2023 SUMMARY OF BENEFITS

LIBERTY MEDICARE ADVANTAGE (HMO C-SNP)

H6351, PLAN 004

Liberty Medicare Advantage (HMO C-SNP) is a Medicare Advantage HMO Plan with a Medicare contract. Enrollment in the plan depends on contract renewal. This plan, Liberty Medicare Advantage, is offered by Liberty Advantage, LLC dba Liberty Medicare Advantage. To get a complete list of services we cover, access our Evidence of Coverage at www.libertymedicareadvantage.com, or call Member Services at 1-844-854-6884 (TTY 711)

To join Liberty Advantage Nursing Home Plan (HMO I-SNP), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes these counties in North Carolina: Alamance, Bertie, Bladen, Brunswick, Buncombe, Burke, Cabarus, Caldwell, Catawba, Chatham, Columbus, Cumberland, Davidson, Davie, Durham, Forsyth, Franklin, Granville, Greene, Guilford, Halifax, Harnett, Henderson, Hyde, Johnston, Lee, Lenoir, Martin, Moore, New Hanover, Orange, Pender, Person, Pitt, Randolph, Richmond, Robeson, Rockingham, Rowan, Sampson, Scotland, Stokes, Union, Vance, Wake, Warren, Watauga, Wayne, Wilkes, Wilson, and Yadkin.

You must also have one of the following conditions: Chronic Heart Failure (CHF), Diabetes, Cardiovascular Disorders (CVD)

Liberty Medicare Advantage (HMO C-SNP) has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at www.libertymedicareadvantage.com. If you use providers that are not in our network, the plan may not pay for these services. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

This document is also available in Braille and in large print. Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1 of each year. 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 https://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.

Premiums and Benefits	Liberty Medicare Advantage (HMO C-SNP)
Monthly plan premium	$0 You must continue to pay your Medicare Part B premium.
Deductible	$0
Maximum out-of-pocket (does not include Part D prescription drugs)	$3,500
Inpatient Hospital Coverage	
You are admitted to the hospital for an inpatient stay after an official doctor's order, which says you need inpatient hospital care to treat your illness or injury. **Prior Authorization is Required**	• $250 for days 1-6 • After day 6 - $0
Outpatient Hospital Coverage	
Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Prior Authorization is required**	• 20% coinsurance for Medicare-covered services. Amounts are paid until the maximum out-of-pocket is achieved.
Doctor Visits	
Primary Care Providers	• The is no copayment or deductible for Medicare covered Primary Care Services

Specialists	• $0 for Cardiologist and Endocrinologist (Pathology and Labs if part of Service) • All other specialists $25 per visit
Preventive Care	
Examples Include: • Annual Mammogram • Colonoscopy per Medicare guidelines • Annual Wellness Exam	• $0
Emergency Care	
Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. Coverage is only covered within the U.S. **Authorization is required if the result is an inpatient stay**	• $125 per visit. • $125 is waived if you are admitted to a hospital.
Urgently Needed Services	
Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but, given your circumstances, it is not possible, or it is unreasonable, to	• $0 copay, coinsurance & deductible

obtain services from network providers. Examples of urgently needed services that the plan must cover out of network are: • you need immediate care during the weekend, or • You are temporarily outside the service area of the plan. • Services must be immediately needed and medically necessary. • If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider then your plan will cover the urgently needed services from a provider out-of-network. • Coverage within the U.S. only.	
Diagnostic Services/Labs/Imaging	
• Diagnostic tests and procedures • Diagnostic radiology services (e.g., MRI, CAT Scan)	• 20% coinsurance for Medicare-covered services. Amounts are paid until the maximum out-of-pocket is achieved.
• Surgical supplies such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests	• 20% coinsurance for Medicare-covered services. Amounts are paid until the maximum out-of-pocket is achieved.
• X-Rays and Radiation (radium and isotope) therapy including technician materials and supplies **Prior authorization will be required with the exception of X-rays when services are rendered in a Physician's Office. Genetic testing requires authorization.**	• 20% coinsurance for Medicare-covered services. Amounts are paid until the maximum out-of-pocket is achieved.
Hearing Services	

• Hearing exam	• $0 coinsurance for annual routine exam
• Hearing Aids **Authorization is Required**	• Part of a Liberty Medicare Advantage Freedom flex card that allows a maximum of $2,000 per year to be used with either Vision, Dental or Hearing.
Vision Services	
• Yearly eye exam	• $0 copayment/coinsurance
• Eyeglasses, lenses, frames, contacts	• Part of a Liberty Medicare Advantage Freedom flex card that allows a maximum of $2,000 per year to be used with either Vision, Dental or Hearing.
Dental	
• Annual Exam	• $0
• Comprehensive and Preventative Services	• Part of a Liberty Medicare Advantage Freedom flex card that allows a maximum of $2,000 per year to be used with either Vision, Dental or Hearing.
Mental Health Services	
• Inpatient Visit	• $1,556 (2022 may change in 2023) A per admission deductible is applied once during the defined benefit period • Days 1 – 60: $0 coinsurance • Days 61- 90: $398.00 coinsurance per day • Days 91 and beyond: $778 coinsurance per each lifetime reserve day after day 90 for each benefit period (up to 60 days over your life-time) • Beyond lifetime reserved days: all costs • If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.

