HealthSun HealthAdvantage Plan (HMO) offered by HealthSun Health Plans

Annual Notice of Changes for 2022

You are currently enrolled as a member of HealthSun HealthAdvantage Plan (HMO). Next year, there will be some changes to the plan's costs and benefits*. This booklet tells about the changes.*

- **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.
- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.5 and 1.6 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.
- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2022 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices, and click the "dashboards" link in the middle of the second Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.
- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our *Provider Directory*.

☐ Think about your overall health care costs.
- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ 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 personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your *Medicare & You 2022* handbook.
- Look in Section 2.2 to learn more about your choices.

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☐ 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, 2021, you will be enrolled in HealthSun HealthAdvantage Plan (HMO).
   - To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2021**
   - If you don't join another plan by **December 7, 2021**, you will be enrolled in HealthSun HealthAdvantage Plan (HMO).
   - If you join another plan by **December 7, 2021**, your new coverage will start on **January 1, 2022.** You will be automatically disenrolled from your current plan.

Additional Resources

- This document is available for free in Spanish. Este documento está disponible en español. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-336-2069 (TTY: 1-877-206-0500).
- Please contact our Member Services number at 1-877-336-2069 for additional information. (TTY users should call 1-877-206-0500.) Hours are 8am to 8pm. During October 1st through March 31st we are open seven days a week from 8am to 8pm. From April 1st through September 30th we are available Monday through Friday from 8am to 8pm.
- This document is available in other formats such as Braille, large print or other alternate formats.
- **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 HealthSun HealthAdvantage Plan (HMO)

- HealthSun Health Plans is an HMO plan with a Medicare contract. Enrollment in HealthSun Health Plans depends on contract renewal.
- When this booklet says "we," "us," or "our," it means HealthSun Health Plans (Plan/Part D Sponsor). When it says "plan" or "our plan," it means HealthSun HealthAdvantage Plan (HMO).

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for HealthSun HealthAdvantage Plan (HMO) in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at www.healthsun.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	**$0**	**$0**
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 1.2 for details.)	**$3,450**	**$2,500**
Doctor office visits	Primary care visits: **$0 copay** per visit Specialist visits: **$0 copay** per visit	Primary care visits: **$0 copay** per visit Specialist visits: **$0 copay** per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**Inpatient acute:** **$0 copay** per stay. **Inpatient mental health care:** **$0 copay** per stay. **Skilled nursing facility (SNF):** **$0 copay** per stay for days 1 - 20 **$55 copay** per stay for days 21 - 100.	**Inpatient acute:** **$0 copay** per stay. **Inpatient mental health care:** **$0** copay per stay. **Skilled nursing facility (SNF):** **$0 copay** per stay for days 1 - 20 **$55 copay** per stay for days 21 - 100.
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: **$0** Copayment/ Coinsurance during the Initial Coverage Stage: **Preferred Retail Pharmacy** • Drug Tier 1: **$0** • Drug Tier 2: **$0** • Drug Tier 3: **$15** • Drug Tier 4: **$30** • Drug Tier 5: **33%** • Drug Tier 6: **$0** **Standard Retail Pharmacy** • Drug Tier 1: **$0** • Drug Tier 2: **$0** • Drug Tier 3: **$20** • Drug Tier 4: **$35** • Drug Tier 5: **33%** • Drug Tier 6: **$0**	Deductible: **$0** Copayment/Coinsurance during the Initial Coverage Stage: **Preferred Retail Pharmacy** • Drug Tier 1: **$0** • Drug Tier 2: **$0** • Drug Tier 3: **$0** • Drug Tier 4: **$30** • Drug Tier 5: **33%** • Drug Tier 6: **$0** **Standard Retail Pharmacy** • Drug Tier 1: **$0** • Drug Tier 2: **$0** • Drug Tier 3: **$20** • Drug Tier 4: **$35** • Drug Tier 5: **33%** • Drug Tier 6: **$0**

Annual Notice of Changes for 2022
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SECTION 1 Changes to Benefit and Cost for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	**$0**	**$0**

- 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.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 7 regarding "Extra Help" from Medicare.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during 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	2021 (this year)	2022 (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.	**$3,450**	**$2,500** Once you have paid **$2,500** 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 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider Directory* is located on our website at www.healthsun.com. You may also call Member Services for updated provider information or to ask us to mail you a *Provider Directory*. **Please review the 2022 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan, you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.

- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated *Pharmacy Directory* is located on our website at www.healthsun.com. You may also call Member Services for updated provider information or to ask us to mail you a *Pharmacy Directory*. **Please review the 2022 *Pharmacy Directory* to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2022 Evidence of Coverage.*

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Comprehensive Dental Services	Dental Implants are not covered. **$4,000** is the maximum plan benefit covered every year for preventive and comprehensive dental services combined. ***Prior authorization is not required for comprehensive dental services.***	**We cover the following:** **• Up to Two Dental Implants every year** • Up to Two Crowns every year • Up to Two Root Canals every year • One Scaling/root planing per quadrant per year • One Full mouth debridement every 24 months • One Total superior prosthesis every three years • One Total inferior prosthesis every three years • One Partial Dentures every three years **$5,000** is the maximum plan benefit covered every year for preventive and comprehensive dental services combined. ***Prior authorization is required for comprehensive dental services.***
In-Home Support Services	In-Home Support is not covered.	**We cover In-Home Support Services.** Up to 30 hours per calendar year of companionship and independent activities of daily living, such as helping with light chores, errands, tech support, and more. Must use the plan's contracted provider.
Medicare Part B Rx Drugs	You pay **20% of the total cost** for Medicare Part B drugs chemotherapy drugs.	You pay **0% of the total cost** for Medicare Part B drugs and chemotherapy drugs provided at a participating medical center. You pay **20% of the total cost** for Medicare Part B drugs and chemotherapy drugs provided at a physician's office, pharmacy, or hospital facility as an outpatient service.
Over the Counter (OTC)	**$48 every month** for plan-approved OTC items.	**$80 every month** for plan-approved OTC items.
Outpatient Diagnostic Procedures/ other tests	You pay a **$0 copay** at a participating physician's office or free-standing diagnostic/ ambulatory center. You pay a **$50 copay** at a hospital facility as an outpatient service.	You pay a **$0 copay** at all network provider locations**.**
Outpatient Diagnostic Radiological Services and X-Rays	You pay a **$0 copay** at a participating physician's office or free-standing diagnostic/ ambulatory center. You pay a **$50 copay** at a hospital facility as an outpatient service.	You pay a **$0 copay** at all network provider locations**.**
Outpatient Therapeutic Radiological Services	You pay a **$0 copay** at a participating physician's office or free-standing diagnostic/ ambulatory center. You pay a **$25 copay** at a hospital facility as an outpatient service.	You pay a **$0 copay** at all network provider locations**.**

Cost	2021 (this year)	2022 (next year)
Outpatient Hospital Services	You pay a **$100 copay.**	You pay a **$40 copay.**
Ambulatory Surgical Center (ASC)	You pay a **$50 copay.**	You pay a **$20 copay.**
Outpatient Rehabilitation Services: Physical Therapy Services	You pay a **$5 copay** for physical therapy services.	You pay a **$0 copay per visit** for physical therapy services at a participating medical center. You pay a **$5 copay per visit** for physical therapy services at a physician's office, rehab center or hospital facility as an outpatient service.
Personal Emergency Response System (PERS)	Personal Emergency Response (PERS) is not covered.	**We cover Personal Emergency Response (PERS).** One unit covered per member and includes the monitoring device and monitoring service.
Special Supplemental Benefit for the Chronically Ill (SSBCI): Healthy Meals	One meal a day for up to **15 meals** per month.	One meal a day for up to **20 meals** per month.
Special Supplemental Benefit for the Chronically Ill (SSBCI): Personal Hygiene Care	Personal Hygiene Care is not covered	**We cover Personal Hygiene Care, up to $25 every month** for routine maintenance of scalp and hair care (washing/cutting), and hands and feet (treatment of nails).
Urgently Needed Services	You pay a **$25 copay** for urgent care.	You pay a **$0 copay** for urgent care.
Additional Telehealth Services	Additional Telehealth is not covered.	**We cover Additional Telehealth Services.** Certain services are covered with a participating provider. Services include PCP services, individual sessions for mental health specialty or psychiatric services, and other health care professional services.

Section 1.6 – 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, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
  - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Member Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you stay in the same plan and are on a drug as a result of an exception from the previous plan year, you may continue to receive that exception into the new plan year. If the Plan does not honor the exception past the end of the benefit year, we will notify you in writing at least 60 days before the end of the current benefit year and will do either of the following:

1. We will offer to process an exception request for the next plan year.
2. We will give you a temporary supply of the requested drug at the beginning of the plan year and then tell you in writing that you must switch to a therapeutically appropriate drug on the formulary or get an exception to continue taking the requested drug.

