



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

Annual Notice of Change for 2026

You're enrolled as a member of VillageHealth.

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in VillageHealth.
- To change to a **different plan**, visit www.Medicare.gov or review the list in the back of your *Medicare & You 2026* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at www.villagehealthca.com or call Member Services at 1-800-399-7226 (TTY users call 711) to get a copy by mail.

More Resources

- This material is available for free in Spanish.
- Call Member Services at 1-800-399-7226 (TTY users call 711) for more information. 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. This call is free.
- We can also give you information for free in large print, braille, audio recording, or other alternate formats if you need it.

About VillageHealth

- VillageHealth (HMO POS C-SNP) is an HMO plan with a Medicare contract. Enrollment in SCAN Health Plan depends on contract renewal.
- When this material says "we," "us," or "our," it means SCAN Health Plan. When it says "plan" or "our plan," it means VillageHealth.
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in VillageHealth.** Starting January 1, 2026, you'll get your medical and drug coverage through VillageHealth. Go to Section 3 for more information about how to change plans and deadlines for making a change.

H5943-004

Y0057_SCAN_21916_2026_M

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Summary of Important Costs for 2026

	2025 (this year)	2026 (next year)
Monthly plan premium* * Your premium can be higher or lower than this amount. Go to Section 1 for details.	\$0	\$12
Deductible	\$257, except for insulin furnished through an item of durable medical equipment.	\$257, except for insulin furnished through an item of durable medical equipment. This is a 2025 deductible amount and can change for 2026.
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	In and Out-of-Network \$9,350	In and Out-of-Network \$9,250
Primary care office visits	In-Network \$0 copayment per visit. Out-of-Network 20% of the total cost per visit.	In-Network \$0 copayment per visit. Out-of-Network 20% of the total cost per visit.
Specialist office visits	In-Network \$0 copayment for nephrology visits. 20% of the total cost for all other specialist services per visit. Out-of-Network \$0 copayment for nephrology visits. 20% of the total cost for all other specialist services per visit.	In-Network \$0 copayment per visit. Out-of-Network \$0 copayment per visit.

	2025 (this year)	2026 (next year)
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're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	In and Out-of-Network \$1,676 deductible for days 1-60, a \$419 copayment per day for days 61-90, and a \$838 copayment per day for lifetime reserve days (up to 60 days per lifetime) per benefit period.	In and Out-of-Network \$1,676 deductible for days 1-60, a \$419 copayment per day for days 61-90, and a \$838 copayment per day for lifetime reserve days (up to 60 days per lifetime) per benefit period. These are 2025 cost-sharing amounts and can change for 2026. VillageHealth will provide updated rates as soon as they're released.
Part D drug coverage deductible (Go to Section 1.7 for details.)	\$490 except for covered insulin products and most adult Part D vaccines.	\$490 except for covered insulin products and most adult Part D vaccines.
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Copayment/Coinsurance during the Initial Coverage Stage: - Drug Tier 1: \$3 per prescription (<i>Standard cost-sharing 30-day supply</i>) \$0 per prescription (<i>Preferred cost-sharing 30-day supply</i>)	Copayment/Coinsurance during the Initial Coverage Stage: Drug Tier 1: \$3 per prescription (<i>Standard cost-sharing 30-day supply</i>) \$0 per prescription (<i>Preferred cost-sharing 30-day supply</i>)

	2025 (this year)	2026 (next year)
	- Drug Tier 2: \$6 per prescription (<i>Standard cost-sharing 30-day supply</i>) \$1 per prescription (<i>Preferred cost-sharing 30-day supply</i>) - Drug Tier 3: 25% of the total cost for other drugs (<i>Standard cost-sharing 30-day supply</i>) - You pay \$35 per month supply of each covered insulin product on this tier. (<i>Standard cost-sharing 30-day supply</i>) 25% of the total cost for other drugs (<i>Preferred cost-sharing 30-day supply</i>) - You pay \$35 per month supply of each covered insulin product on this tier. (<i>Preferred cost-sharing 30-day supply</i>)	Drug Tier 2: \$6 per prescription (<i>Standard cost-sharing 30-day supply</i>) \$1 per prescription (<i>Preferred cost-sharing 30-day supply</i>) Drug Tier 3: 25% of the total cost for other drugs (<i>Standard cost-sharing 30-day supply</i>) You pay \$35 per month supply of each covered insulin product on this tier. (<i>Standard cost-sharing 30-day supply</i>) 25% of the total cost for other drugs (<i>Preferred cost-sharing 30-day supply</i>) You pay \$35 per month supply of each covered insulin product on this tier. (<i>Preferred cost-sharing 30-day supply</i>)

