

2020

Summary of Benefits

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

January 1, 2020 - December 31, 2020

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 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 Services Department at the phone number listed in this document or online at www.villagehealthca.com.

Y0057_SCAN_11554_2019F_M

R1125 08/19 20C-SMBVH1



SUMMARY OF BENEFITS JANUARY 1, 2020 – DECEMBER 31, 2020

PREMIUM AND BENEFITS	VILLAGEHEALTH		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Monthly Health Plan Premium	You pay \$32 per month	You pay \$32 per month	You must continue to pay your Medicare Part B premium.
Deductible	<p>You pay \$185 deductible per year for in-network services in 2019. This amount may change for 2020.</p> <p>You pay \$370 per year for Part D prescription drugs for Tiers 2-5.</p>	<p>You pay \$185 deductible per year for in-network services in 2019. This amount may change for 2020.</p> <p>You pay \$370 per year for Part D prescription drugs for Tiers 2-5.</p>	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	<p>In 2019, the amounts for each benefit period* were:</p> <ul style="list-style-type: none"> • \$1,364 deductible per benefit period • \$0 per day for days 1-60 • \$341 copay per day for days 61-90 • \$682 copay per day for each “lifetime reserve day” 1-60 <p>These amounts may change for 2020.</p>	<p>In 2019, the amounts for each benefit period* were:</p> <ul style="list-style-type: none"> • \$1,364 deductible per benefit period • \$0 per day for days 1-60 • \$341 copay per day for days 61-90 • \$682 copay per day for each “lifetime reserve day” 1-60 <p>These amounts may change for 2020.</p>	<p>You are covered for up to 90 days per benefit period.*</p> <p>You are also covered up to 60 additional days for days 91 and beyond per lifetime.</p>

* 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 Services <ul style="list-style-type: none"> • Ambulatory Surgical Center • Outpatient Hospital 	<p>You pay \$0</p> <p>You pay 20% of the total cost</p>	<p>You pay 20% of the total cost</p> <p>You pay 20% of the total cost</p>	
Doctor Visits <ul style="list-style-type: none"> • Primary Care • Specialists 	<p>You pay \$0</p> <p>You pay 20% of the total cost</p>	<p>You pay \$0</p> <p>You pay 20% of the total cost</p>	
Preventive Care	<p>You pay \$0</p>	<p>You pay \$0</p>	<p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>
Emergency Care	<p>You pay 20% of the total cost for up to \$90 per visit</p>	<p>You pay 20% of the total cost for up to \$90 per visit</p>	<p>The emergency room copay will be waived if you are immediately admitted to the hospital.</p> <p>Not covered outside of the U.S. except under limited circumstances as defined by Medicare.</p>
Urgently Needed Services	<p>You pay \$0</p>	<p>You pay \$0</p>	<p>Not covered outside of the U.S. except under limited circumstances as defined by Medicare.</p>

PREMIUM AND BENEFITS	VILLAGEHEALTH		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
<p>Diagnostic Services/ Labs/Imaging</p> <ul style="list-style-type: none"> • Lab services • Diagnostic tests and procedures • Outpatient X-rays • Therapeutic radiology • Diagnostic radiology (e.g., MRI, CT) 	<p>You pay \$0</p> <p>You pay 20% of the total cost</p> <p>You pay 20% of the total cost</p> <p>You pay 20% of the total cost</p> <p>You pay 20% of the total cost</p>	<p>You pay \$0</p> <p>You pay 20% of the total cost</p> <p>You pay 20% of the total cost</p> <p>You pay 20% of the total cost</p> <p>You pay 20% of the total cost</p>	
<p>Hearing Services</p> <ul style="list-style-type: none"> • Medicare-covered diagnostic hearing and balance exam • Non-Medicare-covered (routine) hearing exam • Non-Medicare-covered (routine) hearing aids 	<p>You pay 20% of the total cost</p> <p>Not covered</p> <p>Not covered</p>	<p>You pay 20% of the total cost</p> <p>Not covered</p> <p>Not covered</p>	

PREMIUM AND BENEFITS	VILLAGEHEALTH		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
<p>Dental Services</p> <ul style="list-style-type: none"> • Medicare-covered dental services • Non-Medicare-covered (routine) oral exam • Non-Medicare-covered (routine) dental cleaning • Non-Medicare-covered (routine) dental X-rays 	<p>You pay 20% of the total cost</p> <p>You pay \$0</p> <p>You pay \$0 for up to 2 visits every 12 months</p> <p>You pay \$0 for up to 1 series every 6 months</p>	<p>You pay 20% of the total cost</p> <p>Not covered out-of-network</p> <p>Not covered out-of-network</p> <p>Not covered out-of-network</p>	<p>Routine dental services do not require a prior authorization.</p> <p>You must go to a VillageHealth-contracted dentist to obtain routine dental services.</p>
<p>Vision Services</p> <ul style="list-style-type: none"> • Medicare-covered vision exam to diagnose/treat diseases of the eye • Medicare-covered glasses after cataract surgery • Non-Medicare-covered (routine) vision exam • Non-Medicare-covered (routine) glasses or contact lenses • Non-Medicare-covered (routine) vision coverage limit 	<p>You pay 20% of the total cost</p> <p>You pay 20% of the total cost</p> <p>You pay \$0 for up to 1 visit every 12 months</p> <p>You pay \$25 copay per pair every 24 months</p> <p>You are covered for up to \$200 for frames or contact lenses every 24 months</p>	<p>You pay 20% of the total cost</p> <p>You pay 20% of the total cost</p> <p>Not covered out-of-network</p> <p>Not covered out-of-network</p> <p>Not covered out-of-network</p>	<p>Routine vision services do not require a prior authorization.</p> <p>You must go to a VillageHealth-contracted vision provider to obtain routine vision services.</p>

