2020
ANNUAL NOTICE
OF CHANGE

HealthAdvantage Plan (HMO) | 012
BROWARD COUNTY
You are currently enrolled as a member of HealthSun HealthAdvantage Plan. 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 and 2 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 2020 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 [https://go.medicare.gov/drugprices](https://go.medicare.gov/drugprices). 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.

OMB Approval 0938-1051 (Expires: December 31, 2021)
2. COMPARE: Learn about other plan choices
   □ Check coverage and costs of plans in your area.
     ○ Review the list in the back of your Medicare & You handbook.
     ○ Look in Section 3.2 to learn more about your choices.
   □ 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 want to keep HealthSun HealthAdvantage Plan, you don’t need to do anything. You will stay in HealthSun HealthAdvantage Plan.
   ○ 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, 2019
   ○ If you don’t join another plan by December 7, 2019, you will stay in HealthSun HealthAdvantage Plan.
   ○ If you join another plan by December 7, 2019, your new coverage will start on January 1, 2020.

Additional Resources
- Please contact our Member Services number at 1-877-336-2069 for additional information. TTY users should call 1-877-206-0500. Hours during October 1st through March 31st are 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).
- 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 https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About HealthSun HealthAdvantage Plan
- 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. When it says “plan” or “our plan,” it means HealthSun HealthAdvantage Plan.
### Summary of Important Costs for 2020

The table below compares the 2019 costs and 2020 costs for HealthSun HealthAdvantage Plan 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](http://www.HealthSun.com). You may also call Member Services to ask us to mail you an Evidence of Coverage.

<table>
<thead>
<tr>
<th>Cost</th>
<th>2019 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly plan premium</strong></td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><em>Your premium may be higher or lower than this amount. See Section 1.1 for details.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maximum out-of-pocket amount</strong></td>
<td>$3,400</td>
<td>$3,400</td>
</tr>
<tr>
<td>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.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Doctor office visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visits:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$0 per visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist visits:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$0 per visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient hospital stays</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient acute:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$0 copay per stay.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient mental health care:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$0 copay per stay.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing facility (SNF):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$0 copay for days 1 through 20. You pay a $55 copay per day for days 21 through 100.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Part D prescription drug coverage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(See Section 1.6 for details.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible:</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments/Coinsurance during the Initial Coverage Stage.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred retail pharmacy:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Drug Tier 1: $0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Drug Tier 2: $0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Drug Tier 3: $15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Drug Tier 4: $30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Drug Tier 5: 33%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Drug Tier 6: $0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost (cont)</td>
<td>2019 (this year)</td>
<td>2020 (next year)</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td><strong>Part D prescription drug coverage</strong></td>
<td>Standard retail pharmacy:</td>
<td>Standard retail pharmacy:</td>
</tr>
<tr>
<td>(See Section 1.6 for details.)</td>
<td>• Drug Tier 1: $0</td>
<td>• Drug Tier 1: $0</td>
</tr>
<tr>
<td></td>
<td>• Drug Tier 2: $10</td>
<td>• Drug Tier 2: $0</td>
</tr>
<tr>
<td></td>
<td>• Drug Tier 3: $25</td>
<td>• Drug Tier 3: $20</td>
</tr>
<tr>
<td></td>
<td>• Drug Tier 4: $50</td>
<td>• Drug Tier 4: $35</td>
</tr>
<tr>
<td></td>
<td>• Drug Tier 5: 33%</td>
<td>• Drug Tier 5: 33%</td>
</tr>
<tr>
<td></td>
<td>• Drug Tier 6: $0</td>
<td>• Drug Tier 6: $0</td>
</tr>
</tbody>
</table>
Annual Notice of Changes for 2020

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

<table>
<thead>
<tr>
<th>Cost</th>
<th>2019 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly premium</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>(You must also continue to pay your Medicare Part B premium.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 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.

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.