	2025 (this year)	2026 (next year)
	• Drug Tier 4: 25% of the total cost (<i>Standard cost-sharing</i> 30-day supply) 25% of the total cost (<i>Preferred cost-sharing</i> 30-day supply) • Drug Tier 5: 25% of the total cost (<i>Standard cost-sharing</i> 30-day supply) 25% of the total cost (<i>Preferred cost-sharing</i> 30-day supply) Catastrophic Coverage Stage: • During this payment stage, you pay nothing for your covered Part D drugs.	• Drug Tier 4: 25% of the total cost (<i>Standard cost-sharing</i> 30-day supply) 25% of the total cost (<i>Preferred cost-sharing</i> 30-day supply) • Drug Tier 5: 25% of the total cost (<i>Standard cost-sharing</i> 30-day supply) 25% of the total cost (<i>Preferred cost-sharing</i> 30-day supply) Catastrophic Coverage Stage: • During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2025 (this year)	2026 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	\$0	\$12

Factors that could change your Part D Premium Amount

- **Late Enrollment Penalty** - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- **Higher Income Surcharge** - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.
- **Extra Help** - Your monthly plan premium will be *less* if you get Extra Help with your drug costs. Go to Section 4 for more information about Extra Help from Medicare.

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

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

	2025 (this year)	2026 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copayments and deductibles) count toward your maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs don't count toward your maximum out-of-pocket amount.	In and Out-of-Network \$9,350	In and Out-of-Network \$9,250 Once you've paid \$9,250 out of pocket for covered Part A and Part B services, you'll 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

Our network of providers has changed for next year. Review the 2026 *Provider & Pharmacy Directory* at www.villagehealthca.com to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider & Pharmacy Directory*:

- Visit our website at www.villagehealthca.com.
- Call Member Services at 1-800-399-7226 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider & Pharmacy Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Member Services at 1-800-399-7226 (TTY users call 711) for help. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your *Evidence of Coverage*.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can 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.

Our network of pharmacies has changed for next year. Review the 2026 *Provider & Pharmacy Directory* at www.villagehealthca.com to see which pharmacies are in our network. Here's how to get an updated *Provider & Pharmacy Directory*:

- Visit our website at www.villagehealthca.com.
- Call Member Services at 1-800-399-7226 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Provider & Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Member Services at 1-800-399-7226 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

	2025 (this year)	2026 (next year)
Acupuncture services (Medicare-covered)	In and Out-of-Network 20% of the total cost per visit.	In and Out-of-Network \$0 copayment per visit.

	2025 (this year)	2026 (next year)
Care Memory Assistance Program (Care MAP)	In- and Out-of-Network Care Memory Assistance Program (Care MAP) is <u>not</u> covered.	In-Network \$0 copayment for Care MAP which provides assessment, care planning, caregiver training, and a 24/7 support line for individuals with a diagnosis or at risk for dementia. Please see your <i>Evidence of Coverage</i> for more details.
Cognifit (Memory Fitness)	In-Network \$0 copayment for Cognifit (Memory Fitness).	In-Network Cognifit (Memory Fitness) is <u>not</u> covered.
Dental services (routine/non-Medicare-covered)	In-Network You have a dental plan through Delta Dental. This plan does <u>not</u> offer out-of-network dental coverage.	In-Network You have a dental plan with a \$2,000 allowance through a new partner: DentaQuest. You do not have to select a primary care dentist. This plan offers in-network and out-of-network dental coverage for both preventive and comprehensive dental services. Only comprehensive services apply to the allowance.

