2022 Summary of Benefits

Liberty Medicare Heart and Diabetes Plan (HMO C-SNP)

H6351, Plan 004

This is a summary of drug and health services covered by Liberty Medicare Heart and Diabetes Plan (HMO C-SNP) January 1, 2022 - December 31, 2022.

Liberty Medicare Heart and Diabetes Plan (HMO C-SNP) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) with a Medicare contract. This plan, Liberty Medicare Heart and Diabetes Plan, is offered by Liberty Advantage, LLC dba Liberty Medicare Advantage. Enrollment in the Plan depends on contract renewal.

This information is not a complete description of benefits. Call 1-844-854-6884, 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 Libertymedicareadvantage.com, or call Member Services and request the *Evidence of Coverage*.

To Reach Our Member Services Representatives:

- Toll Free 1-844-854-6884, TTY/TDD should call 711.
- Hours of operation: 8 a.m. to 8 p.m., seven days a week.

To join Liberty Medicare Heart and Diabetes Plan (HMO C-SNP), you must:

- be entitled to Medicare Part A,
- -- *and* -- be enrolled in Medicare Part B,
- -- *and* -- live in our service area,
- -- *and* -- you meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the specialized needs of people who have certain medical conditions. To be eligible for our plan, you must have Cardiovascular Disorders, Chronic Heart Failure, and/or Diabetes.

Our service area includes these counties in North Carolina: Alamance, Bertie, Bladen, Brunswick, Buncombe, Catawba, Chatham, Columbus, Cumberland, Davie, Forsyth, Franklin, Guilford, Halifax, Hyde, Johnston, Lee, New Hanover, Orange, Person, Robeson, Rowan, Sampson, Scotland, Wake, Warren, Watauga, Yadkin.

Liberty Medicare Heart and Diabetes Plan (HMO C-SNP) has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at 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 1800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-4862048.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

	Liberty Medicare Heart and Diabetes Plan (HMO C-SNP)
Monthly plan premium	You do not pay a separate monthly plan premium for Liberty Medicare Heart and Diabetes Plan (HMO C-SNP). You must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
Deductible	No deductible
Maximum out-of-pocket amount (does not include Part D Prescription drugs)	$5,000
Inpatient Hospital coverage	You pay the 2021 Original Medicare cost-sharing amounts. $0 copayment each day for days 1-60; $371 copayment each day for days 61 to 90; $742 copayment each day for days 91 to 150 (lifetime reserve days). **Prior Authorization is required.*
Outpatient Hospital coverage	
Outpatient hospital services	20% coinsurance **Prior Authorization may be required.*
Outpatient hospital observation services	20% coinsurance **Prior Authorization may be required.*
Doctor Visits	
Primary Care Providers	There is no coinsurance, copayment, or deductible for Medicare covered Primary Care Physician Services.
Specialists	$0 copayment for Cardiologist and Endocrinologist. 20% Coinsurance for all other Physician Specialist Services. You pay these amounts until you reach the out-of- pocket maximum.

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Preventive Care	You pay nothing. Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency care	20% coinsurance up to a max of $90 Coinsurance is waived if you are admitted to a hospital within 3 days.
Urgently needed services	$35 copayment Copayment is waived if you are admitted to a hospital within 3 days.
Diagnostic Services/Labs/Imaging	
Diagnostic tests and procedures	20% coinsurance **Prior Authorization may be required.*
Lab services	20% coinsurance **Prior Authorization may be required.*
Diagnostic radiology services (e.g. MRI, CAT Scan)	20% coinsurance **Prior Authorization may be required.*
Outpatient X-rays	20% coinsurance **Prior Authorization may be required.*
Hearing services Hearing exam	20% coinsurance of the cost for Medicare-covered hearing services.
Supplemental Benefit Routine hearing exam, fitting and evaluation for hearing aids	No coinsurance for 1 routine hearing exam and unlimited hearing aid fitting/evaluations every year.

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Hearing aids	Up to a $2,400 credit for both ears combined every three years for hearing aids. **Prior Authorization may be required.*
Dental services Medicare-covered dental We cover anything that is deemed medically necessary under Medicare.	20% coinsurance for each Medicare-covered service. **Prior Authorization is required.*
Vision care Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. *Supplemental Benefit* Routine eye exam Glaucoma testing Eyeglasses, lenses, frames, contacts	20% coinsurance for the Medicare-covered Vision Care services. There is no coinsurance, copayment, or deductible for one routine eye exam once per year. There is no coinsurance, copayment, or deductible for glaucoma testing once per year. Allowance of up to $300 every two years.
Mental Health Services Inpatient visit	You pay the 2021 Original Medicare cost-sharing amounts. $0 copayment each day for days 1-60; $371 copayment each day for days 61 to 90; $742 copayment each day for days 91 to 150 (lifetime reserve days). **Prior Authorization may be required.*

