

2021 Summary of Benefits

Liberty Advantage (HMO I-SNP)

H6351, Plan 001

This is a summary of drug and health services covered by Liberty Advantage (HMO I-SNP) January 1, 2021 - December 31, 2021.

Liberty Advantage (HMO I-SNP) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) with a Medicare contract. 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 www.libertyadvantageplan.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 Advantage (HMO I-SNP), you must:

- be entitled to Medicare Part A,
- -- *and* -- be enrolled in Medicare Part B,
- -- *and* -- live in our service area,
- -- *and* -- reside in one of our nursing facilities for greater than 90 days or reside in one of our participating assisted living communities and meet the nursing facility level of care. For a list of participating communities/facilities, contact the plan's *Provider Directory* has a list of participating assisted living communities or nursing facilities, you can access this list on our website www.libertyadvantageplan.com or call Member Services and ask us to send you a list.

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, and Yadkin.

Liberty Advantage (HMO I-SNP) has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at www.libertyadvantageplan.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.

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

	Liberty Advantage (HMO I-SNP)
Monthly plan premium	\$30.30 You must continue to pay your Medicare Part B premium.
Deductible	The Part B deductible is \$198.
Maximum out-of-pocket amount (does not include Part D Prescription drugs)	\$6,600
Inpatient Hospital coverage	You pay the 2021 Original Medicare cost-sharing amounts. \$1,484 deductible; \$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). <i>*Prior Authorization is required.</i>
Outpatient Hospital coverage	
Outpatient hospital services	20% coinsurance <i>*Prior Authorization may be required.</i>
Outpatient hospital observation services	20% coinsurance <i>*Prior Authorization may be required.</i>
Doctor Visits	
Primary Care Providers	20% coinsurance
Specialists	20% coinsurance
Preventive Care	You pay nothing. Any additional preventive services approved by Medicare during the contract year will be covered.

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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	20% coinsurance up to a max of \$65 Coinsurance is waived if you are admitted to a hospital within 3 days.
Diagnostic Services/Labs/Imaging	
Diagnostic tests and procedures	0% - 20% coinsurance <i>*Prior Authorization may be required.</i>
Lab services	0%- 20% copayment <i>*Prior Authorization may be required.</i>
Diagnostic radiology services (e.g. MRI, CAT Scan)	0% - 20% coinsurance <i>*Prior Authorization may be required.</i>
Outpatient X-rays	0% - 20% coinsurance <i>*Prior Authorization may be required.</i>
Hearing services	
Hearing exam	20% coinsurance of the cost for Medicare-covered hearing services.
<i>Supplemental Benefit</i>	
Routine hearing exam, fitting and evaluation for hearing aids	
Hearing aids	Up to a \$2,400 credit for both ears combined every three years for hearing aids. <i>*Prior Authorization may be required.</i>

	Liberty Advantage (HMO I-SNP)
<p>Dental services</p> <p>Medicare-covered dental</p>	<p>20% coinsurance for each Medicare-covered service.</p> <p><i>*Prior Authorization is required.</i></p>
<p>Vision care</p> <p>Yearly eye exam for diabetic retinopathy</p> <p><i>Supplemental Benefit</i> Routine eye exam</p> <p>Eyeglasses, lenses, frames, contacts</p>	<p>0% - 20% coinsurance</p> <p>You pay 0% coinsurance when services provided in Nursing Home for 1 routine eye exam visit every year. 20% coinsurance when services are provided in professional providers office for 1 routine eye exam visit every year.</p> <p>Allowance of up to \$300 per year.</p>
<p>Mental Health Services</p> <p>Inpatient visit</p> <p>Outpatient group therapy visit</p> <p>Outpatient individual therapy visit</p>	<p>You pay the 2021 Original Medicare cost-sharing amounts. \$1,484 deductible; \$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). <i>*Prior Authorization may be required.</i></p> <p>0% - 20% coinsurance <i>*Prior Authorization is required.</i></p> <p>0% - 20% coinsurance <i>*Prior Authorization is required.</i></p>

Skilled nursing facility (SNF) care	\$0 copayment for days 1 to 100 for each Medicare-covered skilled nursing facility stay. Traditional Medicare benefit period <i>*Prior Authorization is required.</i>
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Physical Therapy	20% coinsurance <i>*Prior Authorization is required.</i>
Ambulance services Ground Ambulance	20% coinsurance <i>*Prior Authorization may be required.</i>
Air Ambulance	20% coinsurance <i>*Prior Authorization may be required.</i>
Transportation (non-emergency)	\$0 copayment Routine transportation for up to 20 trips every year. 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	20% coinsurance <i>*Prior Authorization may be required.</i>
Other Part B drugs	20% coinsurance <i>*Prior Authorization may be required.</i>
Ambulatory Surgical Center	20% coinsurance <i>*Prior Authorization is required.</i>
Medical Equipment/Supplies	
Durable Medical Equipment (e.g. wheelchairs, oxygen)	20% coinsurance <i>*Prior Authorization is required.</i>
Prosthetics (e.g., braces, artificial limbs)	20% coinsurance <i>*Prior Authorization is required.</i>
Diabetic supplies	20% coinsurance <i>Prior Authorization may be required.</i>

Diabetic Therapeutic Shoes and Inserts	20% coinsurance
Pulmonary rehabilitation services	20% coinsurance <i>*Prior Authorization may be required.</i>

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Outpatient Prescription Drugs			
	<table border="1"> <tr> <td>Standard retail cost-sharing (in-network) (up to a 30-day supply)</td> <td>Long-term care (LTC) cost-sharing (up to a 31-day supply)</td> </tr> </table>	Standard retail cost-sharing (in-network) (up to a 30-day supply)	Long-term care (LTC) cost-sharing (up to a 31-day supply)
Standard retail cost-sharing (in-network) (up to a 30-day supply)	Long-term care (LTC) cost-sharing (up to a 31-day supply)		
Deductible	\$445 for all Part D prescription drugs.		
Cost-Sharing for Covered Drugs	<table border="1"> <tr> <td>25% coinsurance</td> <td>25% coinsurance</td> </tr> </table>	25% coinsurance	25% coinsurance
25% coinsurance	25% coinsurance		
Coverage Gap	After your total drug costs (including what our plan has paid and what you have paid) reach \$4,130, 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	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,550, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% coinsurance, or • \$3.70 copayment for generic (including brand drugs treated as generic) and a \$9.20 copayment for all other drugs. 		

Cost-sharing may differ based on point-of-service (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).