	2025 (this year)	2026 (next year)
Dental services (routine/non-Medicare-covered) (continued)		Comprehensive dental services include, but are not limited to: • Fillings and crowns • Root canals • Dentures and bridges • Extractions and oral surgery • Implants
Doctor office visits - Specialists	In and Out-of-Network \$0 copayment for each nephrology visit. 20% of the total cost per all other specialist visits.	In and Out-of-Network \$0 copayment per visit.
Groceries (SSBCI), Over-the-counter (OTC) items (SSBCI), Utilities (SSBCI)	In-Network You are covered for up to \$60 per month for Groceries (SSBCI), OTC items, and Utilities (SSBCI) benefits. OTC does <u>not</u> require SSBCI eligibility.	In-Network You are covered for up to \$74 per month with the FlexEssentials card. This amount can be spent on Groceries (SSBCI), OTC items (SSBCI), and Utilities (SSBCI) benefits. OTC requires SSBCI eligibility. Please see your <i>Evidence of Coverage</i> for more details.

	2025 (this year)	2026 (next year)
In-home care	In-Network To qualify for this benefit, in-home care services must be requested within 7 days of the member being discharged from a hospital or skilled nursing facility.	In-Network To qualify for this benefit, in-home care services must be requested within 15 business days of the member being discharged from a hospital or skilled nursing facility or undergoing outpatient knee or hip surgery. Members who need assistance with two or more Activities of Daily Living (ADLs) also qualify. Please see your Evidence of Coverage for more details.
Inpatient hospital care	In and Out-of-Network \$1,676 deductible for days 1-60, a \$419 copayment per day for days 61-90, and a \$838 copayment per day for lifetime reserve days (up to 60 days per lifetime) per benefit period.	In and Out-of-Network \$1,676 deductible for days 1-60, a \$419 copayment per day for days 61-90, and a \$838 copayment per day for lifetime reserve days (up to 60 days per lifetime) per benefit period. These are 2025 cost-sharing amounts and can change for 2026. VillageHealth will provide updated rates as soon as they're released.

	2025 (this year)	2026 (next year)
Inpatient mental health care	In and Out-of-Network \$1,676 deductible for days 1-60, a \$419 copayment per day for days 61-90, and a \$838 copayment per day for lifetime reserve days (up to 60 days per lifetime) per benefit period.	In and Out-of-Network \$1,676 deductible for days 1-60, a \$419 copayment per day for days 61-90, and a \$838 copayment per day for lifetime reserve days (up to 60 days per lifetime) per benefit period. These are 2025 cost-sharing amounts and can change for 2026. VillageHealth will provide updated rates as soon as they're released.
Part B Drugs	In and Out-of-Network Part B Drugs are <u>not</u> subject to Step Therapy requirements.	In-Network Select Part B Drugs may be subject to Step Therapy requirements. To get more information, review Chapter 4 of your <i>Evidence of Coverage</i> . Step Therapy is a utilization tool that requires you to first try another drug to treat your medical condition before we'll cover the drug your physician may have initially prescribed.

	2025 (this year)	2026 (next year)
Skilled nursing facility (SNF) care	In-Network \$0 copayment per day for days 1-20 and a \$209.50 copayment per day for days 21-100.	In-Network \$0 copayment per day for days 1-20 and a \$209.50 copayment per day for days 21-100. These are 2025 cost-sharing amounts and can change for 2026. VillageHealth will provide updated rates as soon as they're released.
Telehealth services - Urgent Care - Behavioral	In- and Out-of-Network Telehealth services are <u>not</u> covered.	In-Network \$0 copayment per virtual visit. Please see your <i>Evidence of Coverage</i> for more details.

Section 1.6 Changes to Part D 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, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Member Services at 1-800-399-7226 (TTY users call 711) for more information.

Section 1.7 Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you**. We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get Extra Help and you don't get this material by September 30, 2025, call Member Services at 1-800-399-7226 (TTY users call 711) and ask for the *LIS Rider*.

Drug Payment Stages

There are **3 drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit.

- **Stage 1: Yearly Deductible**

You start in this payment stage each calendar year. During this stage, you pay the full cost of your Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, and Tier 5: Specialty Tier drugs until you've reached the yearly deductible.

- **Stage 2: Initial Coverage**

Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date out-of-pocket costs reach \$2,100.

