



# 2024 SUMMARY OF BENEFITS SOLIS GUARDIAN PLAN (D-SNP)

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# 2024 SUMMARY OF BENEFITS

## Solis Guardian Plan (D-SNP)

Our service area includes this county in Florida; **Hillsborough**  
January 1, 2024 - December 31, 2024

The Summary of Benefits does not list every service that we cover, or list every limitation or exclusion. To obtain a complete list of services we cover, please visit our website or call us to request a copy.

### To Learn More About Medicare:

- Compare your Medicare options with other plans you can use the Medicare Plan Finder on [www.medicare.gov](http://www.medicare.gov)
- Learn more about the 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.

To join **Solis Guardian Plan (D-SNP)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

### What Does This Plan Cover?

- Our plans cover everything that Original Medicare covers - and more!
- Our plans have prescription drug coverage (Part D). You can see Solis' comprehensive prescription drug list (Formulary) on our website.
- 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. Services are available when using an in-network provider. Out-of-network provider services are not covered except in emergency situations.

### Do You Have Questions?

Our Member Services Department is ready to help with any questions you have.



**1-844-447-6547 (TTY:711)**

From October 1 - March 31, we are open 7 days a week: 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday from 8 a.m. to 8 p.m.

Visit us online at **[www.solishealthplans.com](http://www.solishealthplans.com)**

# 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 Member Service representative at 1-844-447-6547 (TTY: 711).

## Understanding the Benefits

- The Evidence of Coverage (EOC), provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. 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/Pharmacy 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 Provider/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.
- Review the Formulary to make sure your drugs are covered.

## Understanding Important Rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2025.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the Provider/Pharmacy Directory).
- Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.
- This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

**Questions:** 1-844-447-6547 (TTY:711)

## Monthly Plan Premium

**\$0 - \$37.70** Monthly Premium

You must continue to pay your Part B premium.

## Deductible

**\$0** Deductible

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

**\$3,400** In-network only

Under our plan this is the most you will pay during the plan year for approved medical services. Should you meet the maximum, you will not have to pay any out-of-pocket costs for covered Part A and Part B services for the rest of the year.

# Covered Medical and Hospital Benefits

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

**\$0** copay

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

**\$0** copay per observation or per stay

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

**\$0** copay

## Doctor Visits

Primary Care: **\$0** copay

Specialists:<sup>A,R</sup> **\$0** copay

Authorization not required for initial evaluation

Authorization may be required for subsequent visits

**A** - Authorization may be required    **R** - Referral may be required

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## Preventive Care

**\$0** copay for all Medicare-covered preventive services, including:

- 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<sup>A,R</sup> (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- Depression screening
- Diabetes screening
- Diabetes self-management training
- HIV screening
- Immunizations
- Lung cancer screening<sup>R</sup>
- Medical nutrition therapy<sup>R</sup>
- Medicare Diabetes prevention program<sup>R</sup>
- Obesity screening and therapy<sup>R</sup>
- Prostate cancer screening (PSA)
- Screening and counseling to reduce alcohol misuse
- Screening for sexually transmitted infections and counseling<sup>R</sup>
- Tobacco use cessation counseling<sup>R</sup> (counseling for people with no sign of tobacco-related disease)
- “Welcome to Medicare” preventive visit (one-time)

## Emergency Care<sup>A</sup>

**\$0** copay

International Emergencies - **\$75,000** annual benefit max

**\$0** copay

## Urgently Needed Services

**\$0** copay

**A** - Authorization may be required    **R** - Referral may be required

**Questions:** 1-844-447-6547 (TTY:711)

## Diagnostic Services/Labs/Imaging

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

**\$0** copay - In Network Non-Hospital Facility

**\$0** copay - Hospital Facility

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

**\$0** copay - In Network Non-Hospital Facility

**\$0** copay - Hospital Facility

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

**\$0** copay - In Network Non-Hospital Facility

**\$0** copay - Hospital Facility

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

**\$0** copay - In Network Non-Hospital Facility

**\$0** copay - Hospital Facility

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

**\$0** copay - In Network Non-Hospital Facility

**\$0** copay - Hospital Facility

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

**\$0** copay Unlimited Hearing Exam & Hearing Aid Evaluation

**\$1,000** Hearing Aid allowance - both ears combined per year

This plan offers a Flex Card that allows you to pay for out-of-pocket, or additional services for dental, vision and/or hearing on a prepaid card. For more details, see the Additional Benefits section.

