SOLIS
HEALTH PLANS

2026
SUMMARY OF BENEFITS
SOLIS HEALTHY LIVING PLAN (HMO)

Solis Healthy Living Plan (HMO)

Our service area includes these counties in Florida; **Hillsborough, Pasco, Pinellas | January 1, 2026 - December 31, 2026**

The Summary of Benefits does not list every service that we cover, or list every limitation or exclusion. To obtain a complete list of services we cover, please visit our website or call us to request a copy.

To Learn More About Medicare:

- Compare your Medicare options with other plans you can use the Medicare Plan Finder on www.medicare.gov.
- Learn more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. This document is available in other formats such as braille, large print or audio.

To join **Solis Healthy Living Plan (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

What Does This Plan Cover?

- Our plans cover everything that Original Medicare covers - and more!
- Our plans have prescription drug coverage (Part D). You can see Solis' comprehensive prescription drug list (Formulary) on our website.
- Solis has a network of hospitals, doctors, specialists, pharmacies, and other providers ready to serve all of your healthcare needs. You can access the Provider/ Pharmacy Directory on our website. Services are available when using an in-network provider. Out-of-network provider services are not covered except in emergency situations.

Do You Have Questions?

Our Member Services Department is ready to help with any questions you have.

1-844-447-6547 (TTY: 711)

From October 1 - March 31, we are open 7 days a week: 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday from 8 a.m. to 8 p.m.

Visit us online at www.solishealthplans.com

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Member Service representative at **1-844-447-6547 (TTY: 711)**.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC), provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit www.solishealthplans.com or call **1-844-447-6547 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the Provider/Pharmacy Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the Provider/Pharmacy Directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the Formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2027.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the Provider/Pharmacy Directory).
- ☐ Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.

Monthly Premium

$0 monthly premium

You must continue to pay your Part B premium.

Deductible

$0 deductible

Maximum Out-of-Pocket Responsibility (does not include prescription drugs)

$2,900 in-network only

Under our plan this is the most you will pay during the plan year for approved medical services. Should you meet the maximum, you will not have to pay any out-of-pocket costs for covered Part A and Part B services for the rest of the year.

Covered Medical and Hospital Benefits

Inpatient Hospital [A,R]

$50 copay - per day, for days 1-7
$0 copay - per day, for days 8-94, per admission

The plan covers 94 days for an inpatient hospital stay.

Outpatient Hospital [A,R]

$85 copay for surgery services at an outpatient hospital
$50 copay per stay for outpatient hospital observation services

Ambulatory Surgical Center [A,R]

$0 copay

Doctor Visits

Primary Care	**$0** copay
Specialists [R]	**$0** copay

A - Authorization may be required **R** - Referral may be required

Preventive Care [R]

$0 copay for all Medicare-covered preventive services, including:

- Abdominal aortic aneurysm screening
- Annual "wellness" visit
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)
- Cardiovascular disease testing
- Cervical and vaginal cancer screening
- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- Depression screening
- Diabetes screening
- Diabetes self-management training
- HIV screening
- Immunizations
- Lung cancer screening
- Medical nutrition therapy
- Medicare Diabetes prevention program (MDPP)
- Obesity screening and therapy
- Prostate cancer screening (PSA)
- Screening and counseling to reduce alcohol misuse
- Screening for sexually transmitted infections and counseling
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)
- "Welcome to Medicare" preventive visit (one-time)

Any additional preventive services approved by Medicare during the contract year will be covered.

Emergency Care

$100 copay

The copay is waived if you are admitted to the hospital within 24 hours.

Worldwide Emergency Coverage - **$100** copay for emergency care outside the United States. The benefit is limited to **$75,000** per year.

The copay is waived if you are admitted to the hospital within 24 hours.