- **Stage 3: Catastrophic Coverage**

This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program don't count toward out-of-pocket costs.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

	2025 (this year)	2026 (next year)
Yearly Deductible	\$490 During this stage, you pay \$0 cost-sharing for drugs on Tier 1: Preferred Generic at preferred pharmacies for a one-month (30-day) supply, \$3 cost-sharing for drugs on Tier 1: Preferred Generic at standard pharmacies for a one-month (30-day) supply. You pay \$1 cost-sharing for drugs on Tier 2: Generic at preferred pharmacies for a one-month (30-day) supply, \$6 cost-sharing for drugs on Tier 2: Generic at standard pharmacies for a one-month (30-day) supply, and the full cost of drugs on Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, and Tier 5: Specialty Tier until you’ve reached the yearly deductible.	\$490 During this stage, you pay \$0 cost-sharing for drugs on Tier 1: Preferred Generic at preferred pharmacies for a one-month (30-day) supply, \$3 cost-sharing for drugs on Tier 1: Preferred Generic at standard pharmacies for a one-month (30-day) supply. You pay \$1 cost-sharing for drugs on Tier 2: Generic at preferred pharmacies for a one-month (30-day) supply, \$6 cost-sharing for drugs on Tier 2: Generic at standard pharmacies for a one-month (30-day) supply, and the full cost of drugs on Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, and Tier 5: Specialty Tier until you’ve reached the yearly deductible.

Drug Costs in Stage 2: Initial Coverage

The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy with standard and preferred cost sharing.

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. Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs for a long-term supply; or at a network pharmacy that offers preferred cost sharing; or for mail-order prescriptions, go to Chapter 6 of your *Evidence of Coverage*.

Once you've paid \$2,100 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2025 (this year)	2026 (next year)
Tier 1: Preferred Generic	<i>Standard cost-sharing:</i> You pay \$3. Your cost for a one-month mail-order prescription is \$3. <i>Preferred cost-sharing:</i> You pay \$0. Your cost for a one-month mail-order prescription is \$0.	<i>Standard cost-sharing:</i> You pay \$3. Your cost for a one-month mail-order prescription is \$3. <i>Preferred cost-sharing:</i> You pay \$0. Your cost for a one-month mail-order prescription is \$0.
Tier 2: Generic	<i>Standard cost-sharing:</i> You pay \$6. Your cost for a one-month mail-order prescription is \$6. <i>Preferred cost-sharing:</i> You pay \$1. Your cost for a one-month mail-order prescription is \$1.	<i>Standard cost-sharing:</i> You pay \$6. Your cost for a one-month mail-order prescription is \$6. <i>Preferred cost-sharing:</i> You pay \$1. Your cost for a one-month mail-order prescription is \$1.

	2025 (this year)	2026 (next year)
Tier 3: Preferred Brand	<i>Standard cost-sharing:</i> You pay 25% of the total cost for other drugs. You pay \$35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 25% of the total cost. <i>Preferred cost-sharing:</i> You pay 25% of the total cost for other drugs. You pay \$35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 25% of the total cost.	<i>Standard cost-sharing:</i> You pay 25% of the total cost for other drugs. You pay \$35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 25% of the total cost. <i>Preferred cost-sharing:</i> You pay 25% of the total cost for other drugs. You pay \$35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 25% of the total cost.

	2025 (this year)	2026 (next year)
Tier 4: Non-Preferred Drug	<i>Standard cost-sharing:</i> You pay 25% of the total cost. Your cost for a one-month mail-order prescription is 25% of the total cost. <i>Preferred cost-sharing:</i> You pay 25% of the total cost. Your cost for a one-month mail-order prescription is 25% of the total cost.	<i>Standard cost-sharing:</i> You pay 25% of the total cost. Your cost for a one-month mail-order prescription is 25% of the total cost. <i>Preferred cost-sharing:</i> You pay 25% of the total cost. Your cost for a one-month mail-order prescription is 25% of the total cost.
Tier 5: Specialty Tier	<i>Standard cost-sharing:</i> You pay 25% of the total cost. Your cost for a one-month mail-order prescription is 25% of the total cost. <i>Preferred cost-sharing:</i> You pay 25% of the total cost. Your cost for a one-month mail-order prescription is 25% of the total cost.	<i>Standard cost-sharing:</i> You pay 25% of the total cost. Your cost for a one-month mail-order prescription is 25% of the total cost. <i>Preferred cost-sharing:</i> You pay 25% of the total cost. Your cost for a one-month mail-order prescription is 25% of the total cost.

