Summary of Benefits 2021

Medicare Advantage Plan with Prescription Drugs

Erickson Advantage® Freedom (HMO-POS)
H5652-006-000

Look inside to take advantage of the health services and drug coverages the plan provides. Call Customer Service or go online for more information about the plan.

Toll-free **1-866-774-9671**, TTY **711**
8 a.m. - 8 p.m. local time, 7 days a week

www.EricksonAdvantage.com

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Summary of Benefits

January 1st, 2021 - December 31st, 2021

The benefit information provided is 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. The Evidence of Coverage (EOC) provides a complete list of services we cover. You can see it online at www.EricksonAdvantage.com or you can call Customer Service for help. When you enroll in the plan you will get information that tells you where you can go online to view your Evidence of Coverage.

About this plan.

Erickson Advantage® Freedom (HMO-POS) is a Medicare Advantage HMOPOS plan with a Medicare contract.

To join this plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live within our service area listed below, and be a United States citizen or lawfully present in the United States.

Our service area includes these counties in:

Colorado: Douglas;

Florida: Collier;

Kansas: Johnson;

Maryland: Baltimore, Montgomery, Prince George's;

Massachusetts: Essex, Plymouth;

Michigan: Oakland;

New Jersey: Monmouth, Morris, Union;

North Carolina: Mecklenburg;

Pennsylvania: Bucks, Delaware;

Texas: Collin, Harris;

Virginia: Fairfax, Loudoun.

Use network providers and pharmacies.

Erickson Advantage® Freedom (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. For some services you can use providers that are not in our network. If you use pharmacies that are not in our network, the plan may not pay for those drugs, or you may pay more than you pay at a network pharmacy.

You can go to www.EricksonAdvantage.com to search for a network provider or pharmacy using the online directories. You can also view the plan Drug List (Formulary) to see what drugs are covered, and if there are any restrictions.

Erickson Advantage® Freedom (HMO-POS)

Premiums and Benefits

	In-Network	Out-of-Network
Monthly Plan Premium	$70	
Annual Medical Deductible	This plan does not have a deductible.	
Maximum Out-of-Pocket Amount (does not include prescription drugs)	$4,300 annually for Medicare-covered services you receive from in-network providers.	Unlimited Out-of-Network
	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 share of the cost for your Part D prescription drugs.	

Erickson Advantage® Freedom (HMO-POS)

Benefits

		In-Network	Out-of-Network
Inpatient Hospital[2]		$225 copay per day: for days 1-7 $0 copay per day: for days 8 and beyond	30% coinsurance per stay
		Our plan covers an unlimited number of days for an inpatient hospital stay.	
Outpatient Hospital Cost sharing for additional plan covered services will apply.	Ambulatory Surgical Center (ASC)[2]	$0 copay for a diagnostic colonoscopy $225 copay otherwise	30% coinsurance
	Outpatient Hospital, including surgery[2]	$0 copay for a diagnostic colonoscopy $225 copay otherwise	30% coinsurance
	Outpatient Hospital Observation Services[2]	$225 copay	30% coinsurance
Doctor Visits	Primary Care Provider	Type 1: $0 copay | Type 2: $20 copay	30% coinsurance
	Specialists[2]	$40 copay	30% coinsurance
	Virtual Medical Visits	$0 copay; Speak to network telehealth providers using your computer or mobile device.	
Preventive Care	Medicare-covered	$0 copay	$0 copay - 30% coinsurance (depending on the service)
		Abdominal aortic aneurysm screening Alcohol misuse counseling Annual “Wellness” visit Bone mass measurement Breast cancer screening (mammogram) Cardiovascular disease (behavioral therapy) Cardiovascular screening Cervical and vaginal cancer screening Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)	

Benefits

		In-Network	Out-of-Network
		Depression screening Diabetes screenings and monitoring Hepatitis C screening HIV screening Lung cancer with low dose computed tomography (LDCT) screening Medical nutrition therapy services Medicare Diabetes Prevention Program (MDPP) Obesity screenings and counseling Prostate cancer screenings (PSA) Sexually transmitted infections screenings and counseling 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)	
		Any additional preventive services approved by Medicare during the contract year will be covered. This plan covers preventive care screenings and annual physical exams at 100% when you use in-network providers.	
	Routine physical	$0 copay; 1 per year*	30% coinsurance; 1 per year*
Emergency Care		$75 copay ($0 copay for worldwide coverage) per visit If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Emergency copay. See the "Inpatient Hospital" section of this booklet for other costs.	
Urgently Needed Services		$30 copay ($0 copay for worldwide coverage)	