**A** - Authorization may be required    **R** - Referral may be required

## Dental Services

### Preventive<sup>R</sup>

Oral Exam **\$0** copay - 2 per year

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Prophylaxis Cleaning **\$0** copay - 2 per year

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Fluoride Treatment **\$0** copay - 2 per year

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Dental X-Rays **\$0** copay - 2 series of bitewing film, and 1 Panoramic film per year

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

Deep Cleaning: Periodontal Scaling & Root Planing **\$0** copay - 2 visits a year

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Extractions **\$0** copay - Unlimited

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Root Canal **\$0** copay - 1 per year (2 visits a year)

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Dentures **\$0** copay - Dentures every 5 years (1 complete set or 2 partials) and 1 Re-Alignment per year

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Crowns & Filling **\$0** copay - 2 crowns a year and 1 filling (3 visits a year)

This plan offers a Flex Card that allows you to pay for out-of-pocket, or additional services for dental, vision and/or hearing on a prepaid card. For more details, see the Additional Benefits section.

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

**\$0** copay - 1 Eye exam per year

**\$350** Annual allowance for contact lenses; Eyeglasses (lenses and frames)

This plan offers a Flex Card that allows you to pay for out-of-pocket, or additional services for dental, vision and/or hearing on a prepaid card. For more details, see the Additional Benefits section.

**A** - Authorization may be required **R** - Referral may be required

**Questions:** 1-844-447-6547 (TTY:711)

## Mental Health Services

Inpatient hospital (Psychiatric)<sup>A,R</sup> **\$0** copay

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Mental Health Specialty Services<sup>R</sup> **\$0** copay - Individual Sessions  
(Medicare-covered) **\$0** copay - Group Sessions

## Skilled Nursing Facility<sup>A,R</sup>

**\$0** copay

2 day prior network hospital admission prerequisite

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

**\$0** copay

## Ambulance<sup>A</sup>

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

**\$0** copay

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**Medicare-covered Air Ambulance Services:**

**\$0** copay

Authorization is required for non-emergency Medicare service

## Transportation<sup>R</sup>

**\$0** copay

Unlimited trips to plan approved health-related locations through our transportation vendor. Members may request Uber or Lyft.

## Medicare Part B Drugs<sup>A</sup>

**\$0** copay

Chemotherapy/Radiation Drugs and Other Medicare Part B Drugs

Insulin cost sharing is subject to a coinsurance cap of \$35 for one-month's supply of insulin.

**A** - Authorization may be required    **R** - Referral may be required

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# Additional Benefits

## Healthy Living Card

**\$140** monthly allowance on a pre-paid card that can be used to pay for rent, utilities, groceries, and transportation.

## Flex Card (Dental, Vision & Hearing)

**\$1,250** annual allowance on a pre-paid card to pay for out-of-pocket cost or additional services for dental, vision and/or hearing. Allowance for benefits that are included in your combined supplemental benefit group of dental, vision and hearing.

## Over-the-Counter (OTC)

**\$75** per month for plan approved over-the-counter and health-related products. Please visit our website or call our Member Services Department to request an OTC Catalog.

## Erectile Dysfunction Drugs (ED)

You are covered for up to 6 pills per month (Generic versions: Cialis & Viagra)

## Papa™ A,R (In-Home Support/Companionship)

**100 hours** total per year (10 hours max per month)

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.

## Silver&Fit® R (Fitness)

**\$0** copay

Stay active with Silver&Fit®: A fitness membership that provides gym facilities and at-home resources, including online workout classes and home fitness kits, at no additional cost to you.

## Meals<sup>A</sup>

2 meals a day for 7 days following surgery or inpatient hospitalization, for unlimited hospitalizations.

