HealthSun
HEALTH PLANS

2020
SUMMARY OF BENEFITS

HealthAdvantage Plan (HMO) | 012

BROWARD COUNTY

2020 SUMMARY OF BENEFITS

HealthSun HealthAdvantage Plan (HMO)

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 877-336-2069 (TTY users call 877-206-0500). Our hours of operation are Monday through Friday, 8am to 8pm (October through March we are open 7 days a week, 8am to 8pm).

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.HealthSun.com or call 877-336-2069 (TTY users call 877-206-0500) 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

☐ 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, 2021.

☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory.

HealthSun HealthAdvantage Plan (HMO)
Summary of Benefits

This booklet provides you with a summary of the medical and prescription drug benefits covered by **HealthSun HealthAdvantage Plan (HMO)** beginning January 1, 2020 through December 31, 2020. Please refer to your plan's Evidence of Coverage for a complete list and description of the services covered by the plan. You can find your plan's Evidence of Coverage (EOC) on our website by visiting **www.HealthSun.com**. If you would like us to mail you a copy of the EOC, please call HealthSun Member Services (phone numbers and hours of availability are listed at the bottom of this page).

Who Can Enroll?

You can enroll in HealthSun HealthAdvantage (HMO) as long as you have both Medicare Part A and Medicare Part B and you live in **Broward County.**

What doctors, hospitals, and pharmacies can you use?

You must get your care and services from doctors, other health care providers, or hospitals in the plan's network. If you use providers that are not in the plan's network, the plan may not pay for these services. Prior-authorization or a referral from your PCP may be required for covered medical services provided by a network physician specialist. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. To find network providers and pharmacies near you, download a copy of the Provider Pharmacy Directory or use our online search tool, both located on our website at www.HealthSun.com. If you would like us to mail you a copy of our Provider Pharmacy Directory, please call HealthSun Member Services (phone numbers and hours of availability are listed at the end of this page).

The "Medicare & You" Handbook

If you want to know more about the coverage and costs of Original Medicare, look in your 2020 "Medicare & You" handbook. You can find it online at **www.medicare.gov** or request a copy 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.**

This information is available in different formats, including Braille and large print. This document is available for free in Spanish. Este documento está disponible en español. **ATENCIÓN:** Si habla español, tiene a su disposiciónservicios gratuitos de asistencia lingüística. Llame al **1-877-336-2069 (TTY: 1-877-206-0500).**

HealthSun Health Plans is an **HMO** plan with a Medicare contract. Enrollment in HealthSun Health Plans depends on contract renewal. Every year, Medicare evaluates plans based on a 5-star rating system. This information is not a complete description of benefits. Call HealthSun Member Services at **1-877-336-2069 (TTY: 1-877-206-0500)** for more information. Our hours of operation are Monday through Friday, 8am to 8pm (October through March we are open 7 days a week, 8am to 8pm).

Premium, Deductible, & Out-of-Pocket	Our plan covers:
Monthly Plan Premium	$0. You must continue to pay your Medicare Part B premium.
Deductible?	This plan does not have a deductible for medical services.
Maximum Out-of-Pocket	$3,400 per year for services you receive from in-network providers for most Part A & Part B services. Once you have paid this amount, the plan will pay for most of your covered services for the rest of the year. You will still need to pay your Part B premium and your prescription drug costs.

Covered Medical and Hospital Services	Our plan covers:
Note: Services marked with a [1] may require prior authorization and services marked with a [2] may require a referral from your doctor.	
Inpatient Hospital Care[1,2]	**$0 Copay** Our plan covers unlimited additional days for inpatient acute care.
Outpatient Hospital Care[1,2]	**$0 copay** for labs and observation services. $25 copay for radiation therapy. $50 copay for x-rays and diagnostic procedures ($0 at a free-standing facility). $100 copay for surgery and other hospital services ($50 copay for outpatient surgery at a free-standing facility).
Doctor Visits[1,2]	**$0 Copay** Primary Care Physician (PCP) and Specialist visits.
Preventive Care[1,2]	**$0 Copay** Our plan covers the following Medicare-covered preventive services: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit • Cardiovascular disease testing • Cervical and vaginal cancel screening • Colorectal cancer screenings • Depression screening • Diabetes screenings and self-management training • Glaucoma screening • Health and wellness education programs • Nutritional dietary counseling • HIV screening • Lung cancer screening • Medical nutrition therapy • Medicare diabetes prevention program • Obesity screening and counseling • Prostate cancer screenings • Sexually transmitted infections screening and counseling • Smoking and tobacco use cessation counseling • Vaccines, including Flu, Hepatitis B, and Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time)

