

ENGLISH



2022

# SUMMARY OF BENEFITS

MediMax (HMO) | 006  
Miami-Dade & Broward Counties



# HealthSun MediMax (HMO)

## 2022 Summary of Benefits

This booklet provides you with a summary of the medical and prescription drug benefits covered by **HealthSun MediMax (HMO) in Miami-Dade County and Broward County** from January 1, 2022 through December 31, 2022. This plan covers all services that Original Medicare covers and more. Please refer to the Evidence of Coverage (EOC) for a complete list and description of the services covered by the plan. You can find your plan's EOC on our website at [www.HealthSun.com](http://www.HealthSun.com). If you want us to mail you a copy of the EOC or if you have any other questions about our plan benefits, please call us at **1-877-336-2069 (TTY: 1-877-206-0500)**. Our hours of operations are 8am to 8pm. From October 1<sup>st</sup> to March 31<sup>st</sup>, we open seven days a week (we are closed on Christmas and Thanksgiving days). From April 1<sup>st</sup> to September 30<sup>th</sup>, we are available Monday through Friday (we are closed on federal holidays).

### Who Can Enroll?

You can join this Plan as long as you are entitled to Medicare Part A and enrolled in Medicare Part B, and you live in **Miami-Dade County or Broward County**.

### What doctors, hospitals, and pharmacies can you use?

HealthSun has a network of doctors, hospitals, pharmacies, and other providers. You must access all plan-covered services through our network providers. 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 Primary Care Physician (PCP) may be required for you to receive medical services. You must generally use network pharmacies to fill your covered prescription drugs. To find network providers and pharmacies near you, visit our website at [www.HealthSun.com](http://www.HealthSun.com) or call HealthSun Member Services for more information.

### Know your drug plan

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website. Refer to the "Part D Prescription Drugs" section in this booklet for details on what you pay for covered drugs. Your cost will vary based on the amount of "Extra Help" that you get from Medicare.

**If you want to know more about the coverage and costs of Original Medicare**, look in your 2022 "Medicare & You" handbook. You can find it online at [www.medicare.gov](http://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.**

HealthSun Health Plans is an **HMO** plan with a Medicare contract. Enrollment in HealthSun Health Plans depends on contract renewal.

HealthSun MediMax (HMO) - Miami-Dade County and Broward County	
<b>Monthly Premium</b>	<b>\$34.30.</b> You must continue to pay your Medicare Part B premium.
<b>Deductible</b>	Our plan does not have a deductible for medical services.
<b>Maximum Out-of-Pocket (does not include Part D)</b>	<b>\$3,450</b> per year for most medical services you receive from network providers. Once you reach this amount, the plan will pay for your covered Part A and Part B services for the rest of the year.
Services marked with <sup>1</sup> may require prior authorization and <sup>2</sup> may require a referral.	