Current formulary exceptions will be covered until the end of the calendar year. You will need to resubmit a new request to be covered in the next calendar year.

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.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

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 sent you 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. Because you receive "Extra Help" and didn't receive this insert with this packet, or haven't received this insert by September 30th, please call Member Services and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year 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. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*, which is located on our website at www.healthsun.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (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

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply at a network pharmacy: **Tier 1 Preferred Generic:** *Standard cost sharing:* You pay **$0** per prescription. *Preferred cost sharing:* You pay **$0** per prescription. **Tier 2 Generic:** *Standard cost sharing:* You pay **$0** per prescription. *Preferred cost sharing:* You pay **$0** per prescription. **Tier 3 Preferred Brand:** *Standard cost sharing:* You pay **$20** per prescription. *Preferred cost sharing:* You pay **$15** per prescription. **Tier 4 Non-Preferred Brand:** *Standard cost sharing:* You pay **$35** per prescription. *Preferred cost sharing:* You pay **$30** per prescription. **Tier 5 Specialty Tier:** *Standard cost sharing:* You pay **33%** of the total cost. *Preferred cost sharing:* You pay **33%** of the total cost. **Tier 6 Supplemental Drugs:** *Standard cost sharing:* You pay **$0** per prescription. *Preferred cost sharing:* You pay **$0** per prescription. _____ Once your total drug costs have reached **$4,130,** you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply at a network pharmacy: **Tier 1 Preferred Generic:** *Standard cost sharing:* You pay **$0** per prescription. *Preferred cost sharing:* You pay **$0** per prescription. **Tier 2 Generic:** *Standard cost sharing:* You pay **$0** per prescription. *Preferred cost sharing:* You pay **$0** per prescription. **Tier 3 Preferred Brand:** *Standard cost sharing:* You pay **$20** per prescription. *Preferred cost sharing:* You pay **$0** per prescription. **Tier 4 Non-Preferred Brand:** *Standard cost sharing:* You pay **$35** per prescription. *Preferred cost sharing:* You pay **$30** per prescription. **Tier 5 Specialty Tier:** *Standard cost sharing:* You pay **33%** of the total cost. *Preferred cost sharing:* You pay **33%** of the total cost. **Tier 6 Supplemental Drugs:** *Standard cost sharing:* You pay **$0** per prescription. *Preferred cost sharing:* You pay **$0** per prescription. _____ Once your total drug costs have reached **$4,430,** 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**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in HealthSun HealthAdvantage Plan (HMO)

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 HealthSun HealthAdvantage Plan (HMO).

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2022 follow these steps:

Step 1: Learn about and compare your choices

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

To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from HealthSun HealthAdvantage Plan (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from HealthSun HealthAdvantage Plan (HMO).
- 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 this (phone numbers are in Section 6.1 of this booklet).
  - – *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 3 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, 2022.

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

In certain situations, changes are also allowed at other times of the year. For example, 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 may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2022, 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, 2022. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Florida, the SHIP is called SHINE (Serving Health Insurance Needs of Elders).

SHINE is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHINE 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 at 1-800-963-5337 (TTY: 1-800-955-8770). You can learn more about SHINE by visiting their website (www.floridashine.org.).

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"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. Many people are eligible and don't even know it. 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 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); 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 AIDS Drug Assistant Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Florida AIDS Drug Assistant Program at 1-800-352-2437 (1-800-FLA-AIDS) English / 1-800-545-7432 (1-800-545-SIDA) Spanish / 1-800-243-7101 (1-800-AIDS-101) Creole. TTY: 1-888-503-7118. You can also visit on the web at http://www.floridahealth.gov/diseases-and-conditions/aids/adap/.

SECTION 6 Questions?

Section 6.1 – Getting Help from HealthSun HealthAdvantage Plan (HMO)

Questions? We're here to help. Please call Member Services at 1-877-336-2069. (TTY only, call 1-877-206-0500.) We are available for phone calls from 8am to 8pm. During October 1st through March 31st we are open seven days a week from 8am to 8pm (we are closed on Thanksgiving and Christmas Day). From April 1st until September 30th we are available Monday through Friday from 8am to 8pm (our office will be closed on federal holidays). Calls to these numbers are free.