<table>
<thead>
<tr>
<th>Cost</th>
<th>2019 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum out-of-pocket amount</td>
<td>$3,400</td>
<td>$3,400</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Once you have paid $3,400 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 2020 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 and managing 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 2020 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 2020 Evidence of Coverage.

<table>
<thead>
<tr>
<th>Cost</th>
<th>2019 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>Acupuncture is not covered.</td>
<td>This plan offers acupuncture. You pay a $0 copay for each treatment, up to 12 treatments every year.</td>
</tr>
<tr>
<td>Cardiac Rehabilitation Services</td>
<td>You pay a $40 copay per service for cardiac rehabilitation services.</td>
<td>You pay a $5 copay per visit for cardiac rehabilitation services.</td>
</tr>
<tr>
<td></td>
<td>You pay a $40 copay per service for intensive cardiac rehabilitation services.</td>
<td>You pay a $5 copay per visit for intensive cardiac rehabilitation services.</td>
</tr>
<tr>
<td>Dental</td>
<td>$3,200 maximum annual coverage amount for dental services.</td>
<td>$4,000 maximum annual coverage amount for dental services.</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>You pay 10% of the total cost for all durable medical equipment.</td>
<td>You pay a $0 copay for Continuous Glucose Monitors (CGMs) and their supplies.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>You pay 10% of the total cost for all other durable medical equipment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Freestyle Libre are this plan’s preferred Continuous Glucose Monitors (CGMs).</td>
</tr>
</tbody>
</table>
## Cost (cont.)

<table>
<thead>
<tr>
<th>Service</th>
<th>2019 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meal Benefit</strong></td>
<td>Meal benefit is not covered.</td>
<td>This plan offers meal benefit. You pay $0 copay for meal benefit. Members are eligible to receive three nutritious, precooked frozen meals per day (42 maximum) delivered at no cost for two weeks after an overnight stay in the hospital or nursing facility, or following surgery with an inpatient hospital stay.</td>
</tr>
<tr>
<td><strong>Nursing Hotline</strong></td>
<td>Nursing hotline service is not covered.</td>
<td>This plan offers access to a nursing hotline. You pay a $0 copay nursing hotline services. Members have access to a toll free nurse line to speak directly to a registered nurse who will help answer health-related questions.</td>
</tr>
<tr>
<td><strong>Opioid Treatment</strong></td>
<td>Opioid treatment is not covered.</td>
<td>This plan offers opioid treatment. You pay $0 copay for opioid treatment.</td>
</tr>
<tr>
<td><strong>Outpatient Diagnostic Procedures and Tests</strong></td>
<td>You pay a $125 copay for diagnostic procedures and tests at a hospital facility as an outpatient service.</td>
<td>You pay a $50 copay for diagnostic procedures and tests at a hospital facility as an outpatient service.</td>
</tr>
<tr>
<td><strong>Outpatient Diagnostic Radiological and X-Ray Services</strong></td>
<td>You pay a $100 copay for diagnostic radiological services and x-ray services at a hospital facility as an outpatient service.</td>
<td>You pay a $50 copay for diagnostic radiological services and x-ray services at a hospital facility as an outpatient service.</td>
</tr>
<tr>
<td><strong>Outpatient Rehabilitation Services</strong> (Includes physical therapy, occupational therapy, and speech language therapy)</td>
<td>You pay a $40 copay per visit for physical therapy. You pay a $40 copay per visit for occupational therapy. You pay a $40 copay per visit for speech language therapy.</td>
<td>You pay a $5 copay per visit for physical therapy. You pay a $5 copay per visit for occupational therapy. You pay a $5 copay per visit for speech language therapy.</td>
</tr>
<tr>
<td><strong>Over-the-Counter (OTC)</strong></td>
<td>$35 maximum monthly amount for plan approved OTC items.</td>
<td>$48 maximum monthly amount for plan approved OTC items.</td>
</tr>
<tr>
<td><strong>Pulmonary Rehabilitation Services</strong></td>
<td>You pay a $30 copay per visit.</td>
<td>You pay a $5 copay per visit.</td>
</tr>
</tbody>
</table>
### 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. For 2020, members in long term care (LTC) facilities will now receive a temporary supply that is the same amount of temporary days supply provided in all other cases: 34-day supply of medication rather than the amount provided in 2019 (31-day supply of medication). (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.