Medical Services	This plan covers:
Inpatient Hospital Care <sup>1,2</sup>	<b>\$0 copay per stay</b> <ul style="list-style-type: none"> <li>• Inpatient acute care</li> </ul> <b><i>Unlimited additional days for Medicare-covered stay.</i></b>
Outpatient Hospital Care <sup>1,2</sup>	<b>\$0 copay</b> <ul style="list-style-type: none"> <li>• Outpatient surgery and most other outpatient services billed by the hospital</li> <li>• Observation services (a referral is not required)</li> </ul>
Ambulatory Surgical Center <sup>1,2</sup>	<b>\$0 copay</b> <ul style="list-style-type: none"> <li>• Outpatient surgical services at an ambulatory surgical center</li> </ul>
Doctor Visits: Primary Care Physician (PCP) and Specialists <sup>1,2</sup>	<b>\$0 copay</b> <ul style="list-style-type: none"> <li>• Primary care physician (PCP) services</li> <li>• Specialist physician services</li> <li>• Other Medicare-covered healthcare professional services</li> </ul>
Preventive Care <sup>1,2</sup>	<b>\$0 copay for all Medicare-covered preventive services:</b> <ul style="list-style-type: none"> <li>• Abdominal aortic aneurysm screening</li> <li>• Alcohol misuse counseling</li> <li>• Bone mass measurement</li> <li>• Breast cancer screening</li> <li>• Cardiovascular disease risk visit</li> <li>• Cardiovascular disease testing</li> <li>• Cervical/vaginal cancer screening</li> <li>• Colorectal cancer screenings (or screening barium enema)</li> <li>• Depression screening</li> <li>• Diabetes screenings</li> <li>• Diabetes self-management training</li> <li>• EKG following Welcome visit</li> <li>• Glaucoma screening</li> <li>• Health and wellness education</li> <li>• HIV screening</li> <li>• Lung cancer screening</li> <li>• Medical nutrition therapy</li> <li>• Medicare diabetes prevention</li> <li>• Obesity screening and counseling</li> <li>• Prostate cancer screenings (PSA) and Digital rectal exam</li> <li>• STI screening and counseling</li> <li>• Smoking/tobacco counseling</li> <li>• Vaccines/shots/other immunizations</li> <li>• “Welcome to Medicare” visit</li> </ul>
Emergency Care and Urgently Needed Services	<b>\$0 copay</b> <ul style="list-style-type: none"> <li>• Emergency care services in the U.S.</li> <li>• Worldwide emergency care, worldwide urgent care, and worldwide emergency transportation</li> </ul> <b>\$0 copay</b> <ul style="list-style-type: none"> <li>• Urgently needed services in the U.S.</li> </ul> <b><i>\$100,000 is the plan maximum benefit coverage for worldwide emergency and urgent care services.</i></b>



Medical Services	This plan covers:
<b>Outpatient Diagnostic Services<sup>1,2</sup></b> <b>Laboratory<sup>1,2</sup> and Imaging<sup>1</sup></b>	<b>\$0 copay</b> <ul style="list-style-type: none"> <li>• Laboratory services and outpatient blood services</li> <li>• Diagnostic tests and procedures (electrocardiogram, cardiac evaluation, respiratory function test, allergy test, psychological test, etc.)</li> <li>• X-Rays and Diagnostic radiological services (MRI, CT scan, etc.)</li> <li>• Therapeutic radiological services (radiation therapy for cancer)</li> </ul>
<b>Hearing Services<sup>1,2</sup></b>	<b>\$0 copay</b> <ul style="list-style-type: none"> <li>• Medicare-covered basic hearing and balance exams</li> <li>• One routine hearing exam every year</li> <li>• One fitting and evaluation for hearing aids every year</li> <li>• Hearing aids (all types)</li> </ul> <b><i>\$1,500 benefit amount for hearing aids every two years (both ears combined)</i></b>
<b>Dental Services</b>	<b>\$0 copay</b> <b>Preventive dental services:</b> <ul style="list-style-type: none"> <li>• Two Oral exams every year</li> <li>• Two Cleanings every year</li> <li>• Two Fluoride treatments every year</li> <li>• Two Bitewing dental x-rays every year</li> <li>• One Full-mouth x-rays every three years</li> </ul> <b>Comprehensive dental services (non-routine)<sup>1</sup>:</b> <ul style="list-style-type: none"> <li>• Two Implants every year</li> <li>• Two Crowns every year</li> <li>• Two Root Canals every year</li> <li>• Four Restorative services (up to four teeth) every year</li> <li>• Four Extractions every year</li> <li>• One Scaling/Root Planing per each quadrant every year</li> <li>• One Full mouth debridement every 24 consecutive months</li> <li>• One Total Superior Prosthesis Dentures every three years</li> <li>• One Total Inferior Prosthesis Dentures every three years</li> <li>• One e Partial Dentures every three years</li> <li>• Oral/maxillofacial surgery and other dental services</li> </ul> <b><i>\$5,000 benefit amount for all dental services every year</i></b>
<b>Vision Services</b>	<b>\$0 copay</b> <ul style="list-style-type: none"> <li>• Medicare-covered vision care</li> <li>• One routine eye exam every year</li> <li>• Contact lenses, eyeglasses, eyeglass lenses, and eyeglass frames</li> </ul> <b><i>\$400 benefit amount for all eyewear combined every year</i></b>

