SOLIS
HEALTH PLANS

Annual Notice of Changes

Solis Guardian Plan (HMO D-SNP)

H0982_002_2025_ANOC_M

Solis Guardian Plan (HMO D-SNP) offered by Solis Health Plans, Inc.

Annual Notice of Changes for 2025

You are currently enrolled as a member of Solis Guardian Plan (HMO D-SNP). Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.solishealthplans.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

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.

- Review the changes to medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including coverage restrictions and cost sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies, will be in our network next year.

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at the www.medicare.gov/plan-compare website or review the list in the back of your

Medicare & You 2025 handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan
   - If you don't join another plan by December 7, 2024, you will stay in Solis Guardian Plan.
   - To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025.** This will end your enrollment with Solis Guardian Plan.
   - Look in section 3.2, page 15 to learn more about your choices.
   - If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-844-447-6547 for additional information. (TTY users should call 711.) Hours are 8:00 a.m. to 8:00 p.m. seven days a week from October 1 – March 31 and 8:00 a.m. to 8:00 p.m. Monday-Friday from April 1 - September 30. This call is free.
- To request a document in an alternative format, such as large print, braille or audio please contact Member Services at 1-844-447-6547.
- **Coverage under this plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Solis Guardian Plan

- Solis Health Plans, Inc., is an HMO plan with a Medicare contract. Enrollment in Solis Health Plans, Inc., depends on contract renewal. The plan also has a written agreement with the Florida Medicaid program to coordinate your Medicaid benefits.
- When this document says "we," "us," or "our," it means Solis Health Plans, Inc. When it says "plan" or "our plan," it means Solis Guardian Plan.

Annual Notice of Changes for 2025
Table of Contents

Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Solis Guardian Plan in several important areas. **Please note this is only a summary of costs**.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	**$37.70**	**$20.30**
Doctor office visits	Primary care visits: **$0.00** copay per visit Specialist visits: **$0.00** copay per visit	Primary care visits: **$0.00** copay per visit Specialist visits: **$0.00** copay per visit
Inpatient hospital stays	**$0.00** copay per stay	**$0.00** copay per stay
Part D prescription drug coverage (See Section 1.5 for details.) ***If you receive "Extra Help" you pay $0 copay for all Part D drugs through the plan's participation in the Value Based Insurance Design (VBID) program.***	Deductible: **$545** except for covered insulin products and most adult Part D vaccines. Copayment during the Initial Coverage Stage: • Drug Tier 1: **25%** coinsurance • Drug Tier 2: **25%** coinsurance • Drug Tier 3: **25%** coinsurance You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: **25%** coinsurance	Deductible: **$590** except for covered insulin products and most adult Part D vaccines. Copayment during the Initial Coverage Stage: • Drug Tier 1: **25%** coinsurance • Drug Tier 2: **25%** coinsurance • Drug Tier 3: **25%** coinsurance You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: **25%** coinsurance

Cost	2024 (this year)	2025 (next year)
	• Drug Tier 5: **25%** coinsurance • Drug Tier 6: **$0.00** copay Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs **and for excluded drugs that are covered under our enhanced benefit**. You pay nothing.	• Drug Tier 5: **25%** coinsurance • Drug Tier 6: **$0.00** copay Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs **and for excluded drugs that are covered under our enhanced benefit**.
Maximum out-of-pocket amount This is the most you will pay out of pocket for your covered services. (See Section 1.2 for details.)	**$3,400.00** If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	**$3,400.00** If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	**$37.70**	**$20.30**

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

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2024 (this year)	2025 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** If you are eligible for Medicaid assistance with Part A and Part B copays, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	**$3,400.00**	**$3,400.00** Once you have paid **$3,400.00** out of pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

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.

Updated directories are located on our website at www.solishealthplans.com. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2025 *Provider Directory* www.solishealthplans.com to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2025 *Pharmacy Directory* www.solishealthplans.com to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are a part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2024 (this year)	2025 (next year)
Dental Services (Supplemental)	**$0.00** copay for covered dental services limited to: **<u>Preventive Services</u>** Exams - 2 every year Cleanings - 2 every year Fluoride - 2 every year X-Rays - 2 series bitewing and 1 Panoramic every year **<u>Comprehensive Services</u>** Diagnostic Services – 2 every year Fillings – 1 every year Crowns – 2 every year Extractions – unlimited every year Root Canals – 1 every year Dentures – 1 complete set every 5 years Periodontal Scaling and Planing – 1 per each quadrant every 2 years	**$0.00** copay for non-Medicare covered dental services. The plan covers up to a **$5,000.00** allowance for non-Medicare covered preventive and comprehensive dental services each year. The allowance can be used for most dental services such as exams, cleanings, fluoride treatments, X-rays, fillings and repairs, root canals, crowns implants, and dentures. The allowance amount cannot be used for cosmetic, orthodontic, or maxillofacial prosthetic services. Unused amounts expire at the end of the calendar year.
Diabetic Testing Supplies	**$0.00** copay Diabetic testing supplies (meters, strips AND LANCETS) obtained through the pharmacy are limited to Lifescan and Roche branded products.	**$0.00** copay Diabetic testing supplies (meters, strips AND LANCETS) obtained through the pharmacy are limited to Lifescan and Trividia branded products. Test strips are limited to 100 strips per 30 days.
Flex Allowance – Dental, Vision, Hearing	The plan offers a **$1,250.00** annual spending allowance for routine dental, vision, and/or hearing services.	The plan offers a **$250.00** quarterly spending allowance for covered routine dental, vision, and/or hearing services at a network provider. Unused amounts roll over to the next quarter but expire at the end of the calendar year.

