# Benefit Highlights

## Erickson Advantage Freedom (HMO-POS)

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** | $64 | |

| **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)** | $4,300 In-network | $10,000 out-of-network |
| **Doctor's office visit** | | |
| Primary care provider (PCP) | $0 copay | $0 copay |
| Specialist | $40 copay (no referral needed) | $75 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** | $225 copay per day: days 1-7<br>$0 copay per day: days 8 and beyond | 30% coinsurance per stay for unlimited days |
| **Skilled nursing facility (SNF)** | $0 copay per day: days 1-20<br>$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)** | $250 copay | 30% coinsurance |

| Medical benefits | | |
|---|---|---|
| | **In-network** | **Out-of-network** |
| **Outpatient mental health** | | |
| Group therapy | $20 copay | 30% coinsurance |
| Individual therapy | $0 copay - $40 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)** | $100 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** | $250 copay for ground or air | $250 copay for ground or air |
| **Emergency care** | $90 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* | 30% coinsurance, 1 per year* |
| **Routine eye exams** | $0 copay, 1 per year* | $75 copay, 1 per year* |
| **Routine eyewear** | $0 copay<br>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* |
| **Dental - comprehensive** | 50% coinsurance on dentures and bridges<br>$0 copay for all other covered comprehensive services* | 50% coinsurance on dentures and bridges<br>$0 copay for all other covered comprehensive services* |
| **Dental - benefit limit** | $750 combined limit on all covered dental services*<br>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* | $75 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.*<br><br>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** | $20 copay, 6 visits per year* | $75 copay, 6 visits per year* |
| **Over-the-counter (OTC) credit** | $40 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 | |
| **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] | $10 copay | $0 copay |
| **Tier 3: Preferred Brand** | $45 copay | $125 copay |
| **Tier 3: Covered Insulin Drugs** | $35 copay | $95 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

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