Medical Services	This plan covers:
<b>Mental Health Care<sup>1,2</sup></b>	<p><b>\$0 copay</b></p> <ul style="list-style-type: none"> <li>• Outpatient mental health specialty services for individual and group sessions</li> </ul> <p><b>\$0 copay</b></p> <ul style="list-style-type: none"> <li>• Outpatient psychiatric services for individual and group sessions</li> </ul> <p><b>\$0 copay</b></p> <ul style="list-style-type: none"> <li>• Partial hospitalization</li> </ul> <p><b>\$0 copay per stay</b></p> <ul style="list-style-type: none"> <li>• Inpatient psychiatric services</li> </ul> <p>Our plan has a lifetime limit of 190 days for inpatient mental health care in a psychiatric hospital. This limit does not apply to inpatient mental health services provided in a general hospital.</p>
<b>Skilled Nursing Facility (SNF)<sup>1,2</sup></b>	<p><b>\$0 copay per stay</b></p> <ul style="list-style-type: none"> <li>• Our plan covers up to 100 days in a Skilled Nursing Facility (SNF)</li> </ul> <p><b><i>No prior hospital stay is required.</i></b></p>
<b>Physical Therapy<sup>1,2</sup></b>	<p><b>\$0 copay</b></p> <ul style="list-style-type: none"> <li>• Physical therapy services</li> <li>• Speech-language pathology therapy services</li> <li>• Occupational therapy services</li> </ul>
<b>Ambulance<sup>1</sup></b>	<p><b>\$0 copay</b></p> <ul style="list-style-type: none"> <li>• Ground ambulance services</li> <li>• Air ambulance services</li> </ul>
<b>Transportation<sup>1,2</sup></b>	<p><b>\$0 copay</b></p> <ul style="list-style-type: none"> <li>• Unlimited to plan-approved locations</li> <li>• Mode of transportation includes: van, bus, taxi, or rideshare services</li> </ul>
<b>Medicare Part B Drugs<sup>1</sup></b>	<p><b>\$0 copay</b></p> <ul style="list-style-type: none"> <li>• Medicare Part B Chemotherapy/Radiation Drugs and other Medicare Part B Drugs <b>administered at a medical center.</b></li> </ul> <p>20% of the cost</p> <ul style="list-style-type: none"> <li>• Medicare Part B Chemotherapy/Radiation Drugs and other Medicare Part B Drugs <i>administered at a physician's office, a pharmacy, or at a hospital as an outpatient service.</i></li> </ul> <p>Some Medicare Part B Drugs are eligible for Step Therapy. A process that requires trying another drug before the drug initially prescribed.</p>