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. If you receive “Extra Help” and haven’t received this insert by September 30th, 2019, please call Member Services and ask for the “LIS Rider.” Phone numbers for Member Services are in Section 6.1 of this booklet.

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 can also review the Evidence of Coverage to see if other benefit or cost changes affect you. You may also call Member Services to ask us to mail you an Evidence of Coverage.)
Changes to the Deductible Stage

<table>
<thead>
<tr>
<th>Stage</th>
<th>2019 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 1: Yearly Deductible Stage</strong></td>
<td>Because we have no deductible, this payment stage does not apply to you.</td>
<td>Because we have no deductible, this payment stage does not apply to you.</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Stage</th>
<th>2019 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 2: Initial Coverage Stage</strong></td>
<td>Your cost for a one-month supply filled at a network pharmacy:</td>
<td>Your cost for a one-month supply filled at a network pharmacy:</td>
</tr>
<tr>
<td><strong>Tier 1: Preferred Generic</strong></td>
<td><strong>Standard cost-sharing:</strong> You pay $0 per prescription.</td>
<td><strong>Standard cost-sharing:</strong> You pay $0 per prescription.</td>
</tr>
<tr>
<td></td>
<td><strong>Preferred cost-sharing:</strong> You pay $0 per prescription.</td>
<td><strong>Preferred cost-sharing:</strong> You pay $0 per prescription.</td>
</tr>
<tr>
<td><strong>Tier 2: Generic</strong></td>
<td><strong>Standard cost-sharing:</strong> You pay $10 per prescription.</td>
<td><strong>Standard cost-sharing:</strong> You pay $0 per prescription.</td>
</tr>
<tr>
<td></td>
<td><strong>Preferred cost-sharing:</strong> You pay $0 per prescription.</td>
<td><strong>Preferred cost-sharing:</strong> You pay $0 per prescription.</td>
</tr>
<tr>
<td><strong>Tier 3: Preferred Brand</strong></td>
<td><strong>Standard cost-sharing:</strong> You pay $25 per prescription.</td>
<td><strong>Standard cost-sharing:</strong> You pay $20 per prescription.</td>
</tr>
<tr>
<td></td>
<td><strong>Preferred cost-sharing:</strong> You pay $15 per prescription.</td>
<td><strong>Preferred cost-sharing:</strong> You pay $15 per prescription.</td>
</tr>
<tr>
<td><strong>Tier 4: Non-Preferred Brand</strong></td>
<td><strong>Standard cost-sharing:</strong> You pay $50 per prescription.</td>
<td><strong>Standard cost-sharing:</strong> You pay $35 per prescription.</td>
</tr>
<tr>
<td></td>
<td><strong>Preferred cost-sharing:</strong> You pay $30 per prescription.</td>
<td><strong>Preferred cost-sharing:</strong> You pay $30 per prescription.</td>
</tr>
<tr>
<td><strong>Tier 5: Specialty Tier</strong></td>
<td><strong>Standard cost-sharing:</strong> You pay 33% of the total cost.</td>
<td><strong>Standard cost-sharing:</strong> You pay 33% of the total cost.</td>
</tr>
<tr>
<td></td>
<td><strong>Preferred cost-sharing:</strong> You pay 33% of the total cost.</td>
<td><strong>Preferred cost-sharing:</strong> You pay 33% of the total cost.</td>
</tr>
</tbody>
</table>

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.
Stage 2: Initial Coverage Stage (cont.)