Emergency Care	$75 copay Copay waived if you are admitted to the hospital within 24 hours. **$50,000** maximum benefit coverage amount for worldwide emergency.
Urgently Needed Services	$25 copay Copay waived if you are admitted to the hospital within 24 hours.
Outpatient Diagnostic Services/Labs/Imaging[1,2]	**$0 copay** for lab services. **$0 copay** at a physician office or free-standing facility and $50 copay at a hospital as an outpatient for the following services: • Diagnostic tests and procedures (EKG, cardiac evaluation, respiratory function tests, allergy tests, psychological test, etc.) • X-rays • Diagnostic radiological services (MRI, CT scan, etc.) **$0 copay** at a physician office or free-standing facility and $25 copay at a hospital as an outpatient for the following services: • Therapeutic radiological services (radiation therapy for cancer)
Hearing Services[1,2]	**$0 copay** Our plan covers the following supplemental benefits: • Routine hearing exam • Hearing aid fitting and evaluation • Hearing aids **$1,500** maximum benefit coverage amount for 2 hearing aids, both ears combined, every 2 years.
Dental Services	**$0 copay** Our plan covers the following dental services: Preventive • Oral exams, 2 every year • Cleanings, 2 every year • Fluoride treatments, 2 every year • Bitewing dental x-rays, 2 every year • Full-mouth x-rays, 1 every 3 years Comprehensive • Resin filing on anterior teeth • Amalgam filing • Simple extraction performed by General Dentist • Full mouth debridement • Total superior prosthesis • Total inferior prosthesis • Partial dentures **$4,000** maximum benefit coverage amount for all dental services every year.

Vision Services	**$0 Copay** Our plans covers the following supplemental benefits: • Routine eye exam • Contact lenses • Eyeglasses (frames and lenses) **$300** maximum benefit coverage amount for contact lenses and eyeglasses (frames and lenses) every year.
Mental Health Care[1,2]	**$0 copay** Our plan covers inpatient mental health care services and individual and group therapy sessions for outpatient mental health care.
Skilled Nursing Facility (SNF)[1,2]	**$0 copay** for days 1 through 20. $55 copay per day for days 21 through 100. No prior hospital stay is required.
Physical Therapy[1,2]	$5 Copay
Ambulance	$200 copay Copay waived if you are admitted to the hospital. Our plan covers ground and air ambulance services.
Transportation[1,2]	**$0 Copay** Trips are unlimited to plan-approved health-related locations.
Medicare Part B Drugs[1]	20% of the total cost.
Ambulatory Surgical Center[1,2]	$50 copay for outpatient surgery at an ambulatory surgical center.

Prescription Drug Benefits	**Our plan covers:**
Deductible Stage	This plan does not have a Part D deductible.
Initial Coverage Stage	The Initial Coverage Limit (ICL) for our plan is **$4,020**. During this stage, you pay your share of the cost and the plan pays the rest for your covered drugs. You stay in this stage until your total drug costs paid by both you and the plan reach the ICL. In the tables below, you will find your share of the cost for your covered Part D drugs during Initial Coverage Stage. **Preferred Retail Pharmacy and Mail-Order Pharmacy**

Tier	One-month, supply (30 days)	Three-month, supply (90 days)
Tier 1 (Preferred Generic)	$0	$0
Tier 2 (Generic)	$0	$0
Tier 3 (Preferred Brand)	$15	N/A
Tier 4 (Non-Preferred Brand)	$30	N/A
Tier 5 (Specialty Tier)	33%	N/A
Tier 6 (Supplemental)	$0	N/A

Initial Coverage (cont)

Standard Retail Pharmacy

Tier	One-month, supply (30 days)	Three-month, supply (90 days)
Tier 1 (Preferred Generic)	$0	$0
Tier 2 (Generic)	$0	$0
Tier 3 (Preferred Brand)	$20	N/A
Tier 4 (Non-Preferred Brand)	$35	N/A
Tier 5 (Specialty Tier)	33%	N/A
Tier 6 (Supplemental)	$0	N/A