**A** - Authorization may be required    **R** - Referral may be required

**Questions:** 1-844-447-6547 (TTY:711)

## 24-Hour Nurse Hotline

Solis Health Plans offers a Nurse Hotline, 24-hours a day, 7 days a week, to offer advice and attention on symptoms or health related questions by calling 1-833-371-9569 (TTY/TDD:711).

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

**\$0** copay for Medicare-covered Chiropractic Services  
Unlimited Routine Care  
Authorization may be required after first 12 visits

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

**\$0** copay - Unlimited Routine Care  
Referral and/or authorization may be required after initial evaluation and first 11 treatments

## Acupuncture<sup>A</sup>

**\$0** copay for up to 24 visits  
Authorization may be required after the 12th visit

## Medical Equipment/Supplies

Diabetic Supplies	<b>\$0</b> copay
Diabetic Therapeutic Shoes or Inserts <sup>A</sup>	<b>\$0</b> copay

Diabetic Supplies and Services have preferred manufacturers

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Durable Medical Equipment <sup>A</sup>	<b>\$0</b> copay
- Medicare-covered ventilators	
- Bone growth stimulators	
- Portable oxygen concentrators	
- Bariatric equipment	
- Specialty beds	
- Custom wheelchairs	
- Seat lifts	
- Specialty brand items	

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All other Durable Medical Equipment	<b>\$0</b> copay
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Prosthetic Devices <sup>A</sup>	<b>\$0</b> copay
- 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

# Prescription Drug Benefits

## Important Message About What You Pay for Vaccines:

Our plan covers most Part D vaccines at no cost to you. Call our Member Services Department for more information.

## Important Message About What to Pay for Insulin:

You won't pay more than \$35 for one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

## Deductible

Your deductible amount is either \$0 or \$545, depending on the level of "Extra Help" you receive.

## Initial Coverage

You stay in this stage until the total amount of your prescription drugs, which you pay and our Part D plan pays, reaches **\$5,030**.

Your copayment or coinsurance amount can be found on the following table:

<b>TIERS</b>	<b>Standard Retail Rx 30-day Supply</b>	<b>Standard Retail Rx 90-day Supply</b>	<b>Out-of-Network Retail Rx 30-day Supply</b>	<b>Mail Order 90-day Supply</b>
<b>Tier 1: Preferred Generic</b>	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
<b>Tier 2: Generic</b>	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
<b>Tier 3: Preferred Brand</b>	25% coinsurance	25% coinsurance	25% coinsurance	Not Available
<b>Tier 4: Non-Preferred Drug</b>	25% coinsurance	25% coinsurance	25% coinsurance	Not Available
<b>Tier 5: Specialty</b>	25% coinsurance	Not Available	25% coinsurance	Not Available
<b>Tier 6: Supplemental Drugs</b>	\$0 copay	\$0 copay	\$0 copay	\$0 copay

## Coverage Gap

After your total yearly drug costs (what you and the plan pay) reach **\$5,030** you enter the Coverage Gap.

In this stage your cost for Tier 1 through Tier 4 is the same and you will pay 25% of the plans' cost for all other covered drugs while in the Coverage Gap.

## Catastrophic Coverage

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the **\$8,000** limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will pay the greater of; \$4.50 for a generic drug or a drug that is treated like a generic and \$11.20 copayment for all other drugs, or a 5% coinsurance.

## Prescription Coverage When You Have 'Extra Help'

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.

"Extra Help" Level	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>	\$4.50	\$11.20
<b>Level 2</b>	\$1.55	\$4.60
<b>Level 3</b>	\$0	\$0
<b>Level 4</b>	CMS will be transitioning LIS 4 Beneficiaries to LIS 1	

Amounts change yearly. For the most updated information, please visit our website [www.solishealthplans.com](http://www.solishealthplans.com).

Solis Health Plans Inc., is an HMO plan with a Medicare contract. Enrollment in Solis Health Plans, Inc., depends on contract renewal. This information is not a complete description of benefits. Call Member Services at 1-844-447-6547 (TTY: 711). We are open from October 1 - March 31, we are open 7 days a week; 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday from 8 a.m. to 8 p.m.