Cost	2024 (this year)	2025 (next year)
Healthy Living Allowance *Value Based Insurance Design (VBID) Benefit* *If you receive "Extra Help" to pay for your Medicare prescription drug program costs, you are eligible for this benefit through the plan's participation in the Value-Based Insurance Design (VBID) model.*	The plan offers a **$160.00** monthly allowance on a prepaid card. This allowance can be used to buy approved food and produce from participating retail locations. It can also be used to pay for non-medical transportation costs like Uber and Lyft and help to pay utilities, rent, and/or mortgage payments where card payments are accepted. Unused amounts expire at the end of each month. Pest control and pet supplies are not covered.	The plan offers a **$200.00** monthly allowance on a prepaid card. This allowance can be used to buy approved food, produce and **pet supplies** from participating retail locations. It can also be used to pay for **home pest control services**, non-medical transportation costs like Uber and Lyft and help to pay utilities, rent, and/or mortgage payments where card payments are accepted. Unused amounts expire at the end of each month.
Medicare Part B prescriptions drugs	Your plan currently does not require step therapy for any Part B drugs. Step therapy is a utilization tool that requires you to try another drug first to treat your medical condition before we cover the drug your physician initially prescribed.	There are some Medicare Part B Drugs that will now require this step in addition to obtaining prior authorization.
Papa® (In home support/ companionship)	**$0.00** copay for **100** hours annually (up to 10 hours max per month)	**$0.00** copay for **96** hours annually (up to 8 hours max per month)

Cost	2024 (this year)	2025 (next year)
Prior Authorization	The following benefits require prior authorization: • Medicare Covered Chiropractic Services • Routine Chiropractic Services • Occupational Therapy Services • Physician Specialist Services • Other Health Care Professional Services • Additional Telehealth Benefits • Post Discharge Meals • Kidney Disease Education Services • Glaucoma Screening • Diabetes Self-Management Training • Barium Enemas • Digital Rectal Exams • EKG following Welcome Visit • Non-Medicare covered eyewear	The following benefits **do not** require prior authorization: • Medicare Covered Chiropractic Services • Routine Chiropractic Services • Occupational Therapy Services • Physician Specialist Services • Other Health Care Professional Services • Additional Telehealth Benefits • Post Discharge Meals • Kidney Disease Education Services • Glaucoma Screening • Diabetes Self-Management Training • Barium Enemas • Digital Rectal Exams • EKG following Welcome Visit • Non-Medicare covered eyewear
Referrals	The following benefits require a referral: • Transportation Services - Supplemental • Preventive Dental Services • Routine Eye Exams • Non-Medicare covered eyewear The following benefits **do not** require a referral: • Post Discharge Meals	The following benefits **do not** require a referral: • Transportation Services - Supplemental • Preventive Dental Services • Routine Eye Exams • Non-Medicare covered eyewear The following benefits require a referral: • Post Discharge Meals

Section 1.5 – 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, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. You can also contact Member Services for more information.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact Member Services or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and Costs

Beginning in 2025, there are three **drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Part D drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.	The deductible is **$545** During this stage, you pay **$0** cost sharing for drugs on Tier 6 and the full cost of drugs on Tiers 1-5 until you have reached the yearly deductible. **If you receive "Extra Help" this payment stage does not apply to you.**	The deductible is **$590** During this stage, you pay **$0** cost sharing for drugs on Tier 6 and the full cost of drugs on Tiers 1-5 until you have reached the yearly deductible. **If you receive "Extra Help" this payment stage does not apply to you.**

Changes to Your Cost Sharing in the Initial Coverage Stage

Please see the following chart for the changes from 2024 to 2025.