Long Term Care (LTC) Pharmacy

Tier	One-month, supply (34 days)	Three-month, supply (90-days)
Tier 1 (Preferred Generic)	$0	N/A
Tier 2 (Generic)	$0	N/A
Tier 3 (Preferred Brand)	$20	N/A
Tier 4 (Non-Preferred Brand)	$35	N/A
Tier 5 (Specialty Tier)	33%	N/A
Tier 6 (Supplemental)	$0	N/A

Coverage Gap Stage

The out-of-pocket limit for our plan is **$6,350**.

During this stage, you continue to pay $0 for drugs in Tier 1 (preferred generic) and in Tier 2 (generic). You pay 25% of the negotiated price for brand name drugs and you pay no more than 25% of the cost for all other generic drugs. You stay in this stage until you reach the out-of-pocket limit.

In the tables below, you will find your share of the cost for your covered Part D drugs during Coverage Gap Stage.

Preferred Retail Pharmacy and Mail-Order Pharmacy

Tier	One-month, supply (30 days)	Three-month, supply (90 days)
Tier 1 (Preferred Generic)	$0	$0
Tier 2 (Generic)	$0	$0

Standard Retail Pharmacy

Tier	One-month, supply (30 days)	Three-month, supply (90 days)
Tier 1 (Preferred Generic)	$0	$0
Tier 2 (Generic)	$0	$0

Catastrophic Coverage Stage	Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year. During this stage, the plan will pay most of the cost for your drugs. Your share of the cost for a covered drug will be either coinsurance or a copayment, whichever is the larger amount: • –either – 5% of the cost of the drug • –or – $3.60 for a generic drug or a drug that is treated like a generic and $8.95 for all other drugs.
Note: You pay $0 for Part D excluded drugs in Tier 6 (supplemental brand and generic drugs) during all four stages.	

Generally, the drugs provided through mail order are those you take on a regular basis, for a chronic or long-term medical condition. The drugs available through our plan's mail-order services are marked as "mail-order" drugs in our Drug List.

We cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy under plan-approved circumstances. If approved, your share of the cost is what you pay for the drug at an in-network pharmacy. In these situations, please check first if there is a network pharmacy nearby. Costs may differ based on pharmacy type or status

Additional Covered Medical Benefits	**Our plan covers:**
Note: Services marked with a [1] may require prior authorization and services marked with a [2] may require a referral from your doctor.	
Acupuncture[1,2]	**$0 Copay** Our plan covers 12 treatments every year.
Chiropractic Care	**$0 Copay** Our plan covers 12 routine care visits every year.
Diabetic Supplies and Services[1]	**$0 Copay** for diabetic supplies and services. 10% of the cost for diabetic therapeutic shoes or inserts.
Durable Medical Equipment[1]	**$0 copay** for Continuous Glucose Monitors (CGMs). 10% of the cost for all other durable medical equipment.
Foot Care (Podiatry services)[1]	**$0 Copay** Our plan covers up to 1 routine care visit every 3 months.
Health Education, Nutritional/Dietary	**$0 Copay** **Health Education** Health Education is available and offered to all enrollees for whom a need for education about a specific disease or condition is identified through a health risk assessment or a physician- or self-generated referral. **Nutritional Benefits** Unlimited nutritional counseling provided to beneficiaries in an individual or group setting by a nutrition professional as deemed medically necessary by the treating physician.