Part D Benefits	This plan covers:																																										
Deductible Stage	<p><b>\$430 is this plan's Deductible.</b></p> <p>During this stage, you pay the full cost of your covered drugs</p> <p><b>You stay in this stage until</b> your total drug costs paid by you <b>reach the deductible.</b></p> <p><i>If you receive “Extra Help” from Medicare, your deductible may reduce depending on your category level of “Extra Help”.</i></p>																																										
Initial Coverage Stage	<p><b>\$4,430 is this plan's Initial Coverage Limit (ICL).</b></p> <p>During this stage, you pay a cost-share of your covered drugs.</p> <p><b>You stay in this stage until</b> your total drug costs paid by both you and the plan <b>reach the Initial Coverage Limit (ICL).</b></p> <p><i>If you receive “Extra Help” from Medicare, you pay whichever is less, either your cost-share under the Plan or your Low-Income Subsidy (LIS) cost-share depending on your category level of “Extra Help”.</i></p> <p><b>Standard Retail Pharmacy and Mail-Order Pharmacy cost-sharing</b></p> <table><tr><th>Drug Tier</th><th>One-month Supply (30 days)</th><th>Long-term Supply (60 or 90 days)</th></tr><tr><td>Tier 1 (Preferred Generic)</td><td>25%</td><td>25%</td></tr><tr><td>Tier 2 (Generic)</td><td>25%</td><td>25%</td></tr><tr><td>Tier 3 (Preferred Brand)</td><td>25%</td><td>n/a</td></tr><tr><td>Tier 4 (Non-Preferred Brand)</td><td>25%</td><td>n/a</td></tr><tr><td>Tier 5 (Specialty Tier)</td><td>25%</td><td>n/a</td></tr><tr><td>Tier 6 (Supplemental)</td><td>\$0</td><td>n/a</td></tr></table> <p><b>Long Term Care (LTC) Pharmacy cost-sharing</b></p> <table><tr><th>Drug Tier</th><th>One-month Supply (34 days)</th><th>Long-term Supply (60 or 90 days)</th></tr><tr><td>Tier 1 (Preferred Generic)</td><td>25%</td><td>n/a</td></tr><tr><td>Tier 2 (Generic)</td><td>25%</td><td>n/a</td></tr><tr><td>Tier 3 (Preferred Brand)</td><td>25%</td><td>n/a</td></tr><tr><td>Tier 4 (Non-Preferred Brand)</td><td>25%</td><td>n/a</td></tr><tr><td>Tier 5 (Specialty Tier)</td><td>25%</td><td>n/a</td></tr><tr><td>Tier 6 (Supplemental)</td><td>\$0</td><td>n/a</td></tr></table>	Drug Tier	One-month Supply (30 days)	Long-term Supply (60 or 90 days)	Tier 1 (Preferred Generic)	25%	25%	Tier 2 (Generic)	25%	25%	Tier 3 (Preferred Brand)	25%	n/a	Tier 4 (Non-Preferred Brand)	25%	n/a	Tier 5 (Specialty Tier)	25%	n/a	Tier 6 (Supplemental)	\$0	n/a	Drug Tier	One-month Supply (34 days)	Long-term Supply (60 or 90 days)	Tier 1 (Preferred Generic)	25%	n/a	Tier 2 (Generic)	25%	n/a	Tier 3 (Preferred Brand)	25%	n/a	Tier 4 (Non-Preferred Brand)	25%	n/a	Tier 5 (Specialty Tier)	25%	n/a	Tier 6 (Supplemental)	\$0	n/a
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Part D Benefits	This plan covers:
<b>Coverage Gap Stage</b>	<p>During this stage, you pay up to <b>25%</b> of the negotiated price for brand name drugs and you pay no more than <b>25%</b> of the cost for generic drugs.</p> <p><b>You stay in this stage until</b> your total drug costs paid by you <b>reach the True Out-of-Pocket Limit (TrOOP).</b></p> <p><b><i>If you receive “Extra Help” from Medicare,</i></b> you will continue to pay your Low-Income Subsidy (LIS) cost-sharing for your covered drugs.</p>
<b>Catastrophic Coverage Stage</b>	<p><b>\$7,050 is this plan’s Out-of-pocket limit (TrOOP).</b></p> <p>You enter this stage when your total drug costs paid by you reach the yearly out-of-pocket maximum amount (TrOOP) during the Coverage Gap Stage. If you reach the Catastrophic Coverage Stage, you stay in this stage until the end of the calendar year.</p> <p>During this stage, you <b>pay the greater of</b> either:</p> <ul style="list-style-type: none"> <li>• <b>\$3.95</b> for a generic drug or a preferred multi-source drug and <b>\$9.85</b> for brand-name drugs; <b>or</b></li> <li>• <b>5% of the cost</b> (whichever is greater).</li> </ul> <p><b>Our plan pays the rest of the cost.</b></p> <p><b><i>If you receive “Extra Help” from Medicare,</i></b> your costs for covered drugs will depend on the category level of “Extra Help” you receive.</p>
<p><b>Note: You pay \$0 for Part D excluded drugs in Tier 6 (supplemental brand and generic drugs) during all four stages.</b></p>	

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 that are not available through our plan's mail-order services are marked as “NM” drugs in our Drug List.