Changes to the Catastrophic Coverage Stage

For specific information about your costs in the Catastrophic Coverage Stage, go to Chapter 6, Section 6 in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

The table below compares the administrative changes for next year:

	2025 (this year)	2026 (next year)
Medicare Prescription Payment Plan	The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option.	If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026. To learn more about this payment option, call us at 1-866-845-1803 (TTY users call 1-800-716-3231) or visit www.Medicare.gov.
PBP Change	Enrolled in VillageHealth (H5943-002).	Enrolled in VillageHealth (H5943-004).
SSBCI Eligibility Requirements	Eligibility for special supplemental benefits for the chronically ill includes an expanded list of chronic conditions such as cardiovascular disorders, chronic heart failure, diabetes, cancer, and chronic lung disorders.	Eligibility for special supplemental benefits for the chronically ill includes an expanded list of chronic conditions in addition to heart disease, diabetes, cancer, lung disease, or dementia. Please see your <i>Evidence of Coverage</i> for a full list and for changes to applicable eligibility requirements.

SECTION 3 How to Change Plans

To stay in VillageHealth, you don't need to do anything. Unless you sign up for a different plan or change to Original Medicare by December 7, you'll automatically be enrolled in our VillageHealth.

If you want to change plans for 2026, follow these steps:

- **To change to a different Medicare health plan**, enroll in the new plan. You'll be automatically disenrolled from VillageHealth.
- **To change to Original Medicare with Medicare drug coverage**, enroll in the new Medicare drug plan. You'll be automatically disenrolled from VillageHealth.
- **To change to Original Medicare without a drug plan**, you can send us a written request to disenroll or visit our website to disenroll online at www.villagehealthca.com. Call Member Services at 1-800-399-7226 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 1.1).
- **To learn more about Original Medicare and the different types of Medicare plans**, visit www.Medicare.gov, check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227).

Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2026.

Section 3.2 Are there other times of the year to make a change?

In certain situations, people may have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

If you recently moved into, or currently live in, an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 4 Get Help Paying for Prescription Drugs

You may qualify for help paying for prescription drugs. Different kinds of help are available:

- **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 drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
 - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
 - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday – Friday for a representative. Automated messages are available 24 hours a day. TTY users can call 1-800-325-0778.
 - Your State Medicaid Office.
- **Help from your state's pharmaceutical assistance program (SPAP).** 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 (SHIP). To get the phone number for your state, visit shiphelp.org, or call 1-800-MEDICARE.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you 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 drugs that are also covered by ADAP qualify for prescription cost-sharing help through the Office of AIDS, Center for Infectious Diseases – California Department of Public Health, MS7700, P.O. Box 997426, Sacramento, CA 95899-7426. For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call 1-844-421-7050. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in the Medicare Prescription Payment Plan

payment option. To learn more about this payment option, call us at 1-866-845-1803 (TTY users call 1-800-716-3231) or visit www.Medicare.gov.

SECTION 5 Questions?

Get Help from VillageHealth

- **Call Member Services at 1-800-399-7226. (TTY users call 711.)**

We're 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 2026 *Evidence of Coverage***

This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 *Evidence of Coverage* for VillageHealth. The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at www.villagehealthca.com or call Member Services at 1-800-399-7226 (TTY users call 711) to ask us to mail you a copy.

- **Visit www.villagehealthca.com**

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).

Get Free Counseling about Medicare

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

Call Health Insurance Counseling and Advocacy Program (HICAP) to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222. Learn more about Health Insurance Counseling and Advocacy Program (HICAP) by visiting aging.ca.gov/hicap/.

Get Help 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 can call 1-877-486-2048.

- **Chat live with www.Medicare.gov**

You can chat live at www.Medicare.gov/talk-to-someone.

