



# 2023

## SUMMARY OF BENEFITS

### SPF 007 (HMO)



# 2023 SUMMARY OF BENEFITS

## Solis Health Plans SPF 007 (HMO)

January 1, 2023 - December 31, 2023

SPF-007 HMO

### H0982, Plan 007 - Broward County

**Solis Health Plans** is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

This summary of 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" (EOC) online at [www.solishealthplans.com](http://www.solishealthplans.com) or call us and request a copy.

#### What does Solis Health Plans (HMO) Cover?

Like all Medicare health plans, we cover everything that Original Medicare covers—**and more!**

- ✓ Our members receive more benefits than are covered by Original Medicare. Some of these supplemental benefits are outlined in this Summary of Benefits.
- ✓ We cover Part D drugs. You can see Solis's Comprehensive Prescription Drug List (formulary) on our website at [www.solishealthplans.com](http://www.solishealthplans.com) or call toll-free 1 (844) 447-6547 (TTY 711).
- ✓ Solis has a network of hospitals, doctors, specialists, pharmacies, and other providers ready to serve all of your healthcare needs. You can access the Provider Directory on our website at [www.solishealthplans.com](http://www.solishealthplans.com) or call toll-free 1 (844) 447-6547 (TTY 711). Services are available when using an in-network provider. Out of network provider services are not covered except in emergency situations.

Medicare Plan Finder on [www.medicare.gov](http://www.medicare.gov) allows you to compare our plan with other plans for their Summary of Benefits.

If you are already a member of Solis Health Plans, call toll-free 1 (844) 447-6547 (TTY 711). Customer Service is available October 1 - March 31, 8 a.m. - 8 p.m. local time, 7 days a week. From April 1 - September 30, Monday - Friday 8 a.m. - 8 p.m. local time. Our automated phone system may answer your call weekends, holidays and after hours.

To join **Solis Health Plans (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**.

For coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at [www.medicare.gov](http://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 1 (844) 447-6547 / (TTY : 711), or visit us at <https://solishealthplans.com>. 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.

# 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](http://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, 2023.
- 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).

## 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)

- \$3,400 In-network
- Includes copays and other costs for medical services for the year

## Covered Medical and Hospital Benefits

### Inpatient Hospital<sup>A,R</sup>

- \$0 Copayment

### Outpatient Hospital<sup>A,R</sup>

- \$75 Copayment per observation or per stay

### Doctor Visits

Primary Care: • \$0 Copayment

Specialists:<sup>A,R</sup> • \$0 Copayment

Authorization not required for initial evaluation

Authorization may be required for subsequent visits

**A** - Authorization may be required

**R** - Referral may be required

## Preventive Care

- \$0 Copayment
- Abdominal aortic aneurysm screening<sup>R</sup>
- Annual “wellness” visit
- Bone mass measurement<sup>R</sup>
- Breast cancer screening (mammogram)<sup>R</sup>
- Cardiovascular disease risk reduction visit
- Cardiovascular disease testing<sup>R</sup>
- Cervical and vaginal cancer screening<sup>R</sup>
- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)<sup>A,R</sup>
- Depression screening
- Diabetes screenings
- HIV screening
- Immunizations
- Lung cancer screenings<sup>R</sup>
- Medical nutrition therapy<sup>R</sup>
- Medicare Diabetes prevention program<sup>R</sup>
- Obesity screenings and therapy<sup>R</sup>
- Prostate cancer screenings (PSA)
- Screening and counseling to reduce alcohol misuse
- Sexually transmitted infections screenings and counseling<sup>R</sup>
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<sup>R</sup>
- “Welcome to Medicare” preventive visit (one-time)

## Emergency Care / Post-Stabilization Care<sup>A</sup>

- \$75 Copayment - waived if admitted to hospital within 1 day
- International Emergencies - \$50,000 annual benefit max
  - \$50 Copayment - waived if admitted to hospital

## Urgently Needed Services

- \$0 Copayment

# Outpatient Care and Services

## Diagnostic Services/Labs/Imaging

### Medicare-covered Diagnostic Procedures / Tests:<sup>R</sup>

- \$0 Copayment - In Network Non-Hospital Facility
- \$25 Copayment - Hospital Facility

