In Network** You pay $0 for up to 80 one-way trips per year. **Out-of-Network** Routine transportation is not covered out-of-network.	**In Network** You pay $0 for up to 30 one-way trips per year. **Out-of-Network** Routine transportation is not covered out-of-network.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or “Drug List.” A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions**.

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Member Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage*.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor 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.

In most cases, if the Plan has approved a formulary exception to cover your current drug, this drug will continue to be covered next year.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the *Evidence of Coverage*.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you**. We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and haven't received this insert by September 30, 2019, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are in Section 6.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*, which is located on our website at www.villagehealthca.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2019 (this year)	2020 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, and Tier 5: Specialty Tier drugs until you have reached the yearly deductible.	The deductible is $415. During this stage, you pay $0 cost-sharing for drugs on Tier 1: Preferred Generic at preferred pharmacies, $3 cost-sharing for drugs on Tier 1: Preferred Generic at standard pharmacies, and the full cost of drugs on Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, and Tier 5: Specialty Tier until you have reached the yearly deductible.	The deductible is $435. During this stage, you pay $0 cost-sharing for drugs on Tier 1: Preferred Generic at preferred pharmacies, $3 cost-sharing for drugs on Tier 1: Preferred Generic at standard pharmacies, and the full cost of drugs on Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, and Tier 5: Specialty Tier until you have reached the yearly deductible.

Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2019 (this year)	2020 (next year)
Stage 2: Initial Coverage Stage **Once you pay the yearly deductible, you move to the Initial Coverage Stage.** During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply at a network pharmacy: **Tier 1: Preferred Generic:** *Standard cost-sharing:* You pay $3 per prescription. *Preferred cost-sharing:* You pay $0 per prescription. **Tier 2: Generic:** *Standard cost-sharing:* You pay 25% of the total cost. *Preferred cost-sharing:* You pay 25% of the total cost. **Tier 3: Preferred Brand:** *Standard cost-sharing:* You pay 25% of the total cost. *Preferred cost-sharing:* You pay 25% of the total cost.	Your cost for a one-month supply at a network pharmacy: **Tier 1: Preferred Generic:** *Standard cost-sharing:* You pay $3 per prescription. *Preferred cost-sharing:* You pay $0 per prescription. **Tier 2: Generic:** *Standard cost-sharing:* You pay 25% of the total cost. *Preferred cost-sharing:* You pay 25% of the total cost. **Tier 3: Preferred Brand:** *Standard cost-sharing:* You pay 25% of the total cost. *Preferred cost-sharing:* You pay 25% of the total cost.

Stage	2019 (this year)	2020 (next year)
	Tier 4: Non-Preferred Drug: *Standard cost-sharing:* You pay 25% of the total cost. *Preferred cost-sharing:* You pay 25% of the total cost. **Tier 5: Specialty Tier:** *Standard cost-sharing:* You pay 25% of the total cost. *Preferred cost-sharing:* You pay 25% of the total cost. _____ Once your total drug costs have reached $3,820, you will move to the next stage (the Coverage Gap Stage).	**Tier 4: Non-Preferred Drug:** *Standard cost-sharing:* You pay 25% of the total cost. *Preferred cost-sharing:* You pay 25% of the total cost. **Tier 5: Specialty Tier:** *Standard cost-sharing:* You pay 25% of the total cost. *Preferred cost-sharing:* You pay 25% of the total cost. _____ Once your total drug costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage.*

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in VillageHealth

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2020.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2020 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- *OR* -- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2020*, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from VillageHealth.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from VillageHealth.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 6.1 of this booklet).
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 3 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2020.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get “Extra Help” paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2020, and don’t like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2020. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 4 Programs That Offer Free Counseling about Medicare

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

Health Insurance Counseling and Advocacy Program (HICAP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. The Health Insurance Counseling and Advocacy Program (HICAP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222. You can learn more about the Health Insurance Counseling and Advocacy Program (HICAP) by visiting their website (https://www.cahealthadvocates.org/hicap/).

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- "**Extra Help**" **from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** California has a program called the Genetically Handicapped Persons Program (GHPP) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 4 of this booklet).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Office of AIDS, Centers for Infectious Disease – California Department of Public Health, MS7700, P.O. Box 997426, Sacramento, CA 95899-7426. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-844-421-7050.

SECTION 6 Questions?

Section 6.1 – Getting Help from VillageHealth

Questions? We're here to help. Please call Member Services at 1-800-399-7226. (TTY only, call 711.) We are available for phone calls 8 a.m. to 8 p.m., 7 days a week from October 1 to March 31. From April 1 to September 30 hours are 8 a.m. to 8 p.m., Monday through Friday. We are closed on most federal holidays. When we are closed you have an option to leave a message. Messages received on holidays and outside of our business hours will be returned within one business day. Calls to these numbers are free.

Read your 2020 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2020. For details, look in the 2020 *Evidence of Coverage* for VillageHealth. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.villagehealthca.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.villagehealthca.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider & Pharmacy Directory*) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (https://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to https://www.medicare.gov and click on "Find health & drug plans.")

Read *Medicare & You 2020*

You can read the *Medicare & You 2020* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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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.

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 می‌کنید تسهیلات زبانی بصورت رایگان برای شما فراهم می‌باشد. با 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 اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا. اتصل بالرقم 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)

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-559-3500 (TTY: 711).