2025 Summary of Benefits

Perennial Advantage Freedom (HMO-POS)

H3419, Plan 003

This is a summary of drug and health services covered by Perennial Advantage Freedom (HMO-POS) from January 1 – December 31, 2025.

Perennial Advantage Freedom (HMO-POS) is a Medicare Advantage HMO-POS plan with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.

This information is not a complete description of benefits. Call 1-844-788-6959, TTY should call 711, for more information.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, visit our website at PerennialAdvantage.com, or call Member Services and request the *Evidence of Coverage*.

To reach our Member Services Representatives:

- Toll-free number: 1-844-788-6959, TTY/TDD should call 711.
- Hours of operation: 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

To join Perennial Advantage Freedom (HMO-POS), you must:

- Have both Medicare Part A and Medicare Part B,
- -- *and* -- live in our geographic service area,
- -- *and* -- be a United States citizen or be lawfully present in the United States

Our service area includes these counties in Colorado: Adams, Arapahoe, Boulder, Broomfield, Denver, and Jefferson.

Perennial Advantage Freedom (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at PerennialAdvantage.com. If you use

providers that are not in our network, the plan may not pay for these services. Your plan includes a Point-of-Service (POS) benefit which means that you can use providers outside the plan's network for certain services. See table below for additional detail.

This document is also available in braille and in large print.

If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2025* handbook. View it online at www.medicare.gov or ask for 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.

Medical Benefits

Benefit category	Your plan benefits
Monthly plan premium *(includes both medical and drug coverage)*	$0 You must continue to pay your Medicare Part B premium.
Deductible	$0 This plan does not have a medical deductible.
Maximum out-of-pocket amount *(does not include Part D prescription drugs)*	$3,900 combined for in- and out-of-network services
Inpatient hospital coverage	$225 copayment per day for days 1-5 $0 copayment per day for days 6-90 Per admission or per stay benefit period applies. *Prior authorization is required.* $0 for unlimited additional days *Prior authorization is required.*
Outpatient hospital coverage	
Outpatient hospital services	$0-$250 copayment $0 copayment for diagnostic colonoscopy and polyp removal $250 copayment for all other services *Prior authorization is required.*
Outpatient hospital observation services	$100 copayment *Prior authorization is required.*
Ambulatory Surgical Center (ASC) services	20% coinsurance *Prior authorization is required.*

Benefit category	Your plan benefits
Doctor visits	
Primary care providers	**In-Network:** $0 copayment **Out-of-Network (POS):** $0 copayment
Specialists	**In-Network:** $20 copayment **Out-of-Network (POS):** $20 copayment
Preventive care (e.g., flu vaccine, diabetic screenings)	$0 copayment
Emergency care	$90 copayment You do not pay this amount if you are admitted to the hospital within 3 days.
Urgently needed services	$20-$55 copayment per visit $20 copayment per visit for in-community urgent care $55 copayment per visit for all other places of service You do not pay this amount if you are admitted to the hospital within 3 days.

Benefit category	Your plan benefits
Diagnostic services/labs/imaging	
Diagnostic tests and procedures	20% coinsurance *Prior authorization is required except for services rendered in a Nursing Facility or Physician Office.*
Diagnostic radiology services (e.g., MRI, CAT scan)	20% coinsurance *Prior authorization is required.*
Lab services	$0 copayment *Prior authorization is required only for genetic testing.*
Outpatient x-rays	$0 copayment *Prior authorization is required except for services rendered in a Nursing Facility or Physician Office.*
Therapeutic radiology	20% coinsurance *Prior authorization is required.*
Hearing services (Medicare-covered)	
Medicare-covered services	20% coinsurance
Hearing services (Supplemental)	
Routine hearing exam	$0 copayment Limit 1 visit every year
Fitting/evaluation(s) for hearing aids	$0 copayment Limit 1 visit every year
Hearing aids	$1,350 every year for both ears combined Benefit is administered by NationsBenefits.

Benefit category	Your plan benefits
Dental services (Medicare-covered)	
Medicare-covered services	20% coinsurance *Prior authorization is required.*
Dental services (Supplemental)	
Preventive and comprehensive services	$0 copayment for oral exam(s) (limit 2 every year), cleaning(s) (limit 2 every year), and Fluoride treatment(s) (limit 1 every 6 months). See *Evidence of Coverage* for Dental x-rays limitations. Maximum: $2,000 every year for preventive services and comprehensive services All services must be provided by **Liberty Dental**. To locate a network provider, you may call Member Services, or search the Liberty Dental provider directory online at libertydentalplan.com/perennialadvantage.
Vision services (Medicare-covered)	
Exam to diagnose and treat diseases and conditions of the eye	20% coinsurance
For people with diabetes, screening for diabetic retinopathy is covered once per year	20% coinsurance
Eyewear after cataract surgery	20% coinsurance
Glaucoma screening	$0 copayment
Vision services (Supplemental)	
Routine eye exam	$0 copayment Limit 1 visit every year
Additional routine eyewear	$250 every year for lenses, frames or eyewear upgrades

