2018 SUMMARY OF BENEFITS

HealthSun HealthAdvantage Plan (HMO)

HealthSun HealthAdvantage Plan (HMO)
Summary of Benefits
January 1, 2018 - December 31, 2018

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage" or you can find it on our website at www.HealthSun.com.

Who can join HealthSun HealthAdvantage Plan (HMO)?

- To join HealthSun HealthAdvantage Plan (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.
- Our service area includes the following counties in Florida: Broward

What doctors, hospitals, and pharmacies can you use?

- HealthSun HealthAdvantage Plan (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services. Prior authorization or a physician referral may be required for covered in-network medical services.
- You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.
- If you need help finding a network provider/pharmacy, or if you have a question about covered drugs, please call our Member Services Department (phone numbers provided below), or visit www.HealthSun.com to download a copy of the Combined Provider and Pharmacy Directory. You can also access our online searchable directory to locate our network providers and pharmacies near you. If you would like a hardcopy of the Combined Provider and Pharmacy Directory mailed to you, you may call our Member Services Department.

The "Medicare & You" Handbook

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. You can view it online at www.medicare.gov or get 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.

Need additional information?

Please contact our Member Services Department at (305) 447-4458 or toll free at (877) 336-2069 for additional information. TTY users should call (877) 206-0500. Our hours of operation from October 1 to February 14 are 7 days a week from 8am to 8pm. Beginning February 15 until September 30, we are available Monday through Friday from 8am to 8pm.

Monthly Premium, Deductible, and Out-of-Pocket Limits	
Monthly Plan Premium?	$0 per month. In addition, you must continue to pay your Medicare Part B premium.
How much is the Deductible?	This plan does not have a deductible for medical services.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly maximum out-of-pocket limit in this plan: • $3,400 for services you receive from in-network providers for most Part A & Part B services. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	Our plan has coverage limit every year for certain in-network benefits. Contact us for the services that apply.

Covered Medical and Hospital Benefits

Note: Services marked with a [1] may require prior authorization.
Services marked with a [2] may require a referral from your doctor.

Outpatient Care and Services

Inpatient Hospital Care[1,2]	$50 Copay per day, days 1 through 6. **$0 Copay** per day, days 7 through 90. Our plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient Hospital Care[1,2]	Outpatient hospital services: $100 Copay Ambulatory surgical center services: $50 Copay
Doctor Visits[1,2]	Primary care physician visits: **$0 Copay** Specialist visits: **$0 Copay**

Preventive Care[1,2]	**$0 Copay** Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit (therapy for cardiovasculary disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • Diabetes self-management training • Glaucoma screening • Hepatitis C screening test • HIV screening • Lung cancer screening • Medical Nutrition Therapy • Medicare Diabetes Prevention Program. • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Smoking and tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Annual "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	$75 Copay $50 Copay for worldwide emergency services outside of the U.S. If you are admitted to the hospital within 1 day (24 hours), you do not have to pay your share of the cost for the emergency room visit.
Urgently Needed Services	$25 Copay $50 Copay for worldwide emergency services outside of the U.S. If you are admitted to the hospital within 24 hours (1 day), you do not have to pay your share of the cost for urgently needed services.

Outpatient Diagnostic Services/Labs/ Imaging[1,2]	Lab services: **$0 Copay** Diagnostic procedures and test: $0 - $125 Copay You pay nothing for procedures and tests administered at a participating medical center. Procedures and tests administered at a participating provider office (non-medical center) and/or hospital setting incur the maximum copay. Diagnostic radiological services (such as MRIs, CT scans): $0 - $100 Copay You pay nothing for radiological services administered at a participating medical center. Radiological services administered at a participating provider office (non-medical center) and/or hospital setting incur the maximum copay. X-ray services: $0 - $100 Copay You pay nothing for x-ray services administered at a participating medical center. X-ray services administered at a participating provider office (non-medical center) and/or hospital setting incur the maximum copay. Therapeutic radiological services (such as radiation treatment for cancer): $25 Copay
Hearing Services[1,2]	Exam to diagnose and treat hearing and balance issues: **$0 Copay** Routine hearing exam, up to 1 every year: **$0 Copay** Hearing aid fitting/evaluation, up to 1 every year: **$0 Copay** Hearing aid: **$0 Copay** Our plan pays up to **$1,500** every two years for hearing aids. Maximum benefit amount applies to both ears combined.
Dental Services	**$0 copay** for the following preventive dental services: • Oral exam(s), up to 2 every year • Cleaning(s), up to 2 every year • Fluoride treatment(s), up to 2 every year • Bitewing dental x-ray(s), up to 2 series every year • Full-mouth x-rays (panoramic), up to 1 complete series every year **$0 copay** for the following comprehensive dental services: • Resin filling on anterior teeth • Amalgam filling up to 4 surfaces • Simple Extraction performed by General Dentist • Total superior prosthesis, up to 1 every 3 years • Total inferior prosthesis, up to 1 every 3 years • Full mouth debridement • Partial Dentures Our plan pays up to **$2,850** every year for most dental services.

Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): **$0 Copay** Routine eye exam, up to 1 every year: **$0 Copay** Contact lenses , up to 1 pair every year: **$0 Copay** Eyeglasses (frames and lenses) , up to 1 every year: **$0 Copay** Eyeglasses or contact lenses after cataract surgery: **$0 Copay** Our plan pays up to **$150** every year for contact lenses and eyeglasses (frames and lenses).
Mental Health Care[1,2]	Inpatient visit: $200 Copay per day, days 1 through 5. **$0 Copay** per day, days 6 through 90. Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 60 "lifetime reserve days". These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. **$0 Copay** for Outpatient group therapy and individual therapy visits.
Skilled Nursing Facility (SNF)[1,2]	**$0 Copay** per day, days 1 through 6. $20 Copay per day, days 7 through 20. $100 Copay per day, days 21 through 100. Our plan covers up to 100 days in a SNF. No prior hospital stay is required.
Physical Therapy[1,2]	Physical therapy and speech and language therapy: $40 Copay Occupational therapy services: $40 Copay Cardiac (heart) rehab services, up to a maximum of 2 one-hour sessions per day for up to 36 sessions or up to 36 weeks: $40 Copay Pulmonary rehabilitation services: $30 Copay
Ambulance[1]	$200 Copay If you are admitted to the hospital, you do not have to pay your share of the cost for the ambulance services.

Transportation[1,2]	**$0 Copay** Trips are unlimited for health related services for members assigned to a participating primary care physician (PCP) at a medical center. Trips are limited to 12-round trips per quarter for health related services for members assigned to a participating primary care physician (PCP) with an office at a non-medical center.
Medicare Part B Drugs[1]	Chemotherapy drugs and other Part B drugs: You pay 20% of the cost

Prescription Drug Benefits

Deductible

This plan does not have a deductible for prescription drug benefits.

Initial Coverage

You pay the following until your total yearly drug costs reach $3,750. Total yearly drug costs are the total drug costs paid by both you and our plan.

You may get your drugs at network retail pharmacies.

Standard Retail Cost-Sharing

Tier	One-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$10 Copay
Tier 3 (Preferred Brand)	$25 Copay
Tier 4 (Non-Preferred Brand)	$50 Copay
Tier 5 (Specialty Tier)	33% of the cost
Tier 6 (Supplemental)	$0 Copay

Preferred Retail Cost-Sharing

Tier	One-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$0 Copay
Tier 3 (Preferred Brand)	$15 Copay
Tier 4 (Non-Preferred Brand)	$30 Copay
Tier 5 (Specialty Tier)	33% of the cost
Tier 6 (Supplemental)	$0 Copay

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

Long Term Care Facility (LTC) Cost-Sharing

Tier	One-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$10 Copay
Tier 3 (Preferred Brand)	$25 Copay
Tier 4 (Non-Preferred Brand)	$50 Copay
Tier 5 (Specialty Tier)	33% of the cost
Tier 6 (Supplemental)	$0 Copay

Initial Coverage (cont.)