<table>
<thead>
<tr>
<th>Stage</th>
<th>2018 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once your total drug costs have reached $3,820, you will move to the next stage (the Coverage Gap Stage).</td>
<td>Once your total drug costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).</td>
<td></td>
</tr>
</tbody>
</table>

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 Administrative Changes

There are administrative changes for certain benefits next year. The information found in the table below describes these changes. For more information, review your 2020 Evidence of Coverage.

<table>
<thead>
<tr>
<th>Cost</th>
<th>2019 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuous Glucose Monitors (CGMs)</td>
<td>You may purchase your CGMs through a Durable Medical Equipment DME Provider or at the pharmacy.</td>
<td>Because we have no deductible, this payment stage does not apply to you.</td>
</tr>
<tr>
<td>Mail-order</td>
<td>Your plan currently works with EnvisionPharmacies to process mail-order prescriptions.</td>
<td>Your plan will work with IngenioRx Home Delivery to process mail-order prescriptions. More information on the mail-order process can be found in Chapter 5 Section 2.3 of the Evidence of Coverage (EOC).</td>
</tr>
<tr>
<td>Pharmacy Benefit Manager (PBM)</td>
<td>Your plan currently works with EnvisionRxOptions to process all of your pharmacy claims.</td>
<td>Your plan will work with IngenioRx to process all of your pharmacy claims. It is important for you to know that the information on your member ID card will change and you will need to give your new ID card to your pharmacist when you make your first visit to the pharmacy in 2020. The address for claims reimbursement and customer service numbers for drug-related questions will also change, so please make sure to check your Evidence of Coverage (EOC).</td>
</tr>
</tbody>
</table>
SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in HealthSun HealthAdvantage Plan

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 stay enrolled as a member of our plan for 2020.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2020 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 Medicare & You 2020, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click “Find health & drug plans.” Here, you can find information about costs, coverage, and quality ratings for Medicare plans.

As a reminder, HealthSun Health Plans offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

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.
- 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.
- 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 7.1 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 4 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, 2020.

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, 2020, 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, 2020. For more information, see Chapter 10, Section 2.2 of the Evidence of Coverage.

Section 5 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.

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 or TDD/TTY at 1-800-955-8770. You can learn more about SHINE by visiting their website (www.floridashine.org).

Section 6 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 Department of Health, AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-352-2437 (1-800-FLA-AIDS) for English, 1-800-545-7432 (1-800-545-SIDA) for Spanish and 1-800-2437-101 (1-800-AIDS-101) for Creole. TTY users should call 1-888-503-7118.
SECTION 7 Questions?

Section 7.1 – Getting Help from HealthSun HealthAdvantage Plan

Questions? We’re here to help. Please call Member Services at 305-447-4458 or 1-877 336-2069. (TTY only, call 1-877-206-0500). We are available for phone calls seven days a week from 8am to 8pm. Calls to these numbers are free.

Read your 2020 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 2020. For details, look in the 2020 Evidence of Coverage for HealthSun HealthAdvantage Plan. 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 can review the Evidence of Coverage to see if other benefits or cost changes affect you. 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 7.2 – 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 (https://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 https://www.medicare.gov and click on “Find health & drug plans”).

Read Medicare & You 2020

You can read the Medicare & You 2020 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 (https://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.
Notice of Non-Discrimination

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

1) HealthSun provides free aids and services to people with disabilities to communicate effectively with us, such as:
   - Qualified sign language interpreters.
   - Written information in other formats (large print, audio, accessible electronic formats, other formats)

2) HealthSun provides free language services to people whose primary language is not English, such as:
   - Qualified interpreters
   - Information written in other languages

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

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

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

Discriminación Es Contra La Ley

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

1) HealthSun proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes:
   - Intérpretes de lenguaje de señas capacitados.
   - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos).

2) HealthSun proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes:
   - Intérpretes capacitados
   - Información escrita en otros idiomas.

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

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

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).


