Benefit Highlights

Erickson Advantage Champion (HMO-POS C-SNP)

This is a short description of your 2024 plan benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage. Limitations, exclusions, and restrictions may apply.

Plan costs		
Monthly plan premium	$188	

Medical benefits		
	In-network	**Out-of-network**
Annual Medical Deductible	No deductible in or out-of-network	
Annual out-of-pocket maximum (The most you may pay in a year for covered medical care)	$3,400 In-network	$10,000 out-of-network
Doctor's office visit		
Primary care provider (PCP)	$0 copay	$0 copay
Specialist	$25 copay (no referral needed)	$60 copay (no referral needed)
Virtual visits	$0 copay to talk with a network telehealth provider online through live audio and video	
Preventive services	$0 copay	$0 copay - 30% coinsurance (depending on the service)
Inpatient hospital care	$0 copay per stay for unlimited days	30% coinsurance per stay for unlimited days
Skilled nursing facility (SNF)	$0 copay per day: days 1-20 $203 copay per day: days 21-100	30% coinsurance per stay, up to 100 days
Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)	$75 copay	30% coinsurance

Medical benefits		
	In-network	**Out-of-network**
Outpatient mental health		
Group therapy	$0 copay	30% coinsurance
Individual therapy	$0 copay - $30 copay	30% coinsurance
Virtual visits	$0 copay to talk with a network telehealth provider online through live audio and video	
Diabetes monitoring supplies	$0 copay	30% coinsurance
Diagnostic radiology services (such as MRIs, CT scans)	$50 copay	30% coinsurance
Diagnostic tests and procedures (non-radiological)	$0 copay	30% coinsurance
Lab services	$0 copay	$0 copay
Outpatient x-rays	$15 copay	$30 copay
Ambulance	$175 copay for ground or air	$175 copay for ground or air
Emergency care	$80 copay ($0 copay for emergency care outside the United States) per visit	
Urgently needed services	$30 copay ($0 copay for urgently needed services outside the United States) per visit	

Benefits and services beyond Original Medicare		
	In-network	**Out-of-network**
Routine physical	$0 copay, 1 per year*	$0 copay, 1 per year*
Routine eye exams	$0 copay, 1 per year*	$60 copay, 1 per year*
Routine eyewear	$0 copay Plan pays up to $100 every year toward your purchase of frames (with standard lenses covered in full) or contact lenses (fitting and evaluation may be an additional cost) through UnitedHealthcare Vision.*	

Benefits and services beyond Original Medicare		
	In-network	**Out-of-network**
	Home delivered eyewear available through UnitedHealthcare Vision (select products only). You are responsible for all eyewear costs from providers outside of the UnitedHealthcare Vision network.	
Dental - preventive	$0 copay for exams, cleanings, X-rays, and fluoride*	$0 copay for exams, cleanings, X-rays, and fluoride* If you choose to see an out-of-network dentist you might be billed more, even for services listed as $0 copay
Hearing - routine exam	$0 copay, 1 per year*	$60 copay, 1 per year*
Hearing aids	$99 to $1,249 copay for each hearing aid through UnitedHealthcare Hearing, up to 2 hearing aids every year.* Includes hearing aids delivered directly to you with virtual follow-up care (select models).	
Fitness program	$0 copay for Renew Active®, which includes a free gym membership, plus online fitness classes and brain health content.	
Routine transportation	$0 copay; 24 one-way trips per year to or from approved locations.	No coverage
Foot care - routine	$0 copay, unlimited visits per year*	$60 copay, unlimited visits per year*
Over-the-counter (OTC) credit	$80 credit every quarter to buy covered OTC products	
Falls prevention program	$0 copay for support on how to reduce falls, prevent injuries and improve your balance and strength	No coverage

*Benefits are combined in and out-of-network

Prescription drug payment stages	
Annual Prescription Deductible	$0 for Part D prescription drugs

Prescription drug payment stages		
Initial Coverage	**Standard Retail (30-day supply)**	**Preferred Mail Order (100-day supply)**
Tier 1: Preferred Generic	$0 copay	$0 copay
Tier 2: Generic[1]	$5 copay	$0 copay
Tier 3: Preferred Brand	$45 copay	$125 copay
Tier 3: Covered Insulin Drugs	$25 copay	$65 copay
Tier 4: Non-Preferred Drug	$85 copay	$245 copay
Tier 5: Specialty Tier	33% coinsurance	N/A[3]
Coverage Gap (Donut hole)	After your total drug cost reaches $5,030, the plan continues to pay its share of the cost of your Tier 1 drugs and you pay your copay or coinsurance. For all other tiers, you pay 25% of the negotiated price for covered drugs. You may pay less if your plan has additional coverage in the gap.	
Catastrophic Coverage	After your total out-of-pocket drug cost reaches $8,000, you won't pay anything for Medicare Part D covered drugs for the rest of the plan year.	

[1] Tier includes enhanced drug coverage

[3] Limited to a 30-day supply

Optional riders available – See the Summary of Benefits or Evidence of Coverage for information

This information is not a complete description of benefits. Contact the plan for more information.