Urgently Needed Services

$0 copay

Diagnostic Services/Labs/Imaging

Diagnostic Procedures/Tests [R]

$0 copay - Non-Hospital Facility
$90 copay - Hospital Facility

Lab Services [R]

$0 copay

X-Ray Services [A,R]

$0 copay - Non-Hospital Facility
$50 copay - Hospital Facility

Diagnostic Radiological Services (such as CT, MRI, etc.) [A,R]

$0 copay - Non-Hospital Facility
$90 copay - Hospital Facility

Therapeutic Radiological Services (such as radiation treatment for cancer) [A,R]

20% coinsurance

Hearing Services [A,R]

Medicare-Covered Hearing Services

$0 copay for Medicare-covered hearing services (exam to diagnose and treat hearing and balance issues)

Routine Hearing Services

$0 copay for 1 routine hearing exam

$0 copay for 1 routine hearing aid fitting evaluation

$1,000 maximum allowance both ears combined, for prescribed hearing aids every year

This plan offers a Flex Allowance on a prepaid card to cover out-of-pocket costs for additional covered dental, vision and/or hearing services. For more details, see the Additional Benefits section.

Dental Services

Medicare-Covered Dental Services [A,R]

$0 copay for Medicare-covered dental services

Preventive and Comprehensive Supplemental Dental Services [A]

This plan also covers up to **$3,000** every year for non-Medicare covered preventive and comprehensive dental services.

The benefit covers most dental treatments such as: exams, cleanings, fillings, extractions, root canals, bridges, crowns, implants and dentures.

Any amount not used at the end of the calendar year will expire.

You are responsible for any amount above the allowance amount. Limitations and exclusions may apply. Visit www.solishealthplans.com/2026/member-resources and download the 2026 Dental Guide for additional details.

This plan offers a Flex Allowance on a prepaid card to cover out-of-pocket costs for additional covered dental, vision and/or hearing services. For more details, see the Additional Benefits section.

Vision Services

Medicare-Covered Vision Services [A,R]

$0 copay for Medicare-covered vision services including eyewear after cataract surgery

Routine Vision Services

$0 copay - 1 routine eye exam per year

$250 allowance every year for contact lenses or eyeglasses (lenses and frames) or, 2 pairs of select eyeglasses every year at no cost

This plan offers a Flex Allowance on a prepaid card to cover out-of-pocket costs for additional covered dental, vision and/or hearing services. For more details, see the Additional Benefits section.

Mental Health Services

Inpatient Hospital (Psychiatric) [A,R] The plan covers 90 days for an inpatient hospital stay.	**$50** copay - per day, for days 1-7 **$0** copay - per day, for days 8-90, per admission
Outpatient Mental Health Services [R]	**$20** copay - Individual Sessions **$20** copay - Group Sessions

Skilled Nursing Facility (SNF) [A,R]

$0 copay - per day, for days 1-20
$150 copay - per day, for days 21-100, per admission

The plan covers up to 100 days in a SNF.
Eligibility for this benefit requires a hospital stay of no less than two consecutive days.

Rehabilitation Services [A,R]
(Physical Therapy and Speech Language Pathology Services)

$10 copay - Non-Hospital Facility
$40 copay - Hospital Facility

Ambulance [A]

Ground Ambulance Services (one-way trip only)
$200 copay

Air Ambulance Services
20% coinsurance

Authorization is required for non-emergency ambulance services.

Transportation

$0 copay

Up to 24 one-way trips per year to plan approved health-related locations through our transportation vendor. Members may request Uber or Lyft.

Medicare Part B Drugs [A]

20% coinsurance

Chemotherapy/Radiation Drugs and Other Medicare Part B Drugs

Some rebatable Part B drugs may be subject to a lower coinsurance.

Insulin cost sharing is subject to a coinsurance cap of **$35** for one-month's supply of insulin.

Additional Benefits

Healthy Living Allowance [A]

Special Supplemental Benefits for the Chronically Ill (SSBCI)

$50 monthly allowance loaded to a prepaid card

This allowance can be used to buy approved healthy food and produce or pet services and supplies from participating retail locations; assist in paying utility bills where card payments are accepted; or pay for pest control services or non-medical transportation costs, such as a taxi or ride-share service. See Chapter 4 of your Evidence of Coverage for additional details.

The allowance amount does not roll over to the next month or year.

To be eligible for this SSBCI benefit you must have a chronic condition such as diabetes, cardiovascular disease, chronic heart failure, dementia, or hypertension. Your condition must also limit your overall health or function, put you at high risk of hospitalization, and require intensive care coordination. For additional coverage criteria and other eligible conditions, see chapter 4 of the Evidence of Coverage.

