SOLIS
HEALTH PLANS

Solis Healthy Living Plan (HMO)

2024
SUMMARY OF BENEFITS
SOLIS HEALTHY LIVING PLAN (HMO)

H0982_SUMBNF0072024_M 09/06/23

2024 SUMMARY OF BENEFITS

Solis Healthy Living Plan (HMO)

Our service area includes this county in Florida; **Broward**
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
- Learn more about the 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.

  To join **Solis Healthy Living Plan (HMO)**, 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**

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 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.

Monthly Plan Premium

$0 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[A,R]

$0 copay

Outpatient Hospital[A,R]

$50 copay per observation or per stay

Ambulatory Surgical Center[A,R]

$0 copay

Doctor Visits

Primary Care:	**$0** copay
Specialists:[A,R]	**$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

Preventive Care

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

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

Emergency Care

$75 copay - waived if admitted to the hospital within 1 day

International Emergencies - **$75,000** annual benefit max
$50 copay - waived if admitted to the hospital within 1 day

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:[R]

$0 copay - In Network Non-Hospital Facility
$25 copay - Hospital Facility

Medicare-covered Lab Services:[R]

$0 copay - In Network Non-Hospital Facility
$50 copay - Hospital Facility

Medicare-covered X-Ray Services:[A,R]

$0 copay - In Network Non-Hospital Facility
$25 copay - Hospital Facility

Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc.):[A,R]

$0 copay - In Network Non-Hospital Facility
$75 copay - Hospital Facility

Medicare-covered Therapeutic Radiological Services:[A,R]

$0 copay - In Network Non-Hospital Facility
$25 copay - Hospital Facility

Hearing Services[A,R]

$0 copay Unlimited Hearing Exam & Hearing Aid Evaluation
$1,500 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[R]	
Oral Exam	**$0** copay – 2 per year
Prophylaxis Cleaning	**$0** copay – 2 per year
Fluoride Treatment	**$0** copay – 2 per year
Dental X-Rays	**$0** copay – 2 series of bitewing film, and 1 Panoramic film per year
Comprehensive[A,R]	
Deep Cleaning: Periodontal Scaling & Root Planing	**$0** copay – 3 visits, every 2 years
Extractions	**$0** copay – Unlimited
Root Canal	**$0** copay – 1 per year (2 visits a year)
Dentures	**$0** copay – Dentures every 5 years (1 complete set or 2 partials) and 1 Re-Alignment per year
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[A,R]

$0 copay – 1 Eye exam per year
$250 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

Mental Health Services

Inpatient hospital (Psychiatric)[A,R]	**$0** copay
Mental Health Specialty Services[R] (Medicare-covered)	**$15** copay - Individual Sessions **$5** copay - Group Sessions

Skilled Nursing Facility[A,R]

$0 copay, days 1-20
$50 copay per day, for days 21-100
2 day prior network hospital admission prerequisite

Rehabilitation Services (Physical Therapy and Speech Language Pathology Services)[A,R]

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

Ambulance[A]

Medicare-covered Ground Ambulance Services (one-way trip only)**:**
$75 copay - waived if admitted to the hospital

Medicare-covered Air Ambulance Services:
20% coinsurance - waived if admitted to the hospital

Authorization is required for non-emergency Medicare service

Transportation[R]

$0 copay
Unlimited trips to plan approved health-related locations through our transportation vendor. Members may request Uber or Lyft.

Medicare Part B Drugs[A]

20% coinsurance
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

Additional Benefits

Flex Card (Dental, Vision & Hearing)

$1,000 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)

$100 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)

40 hours total per year (4 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[A]

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[A,R]

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

Podiatry Services[A,R]

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

Acupuncture[A]

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

Medical Equipment/Supplies

Diabetic Supplies Diabetic Therapeutic Shoes or Inserts[A]	**$0** copay **20%** coinsurance
Diabetic Supplies and Services have preferred manufacturers	
Durable Medical Equipment[A] - Medicare-covered ventilators - Bone growth stimulators - Portable oxygen concentrators - Bariatric equipment - Specialty beds - Custom wheelchairs - Seat lifts - Specialty brand items	**20%** coinsurance
All other Durable Medical Equipment	**0%** coinsurance
Prosthetic Devices[A] - Medicare-covered prosthetic devices	**20%** coinsurance

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

$0 deductible

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:

TIERS	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
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 Drug	$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

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 and Tier 2 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
Level 1	$4.50	$11.20
Level 2	$1.55	$4.60
Level 3	$0	$0
Level 4	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.

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.