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Outpatient group therapy visit Outpatient individual therapy visit	20% coinsurance *Prior Authorization is required.* 20% coinsurance *Prior Authorization is required.*
Skilled Nursing Facility (SNF) care	You pay: Days 1-20 $0 Days 21-100: $185.50 Days 101 and beyond: All coast
Physical Therapy	20% coinsurance *Prior Authorization is required.*
Ambulance services Ground Ambulance Air Ambulance	20% coinsurance *Prior Authorization may be required.* 20% coinsurance *Prior Authorization may be required.*
Transportation (non-emergency)	$0 copayment Routine transportation for up to 18 trips every year - not to exceed 50 miles per trip. A trip is considered one-way transportation by taxi, bus/subway, van, or medical transport to a plan approved health-related location.
Medicare Part B prescription drugs Chemotherapy drugs Other Part B drugs	20% coinsurance *Prior Authorization may be required.* 20% coinsurance *Prior Authorization may be required.*

Ambulatory Surgical Center	20% coinsurance **Prior Authorization is required.*
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Medical Equipment/Supplies Durable Medical Equipment (e.g. wheelchairs, oxygen) Prosthetics (e.g., braces, artificial limbs) Diabetic supplies Diabetic Therapeutic Shoes and Inserts	20% coinsurance **Prior Authorization is required.* 20% coinsurance **Prior Authorization is required.* There is no coinsurance, copayment, or deductible for the Medicare-covered blood glucose monitors and diabetic test strips from specific manufacturers. **Prior Authorization may be required.* 20% coinsurance
Pulmonary rehabilitation services	20% coinsurance **Prior Authorization may be required.*
Special Supplemental Benefits for the Chronically Ill The covered chronic conditions include Chronic heart failure; Diabetes; End-stage renal disease (ESRD); and/or COPD.	$0 Copay Assistance with meal prep, light housekeeping, personal care and hygiene, medication reminders, and assistance with ADLs. To be eligible, this benefit must be recommended by a licensed health care provider or your care manager and included as part of your care management plan. You may schedule up to 20 hours of assistance per quarter in 4-hour increments. Remote monitoring equipment will be installed in the members home for qualifying diagnosis. The data will be monitored by centralized LPNs. Care manager must recommend this service to be eligible. The plan provides a limited duration Meal Benefit as a supplemental benefit under Part C immediately following surgery or inpatient hospitalization for a chronic illness. Post-Acute Meal Plan: 2 meals/ day up to 7 days. Applicable to 2 events per year. Chronic Meal Plan: 3 meals/day up to 28 meals per month for up to 2 months.

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Outpatient Prescription Drugs				
	Standard retail cost sharing (in-network) (up to a 30- day supply)	**Preferred retail cost sharing (in-network)** (up to a 30day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing** (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 10-day supply)
Deductible	No deductible for Part D prescription drugs.			
Cost-Sharing Tier 1 Preferred Generic	$5 copayment	$0 copayment	$5 copayment	$5 copayment
Cost-Sharing Tier 2 Generic	$15 copayment	$5 copayment	$15 copayment	$15 copayment
Cost-Sharing Tier 3 Preferred Brand	$45 copayment	$35 copayment	$45 copayment	$45 copayment
Cost-Sharing Tier 4 Non-Preferred Brand	$100 copayment	$95 copayment	$100 copayment	$100 copayment
Cost-Sharing Tier 5 Specialty Tier	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance
Cost-Sharing Tier 6 Select Diabetic Drugs	$0 copayment	$0 copayment	$0 copayment	$0 copayment
Coverage Gap	After your total drug costs (including what our plan has paid and what you have paid) reach $4,430, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs for any drug tier 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 $7,050, you pay the greater of: • 5% coinsurance, or • $3.95 copayment for generic (including brand drugs treated as generic) and a $9.85 copayment for all other drugs.			

Cost-sharing may differ based on point-of-service (Standard Retail, Preferred Retail, Long-Term Care (LTC)), home infusion, whether the pharmacy is in our standard network, or whether the prescription is a short-term (30-day supply) or long-term (90-day supply).

Optional Supplemental Benefits	
	Liberty Medicare Heart and Diabetes Plan (HMO C-SNP)
Monthly premium for the Optional Supplemental Package	$30 per month This is in addition to your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
Preventive and Comprehensive Dental If you signed up for the Optional Supplemental Package, your Preventive and Comprehensive Dental benefits include the following services: • Oral Exams; • Prophylaxis (Cleaning); • Dental X-Rays; • Diagnostic Services; • Restorative Services; • Endodontics; • Periodontics; • Extractions; • Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services;	There is no coinsurance, copayment, or deductible for the Preventive and Comprehensive Dental if you chose to sign up for these optional supplemental benefits. There is a $2,000 limit on Preventive and Comprehensive Dental benefits each year. Cosmetic procedures not covered.