2020
SUMMARY OF BENEFITS

SOLIS Health Plans **SPF 007 (HMO)**

January 1, 2020 - December 31, 2020

H0982, Plan 007 - Broward County

Solis Health Plan is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the 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."

To join **Solis Health Plan (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Florida: **Broward County**. Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services.

For coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048. This document is available in other formats such as Braille, large print or audio.

For more information, please call us at (844) 44-SOLIS(76547) / (TTY : 711), 8 a.m. to 8 p.m. seven days a week from Oct. 1 – March 31 8 a.m. to 8 p.m. Monday-Friday from April 1 - Sept. 30 or visit us at www.solishealthplans.com.

SPF 007 (HMO) H0982-007

Monthly Plan Premium

- $0
- You must continue to pay your Part B premium.

Deductible

- No deductible

Maximum Out-of-Pocket Responsibility (does not include prescription drugs)

- You pay no more than $3,400 annually
- Includes copays and other costs for medical services for the year

BENEFITS

Inpatient Hospital

- $0 Copayment

Outpatient Hospital

- $75 Copayment

Authorization and Referral is required

Ambulatory Surgery Center

- $50 Copayment

Authorization and Referral is required

Doctor Visits

- Primary Care: $0 Copayment
- Specialists: $0 Copayment

Authorization is not required for initial evaluation. Authorization required for certain treatment plans.

Preventive Care (e.g., flu vaccine, diabetic screenings)

- $0 Copayment

Other preventive services are available. There are some covered services that have a cost. Referral is required

Emergency Care / Post-Stabilization Care

- $95 Copayment

Copayment waived if admited

Urgently Needed Services

• $10 Copayment

Diagnostic Services/Labs/Imaging

Medicare-covered Diagnostic Procedures / Tests:
• $0 Copayment - In Network Non-Hospital Facility
• $25 Copayment - Hospital Facility

Medicare-covered Lab Services:
• $0 Copayment - In Network Non-Hospital Facility
• $50 Copayment - Hospital Facility

X-Ray Services:
• $0 Copayment - In Network Non-Hospital Facility
• $25 Copayment - Hospital Facility

Diagnostic Radiological Services (e.g., CT, MRI, etc.):
• $0 Copayment - In Network Non-Hospital Facility
• $75 Copayment - Hospital Facility

Medicare-covered Therapeutic Radiological Services:
• $0 Copayment - In Network Non-Hospital Facility
• $25 Copayment - Hospital Facility

Referral is required

Hearing Services (Routine hearing exam and hearing aid)

• $0 Copayment
• $600 per ear annual total allowance

Referral is required

Dental Services (Preventive)

• Oral Exam	$0 Copayment – 2 exams every year
• Fluoride Treatment	$0 Copayment – 2 treatments every year
• Dental X-Rays	$0 Copayment – 2 X-Rays every year
• Cleaning	$0 Copayment – 2 Cleanings every year

Dental Services (Comprehensive)

• Diagnostic Services	$0 Copayment – 1 service every 2 years
• Restorative Services	$0 Copayment – 2 services every year
• Endodontics	$0 Copayment – 1 service every 2 years
• Periodontics	$0 Copayment – 1 service every 2 years
• Extractions	$0 Copayment – 3 extractions every year
• Prosthodontics, Other Oral/ Maxillofacial Surgery, Other Services	$0 Copayment – 1 service every 2 years
• $1,500 annual total allowance	

Vision Services

• Eye exams:	$0 Copayment – 1 exam every year in addition to Medicare covered services.
• Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames; Upgrades:	$250 annual total allowance

Referral is required

Mental Health Services

Outpatient group therapy/ individual therapy visit

- $15 Copayment - Medicare-covered Individual Sessions
- $5 Copayment - Medicare-covered Group Sessions

Referral is required

Skilled Nursing Facility (SNF)

- $0 Copayment, days 1-20
- $50 Copayment per day, for days 21-100

Authorization and Referral is required

Physical Therapy and Speech-language Therapy Pathology Services

- $5 Copayment - In Network Non-Hospital Facility
- $25 Copayment - Hospital Facility

Authorization not required for initial evaluation. Authorization may be required for subsequent visits.

Referral Required

Ambulance

• Medicare-covered Air Ambulance Services: 20% Coinsurance
    - Copayment not waived if admitted to hospital

• Medicare-covered Ground Ambulance Services: $50 Copay
    - Copayment waived if admitted to hospital

Authorization is required

Transportation

• 24 One-way Trips to Plan Approved Health-Related Locations

Referral is required

Medicare Part B Drugs

• 20% coinsurance

Authorization Is required

Over-the-Counter

$0 Copayment

The plan covers up to $45 per month for plan approved over-the-counter and health-related products.

Therapeutic Massage

$0 Copayment

The plan covers up to 6 sessions per year.

Fitness

$0 Copayment

Silver & Fit - Gym Membership

Prescription Drugs

Deductible Phase	The plan has no deductible stage		
	Standard Retail Rx 30-day supply	Out-of-Network Retail Rx 30-day supply	Mail Order 90-Day Supply
Initial Coverage - $4,020			
Tier 1: Preferred Generic	You pay $0	You pay $0	You pay $0
Tier 2: Generic	You pay $0	You pay $0	You pay $0
Tier 3: Preferred Brand	You pay $20	You pay $20	
Tier 4: Non-Preferred	You pay $85	You pay $85	
Tier 5: Specialty Tier	You pay 33%	You pay 33%	
Tier 6: Supplemental Brand and Generic Drugs	You pay $0	You pay $0	You pay $0
Coverage Gap - $6,350 Out of Pocket			
Tier 1: Preferred Generic	You pay $0	You pay $0	You pay $0
Tier 2: Generic	You pay $0	You pay $0	You pay $0
Catastrophic Coverage			
Tier 1: Preferred Generic	$3.60 copay or 5% (whichever costs more)	$3.60 copay or 5% (whichever costs more)	$3.60 copay or 5% (whichever costs more)
Tier 2: Generic	$8.95 copay or 5% (whichever costs more)	$8.95 copay or 5% (whichever costs more)	$8.95 copay or 5% (whichever costs more)

Cost-Sharing may change depending on the pharmacy you choose and when you enter a new phase of the Part D benefit.

This information is not a complete description of benefits.
Call 1 (844) 447-6547 / (TTY : 711) 8 a.m. to 8 p.m. seven days a week from Oct. 1 – March 31
8 a.m. to 8 p.m. Monday-Friday from April 1 - Sept. 30 for more information.

ATENCIÓN: Si usted habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-447-6547 (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 1-844-447-6547, TTY 711.

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.solishealthplans.com or call 1-844-447-6547, TTY 711 to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine 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, 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, 2020.
- ☐ Except in certain emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).