Benefit category	Your plan benefits
Mental health services	
Inpatient visit	$225 copayment per day for days 1-5 $0 copayment per day for days 6-90 Per admission or per stay benefit period applies. *Prior authorization is required.*
Outpatient group therapy visit	$25 copayment
Outpatient individual therapy visit	$25 copayment
Skilled Nursing Facility (SNF)	**In-Network:** You pay the 2025 Original Medicare cost-sharing amounts. $0 copayment per day for days 1-20 $209.50 copayment per day for days 21-100 *Prior authorization is required.* **Out-of-Network (POS):** You pay the 2025 Original Medicare cost-sharing amounts. $0 copayment per day for days 1-20 $209.50 copayment per day for days 21-100 *Prior authorization is required.*
Physical therapy	$20 copayment *Prior authorization may be required. Please contact the plan for additional details.*
Ambulance	
Ground ambulance	$250 copayment
Air ambulance	20% coinsurance *Prior authorization is required for non-emergency Medicare services.*

Benefit category	Your plan benefits
Transportation *(non-emergency)* • Any health-related location • Non-medical needs*	$0 copayment Limit 24 one-way rides every year Each ride is limited to 30 miles *Some benefits have additional eligibility requirements. See section after the benefits chart for additional information.
Medicare Part B prescription drugs	
Chemotherapy/Radiation drugs	0%-20% coinsurance Cost-sharing is dependent on the drug administered. *Prior authorization is required.*
Other Part B drugs	0%-20% coinsurance 0% coinsurance is the minimum possible for a Part B rebatable drug 20% coinsurance is the maximum *Prior authorization is required.*

Outpatient Prescription Drugs

Prescription drug payment stages	**Your plan benefits**		
Prescription drug deductible	$0 This plan does not have a prescription drug deductible. Your coverage starts in the Initial Coverage stage.		
Initial coverage	You stay in the Initial Coverage stage until your total out-of-pocket costs reach $2,000. You then move on to the Catastrophic Coverage Stage.		
Tier drug coverage	**Standard retail cost sharing** (in-network) (up to a 30-day supply)	**Mail-order cost sharing** (up to a 90-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)
Tier 1 (Preferred Generic)	$0 copayment	$0 copayment	$0 copayment
Tier 2 (Generic)	$10 copayment	$30 copayment	$10 copayment
Tier 3 (Preferred Brand)	$45 copayment	$135 copayment	$45 copayment
Tier 4 (Non-Preferred Brand)	$95 copayment	$285 copayment	$95 copayment
Tier 5 (Specialty Tier)	25% coinsurance	Not covered	25% coinsurance
Catastrophic coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,000, you pay nothing for your covered Part D prescription drugs.		

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Additional Benefits

Benefit category	Your plan benefits
Diabetic monitoring supplies	0% coinsurance
Dialysis services	20% coinsurance
Durable Medical Equipment (DME)	20% coinsurance *Prior authorization is required.*
Healthy Living Flex Card • Groceries* • Over-The-Counter (OTC) benefit	$140 every 3 months to spend towards OTC Products and Groceries. Funds rollover each period until the end of the year. This benefit is administered by The Helper Bees. See your EOC for more details. *Some benefits have additional eligibility requirements. See section after the benefits chart for additional information.
General supports for living* (Housing, Rent or Mortgage)	$75 every month Members may apply these funds to their housing, rent, or mortgage *Some benefits have additional eligibility requirements. See section after the benefits chart for additional information.
In-home support services (Support With Daily Tasks)	$0 copayment Limited to 60 hours annually Members have access to an In-Home Support Services benefit that may include support with ADLs or IADLs including personal hygiene needs, light housekeeping, laundry tasks, meal preparation, feeding, bathing, and toileting.
Occupational therapy	$20 copayment *Prior authorization may be required. Please contact the plan for additional details.*

Benefit category	Your plan benefits
Podiatry services (Foot care)	
Medicare-covered services	$35 copayment
Routine foot care	$0 copayment Limit 6 visits every year
Speech therapy	$20 copayment *Prior authorization may be required. Please contact the plan for additional details.*

*The benefits mentioned are part of a special supplemental program for the chronically ill. Not all members qualify. Special supplemental benefits for the chronically ill (SSBCI) are only available to members with certain chronic conditions. You may be eligible if you have one of the following conditions:

- Autoimmune disorders
- Cancer
- Cardiovascular disorders
- Chronic alcohol and other drug dependence
- Chronic and disabling mental health conditions
- Chronic heart failure
- Chronic lung disorders
- COPD
- Dementia
- Diabetes
- End-stage liver disease
- End-stage renal disease (ESRD)
- HIV/AIDS
- Hyperlipidemia
- Hypertension
- Neurologic disorders
- Osteoarthritis
- Osteoporosis
- Severe hematologic disorders
- Stroke