Read your 2022 *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 2022. For details, look in the 2022 *Evidence of Coverage* for HealthSun HealthAdvantage Plan (HMO). 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 www.healthsun.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 www.healthsun.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 6.2 – 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

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare).

Read *Medicare & You 2022*

You can read the *Medicare & You 2022* handbook. Every year in the fall, this booklet 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 booklet, you can get it at the Medicare website (www.medicare.gov) 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.

How to Find Important Plan Information

Provider and Pharmacy Directory • Part D Formulary (List of Covered Drugs) • Evidence of Coverage (EOC)

Please visit our website at www.HealthSun.com to locate your plan's *Evidence of Coverage*, *Part D Formulary (list of covered drugs)*, and *OTC Formulary Order Form*. You can also download a copy of the *Provider and Pharmacy Directory* or you can use the online searchable directory to find network providers near you or to find the network pharmacies near you. You will also find on our website your plan's Summary of Benefits.

Your plan information for **2022** is **available on our website from October 1, 2021 until December 31, 2022.**

Please call our Member Services Department at 1-877-336-2069 (TTY: 1-877-206-0500) if you would like any one of the documents mentioned in this notice mailed to you or sent electronically. You can also e-mail MemberServicesInbox@healthsun.com.

Our hours of operation from **October 1st through March 31st** are seven days a week from 8am to 8pm (closed on Thanksgiving and Christmas Day). During **April 1st until September 30th** we are available Monday through Friday from 8am to 8pm (our office will be closed on federal holidays).

HealthSun Health Plans is a HMO plan with a Medicare contract and a Medicaid contract with the State of Florida Agency for Health Care Administration. Enrollment in HealthSun Health Plan depends on contract renewal. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Cómo Encontrar Información Importante del Plan

Directorio de Proveedores y Farmacias • Formulario de la Parte D (Lista de Medicinas Cubiertas) • Evidencia de Cobertura (EOC)

Visite nuestro sitio web www.HealthSun.com para ubicar la *Evidencia de cobertura* de su plan, el *Formulario de la Parte D (lista de medicamentos cubiertos)*, y el *Formulario de pedido para medicamentos sin receta (OTC)*. También puede descargar una copia del *Directorio de Proveedores y Farmacias* o puede utilizar el sistema de búsqueda en línea para buscar proveedores de la red cerca de usted o para buscar las farmacias de la red cerca de usted. También encontrará en nuestro sitio web el Resumen de beneficios de su plan.

Su información del plan del año **2022** está actualmente **disponible en nuestro sitio web desde el 1 de octubre de 2021 hasta el 31 de diciembre de 2022.**

Llame a nuestro Departamento de Servicios para Afiliados al 1-877-336-2069 (TTY: 1-877-206-0500) si desea que le enviemos por correo o electrónicamente cualquiera de los documentos mencionados en este aviso. También puede enviar su solicitud a MemberServicesInbox@healthsun.com.

Nuestro horario operación desde el **1 de octubre hasta el 31 de marzo** son siete días a la semana de 8am a 8pm (cerrado el Día de Acción de Gracias y Navidad). Del **1 de abril al 30 de septiembre**, estamos disponibles de lunes a viernes de 8am a 8pm. (nuestra oficina permanecerá cerrada los días feriados federales).

HealthSun es un plan HMO con un contrato de Medicare y un contrato de Medicaid con la Agencia de Administración de la Atención de la Salud (Agency for Health Care Administration) del estado de Florida. La inscripción en HealthSun depende en la renovación del contrato. El formulario, la red de proveedores y/o la red de farmacias pueden cambiar en cualquier momento. Usted recibirá un aviso cuando sea necesario.

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, or TTY at 711. 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
9250 W Flagler Street, Suite 600
Miami, FL 33174
T. 877-336-2069 (TTY: 711) 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

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Aviso de no discriminación

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 tratas 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 Afiliado al teléfono 877-336-2069, o TTY al 711. 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
9250 W Flagler Street, Suite 600
Miami, FL 33174
T. 877-336-2069 (TTY: 711) 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 Afiliado 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 Human Services, 200 Independence Avenue SW., Room 509F, HHH Building Washington, DC 20201800-368-1019, (TDD: 800-537-7697. Puede obtener los formularios de reclamo en el sitio web http://www.hhs.gov/ocr/office/file/index.html

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 1-877-336-2069 (رقم هاتف الصم والبكم: 1-877-206-0500).

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) સુચના: 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).