### Medicare-covered Lab Services:<sup>R</sup>

- \$0 Copayment - In Network Non-Hospital Facility
- \$50 Copayment - Hospital Facility

### Medicare-covered X-Ray Services:<sup>A,R</sup>

- \$0 Copayment - In Network Non-Hospital Facility
- \$25 Copayment - Hospital Facility

### Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc.):<sup>A,R</sup>

- \$0 Copayment - In Network Non-Hospital Facility
- \$75 Copayment - Hospital Facility

### Medicare-covered Therapeutic Radiological Services:<sup>A,R</sup>

- \$0 Copayment - In Network Non-Hospital Facility
- \$25 Copayment - Hospital Facility

**A** - Authorization may be required

**R** - Referral may be required

# Hearing Services

## Hearing Services (Routine Hearing Exam and Hearing Aid)<sup>A,R</sup>

- \$0 Copayment
- \$2,500 Hearing Aid allowance both ears combined per year
- Unlimited Routine Hearing Exams
- Hearing Aid Fitting included

# Dental Services

## Preventive<sup>R</sup>

Oral Exam	• \$0 Copayment - 2 every year
Cleaning	• \$0 Copayment - 2 every year
Fluoride Treatment	• \$0 Copayment - 2 every year
Dental X-Rays	• \$0 Copayment - 2 every year

## Comprehensive<sup>A,R</sup>

Diagnostic Services	• \$0 Copayment - 1 visit every 2 years
Restorative Services	• \$0 Copayment - 3 every year
Endodontics	• \$0 Copayment - 1 visit every 2 years
Periodontics	• \$0 Copayment - 3 visits every 2 years
Extractions	• \$0 Copayment - 3 extractions every year
Prosthodontics, Other Oral/ Maxillofacial Surgery, Other Services	• \$0 Copayment - 1 visit every 2 years

**A** - Authorization may be required

**R** - Referral may be required



## Vision Services

### Vision Services<sup>A,R</sup>

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:<sup>A,R</sup>

• \$0 Copayment \$350 annual total allowance

## Additional Outpatient Care and Services

### Mental Health Services

Inpatient hospital (Psychiatric)<sup>A,R</sup> • \$0 Copayment

Mental Health Specialty Services<sup>R</sup>

- \$15 Copay Medicare-covered Individual Sessions
- \$5 Copay Medicare-covered Group Sessions

### Skilled Nursing Facility (SNF)<sup>A,R</sup>

- \$0 Copayment, days 1-20
- \$50 Copayment days 21-100

2 day prior network hospital admissions prerequisite

### Rehabilitation Services (Physical Therapy and Speech Language Pathology Services)<sup>A,R</sup>

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

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

**A** - Authorization may be required

**R** - Referral may be required

## Ambulance<sup>A</sup>

Medicare-covered Air Ambulance Services:

- 20% Coinsurance - waived if admitted to hospital

Medicare-covered Ground Ambulance Services (One-way trip only):

- \$50 Copay - waived if admitted to hospital

Authorization is required for non-emergency Medicare services

## Transportation<sup>R</sup>

- \$0 Copayment

Unlimited trips to plan approved health-related locations

# Additional Benefits

## Medicare Part B Drugs and Home Infusion Drugs<sup>A</sup>

- 20% coinsurance

## Erectile Dysfunction Drugs (ED)

- You are covered for up to 6 pills per month

## Ambulatory Surgical Center<sup>A,R</sup>

- \$25 Copayment

## Fitness<sup>R</sup>

- \$0 Copayment

Silver & Fit - Gym Membership

## Podiatry Services<sup>A,R</sup>

- \$0 Copayment
- Unlimited Routine Care
- 10 visits included
- Authorization required after initial evaluation
- Authorization required after first 10 visits

**A** - Authorization may be required

**R** - Referral may be required

## Meals<sup>A</sup>

- \$0 Copayment - 2 meals a day for 7 days

Meals are covered immediately following surgery or inpatient hospitalization.