Benefits

		In-Network	Out-of-Network
Diagnostic Tests, Lab and Radiology Services, and X-Rays	Diagnostic radiology services (e.g. MRI)[2]	$0 copay for each diagnostic mammogram $50 copay otherwise	30% coinsurance
	Lab services[2]	$0 copay	$0 copay
	Diagnostic tests and procedures[2]	$0 copay	30% coinsurance
	Therapeutic Radiology[2]	$40 copay per service	30% coinsurance
	Outpatient X-rays[2]	$15 copay per service	$20 copay per service
Hearing Services	Exam to diagnose and treat hearing and balance issues[2]	$0 copay	30% coinsurance
	Routine hearing exam	$0 copay; 1 per year*	30% coinsurance; 1 per year*
	Hearing aid[2]	$375 - $2,075 copay for each hearing aid provided through UnitedHealthcare Hearing, up to 2 hearing aids every 2 years.*	$375 copay for home-delivered hearing aids available nationwide through UnitedHealthcare Hearing (select products only)*
Routine Dental Benefits	Optional Dental Rider	Additional dental benefits available with a separate premium. Please see optional benefits section below for details.	
	Preventive	$0 copay for exams, cleanings, x-rays, and fluoride*	$0 copay for exams, cleanings, x-rays, and fluoride*

Benefits

		In-Network	Out-of-Network
Vision Services	Exam to diagnose and treat diseases and conditions of the eye[2]	$0 copay	30% coinsurance
	Eyewear after cataract surgery	$0 copay	$0 copay
	Routine eye exam	$0 copay; 1 every year*	30% coinsurance; 1 every year*
	Eyewear	$0 copay every 2 years; up to $100 for frames or contact lenses. Standard single, bifocal, trifocal, or progressive lenses are covered in full.*	$0 copay; up to $100 for home-delivered eyewear available nationwide only through UnitedHealthcare Vision. (select products only)*
Mental Health	Inpatient visit[2]	$225 copay per day: for days 1-7 $0 copay per day: for days 8-90	30% coinsurance per stay
		Our plan covers 90 days for an inpatient hospital stay.	
	Outpatient group therapy visit[2]	$20 copay	30% coinsurance
	Outpatient individual therapy visit[2]	$20 copay - $40 copay	30% coinsurance
Skilled Nursing Facility (SNF)[2]		$0 copay per day: for days 1-20 $184 copay per day: for days 21-44 $0 copay per day: for days 45-100	30% coinsurance per stay, up to 100 days
		Our plan covers up to 100 days in a SNF.	
Physical therapy and speech and language therapy visit[2]		$20 copay	30% coinsurance

Benefits

		In-Network	Out-of-Network
Ambulance[2] Your provider must obtain prior authorization for non-emergency transportation.		$225 copay for ground $225 copay for air	$225 copay for ground $225 copay for air
Routine Transportation		$0 copay; 24 one-way trips per year to or from approved locations	Not covered
Medicare Part B Drugs	Chemotherapy drugs[2]	20% coinsurance	30% coinsurance
	Other Part B drugs[2]	20% coinsurance	30% coinsurance

Prescription Drugs

If you reside in a long-term care facility, you pay the same for a 31-day supply as a 30-day supply at a retail pharmacy.

Stage 1: Annual Prescription (Part D) Deductible	$0 per year for Tier 1, Tier 2 and Tier 3; $200 for Tier 4 and Tier 5 Part D prescription drugs.			
Stage 2: Initial Coverage (After you pay your deductible, if applicable)	**Retail**		**Mail Order**	
	Standard		**Preferred**	**Standard**
	30-day supply	**90-day supply**	**90-day supply**	**90-day supply**
Tier 1: Preferred Generic Drugs	$5 copay	$15 copay	$0 copay	$15 copay
Tier 2: Generic Drugs[3]	$15 copay	$45 copay	$0 copay	$45 copay
Tier 3: Preferred Brand Drugs	$45 copay	$135 copay	$125 copay	$135 copay
Select Insulin Drugs[4]	$35 copay	$105 copay	$95 copay	$105 copay
Tier 4: Non-Preferred Drugs	$85 copay	$255 copay	$245 copay	$255 copay
Tier 5: Specialty Tier Drugs	29% coinsurance	N/A[5]	N/A[5]	N/A[5]
Stage 3: Coverage Gap Stage	After your total drug costs reach $4,130, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.			
Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,550, you pay the greater of: □ 5% coinsurance, or □ $3.70 copay for generic (including brand drugs treated as generic) and a $9.20 copay for all other drugs.			

[3] Tier includes enhanced drug coverage.