90 Day Cost Sharing Supply

	Standard retail cost-sharing (in-network) (up to a 90-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	**$0 Copay** (60 day cost for a 90-day supply of selected Tier 1 maintenance drugs)
Cost-Sharing Tier 2 (Generic)	$20 Copay (60 day cost for a 90-day supply of selected Tier 2 maintenance drugs)

	Preferred retail cost-sharing (in-network) (up to a 90-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	**$0 Copay** (60 day cost for a 90-day supply of selected Tier 1 maintenance drugs)
Cost-Sharing Tier 2 (Generic)	**$0 Copay** (60 day cost for a 90-day supply of selected Tier 2 maintenance drugs)

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750.

During this stage, you pay 35% of the plan's cost for covered brand name drugs and 44% of the plan's cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, you may pay even less for some of the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out which tiers our plan covers in the coverage gap and how much it will cost you.

Standard Retail Cost-Sharing

Tier	Drugs Covered	One-month supply
Tier 1 (Preferred Generic)	All	$0 Copay
Tier 2 (Generic)	All	$10 Copay

Preferred Retail Cost-Sharing

Tier	Drugs Covered	One-month supply
Tier 1 (Preferred Generic)	All	$0 Copay
Tier 2 (Generic)	All	$0 Copay

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy) reach $5,000, you pay the greater of:

- 5% of the cost, or
- $3.35 copay for generic (including brand drugs treated as generic) and $8.35 copay for all other drugs.

Additional Covered Medical Benefits	
Chiropractic Care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): **$0 Copay** Routine chiropractic visit, up to 12 every year: **$0 Copay**
Diabetes Supplies and Services[1]	Diabetes self-management training: **$0 Copay** Diabetes monitoring supplies and therapeutic shoes or inserts: You pay 10% of the cost
Durable Medical Equipment[1] (wheelchairs, oxygen, etc.)	You pay 10% of the cost.
Foot Care[1] (podiatry services)	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: **$0 Copay** Routine foot care, up to 1 visit every 3 months: **$0 Copay**
Health Education, Nutritional/Dietary and Fitness Benefit	**$0 Copay** **Health Education** In accordance with the Medicare Managed Care Manual, Chapter 4, the Health Education program is designed to help Enrollees develop knowledge and self-care skills and to foster the motivation and confidence necessary to use those skills to improve and maintain health. Educational services are provided by certified health educator or other licensed professionals and include the provision of information about specific disease processes, treatments and drug therapies, signs and symptoms to watch for, self- care strategies and techniques, dietary restrictions, and nutritional counseling through written materials and one-on-one interactive telephonic coaching sessions. 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.

Health Education, Nutritional/Dietary and Fitness Benefit (cont.)	**Membership in Health Club/Fitness Classes** A basic fitness center membership at a participating location near you with access to the basic amenities. Custom designed low impact classes designed to improve your body's strength and flexibility; on-site advisors to act as your contact for information and personalized service. Enrollee also receives an orientation to the facility/equipment.
Home Health Care[1,2]	**$0 Copay**
Outpatient Substance Abuse[1,2]	Group therapy visit: **$0 Copay** Individual therapy visit: **$0 Copay**
Over-the-Counter Items	**$0 Copay** You are eligible for a **$15** maximum monthly benefit to be used towards the purchase of covered over-the-counter (OTC) health and wellness products from the HealthSun HealthAdvantage Plan OTC drug formulary. The OTC benefit does not carry over month to month. Any benefit amount that is not used will be lost.
Partial Hospitalization[1,2]	**$0 Copay**
Prosthetic Devices[1] (braces, artificial limbs, etc.)	Prosthetic devices and related medical supplies: You pay 10% of the cost
Renal Dialysis[1,2]	**$0 Copay**

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.

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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 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 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

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HealthSun Health Plans is an HMO plan with a Medicare contract. Enrollment in HealthSun Health Plans depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1st of each year. You must continue to pay your Medicare Part B premium. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Please contact our Member Services Department at (305) 447-4458 or toll free at (877) 336-2069 for additional information. TTY users should call (877) 206-0500. Our hours of operation from October 1 to February 14 are 7 days a week from 8am to 8pm. Beginning February 15 until September 30, we are available Monday through Friday from 8am to 8pm.

This information is available in different formats, including Braille, large print, and audio tapes. This document is available for free in Spanish. Este documento está disponible gratis 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).