Solis Healthy Living Plan (HMO) offered by Solis Health Plans, Inc.

Annual Notice of Changes for 2024

You are currently enrolled as a member of SPF 007. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at *https://solishealthplans.com*. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

- **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.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2024 "Drug List" to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies will be in our network next year.

☐ 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 Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.

☐ 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 don't join another plan by December 7, 2023, you will stay in Solis Healthy Living Plan.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024.** This will end your enrollment with Solis Healthy Living Plan.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-844-447-6547 for additional information. (TTY users should call 711.) Hours are 8:00 a.m. to 8:00 p.m. seven days a week from October 1 – March 31 and 8:00 a.m. to 8:00 p.m. Monday-Friday from April 1 - September 30. This call is free.
- To request a document in an alternative format, such as large print, braille or audio please contact Member Services at 1-844-447-6547.**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 www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Solis Healthy Living Plan

- Solis Health Plans, Inc., is an HMO plan with a Medicare contract. Enrollment in Solis Health Plans, Inc., depends on contract renewal.
- When this document says "we," "us," or "our", it means Solis Health Plans, Inc. When it says "plan" or "our plan," it means Solis Healthy Living Plan.

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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for Solis Healthy Living Plan in several important areas. **Please note this is only a summary of costs**.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 3.1 for details.	$0.00	$0.00
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 3.2 for details.)	$3,400.00	$3,400.00
Doctor office visits	Primary care visits: $0.00 Copayment per visit Specialist visits: $0.00 Copayment per visit	Primary care visits: $0.00 Copayment per visit Specialist visits: $0.00 per Copayment visit
Inpatient hospital stays	$0.00	$0.00
Part D prescription drug coverage (See Section 3.5 for details.)	Deductible: $0.00 Copayment/Coinsurance as applicable during the Initial Coverage Stage: • Drug Tier 1: $0.00 • Drug Tier 2: $0.00 • Drug Tier 3: $15.00 • Drug Tier 4: $70.00 • Drug Tier 5: 33% • Drug Tier 6: $0.00 Catastrophic Coverage: • During this payment stage, the plan pays	Deductible: $0.00 Copayment/Coinsurance as applicable during the Initial Coverage Stage: • Drug Tier 1: $0.00 • Drug Tier 2: $0.00 • Drug Tier 3: $15.00 • Drug Tier 4: $70.00 • Drug Tier 5: 33% • Drug Tier 6: $0.00 Catastrophic Coverage: • During this payment stage, the plan pays

Cost	2023 (this year)	2024 (next year)
	most of the cost for your covered drugs. • For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called **coinsurance**), or a copayment ($4.15 for a generic drug or a drug that is treated like a generic, and $10.35 for all other drugs.). • You pay $0 for excluded drugs that are covered under our enhanced benefit (Tier 6 drugs)	the full cost for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit. You pay nothing.

SECTION 1 We Are Changing the Plan's Name

On January 1, 2024, our plan name will change from SPF 007 to Solis Healthy Living Plan.

We will issue you a new Member ID card prior to the start of plan year 2024 which will show the new plan name. All member communications you receive in 2024 will reference the new plan name.

SECTION 2 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Solis Healthy Living Plan in 2024

If you do nothing by December 7, 2023, we will automatically enroll you in our Solis Healthy Living Plan. This means starting January 1, 2024, you will be getting your medical and prescription drug coverage through Solis Healthy Living Plan. If you want to change plans or switch to Original Medicare, you must do so between October 15 and December 7. If you are eligible for "Extra Help," you may be able to change plans during other times.

SECTION 3 Changes to Benefits and Costs for Next Year

Section 3.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0.00	$0.00

- 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.

Section 3.2 – 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 reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,400.00	$3,400.00 Once you have paid $3,400.00 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 3.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at https://solishealthplans.com. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2024 *Pharmacy Directory* to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 3.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2023 (this year)	2024 (next year)
Acupuncture	$0 Copayment Up to 20 visits every year Authorization required	$0 Copayment Up to 24 visits every year First 12 treatments do not require authorization. Treatments 13-24 require authorization.
Ambulatory Surgical Center (ASC) Services	$25.00 Copayment	$0 Copayment
Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral / Maxillofacial Surgery, Other Services)	$0 Copayment Diagnostic Services 1 visit every two years $0 Copayment Endodontics 1 visit every two years $0 Copayment Extractions 3 per year $0 Copayment Prosthodontics, Other Oral / Maxillofacial Surgery 1 visit every two years	$0 Copayment Diagnostic Services 1 visit per year $0 Copayment Endodontics 2 visits per year $0 Copayment Extractions Unlimited $0 Copayment Prosthodontics, Other Oral / Maxillofacial Surgery Dentures (1 complete set or 2 partials) every 5 years *and* 1 re-alignment per year

Cost	2023 (this year)	2024 (next year)
Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts	$0 Copayment Medicare-covered Diabetic Supplies 20% Coinsurance Medicare-covered Diabetic Therapeutic Shoes or Inserts. Authorization required only for Medicare-covered Diabetic Therapeutic Shoes or Inserts	$0 Copayment Medicare-covered Diabetic Supplies 20% Coinsurance Medicare-covered Diabetic Therapeutic Shoes or Inserts. Plan coverage limited to FreeStyle Libre continuous glucose monitoring (CGM) devices. Alternative devices covered only with prior approval from plan. Authorization required for CGM devices and Medicare-covered Diabetic Therapeutic Shoes or Inserts.
Eyewear	Annual maximum Plan Benefit Coverage is $350	Annual maximum Plan Benefit Coverage is $250
Flex Card Allows you to pay for out-of-pocket, or additional services for covered routine dental, routine vision and/or routine hearing on a prepaid card.	Flex Card is not covered.	$1,000.00 every year
Ground Ambulance Services	$50.00 Copayment One-Way	$75.00 Copayment One-way
Hearing Aids	Annual maximum Plan Benefit Coverage is $2,500.00 both ears combined per year	Annual maximum Plan Benefit Coverage is $1,500.00 both ears combined per year