Flex Allowance (Dental, Vision & Hearing)

$200 quarterly allowance (up to a maximum of $800 annually*) applied to a prepaid card to pay for out-of-pocket costs for covered dental, vision and/or hearing services.

The allowance will be automatically applied to your prepaid card every quarter. The amount carries over from quarter to quarter, but expires at the end of the calendar year.

*Annual limit is based on a full calendar year of enrollment.

Over-the-Counter (OTC)

$115 per month for plan approved over-the-counter and health-related products. Please visit our website or call our Member Services Department to request an OTC Catalog.

Erectile Dysfunction Drugs (ED)

You are covered for up to **8** pills per month (Generic versions: Cialis & Viagra).

Papa™ (In-Home Support/Companionship)

24 hours per year

Papa™ connects members with Pals for companionship and assistance with everyday activities and tasks such as: conversation, assistance with technology, light cleaning, laundry, organizing, transportation for errands and more.

Fitness Membership

$0 copay

A fitness membership that provides gym facilities and at-home resources, including online workout classes and home fitness kits, at no additional cost to you.

Meals [R]

Post-Discharge Meals

2 meals a day for 7 days following surgery or inpatient hospitalization, for unlimited hospitalizations.

24-Hour Nurse Hotline

Solis Health Plans offers a Nurse Hotline, 24-hours a day, 7 days a week, to offer advice and attention on symptoms or health related questions by calling **1-833-371-9569 (TTY/TDD: 711)**.

Chiropractic Services [R]

Medicare-Covered Chiropractic Services

$0 copay

Routine Chiropractic Services

$0 copay for 12 routine chiropractic visits per year

Podiatry Services [R]

Medicare-Covered Podiatry Services

$0 copay

Routine Podiatry Services

$0 copay for 12 routine foot care visits per year

Medical Equipment/Supplies [A]

Diabetic Supplies — **$0** copay
Diabetic Supplies & Services have preferred manufacturers.

Diabetic Therapeutic Shoes or Inserts — **20%** coinsurance

Durable Medical Equipment — **20%** coinsurance

- » Ventilators
- » Bone growth stimulator
- » Portable oxygen concentrators
- » Bariatric equipment
- » Specialty beds
- » Custom wheelchairs
- » Seat lifts
- » Specialty brand items

All other Durable Medical Equipment — **0%** coinsurance

The plan has preferred vendors/manufacturers for Durable Medical Equipment (DME).

Prosthetic Devices — **20%** coinsurance
Medicare-covered prosthetic devices

Prescription Drug Benefits

Important Message About What You Pay for Vaccines:
Our plan covers most Part D vaccines at no cost to you. Call our Member Services Department for more information.

Important Message About What to Pay for Insulin:
You won't pay more than **$35** for one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Deductible

$0 deductible

Initial Coverage Stage

Your copayment or coinsurance amounts are listed on the next page. You will pay these amounts until your total out-of-pocket costs reach **$2,100**. After that, you will move into the Catastrophic Stage.

TIERS	Standard Retail Rx 30-day Supply	Standard Retail Rx 60-day Supply	Standard Retail Rx 90-day Supply	Mail Order 90-day Supply
Tier 1: Preferred Generic	$0 copay	$0 copay	$0 copay	$0 copay
Tier 2: Generic	$0 copay	$0 copay	$0 copay	$0 copay
Tier 3: Preferred Brand	$25 copay	$50 copay	$70 copay	Not Available
Tier 4: Non-Preferred Drug	$75 copay	Not Available	Not Available	Not Available
Tier 5: Specialty	33% coinsurance	Not Available	Not Available	Not Available
Tier 6: Supplemental Drugs	$0 copay	Not Available	Not Available	Not Available

If you receive "Extra Help", you pay whichever is less: your plan cost-share or the Low Income Subsidy (LIS) cost-share. Please refer to your LIS Rider for the specific amount you pay.

Catastrophic Coverage

After your total out-of-pocket costs reach **$2,100,** you will pay **$0** for covered Part D and excluded drugs.

Solis Health Plans, Inc., is an HMO plan with a Medicare contract. Enrollment in Solis Health Plans, Inc., depends on contract renewal. Solis Health Plans, Inc., complies with all applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Solis Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-447-6547 (TTY: 711).