Prior Authorization is Required	• Medicare benefit periods apply. A benefit period begins on the 1st day you go to a Medicare covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital or SNF after 1 benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.
• Outpatient Psychiatric Group Therapy Visit **Prior Authorization is Required**	• 20% coinsurance for Medicare-covered services. Amounts are paid until the maximum out-of-pocket is achieved.
• Outpatient Psychiatric Individual Therapy Visit **Prior Authorization is Required**	• 20% coinsurance for Medicare-covered services. Amounts are paid until the maximum out-of-pocket is achieved.
Therapies	
Includes: • Occupational Therapy • Speech Pathology, and • Physical Therapy **Prior Authorization is Required**	• $25 per visit
Ambulance Services	
• Ground Ambulance **Prior Authorization is Required**	• $255 per trip
• Air or Water Ambulance **Prior Authorization is Required**	• 20% coinsurance
Transportation (non-emergency)	
	• Part of a Liberty Medicare Advantage Freedom flex card that allows a maximum of $20 per month with no rollover to be used for either non-emergency transportation or fitness.
Medicare Part B Prescription Drugs	

• Chemotherapy drugs **Authorization is required for initial administration of chemotherapy**	• 20% coinsurance for Medicare-covered services. Amounts are paid until the maximum out-of-pocket is achieved.
• Other Part B drugs **Prior Authorization is Required**	• 20% coinsurance for Medicare-covered services. Amounts are paid until the maximum out-of-pocket is achieved.
Ambulatory Surgical Center	
Prior Authorization is Required	• 20% coinsurance for Medicare-covered services. Amounts are paid until the maximum out-of-pocket is achieved.
Medical Equipment/Supplies	
• Durable Medical Equipment (e.g., wheelchairs, oxygen) **Prior Authorization is Required**	• 20% coinsurance for Medicare-covered services. Amounts are paid until the maximum out-of-pocket is achieved.
• Prosthetics (e.g., braces, artificial limbs) **Prior Authorization is Required**	• 20% coinsurance for Medicare-covered services. Amounts are paid until the maximum out-of-pocket is achieved.
• Diabetic Supplies • Limit to blood glucose monitors and diabetic test strips **Prior Authorization is Required**	• 20% coinsurance for Medicare-covered services. Amounts are paid until the maximum out-of-pocket is achieved.
Pulmonary Rehabilitation Services	
• Medicare covered Cardiac Rehabilitation Services • Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) **Prior Authorization is Required**	• 20% coinsurance for Medicare-covered services. Amounts are paid until the maximum out-of-pocket is achieved.
Skilled Nursing Facility	

Prior Authorization is Required	• Follows Original Medicare Fee for Service:
	  ○ Days 1 – 20 - $0 coinsurance per day
	  ○ Days 21 – 100 - $194.50 coinsurance per day
	  ○ Days 101 and beyond all costs.
	The above benefit amounts are based on 2022 rates and can change in 2023 you will be notified of any change.

Out-Patient Prescription Drugs

	Standard 30-day Supply	Standard 60-day Supply	Standard 90-day supply	Long term care (LTC) cost-sharing – up to 31-day supply	Out-of-network cost sharing
Deductible for Part D Prescription Drugs	$505	$505	$505	$505	
Cost Sharing for Covered Drugs					
Cost Sharing Tier 1 – Preferred Generic and Mail Order	$0	$0	$0	$0	$0
Cost Sharing Tier 2 – Generic and Mail Order	$0	$0	$0	$0	$0
Cost Sharing Tier 3 – Preferred Brand	$35	$70	$105	$35	$35
Cost Sharing Tier 3 – Preferred Brand Mail Order	$70	$140	$210		
Cost Sharing Tier 4 – Non-Preferred Brand	$95	$190	$285	$95	$95
Cost Sharing Tier 4 – Non-Preferred Brand Mail Order	$190	$380	$570	$95	
Cost Sharing Tier 5 – Specialty Tier and Mail Order	33%	33%	33%	33%	33%
Cost Sharing Tier 6 – Diabetic Drugs and Mail Order	$0	$0	$0	$0	$0
Coverage GAP					
After your total drug costs (including what our plan has paid and what you have paid) reaches $4,660 you will pay no more than 25% coinsurance for generic drugs and 25%	$4,660	$4,660	$4,660	$4,660	

coinsurance for brand name drugs during the coverage gap.					
Catastrophic Coverage					
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400 you pay the greater of: • 5% coinsurance, or • $4.15 for a generic drug or a drug that is treated like a generic and $10.35 for all other drugs	$7,400	$7,400	$7,400	$7,400	
Cost Sharing may change depending on the pharmacy you choose.					

Combined Benefits

The following benefits are at no cost to you. Some benefits are listed above but here is a complete list:

- Liberty Medicare Advantage offers a "Freedom Flex Card" to be used for certain benefits that are important to you – we have 3 cards with a variety of benefits and you are in control of where/how you spend the dollars!
  - **Vision, Hearing and Dental** Flex Card
    - Allows you to spend $2,000 annually for the services you need
  - **Fitness and Transportation** Flex Card
    - Allows you to spend $20 per month with no rollover. You choose between either fitness or transportation!
  - **OTC Drugs and Groceries Flex Card**
    - Allows you to spend $55 per month with no rollover. You choose between either OTC or Groceries!
- A Meal Benefit is also provided
  - Post-Acute – provides two meals per day for up to 7 days following an inpatient stay
  - Chronic – provides up to two meals per day for up to 60 days. RN referral required.

- Personal Emergency Response