[4] For 2021, this plan participates in the Insulin Senior Savings Program which offers lower, stable, and predictable out of pocket costs for covered insulin through the different Part D benefit coverage stages. You will pay a maximum of $35 for a 1-month supply of covered insulin during the deductible, initial coverage and coverage gap or "donut hole" stages of your benefit. You will pay 5% of the cost of your covered insulin in the catastrophic stage. Your cost maybe less if you receive Extra Help from Medicare.

[5] Limited to a 30-day supply

Additional Benefits

		In-Network	Out-of-Network
Acupuncture	Medicare-covered acupuncture[2]	Type 1: $0 copay | Type 2: $20 copay for services provided by a primary care physician $40 copay for services provided by a specialist	30% coinsurance for services provided by a primary care physician 30% coinsurance for services provided by a specialist
Chiropractic Care	Manual manipulation of the spine to correct subluxation[2]	$20 copay	50% coinsurance
Diabetes Management	Diabetes monitoring supplies[2]	20% coinsurance	30% coinsurance
	Diabetes Self-management training	$0 copay	30% coinsurance
	Therapeutic shoes or inserts[2]	20% coinsurance	30% coinsurance
Durable Medical Equipment (DME) and Related Supplies	Durable Medical Equipment (e.g., wheelchairs, oxygen)[2]	20% coinsurance	30% coinsurance
	Prosthetics (e.g., braces, artificial limbs)[2]	20% coinsurance	30% coinsurance
Falls Prevention Program		Learn how to help reduce falls, prevent injuries and improve your balance and strength	Not covered
Fitness program through Renew Active™		Renew Active provides a standard gym membership with access to an extensive nationwide network of fitness locations nationwide, plus a personalized fitness plan, online fitness classes, and an online brain health program all at no cost to you.	

Additional Benefits

		In-Network	Out-of-Network
Foot Care (podiatry services)	Foot exams and treatment[2]	$20 copay	30% coinsurance
	Routine foot care	$20 copay; for each visit up to 6 visits every year*	30% coinsurance; for each visit up to 6 visits every year*
Home Health Care[2]		$0 copay	30% coinsurance
Hospice		You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan.	
Occupational Therapy Visit[2]		$20 copay	30% coinsurance
Opioid Treatment Program Services[2]		$0 copay	$0 copay
Outpatient Substance Abuse	Outpatient group therapy visit[2]	$40 copay	30% coinsurance
	Outpatient individual therapy visit[2]	$40 copay	30% coinsurance
Renal Dialysis[2]		20% coinsurance	20% coinsurance

Services with a 2 may require your provider to obtain prior authorization from the plan for in-network benefits.

*Benefits are combined in and out-of-network

Optional Supplemental Benefits

Premiums and Benefits

		In-Network
Platinum Dental Rider	Premium	Additional $40.00 per month

Optional Supplemental Benefits

Premiums and Benefits

		In-Network
	Description	The Platinum Dental Rider includes preventive and comprehensive dental benefits.

Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the Benefits

- ✔ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Call us or go online to view a copy of the EOC. Our phone number and website are listed on the back cover of this book.
- ✔ Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ✔ Review the Pharmacy Directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ✔ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ✔ Benefits, premiums and/or copays/coinsurance may change on January 1 of each year.
- ✔ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher copay for services received by non-contracted providers.

Required Information

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in these plans depends on the plan's contract renewal with Medicare.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

If you want to know 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), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-814-6894 (TTY: 711).

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 1-855-814-6894 (TTY: 711).

This information is available for free in other languages. Please call our Customer Service number located on the first page of this book.

Esta información esta disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la cobertura de este libro.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

OptumRx is an affiliate of UnitedHealthcare Insurance Company. You are not required to use OptumRx home delivery for a 90 day supply of your maintenance medication.

If you have not used OptumRx home delivery, you must approve the first prescription order sent directly from your doctor to OptumRx before it can be filled. New prescriptions from OptumRx should arrive within ten business days from the date the completed order is received, and refill orders should arrive in about seven business days. Contact OptumRx anytime at 1-877-266-4832, TTY 711.

Participation in the Renew Active™ program is voluntary. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. Renew Active includes standard fitness membership. Equipment, classes, personalized fitness plans, and events may vary by location.

Certain services, classes and events are provided by affiliates of UnitedHealthcare Insurance Company or other third parties not affiliated with UnitedHealthcare. Participation in AARP® Staying Sharp and the Fitbit® Community for Renew Active is subject to your acceptance of their respective terms and policies. UnitedHealthcare is not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor. The Renew Active program varies by plan/area.