



2026 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, 2026.

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. Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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 2026* 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 <i>(includes both medical and drug coverage)</i>	\$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 <i>(does not include Part D prescription drugs)</i>	\$3,500 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 <i>Prior authorization is required.</i> \$0 for unlimited additional days <i>Prior authorization is required.</i>
Outpatient hospital coverage Outpatient hospital services Outpatient hospital observation services	\$0-\$250 copayment \$0 copayment for diagnostic colonoscopy and polyp removal \$250 copayment for all other services <i>Prior authorization is required.</i> \$100 copayment <i>Prior authorization is required.</i>
Ambulatory Surgical Center (ASC) services	20% coinsurance <i>Prior authorization is required.</i>

Benefit category	Your plan benefits
<p>Diagnostic services/labs/imaging</p> <p>Diagnostic tests and procedures</p> <p>Diagnostic radiology services (e.g., MRI, CAT scan)</p> <p>Lab services</p> <p>Outpatient x-rays</p> <p>Therapeutic radiology</p>	<p>20% coinsurance</p> <p><i>Prior authorization is required except for services rendered in a Nursing Facility or Physician Office.</i></p> <p>20% coinsurance</p> <p><i>Prior authorization is required.</i></p> <p>\$0 copayment</p> <p><i>Prior authorization is required only for genetic testing.</i></p> <p>\$0 copayment</p> <p><i>Prior authorization is required except for services rendered in a Nursing Facility or Physician Office.</i></p> <p>20% coinsurance</p> <p><i>Prior authorization is required.</i></p>
<p>Hearing services (Medicare-covered)</p> <p>Medicare-covered services</p> <p>Hearing services (Supplemental)</p> <p>Routine hearing exam</p> <p>Fitting/evaluation(s) for hearing aids</p> <p>Hearing aids</p>	<p>20% coinsurance</p> <p>\$0 copayment Limit 1 visit every year</p> <p>\$0 copayment Limit 1 visit every year</p> <p>\$1,350 every year for both ears combined</p> <p>Benefit is administered by NationsBenefits. All services must be provided by NationsBenefits. To locate a network provider, you may call Member Services.</p>

Benefit category	Your plan benefits
<p>Dental services (Medicare-covered)</p> <p>Medicare-covered services</p> <p>Dental services (Supplemental)</p> <p>Preventive and comprehensive services</p>	<p>20% coinsurance</p> <p><i>Prior authorization is required.</i></p> <p>\$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 <i>Evidence of Coverage</i> for Dental x-rays limitations.</p> <p>Maximum: \$2,600 every year for preventive services and comprehensive services</p> <p>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.</p>
<p>Vision services (Medicare-covered)</p> <p>Exam to diagnose and treat diseases and conditions of the eye</p> <p>For people with diabetes, screening for diabetic retinopathy is covered once per year</p> <p>Eyewear after cataract surgery</p> <p>Glaucoma screening</p> <p>Vision services (Supplemental)</p> <p>Routine eye exam</p> <p>Additional routine eyewear</p>	<p>20% coinsurance</p> <p>20% coinsurance</p> <p>20% coinsurance</p> <p>\$0 copayment</p> <p>\$0 copayment Limit 1 visit every year</p> <p>\$250 every year for lenses, frames or eyewear upgrades</p>

Benefit category	Your plan benefits
<p>Mental health services</p> <p>Inpatient visit</p> <p>Outpatient group therapy visit</p> <p>Outpatient individual therapy visit</p>	<p>\$225 copayment per day for days 1-5 \$0 copayment per day for days 6-90</p> <p><i>Prior authorization is required.</i></p> <p>\$25 copayment</p> <p>\$25 copayment</p>
<p>Skilled Nursing Facility (SNF)</p>	<p>In-Network: You pay the 2026 Original Medicare cost-sharing amounts.</p> <p>\$0 copayment per day for days 1-20 \$217 copayment per day for days 21-100</p> <p><i>Prior authorization is required.</i></p> <p>Out-of-Network (POS): You pay the 2026 Original Medicare cost-sharing amounts.</p> <p>\$0 copayment per day for days 1-20 \$217 copayment per day for days 21-100</p> <p><i>Prior authorization is required.</i></p>
<p>Physical therapy</p>	<p>\$20 copayment</p> <p><i>Prior authorization may be required. Please contact the plan for additional details.</i></p>
<p>Ambulance</p> <p>Ground ambulance</p> <p>Air ambulance</p>	<p>\$250 copayment</p> <p>20% coinsurance</p> <p><i>Prior authorization is required for non-emergency Medicare services.</i></p>

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 \$2,100. 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 Drug)	\$95 copayment	\$285 copayment	\$95 copayment
Tier 5 (Specialty Tier)	33% coinsurance	Not covered	33% coinsurance
Catastrophic coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$2,100, 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 <i>Prior authorization is required.</i>
General supports for living* (Rent, Mortgage or Wi-Fi)	\$100 every month to spend towards rent, mortgage, or Wi-Fi. *Some benefits have additional eligibility requirements. See section after the benefits chart for additional information.
Healthy Living Flex Card <ul style="list-style-type: none"> • Fitness • Groceries* • Over-The-Counter (OTC) items 	\$140 every 3 months to spend towards Fitness, Groceries, and OTC Items. Funds roll over 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.
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. This may also include general tasks such as errands, accompaniment to appointments, technology assistance, and setting appointments.
Occupational therapy	\$20 copayment <i>Prior authorization may be required. Please contact the plan for additional details.</i>

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

*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 use disorder and other substance use disorders (SUDs)
- Chronic and disabling mental health conditions
- Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell
- Chronic gastrointestinal disease
- Chronic heart failure
- Chronic hyperlipidemia
- Chronic hypertension
- Chronic kidney disease (CKD)
- Chronic lung disorders
- Conditions associated with cognitive impairment
- Conditions that require continued therapy services in order for individuals to maintain or retain functioning
- Conditions with functional challenges
- Dementia
- Diabetes mellitus
- HIV/AIDS
- Immunodeficiency and Immunosuppressive disorders
- Neurologic disorders
- Osteoporosis
- Overweight, obesity, and metabolic syndrome
- Post-organ transplantation
- Severe hematologic disorders
- Stroke