We cover Part D drugs filled at an out-of-network pharmacy during each stage 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 standard retail pharmacy. In these situations, please check first if there is a network pharmacy nearby.

Additional Medical Benefits	This plan covers:
<b>Acupuncture</b> <sup>1,2</sup>	<b>\$0 copay</b> <ul style="list-style-type: none"> <li>• 12 supplemental treatments every year.</li> </ul>
<b>Chiropractic Care</b>	<b>\$0 copay</b> <ul style="list-style-type: none"> <li>• 12 supplemental routine care visits every year.</li> </ul>
<b>Foot Care (Podiatry Services)</b> <sup>1</sup>	<b>\$0 copay</b> <ul style="list-style-type: none"> <li>• One supplemental routine care visit every three months.</li> <li>• Medicare also covers routine foot care for certain medical conditions affecting the feet.</li> </ul>
<b>Home Health Agency Care</b> <sup>1,2</sup>	<b>\$0 copay</b> <ul style="list-style-type: none"> <li>• Home health aide services covered by Medicare.</li> </ul>
<b>Dialysis Services</b> <sup>1,2</sup> <b>and Kidney Disease Education</b>	<b>\$0 copay</b> <ul style="list-style-type: none"> <li>• Dialysis treatment and self-dialysis training</li> <li>• Kidney disease education to teach kidney care</li> </ul>
<b>Outpatient Rehabilitation Services</b> <sup>1,2</sup>	<b>\$0 copay</b> <ul style="list-style-type: none"> <li>• Cardiac rehabilitation and Intensive cardiac rehabilitation services</li> <li>• Pulmonary rehabilitation services</li> <li>• Supervised exercise therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) services</li> <li>• Speech-language pathology and occupational therapy</li> </ul>
<b>Outpatient Substance Abuse and Opioid Treatment Services</b> <sup>1,2</sup>	<b>\$0 copay</b> <ul style="list-style-type: none"> <li>• Individual or group therapy services for outpatient substance abuse and for opioid treatment.</li> </ul>
<b>Prosthetics/Medical and Diabetic Supplies, and Durable Medical Equipment (DME)</b> <sup>1</sup>	<b>\$0 copay</b> <ul style="list-style-type: none"> <li>• Prosthetic devices and other medical supplies</li> <li>• Diabetic therapeutic shoes or inserts</li> <li>• Hyaluronic Acids and all other Durable Medical Equipment <i>DUROLANE, EUFLEXXA, SUPARTZ, and Gel-SYN-3 are the brands covered for Hyaluronic Acids. Other brands covered only if deemed medically necessary by the provider.</i></li> </ul> <b>\$0 copay</b> <ul style="list-style-type: none"> <li>• Continuous Glucose Monitors (CGMs)</li> <li>• Diabetic supplies and services <i>Freestyle Libre is this plan's preferred vendor for CGMs. Precision, TrueMatrix, TrueTest, Contour, Ascensia, and Freestyle are the manufacturers covered for Glucometers, Blood Test Strips, and lancets.</i></li> </ul>