Cost	2023 (this year)	2024 (next year)
PAPA® **In-Home Support Services** Papa connects members with Pals for companionship and assistance with everyday activities and tasks such as: conversation, assistance with technology, light cleaning, laundry, organizing, transportation for errands and more.	In-Home Support Services is not covered.	40 hours total per year (4 hours maximum per month) Contact the plan for details.
Medicare Part B Insulin Drugs	20% Coinsurance	20% Coinsurance Insulin copayment maximum $35.00
Observation Services	$75.00 Copayment	$50.00 Copayment
Outpatient Hospital Services	$75.00 Copayment	$50.00 Copayment
Over-the-Counter (OTC) Items	$85.00 every month	$100.00 every month
Podiatry Services	$0.00 Copayment Unlimited visits for Medicare & Routine Footcare Covered - Authorization required after initial evaluation and first 10 treatments/visits.	$0.00 Copayment Unlimited visits for Medicare & Routine Footcare Covered - Authorization required after initial evaluation and first 11 treatments/visits.
Worldwide Emergency/Urgent Coverage	$50.00 Copayment Worldwide Emergency Plan maximum plan benefit coverage amount: $50,000	$50.00 Copayment Worldwide Emergency Plan maximum plan benefit coverage amount: $75,000

Section 3.5 – 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,” 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, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online “Drug List” to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Member Services for more information.

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 have included 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 didn’t receive this insert with this packet, please call Member Services and ask for the LIS Rider.

There are four **drug payment stages**. The information below shows the changes 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.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Please see the following chart for the changes from 2023 to 2024.

Stage	2023 (this year)	2024 (next year)
Stage 2: 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.** Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 Preferred** **Generic:** You pay $0.00 Copayment per prescription. **Tier 2 Generic:** You pay*:* $0.00 Copayment per prescription. **Tier 3 Preferred Brand**: You pay $15.00 Copayment per prescription. **Tier 4 Non-Preferred Brand**: You pay $70	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 Preferred** **Generic:** You pay*:* $0.00 Copayment per prescription. **Tier 2 Generic:** You pay*:* $0.00 Copayment per prescription. **Tier 3 Preferred Brand**: You pay $15.00 Copayment per prescription. **Tier 4 Non-Preferred Drug**: You pay $70 Copayment per prescription.

Stage	2023 (this year)	2024 (next year)
	Copayment per prescription. **Tier 5 Specialty Tier**: You pay 33% Coinsurance of the total cost. **Tier 6 Supplemental Drugs**: You pay $0.00 Copayment per prescription.	**Tier 5 Specialty Tier**: You pay 33% Coinsurance of the total cost. **Tier 6 Supplemental Drugs**: You pay $0.00 Copayment per prescription.
Stage 2: Initial Coverage Stage (continued) The costs in this row are for a one-month (*30*-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs, look in Chapter 6, Section 5 of your *Evidence of Coverage*.	Once your total drug costs have reached $4,660.00, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $5,030.00, 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**.

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in Solis Healthy Living Plan

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 be enrolled in our Solis Healthy Living Plan.

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *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 3.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

As a reminder, Solis Health Plans, Inc offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Solis Healthy Living Plan.

- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Solis Healthy Living Plan.
- 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 so.
  - – *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 5 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, 2024.

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

In certain situations, changes are also allowed at other times of the year. Examples include 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.

If you enrolled in a Medicare Advantage plan for January 1, 2024, 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, 2024.

If you recently moved into, currently live in, or just moved out of 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 (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 6 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Florida, the SHIP is called SHINE (Florida SHIP-SMP Department of Elder Affairs).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHINE (Florida SHIP-SMP Department of Elder Affairs) 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 SHINE (Florida SHIP-SMP Department of Elder Affairs) at 1-800-963-5337 (TTY 1-800-955-8770). You can learn more about SHINE (Florida SHIP-SMP Department of Elder Affairs) by visiting their website (http://www.floridashine.org/ .

SECTION 7 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. 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 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
  - Your State Medicaid Office (applications).
- **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 Florida ADAP . For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Florida HIV/AIDS Hotline at 1-800-352-2437 (English) / 1-800-545-7432 (Spanish) /1-800-243-7101 (Creole) / 1-888-503-7118 (TTY).

SECTION 8 Questions?

Section 8.1 – Getting Help from Solis Healthy Living Plan

Questions? We're here to help. Please call Member Services at 1-844-447-6547. (TTY only, call 711). We are available for phone calls 8:00 a.m. to 8:00 p.m. seven days a week from October 1st – March 31st and 8:00 a.m. to 8:00 p.m. Monday-Friday from April 1st- September 30th. Calls to these numbers are free.

Read your *2024 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 2024. For details, look in the *2024 Evidence of Coverage* for Solis Healthy Living Plan. 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 http://www.solishealthplans.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 http://www.solishealthplans.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs (Formulary/"Drug List").*

Section 8.2 – 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

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2024*

Read the *Medicare & You 2024* handbook. Every fall, this document 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 document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) 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.