# Summary of Benefits 2021

Medicare Advantage Plan

**Erickson Advantage® Liberty without Drugs (HMO-POS)**
H5652-002-000

Look inside to take advantage of 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**

United Healthcare®

Erickson Living
Erickson Advantage®

Y0066_SB_H5652_002_000_2021_M

# 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® Liberty 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 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.

Erickson Advantage® Liberty 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® Liberty without Drugs (HMO-POS)

## Premiums and Benefits

| | In-Network | Out-of-Network |
|---|---|---|
| **Monthly Plan Premium** | There is no monthly premium for this plan. | |
| **Annual Medical Deductible** | Your deductible is $800 per year for covered medical services you receive from providers as described in the Plan Deductible chart later in this document. Until you have paid the deductible amount, you must pay the full cost of your covered medical services. | No deductible |
| **Maximum Out-of-Pocket Amount** | $6,700 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. | |

# Erickson Advantage® Liberty without Drugs (HMO-POS)

## Benefits

| | | In-Network | Out-of-Network |
|---|---|---|---|
| **Inpatient Hospital**[2] | | $300 copay per day: for days 1-7<br>$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**<br><br>Cost sharing for additional plan covered services will apply. | Ambulatory Surgical Center (ASC)[2] | $0 copay for a diagnostic colonoscopy<br>$300 copay otherwise | 30% coinsurance |
| | Outpatient Hospital, including surgery[2] | $0 copay for a diagnostic colonoscopy<br>$300 copay otherwise | 30% coinsurance |
| | Outpatient Hospital Observation Services[2] | $300 copay | 30% coinsurance |
| **Doctor Visits** | Primary Care Provider | Type 1: $20 copay \|<br>Type 2: $30 copay | 30% coinsurance |
| | Specialists[2] | $50 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<br>Alcohol misuse counseling<br>Annual “Wellness” visit<br>Bone mass measurement<br>Breast cancer screening (mammogram)<br>Cardiovascular disease (behavioral therapy)<br>Cardiovascular screening<br>Cervical and vaginal cancer screening<br>Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) | |

## Benefits

| | | In-Network | Out-of-Network |
|---|---|---|---|
| | | Depression screening<br>Diabetes screenings and monitoring<br>Hepatitis C screening<br>HIV screening<br>Lung cancer with low dose computed tomography (LDCT) screening<br>Medical nutrition therapy services<br>Medicare Diabetes Prevention Program (MDPP)<br>Obesity screenings and counseling<br>Prostate cancer screenings (PSA)<br>Sexually transmitted infections screenings and counseling<br>Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>Vaccines, including flu shots, hepatitis B shots, pneumococcal shots<br>“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** | | $90 copay ($0 copay for worldwide coverage) per visit<br>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<br>($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 $100 copay otherwise | 30% coinsurance |
| | Lab services[2] | $0 copay | $0 copay |
| | Diagnostic tests and procedures[2] | $0 copay | 30% coinsurance |
| | Therapeutic Radiology[2] | $60 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] | $300 copay per day: for days 1-5<br>$0 copay per day: for days 6-90 | 30% coinsurance per stay |
| | | Our plan covers 90 days for an inpatient hospital stay. | |
| | Outpatient group therapy visit[2] | $0 copay | 30% coinsurance |
| | Outpatient individual therapy visit[2] | $0 copay - $30 copay | 30% coinsurance |
| **Skilled Nursing Facility (SNF)[2]** | | $0 copay per day: for days 1-20<br>$184 copay per day: for days 21-57<br>$0 copay per day: for days 58-100 | 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]** | | $40 copay | 30% coinsurance |

## Benefits

| | | In-Network | Out-of-Network |
|---|---|---|---|
| **Ambulance**[2]<br><br>Your provider must obtain prior authorization for non-emergency transportation. | | $250 copay for ground<br>$250 copay for air | $250 copay for ground<br>$250 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 |

## Additional Benefits

| | | In-Network | Out-of-Network |
|---|---|---|---|
| **Acupuncture** | Medicare-covered acupuncture[2] | Type 1: $20 copay \| Type 2: $30 copay for services provided by a primary care physician $50 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] | $50 copay | 30% coinsurance |
| | Routine foot care | $50 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]** | | $40 copay | 30% coinsurance |
| **Opioid Treatment Program Services[2]** | | $0 copay | $0 copay |
| **Outpatient Substance Abuse** | Outpatient group therapy visit[2] | $30 copay | 30% coinsurance |
| | Outpatient individual therapy visit[2] | $30 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. |

# Plan Deductible

Your plan has a deductible for certain services. 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.

The deductible applies to the following Medicare-covered benefit categories, unless otherwise specified.

**Annual Medical Deductible**

Your deductible is $800 per year for covered medical services you receive from providers as described below. Until you have paid the deductible amount, you must pay the full cost of your covered medical services.

**Here's how it works:**

1. You pay your plan's deductible in full; then,
2. You pay your copay or coinsurance; finally,
3. Your plan pays the rest.

The deductible applies in-network to the following Medicare-covered benefit categories, unless otherwise specified:

| In-Network |
| --- |
| List of applicable services |
| **Inpatient Hospital** |
| ☐ Inpatient hospital |
| ☐ Inpatient mental health |
| **Outpatient Hospital** |
| ☐ Ambulatory Surgical Center (ASC), excluding diagnostic colonoscopy |
| ☐ Outpatient Hospital, including surgery, excluding diagnostic colonoscopy |
| ☐ Outpatient Hospital Observation Services |
| **Skilled Nursing Facility (SNF)** |

# 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.

## 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. Enrollment in these plans depends on the plan's contract renewal with Medicare.

Plans may offer supplemental benefits in addition to Part C 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 provider network may change at any time. You will receive notice when necessary.

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.