2019
SUMMARY OF BENEFITS

Overview of your plan

Erickson Advantage® Signature without Drugs (HMO-POS)

H5652-002

Look inside to learn more about the health services 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

Erickson Advantage®

Y0066_SB_H5652_002_2019_M

Our service area includes these counties in:

Colorado: Douglas;
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.

Summary of Benefits

January 1st, 2019 - December 31st, 2019

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® Signature without Drugs (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 inside the cover, and be a United States citizen or lawfully present in the United States.

Use network providers.

Erickson Advantage® Signature without Drugs (HMO-POS) has a network of doctors, hospitals, and other providers. For some services you can use providers that are not in our network.

You can go to www.EricksonAdvantage.com to search for a network provider using the online directory.

Erickson Advantage® Signature without Drugs (HMO-POS)

Premiums and Benefits	In-Network	Out-of-Network
Monthly Plan Premium	$160	
Annual Medical Deductible	This plan does not have a deductible.	
Maximum Out-of-Pocket Amount	$2,900 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 .	

Erickson Advantage® Signature without Drugs (HMO-POS)

Benefits		In-Network	Out-of-Network
Inpatient Hospital		$0 copay per stay	30% coinsurance per stay
		Our plan covers an unlimited number of days for an inpatient hospital stay.	
Outpatient Hospital		$50 copay Cost sharing for additional plan covered services will apply.	30% coinsurance Cost sharing for additional plan covered services will apply.
Outpatient Hospital Observation Services		$50 copay	30% coinsurance
Doctor Visits	Primary	$0 copay	30% coinsurance
	Specialists	$20 copay	30% coinsurance
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) 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)	

Benefits		In-Network	Out-of-Network
		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 (worldwide) 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 Care” section of this booklet for other costs.	
Urgently Needed Services		$30 copay	
Diagnostic Tests, Lab and Radiology Services, and X-Rays	Diagnostic radiology services (e.g. MRI)	$50 copay per service	30% coinsurance
	Lab services	$0 copay	$0 copay
	Diagnostic tests and procedures	$0 copay	30% coinsurance
	Therapeutic Radiology	$30 copay per service	30% coinsurance
	Outpatient X-rays	$20 copay per service	30% coinsurance

Benefits		In-Network	Out-of-Network
Hearing Services	Exam to diagnose and treat hearing and balance issues	$20 copay	30% coinsurance
	Routine hearing exam	$20 copay; 1 per year*	30% coinsurance; 1 per year*
	Hearing aid	$330 - $380 copay for each hearing aid provided through hi HealthInnovations®; up to 2 hearing aids per year	Not covered
Routine Dental Services	Preventive	$35 copay for office visit (includes exam, cleaning, x-rays)	Not covered
Vision Services	Exam to diagnose and treat diseases and conditions of the eye	$20 copay	30% coinsurance
	Eyewear after cataract surgery	$0 copay	$0 copay
	Routine eye exam	$20 copay Up to 1 every year*	30% coinsurance Up to 1 every year*
	Eyewear	$0 copay every 2 years; up to $100 for lenses/ frames and contacts*	$0 copay every 2 years; up to $100 for lenses/ frames and contacts*
Mental Health	Inpatient visit	$0 copay per stay	30% coinsurance per stay
		Our plan covers 90 days for an inpatient hospital stay.	
	Outpatient group therapy visit	$0 copay	30% coinsurance
	Outpatient individual therapy visit	$0 copay - $30 copay	30% coinsurance
Skilled Nursing Facility (SNF)		$0 copay per day: for days 1-100	30% coinsurance per stay, up to 100 days
		Our plan covers up to 100 days in a SNF.	

Benefits		In-Network	Out-of-Network
Physical therapy and speech and language therapy visit		$0 copay	30% coinsurance
Ambulance		$150 copay for ground $150 copay for air	$150 copay for ground $150 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	10% coinsurance	30% coinsurance
	Other Part B drugs	10% coinsurance	30% coinsurance

Additional Benefits		In-Network	Out-of-Network
Chiropractic Care	Manual manipulation of the spine to correct subluxation	$20 copay	50% coinsurance
Diabetes Management	Diabetes monitoring supplies	20% coinsurance	30% coinsurance
	Diabetes Self-management training	$0 copay	30% coinsurance
	Therapeutic shoes or inserts	20% coinsurance	30% coinsurance
Durable Medical Equipment (DME) and Related Supplies	Durable Medical Equipment (e.g., wheelchairs, oxygen)	20% coinsurance	30% coinsurance
	Prosthetics (e.g., braces, artificial limbs)	20% coinsurance	30% coinsurance
Falls Prevention		Learn how to help reduce falls, prevent injuries and improve your balance and strength	Not covered
Foot Care (podiatry services)	Foot exams and treatment	$0 copay	30% coinsurance
	Routine foot care	$0 copay; for each visit up to 6 visits every year*	30% coinsurance; for each visit up to 6 visits every year*
Home Health Care		$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		$0 copay	30% coinsurance

Additional Benefits		In-Network	Out-of-Network
Outpatient Substance Abuse	Outpatient group therapy visit	$30 copay	30% coinsurance
	Outpatient individual therapy visit	$30 copay	30% coinsurance
Outpatient Surgery		$50 copay	30% coinsurance
Renal Dialysis		20% coinsurance	20% coinsurance

*Benefits are combined in and out-of-network

Required Information

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

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 https://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.

Benefits, premium and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party.

Every year, Medicare evaluates plans based on a 5-star rating system.

The provider network may change at any time. You will receive notice when necessary.

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