- **Write to Medicare**

You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- **Visit www.Medicare.gov**

The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You 2026***

The *Medicare & You 2026* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at www.Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

SCAN Health Plan/VillageHealth 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 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 Health Plan - VillageHealth
Attention: Grievance and Appeals Department
P.O. Box 22644
Long Beach, CA 90801-5644

VillageHealth Member Services
PHONE: 1-800-399-7226
FAX: 1-562-989-0958
TTY: 711

Or by filling out the "File a Grievance" form on our website at:
www.scanhealthplan.com/Help-Center/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 www.hhs.gov/civil-rights/filing-a-complaint/index.html.

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call 1-916-440-7370. If you cannot speak or hear well, please call 711 (Telecommunications Relay Services).
- In writing: Fill out a complaint form or send a letter to:
Deputy Director, Office of Civil Rights
Department of Health Care Services
Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413
Complaint forms are available at http://www.dhcs.ca.gov/Pages/Language_Access.aspx.
- Electronically: Send an email to CivilRights@dhcs.ca.gov

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-399-7226. Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, llame al 1-800-399-7226. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Cantonese (Traditional): 我們提供免費的口譯服務，以解答您對我們的健康或藥物計劃可能有的任何問題。如需獲得口譯服務，請致電 1-800-399-7226 聯絡我們。我們有會說中文的工作人員可以為您提供幫助。這是一項免費服務。

Chinese Mandarin (Simplified): 我们提供免费的口译服务，以解答您对我们的健康或药物计划可能有的任何问题。如需获得口译服务，请致电 1-800-399-7226 联系我们。我们有会说中文的工作人员可以为您提供帮助。这是一项免费服务。

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời bất kỳ câu hỏi quý vị có thể có về chương sức khỏe và chương trình thuốc men. Để được thông dịch, chỉ cần gọi theo số 1-800-399-7226. Người nói Tiếng Việt có thể trợ giúp quý vị. Đây là dịch vụ miễn phí.

Tagalog: Mayroon kaming mga libreng serbisyo ng interpreter upang masagot ang anumang katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng interpreter, tawagan lamang kami sa 1-800-399-7226. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-399-7226 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Armenian: Առողջության կամ դեղերի ծրագրի վերաբերյալ որևէ հարց առաջանալու դեպքում կարող եք օգտվել անվճար թարգմանչական ծառայությունից: Թարգմանչի ծառայությունից օգտվելու համար զանգահարե՛ք 1-800-399-7226 հեռախոսահամարով: Ձեզ կօգնի հայերենին տիրապետող մեր աշխատակիցը: Ծառայությունն անվճար է:

Persian: توجه: ما خدمات مترجم رایگان داریم تا به هر سؤالی که ممکن است در مورد برنامه بهداشتی یا داروهای ما داشته باشید پاسخ دهیم. برای آن که مترجم دریافت کنید فقط کافیست با شماره 1-800-399-7226 تماس بگیرید. شخصی که به زبان فارسی صحبت می کند، می تواند به شما کمک کند. این یک سرویس رایگان است.

Russian: Если у вас возникнут вопросы относительно плана медицинского обслуживания или обеспечения лекарственными препаратами, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по номеру 1-800-399-7226. Вам окажет помощь сотрудник, который говорит на русском языке. Данная услуга бесплатная.

Japanese: 当社の健康保険と処方薬プランに関するご質問にお答えするため に、無料の通訳サービスをご用意しています。通訳をご利用になるには、1-800-399-7226 にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة لديك تتعلق بخطةنا الصحية أو جدول الدواء. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على الرقم 1-800-399-7226. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه الخدمة المجانية.