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost**. The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. Most adult Part D vaccines are covered at no cost to you. ***If you receive "Extra Help" you pay $0 copay for all Part D drugs through the plan's participation in the Value Based Insurance Design (VBID) program.***	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 Preferred Generic:** You pay **25%** of the total cost. **Tier 2 Generic:** You pay **25%** of the total cost. **Tier 3 Preferred Brand**: You pay **25%** of the total cost. You pay **$35** per month supply of each covered insulin product on this tier. **Tier 4 Non-Preferred Drug:** You pay **25%** of the total cost. **Tier 5 Specialty Tier** You pay **25%** of the total cost. **Tier 6 Supplemental Drugs**: You pay **$0.00** copay per prescription ——————— Once your total drug costs have reached **$5,030.00** you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 Preferred Generic:** You pay **25%** of the total cost. **Tier 2 Generic:** You pay **25%** of the total cost. **Tier 3 Preferred Brand**: You pay **25%** of the total cost. You pay **$35** per month supply of each covered insulin product on this tier. **Tier 4 Non-Preferred Drug:** You pay **25%** of the total cost. **Tier 5 Specialty Tier** You pay **25%** of the total cost. **Tier 6 Supplemental Drugs**: You pay **$0.00** copay per prescription ——————— Once you have paid **$2,000.00** out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to your VBID Part D Benefit

In 2025, Tier 5 will be added to your VBID Part D benefit. Your copay for Tier 5 drugs will be $0. You will pay $0 copay for all covered Part D drugs through all stages.

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, Section 6, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2024 (this year)	2025 (next year)
Pharmacy benefit manager (PBM)	Your pharmacy benefits manager is Navitus.	Your new pharmacy benefits manager is Prime Therapeutics.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Solis Guardian 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 be enrolled in our Solis Guardian Plan.

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 plans for 2025 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *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.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, Solis Health Plans, Inc. offers other Medicare health 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 Solis Guardian Plan.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Solis Guardian 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 so.
    - – *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.

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

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, 2025.

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

In certain situations, changes are also allowed at other times of the year. Examples include 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.

Because you have Florida Medicaid, you can end your membership in our plan any month of the year. You also have options to enroll in another Medicare plan any month including:

- Original Medicare *with* a separate Medicare prescription drug plan,
- Original Medicare without a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

If you enrolled in a Medicare Advantage plan for January 1, 2025, and don't like your plan choice, you can also 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, 2025.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 5 Programs That Offer Free Counseling about Medicare and Medicaid

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

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHINE (Serving Health Insurance Needs of Elders) 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 (Serving Health Insurance Needs of Elders) at 1-800-963-5337 (TTY 1-800-955-

8770. You can learn more about SHINE (Serving Health Insurance Needs of Elders) by visiting their website (http://www.floridashine.org/).

For questions about your Florida Medicaid benefits, contact the Agency for Health Care Administration (AHCA), 1-888-419-3456, TTY 1-800-955-8771 Monday – Friday, 8:00 a.m. to 5:00 p.m. Ask how joining another plan or returning to Original Medicare affects how you get your Florida Medicaid coverage.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in "Extra Help," also called the Low-Income Subsidy. "Extra Help" pays some of your prescription drug premiums, yearly deductibles, and coinsurance. Because you qualify, you do not have a late enrollment penalty. If you have questions about "Extra Help," 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 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office.
- **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. To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Florida AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call Florida HIV/AIDS Hotline at 1-800-352-2437 (English) / 1-800-545-7432 (Spanish) /1-800-243-7101 (Creole) / 1-888-503-7118 (TTY). Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

SECTION 7 Questions?

Section 7.1 – Getting Help from Solis Guardian Plan

Questions? We're here to help. Please call Member Services at 1-844-447-6547. (TTY only, call 711). We are available for phone calls 8:00 a.m. to 8:00 p.m. seven days a week from October 1st – March 31st and 8:00 a.m. to 8:00 p.m. Monday-Friday from April 1st- September 30th. Calls to these numbers are free.

Read your *2025 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 2025. For details, look in the *2025 Evidence of Coverage* for Solis Guardian 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.solishealthplans.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.solishealthplans.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

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document 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 document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) 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.

Section 7.3 – Getting Help from Medicaid

To get information from Medicaid you can call the Florida Agency for Health Care Administration (AHCA) at 1-888-419-3456. TTY users should call 1-800-955-8771.

SOLIS
HEALTH PLANS

Solis Health Plans, Inc., is an HMO plan with a Medicare contract. Enrollment in Solis Health Plans, Inc., depends on contract renewal.

Medicare approved Solis Health Plans, Inc., to provide these benefits and lower copayments/co-insurance as part of the Value-Based Insurance Design program. This program lets Medicare try new ways to improve Medicare Advantage plans.