Other Medical and Wellness Benefits	This plan offers:
<b>Alternative Medicine: Therapeutic Massage<sup>1,2</sup></b>	<b>\$0 copay</b> <ul style="list-style-type: none"> <li>• 24 therapeutic massage visits every year.</li> </ul>
<b>Alternative Therapy: Platelet-Rich Plasma (PRP) for Osteoarthritis Pain Management<sup>1,2</sup></b>	<b>\$0 copay</b> <ul style="list-style-type: none"> <li>• Platelet-Rich Plasma injections for treatment of an injury or illness applied to any one body part for no more than three consecutive months up to twice per year.</li> </ul>
<b>Fitness SilverSneakers®</b>	<b>\$0 copay</b> <ul style="list-style-type: none"> <li>• Membership access to all basic amenities at participating locations.</li> <li>• Support from certified instructors and access to group classes.</li> <li>• Exercise videos through the SilverSneakers® website.</li> </ul>
<b>Health Education and Nutritional/Dietary Counseling<sup>1,2</sup></b>	<b>\$0 copay</b> <ul style="list-style-type: none"> <li>• Unlimited nutritional counseling individual or group setting by a nutrition professional as deemed medically necessary.</li> <li>• Other health education services about a specific disease or condition.</li> </ul>
<b>Healthy Meals: Chronic Condition (SSBCI)<sup>1,2</sup></b>	<b>\$0 copay</b> <ul style="list-style-type: none"> <li>• <b>One meal a day for up to 20 meals every month.</b></li> </ul> <p>Members are eligible based on qualifying clinical criteria of a chronic condition as determined by their physician. Meals are delivered or provided at participating locations. Method of meal delivery is subject to prior authorization.</p>
<b>Healthy Meals: Post Discharge<sup>1,2</sup></b>	<b>\$0 copay</b> <ul style="list-style-type: none"> <li>• <b>Three meals delivered each day for two weeks</b> after an overnight stay in the hospital or nursing facility, or following surgery with an inpatient hospital stay. Two inpatient admissions per year.</li> </ul>
<b>Over-the-Counter (OTC) items</b>	<b>\$0 copay</b> <ul style="list-style-type: none"> <li>• Plan-approved Over-the-Counter (OTC) medications and other products</li> </ul> <b>\$100 maximum monthly benefit amount for OTC items.</b>

Other Medical and Wellness Benefits	This plan offers:
<b>In-home Support Services</b>	<p><b>\$0 copay</b></p> <ul style="list-style-type: none"> <li>• 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.</li> </ul>
<b>Nurse Hotline</b>	<p><b>\$0 copay</b></p> <ul style="list-style-type: none"> <li>• Speak directly to a registered nurse to answer health-related questions</li> <li>• 24/7 access through our Member Services toll-free phone number</li> </ul>
<b>Personal Emergency Response System (PERS)<sup>1,2</sup></b>	<p><b>\$0 copay</b></p> <ul style="list-style-type: none"> <li>• Personal Emergency Response (PERS) Unit is covered one per member and includes the monitoring device and monitoring service. Member must contact plan Member Services to initiate service and installation.</li> </ul>
<b>Personal Care at-Home Recovery: Readmission Prevention<sup>1,2</sup></b>	<p><b>\$0 copay</b></p> <ul style="list-style-type: none"> <li>• Within 10 days following inpatient discharge to a home setting, members are eligible for an in-home safety assessment, medication reconciliation, and custodial care for Activities of Daily Living and Instrumental Activities of Daily Living. Upon approval, members receive up to 16 hours of home-based support and caregiver respite assistance. Must be used in two-hour increments and up to four hours per day. Maximum of two admissions per year.</li> </ul>

## **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 1-877-336-2069 (TTY users call 1-877-206-0500). Our hours of operations from April 1<sup>st</sup> through September 30<sup>th</sup> are Monday through Friday from 8am to 8pm (we are closed on Federal Holidays). During October 1<sup>st</sup> until March 31<sup>st</sup> we are open seven days a week from 8am to 8pm (we are closed on Thanksgiving Day and Christmas Day).

### **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](http://www.HealthSun.com) or call 1-877-336-2069 (TTY users call 1-877-206-0500) 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**

- ☐ 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, 2022.
- ☐ 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).

# How to Find Important Plan Information

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

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

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](mailto:MemberServicesInbox@healthsun.com).

Our hours of operations from **April 1st through September 30th** are Monday through Friday from 8am to 8pm (we are closed on Federal Holidays). During **October 1st until March 31st** we are open seven days a week from 8am to 8pm (we are closed on Thanksgiving Day and Christmas Day).

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.

### **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](mailto: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>

### **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 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 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](mailto: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 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>



## 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 નિઃશુલ્ક 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).



1.877.336.2069 | 1.877.206.0500 / TTY:711

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