Home Health Care[1,2]	**$0 Copay**
Kidney Disease Education and Dialysis Services[1,2]	**$0 Copay**
Meal Benefit[1,2]	**$0 copay** Members are eligible to receive nutritious, precooked frozen meals delivered to you at no cost after an overnight stay in the hospital or nursing facility or following a surgery with an inpatient hospital stay. The meal program lasts up to 14 days with a maximum of 42 meals (up to 3 meals per day).
Nursing Hotline	**$0 copay** Members have access to a toll free nurse line to speak directly to a registered nurse who will help answer health-related questions.
Outpatient Observation Services[1]	**$0 Copay**
Opioid Treatment Services[1,2]	**$0 Copay**
Outpatient Blood Services[1,2]	**$0 Copay**
Outpatient Rehabilitation Services[1,2]	$5 copay Our plan covers cardiac rehabilitation, intensive cardiac rehabilitation, pulmonary rehabilitation, supervised exercise therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) services, physical therapy, occupational therapy, and speech-language pathology therapy services.
Outpatient Substance Abuse[1,2]	**$0 Copay** Our plan covers individual and group therapy sessions for outpatient substance abuse.
Over-the-Counter (OTC) Items	**$48** benefit amount for plan approved OTC items every month.
Partial Hospitalization[1,2]	**$0 Copay**
Prosthetic Devices and related Medical Supplies[1]	10% of the cost
SilverSneakers® Fitness Benefit	**$0 Copay** The fitness program includes membership access to all basic amenities at all of the participating locations. Members receive support from certified instructors and have access to group classes for desired fitness level. The program also includes health and nutritional tips along with exercise videos through the SilverSneakers website.

Notice of Non-Discrimination

HealthSun Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HealthSun does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

1) HealthSun provides free aids and services to people with disabilities to communicate effectively with us, such as:
   - Qualified sign language interpreters.
   - Written information in other formats (large print, audio, accessible electronic formats, other formats)
2) HealthSun provides free language services to people whose primary language is not English, such as:
   - Qualified interpreters
   - Information written in other languages

If you need these services, contact our Member Services Department at 877-336-2069. TTY 877-206-0500. If you believe that HealthSun has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Grievance Department
3250 Mary Street, Suite 400,
Coconut Grove, FL 33133,
T. 877-336-2069 (TTY: 877-206-0500)
F. 305-234-9275
E-mail: HScivilrights@healthsun.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Member Services is available to help you. You can also file a civil rights complaint electronically with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 800-368-1019, (TDD: 800-537-7697). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Discriminación Es Contra La Ley

HealthSun Health Plans cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. HealthSun no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

1) HealthSun proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes:
   - Intérpretes de lenguaje de señas capacitados.
   - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos).
2) HealthSun proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes:
   - intérpretes capacitados
   - información escrita en otros idiomas.

Si necesita recibir estos servicios, llame a nuestro departamento de Servicios al Miembro al teléfono 877-336-2069. TTY 877-206-0500. Si considera que HealthSun no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo al siguiente:

Departamento de Quejas
3250 Mary Street, Suite 400,
Coconut Grove, FL 33133,
T. 877-336-2069 (TTY: 877-206-0500) F. 305-234-9275
E-mail: HScivilrights@healthsun.com

Puede presentar el reclamo en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo, el departamento de Servicios al Miembro está a su disposición para brindársela. También puede presentar un reclamo de derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios de EE. UU. de manera electrónica a través del Complaint Portal, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, por correo postal a la siguiente dirección o por teléfono: U.S. Department of Health and Room 509F, HHH Building Washington, DC 20201 800-368-1019, (TDD: 800-537-7697. Puede obtener los formularios de reclamo en el sitio web http://www.hhs.gov/ocr/office/file/index.html.

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Multi-language Interpreter Services / Servicios de Intérprete Multilingüe

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-877-336-2069 (TTY: 1-877-206-0500).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-336-2069 **(TTY:** 1-877-206-0500**).**

Kreyòl Ayisyen (French Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-336-2069(TTY: 1-877-206-0500).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-336-2069**(TTY:** 1-877-206-0500**).**

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-336-2069 **(TTY:** 1-877-206-0500**).**

繁體中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-336-2069（TTY: 1-877-206-0500）。

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-336-2069 **(ATS:** 1-877-206-0500**).**

Tagalog (Tagalog – Filipino) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-336-2069 (TTY: 1-877-206-0500).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-336-2069(телетайп: 1-877-206-0500).

العربية (Arabic) ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 2069-336-877-1 (رقم هاتف الصم والبكم: 0500-206-877-1).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-336-2069 (TTY: 1-877-206-0500).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-336-2069 **(**TTY: 1-877-206-0500**).**

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-336-2069 (TTY: 1-877-206-0500) 번으로 전화해 주십시오.

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-336-2069 (TTY: 1-877-206-0500).

ગુજરાતી (Gujarati) સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-336-2069 (TTY: 1-877-206-0500).

ภาษาไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-336-2069 (TTY: 1-877-206-0500).

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Notes