Meals are covered immediately following each surgery or inpatient hospitalization for unlimited hospitalizations

## Medical Equipment/Supplies

- |  |                   |
|--|-------------------|
| Diabetic Supplies                                  | • \$0 Copayment   |
| Diabetic Therapeutic Shoes or Inserts <sup>A</sup> | • 20% Coinsurance |

Diabetic Supplies and Services limited to those from specified manufacturers

- |  |                   |
|--|-------------------|
| Durable Medical Equipment <sup>A</sup> | • 20% Coinsurance |
|--|-------------------|

- Medicare-covered ventilators
- bone growth stimulators
- portable oxygen concentrators
- bariatric equipment
- specialty beds
- custom wheelchairs
- seat lifts
- specialty brand items.

- |                                     |                  |
|-------------------------------------|------------------|
| All other Durable Medical Equipment | • 0% Coinsurance |
|-------------------------------------|------------------|

- |                                 |                   |
|---------------------------------|-------------------|
| Prosthetic Devices <sup>A</sup> | • 20% Coinsurance |
|---------------------------------|-------------------|

- Medicare-covered prosthetic devices

The plan has preferred vendors / manufacturers for Durable Medical Equipment (DME)

**A** - Authorization may be required

**R** - Referral may be required

## **Over-the-Counter (OTC)**

- \$0 Copayment

The plan covers up to \$85 per month for plan approved over-the-counter and health-related products.

## **Chiropractic Services<sup>R</sup>**

- \$0 Copayment for Medicare-covered Chiropractic Services

Unlimited Routine Care

Authorization required after first 12 visits

# Prescription Drug Benefits

SPF-007 HMO

## Prescription Drugs

Deductible Stage	The plan has no deductible stage			
	Standard Retail Rx 30-day Supply	Standard Retail Rx 90-day Supply	Out-of-Network Retail Rx 30-day Supply	Mail Order 90-day Supply
<b>Initial Coverage - You stay in this stage until your year-to-date "total drug costs" (your payments plus any Part D plan's payments) total \$4,660.</b>				
Tier 1: Preferred Generic	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
Tier 2: Generic	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
Tier 3: Preferred Brand	\$15 Copay	\$40 Copay	\$15 Copay	Not Available
Tier 4: Non-Preferred	\$70 Copay	\$200 Copay	\$70 Copay	Not Available
Tier 5: Specialty	33% Coinsurance	Not Available	33% Coinsurance	Not Available
Tier 6: Supplemental Drugs	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
<b>Coverage Gap - Your stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of \$7,400</b>				
Tier 1: Preferred Generic	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
Tier 2: Generic	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
<b>For all other drugs, you pay 25% coinsurance for generic drugs and 25% coinsurance for brand-name drugs.</b>				

	Standard Retail Rx 30-day Supply	Standard Retail Rx 90-day Supply	Out-of-Network Retail Rx 30-day Supply	Mail Order 90-day Supply
<b>Catastrophic Coverage- During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2023).</b>				
<b>Tier 1: Preferred Generic</b>	You pay either 5% of the cost of the drug or \$4.15 for a generic drug or a drug that is treated like a generic and \$10.35 for all other drugs. (whichever is the larger amount)	You pay either 5% of the cost of the drug or \$4.15 for a generic drug or a drug that is treated like a generic and \$10.35 for all other drugs. (whichever is the larger amount)	You pay either 5% of the cost of the drug or \$4.15 for a generic drug or a drug that is treated like a generic and \$10.35 for all other drugs. (whichever is the larger amount)	You pay either 5% of the cost of the drug or \$4.15 for a generic drug or a drug that is treated like a generic and \$10.35 for all other drugs. (whichever is the larger amount)
<b>Tier 2: Generic</b>				
<b>Tier 3: Preferred Brand</b>				
<b>Tier 4: Non-Preferred</b>				
<b>Tier 5: Specialty</b>				
<b>Tier 6: Supplemental Drugs</b>	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
Individuals with “Extra Help” will pay a different copayment or coinsurance amount for Part D drugs. The amount you will pay depends on your qualified level. The table below demonstrates what you will pay if you qualify for “Extra Help” and how much you will pay in the different levels.				
<b>“Extra Help” Level</b>	Your cost sharing amount for generic/preferred multi-source drugs is no more than		Your cost sharing amount for all other drugs is no more than	
<b>Level 1</b>	\$4.15		\$10.35	
<b>Level 2</b>	\$1.45		\$4.30	
<b>Level 3</b>	\$0		\$0	
<b>Level 4</b>	15% Coinsurance		15% Coinsurance	

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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.