Punjabi: ਸਾਡੀ ਸਿਹਤ ਜਾਂ ਦਵਾਈ ਯੋਜਨਾ ਬਾਰੇ ਤੁਹਾਡੇ ਕਿਸੇ ਵੀ ਸਵਾਲਾਂ ਦਾ ਜਵਾਬ ਦੇਣ ਲਈ ਸਾਡੇ ਕੋਲ ਮੁਫਤ ਦੁਬਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਹਨ। ਕੋਈ ਦੁਬਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਬੱਸ ਸਾਨੂੰ 1-800-399-7226 'ਤੇ ਕਾਲ ਕਰੋ। ਕੋਈ ਵਿਅਕਤੀ ਜੋ ਪੰਜਾਬੀ ਬੋਲਦਾ ਹੈ, ਉਹ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦਾ ਹੈ। ਇਹ ਇੱਕ ਮੁਫਤ ਸੇਵਾ ਹੈ।

Mon-Khmer, Cambodian:

យើងខ្ញុំមានសេវាអ្នកបកប្រែផ្ទាល់មាត់ដោយមិនគិតថ្លៃចាំឆ្លើយរាល់សំណួរដែលអ្នកអាចមានអំពីសុខភាព ឬផែនការឱសថរបស់យើងខ្ញុំ។ ដើម្បីទទួលបានអ្នកបកប្រែ គ្រាន់តែហៅទូរស័ព្ទមកយើងខ្ញុំតាមរយៈលេខ 1-800-399-7226។ មានគេដែលនិយាយភាសាខ្មែរអាចជួយលោកអ្នកបាន។ សេវាកម្មនេះមិនគិតថ្លៃទេ។

Hmong: Peb muaj cov kev pab cuam txhais lus los teb koj cov lus nug uas koj muaj txog ntawm peb lub phiaj xwm kho mob thiab tshuaj kho mob. Kom tau txais tus kws txhais lus, tsuas yog hu peb ntawm 1-800-399-7226. Muaj qee tus neeg hais lus Hmoob tuaj yeem pab tau koj. Qhov no yog kev pab cuam pab dawb.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-399-7226 पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Thai: เรามีบริการล่ามฟรีเพื่อตอบสนองข้อสงสัยต่าง ๆ ที่คุณอาจมีเกี่ยวกับแผนสุขภาพและด้านเภสัชกรรมของเรา ขอความช่วยเหลือจากล่ามโดยโทรติดต่อเราที่หมายเลข 1-800-399-7226 เจ้าหน้าที่ในภาษาไทยจะเป็นผู้ให้บริการโดยไม่มีค่าใช้จ่ายใด ๆ

Lao: ພວກເຮົາມີການບໍລິການນາຍພາສາຟຣີ ເພື່ອຕອບຄໍາຖາມທີ່ທ່ານອາດຈະມີກ່ຽວກັບສຸຂະພາບ ຫຼື ແຜນການຢາຂອງ ພວກເຮົາ. ເພື່ອຮັບເອົານາຍພາສາ, ພາລາດໂທຫາພວກເຮົາທີ່ເບີ 1-800-399-7226. ບາງຄົນທີ່ເວົ້າພາສາລາວ ສາມາດຊ່ວຍທ່ານໄດ້. ນີ້ແມ່ນການບໍລິການຟຣີ.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-399-7226. Quelqu'un parlant français pourra vous aider. Ce service est gratuit.

German: Unser kostenloser Dolmetscherservice beantwortet Ihre Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-399-7226. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per usufruire di un interprete, contattare il numero 1-800-399-7226. Un nostro incaricato che parla Italiano Le fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-399-7226. Irá encontrar alguém que fale português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan sante oswa medikaman nou yo. Pou w jwenn yon entèprèt, jis rele nou nan 1-800-399-7226. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-399-7226. Ta usługa jest bezpłatna.

Hmong-Mien: Peb muaj kev pab cuam txhais lus pub dawb los teb cov lus nug uas koj muaj txog ntawm peb lub phiaj xwm kev noj qab haus huv los sis phiaj xwm tshuaj kho mob. Kom tau txais tus kws txhais lus, tsuas yog hu peb ntawm 1-800-399-7226. Muaj tus neeg hais lus Hmoob tuaj yeem pab tau koj. Qhov kev pab cuam no yog pab dawb xwb.

Ukrainian: Ми надаємо безкоштовні послуги усного перекладача, який відповість на будь-які ваші запитання щодо нашого плану медичного обслуговування або лікарського забезпечення. Щоб отримати послуги перекладача, просто зателефонуйте нам за номером 1-800-399-7226. Вам може допомогти людина, яка володіє українською мовою. Ця послуга безкоштовна.

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