PREMIUM AND BENEFITS	VILLAGEHEALTH		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Mental Health Services <ul style="list-style-type: none"> Inpatient visit 	<p>In 2019, the amounts for each benefit period* were:</p> <ul style="list-style-type: none"> \$1,364 deductible per benefit period \$0 per day for days 1-60 \$341 copay per day for days 61-90 \$682 copay per day for each "lifetime reserve day" 1-60 <p>These amounts may change for 2020.</p>	<p>In 2019, the amounts for each benefit period* were:</p> <ul style="list-style-type: none"> \$1,364 deductible per benefit period \$0 per day for days 1-60 \$341 copay per day for days 61-90 \$682 copay per day for each "lifetime reserve day" 1-60 <p>These amounts may change for 2020.</p>	<p>You are covered for up to 90 days per benefit period.*</p> <p>You are also covered up to 60 additional days for days 91 and beyond per lifetime.</p>
<ul style="list-style-type: none"> Outpatient individual/group therapy visit 	You pay \$0	You pay \$0	
<ul style="list-style-type: none"> Outpatient individual/group therapy visit with a psychiatrist 	You pay \$0	You pay \$0	
Skilled Nursing Facility	<p>In 2019, the amounts for each benefit period* were:</p> <ul style="list-style-type: none"> \$0 per day for days 1-20 \$170.50 copay per day for days 21-100 <p>These amounts may change for 2020.</p>	Not covered out-of-network	<p>Prior authorization rules apply for skilled nursing facility services. You are covered for up to 100 days per benefit period.*</p> <p>No prior hospitalization is required.</p>

* 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 per visit	You pay \$0 per visit	
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)	<p>You pay \$0 for up to 50 one-way trips per year</p> <p>75-mile limit applies to each one-way trip</p>	Not covered out-of-network	<p>Prior authorization rules apply for routine transportation services.</p> <p>Transportation services are covered for qualifying medical services such as doctor and dental appointments, pharmacy visits, etc.</p>
Medicare Part B Drugs	<p>You pay \$0 for chemotherapy and other Part B drugs received at a pharmacy</p> <p>You pay 20% of the total cost for chemotherapy and other Part B drugs received at any other setting</p>	<p>You pay \$0 for chemotherapy and other Part B drugs received at a pharmacy</p> <p>You pay 20% of the total cost for chemotherapy and other Part B drugs received at any other setting</p>	Prior authorization rules apply to select drugs.

OUTPATIENT PRESCRIPTION DRUGS

You pay the following:

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 \$5	You pay \$0	You pay \$15	You pay \$0
Tier 2 (Generic)	You pay \$3	You pay \$8	You pay \$9	You pay \$24	You pay \$9
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 \$4,020.

You pay 25% of the negotiated price (and a portion of the dispensing fee) for your brand name drugs and 25% of the cost for your generic drugs.

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs reach \$6,350, you pay the greater of:

- 5% of the cost, or
- \$3.60 copay for generic (including drugs that are treated like a generic) and \$8.95 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. Cost-sharing may change depending on the pharmacy you choose 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.

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

Your cost-sharing may differ depending on the pharmacy you choose (e.g., Preferred Retail, Standard Retail, Mail-Order, Long Term Care (LTC) or Home infusion, etc.) and whether you receive a 30- or 90-day supply. For more information on the pharmacy-specific copays, please call VillageHealth Member Services Department at the phone number in this document or access your Evidence of Coverage online.

ADDITIONAL BENEFITS

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

BENEFITS	VILLAGEHEALTH		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Home Health Care (Medicare-covered)	You pay \$0	Not covered	
Medical Equipment/Supplies <ul style="list-style-type: none"> Durable Medical Equipment (e.g., wheelchairs, oxygen) Prosthetics (e.g., braces, artificial limbs) Diabetic supplies 	<p>You pay 0% to 20% of the total cost</p> <p>You pay 0% to 20% of the total cost</p> <p>You pay \$0</p>	<p>You pay 0% to 20% of the total cost</p> <p>You pay 0% to 20% of the total cost</p> <p>You pay \$0</p>	<p>Prior authorization is only required for certain items including, but not limited to, power chairs, air mattresses, continuous glucose monitors, home ventilators, Hoyer lifts, and bone stimulators. Contact Member Services for more information.</p> <p>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.</p>
Over-the-Counter (OTC) Products	You are covered for up to \$50 per quarter	Not covered	You can use this benefit to order non-prescription items through the VillageHealth OTC mail-order catalog. Items will be shipped directly to your home.

ABOUT VILLAGEHEALTH

Who can join?	You must: <ul style="list-style-type: none">- have both Medicare Part A and Part B- live in the plan service area (Riverside and San Bernardino counties, California)- be a United States citizen or be lawfully present in the United States- be diagnosed with end-stage renal disease (ESRD) 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 March 31: 8 A.M. to 8 P.M., 7 days a week April 1 to September 30: 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.
Website	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 call 1-877-486-2048.

This information is not a complete description of benefits. Call 1-800-399-7226 (TTY: 711) for more information.

You can get prescription drugs shipped to your home through our network mail-order delivery program, which is called Express Scripts PharmacySM. 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 March 31. From April 1 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: 711

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-877-916-1234 (TTY users call 711) Hours are 8 A.M. to 8 P.M., seven 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. Messages received on holidays and outside of our business hours will be returned within one business day.

Understanding the Benefits

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit www.villagehealthca.com or call 1-877-916-1234 to view a copy of the EOC.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2021.
- Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care.
- This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.

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: Չանզհարե՛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 перевода;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। काल करें 1-800-559-3500, (TTY: 711)।

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

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ທ່ານ. ໂທສ 1-800-559-3500 (TTY: 711).