# 2023 SUMMARY OF BENEFITS

# LIBERTY ADVANTAGE NURSING HOMEPLAN (HMO I-SNP)

## H6351, PLAN 001

Liberty Advantage Nursing Home Plan (HMO I-SNP) is a Medicare Advantage HMO Plan with a Medicare contract. Enrollment in the plan depends on contract renewal. This plan, Liberty Medicare Advantage Nursing Home Plan, 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 for 90 days or longer, have had or are expected to need the level of services provided in our contracted long-term care (LTC) skilled nursing facility (SNF) or LTC nursing facility (NF), a SNF/NF.

Liberty Advantage Nursing Home Plan (HMO I-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 1-877486-2048.

| **Premiums and Benefits** | **Liberty Advantage Nursing Home Plan (HMO I-SNP)** |
|---|---|
| **Monthly plan premium** | $38.40<br>You must continue to pay your Medicare Part B premium. |
| **Deductible** | Medicare Fee For Service |
| **Maximum out-of-pocket (does not include Part D prescription drugs)** | $6,600 |
| **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.<br><br>**Prior Authorization is Required** | $1,556 (2022 may change in 2023) per admission deductible is applied once during the defined benefit period.<br>• Days 1 – 60: $0 coinsurance<br>• Days 61 – 90: $398.00 coinsurance per day<br>• Days > 90: $778 coinsurance per each lifetime reserve day after day 90 for each benefit period (up to 60 days over your lifetime).<br>Beyond lifetime reserved days: all costs |
| **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.<br>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.<br><br>**Prior Authorization is required** | • 20% coinsurance for Medicare-covered services. |
| **Doctor Visits** | |
| Primary Care Providers | • 0% coinsurance |
| Specialists | • 20% coinsurance |

| | |
|---|---|
| | |
| **Preventive Care** | |
| Examples Include:<br>• Annual Mammogram<br>• Colonoscopy per Medicare guidelines<br>• Annual Wellness Exam | • $0 |
| **Emergency Care** | |

| | |
|---|---|
| Emergency care refers to services that are:<br>• Furnished by a provider qualified to furnish emergency services, and<br>• Needed to evaluate or stabilize an emergency medical condition.<br>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.<br>Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.<br>Coverage is only covered within the U.S.<br>**Authorization is required if the result is an inpatient stay** | $95 per visit<br>Coinsurance waived if hospital admission<br>• occurs within three (3) days<br>• |
| **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 obtain services from network providers. | • 20% coinsurance for each Medicare-covered service, up to a maximum of $60 per visit.<br>• Coinsurance is waived if you are admitted to a hospital within 3 days of a visit. |

| | |
|---|---|
| Examples of urgently needed services that the plan must cover out of network are:<br>• you need immediate care during the weekend, or<br>• You are temporarily outside the service area of the plan.<br>• Services must be immediately needed and medically necessary.<br>• 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 outof-network.<br>• Coverage within the U.S. only. | |
| **Diagnostic Services/Labs/Imaging** | |
| • Diagnostic tests and procedures<br>• Diagnostic radiology services (e.g. MRI, CAT Scan) | • 0 – 20% coinsurance for Medicare-covered services. |
| • Surgical supplies such as dressings<br>• Splints, casts and other devices used to reduce fractures and dislocations<br>• Laboratory tests | • 20% coinsurance for Medicare covered services. |
| • X-Rays and Radiation (radium and isotope) therapy including technician materials and supplies<br>**Prior authorization will be required with the exception of X-rays when services are rendered in a Nursing Facility or Physician's Office.** | • 20% coinsurance for Medicare covered services. |
| **Hearing Services** | |

| | |
|---|---|
| Diagnostic hearing and balance evaluations performed by your provider to determine if you need | |

| | |
|---|---|
| medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. | |
| • Hearing exam | • $0 coinsurance for annual routine exam |
| • Hearing Aids<br>**Authorization is Required** | • Up to $2,800 for both ears combined every two years |
| **Vision Services** | |
| • Yearly eye exam for diabetic retinopathy | • $0 copayment/coinsurance |
| • Eyeglasses, lenses, frames, contacts | • $350 annually |
| **Mental Health Services** | |
| • Inpatient Visit | • $1,556 (2022 may change in 2023) per admission deductible is applied once during the defined benefit period.<br>o Days 1 – 60: $0 coinsurance o Days 61 – 90: $398.00 coinsurance per day<br>o Days > 90: $778 coinsurance per each lifetime reserve day after day 90 for each benefit period (up to 60 days over your life-time).<br>• Beyond lifetime reserved days: all costs |
| • Outpatient Group Therapy Visit | • 20% coinsurance for Medicare-covered services. |
| • Outpatient Individual Therapy Visit | • 20% coinsurance for Medicare-covered services. |
| **Therapies** | |
| Includes:<br>• Occupational Therapy<br>• Speech Pathology, and<br>• Physical Therapy | • 20% coinsurance |
| **Ambulance Services** | |

| | |
|---|---|
| • Ground Ambulance **Prior Authorization is required** | • 20% coinsurance |
| • Air Ambulance **Prior Authorization is required** | • 20% coinsurance |
| **Transportation (non-emergency)** | |
| Benefit allows 20 one-way trips for approved health-related locations **Authorization is required** | • $0 |
| **Medicare Part B Prescription Drugs** | |
| • Chemotherapy drugs **Authorization may be required** | • 20% coinsurance |
| • Other Part B drugs **Authorization may be required** | • 20% coinsurance |
| **Ambulatory Surgical Center** | |
| **Authorization is required** | • 20% coinsurance |
| **Medical Equipment/Supplies** | |
| • Durable Medical Equipment (e.g., wheelchairs, oxygen) **Authorization is Required** | • 20% coinsurance |
| • Prosthetics (e.g., braces, artificial limbs) **Authorization is Required** | • 20% coinsurance |
| • Diabetic Supplies **Authorization is Required** | • 20% coinsurance |
| • Diabetic Therapeutic Shoes and Inserts **Authorization is Required** | • 20% coinsurance |
| **Pulmonary Rehabilitation Services** | |
| • Medicare covered Cardiac Rehabilitation Services<br>• Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) **Authorization is Required** | • 20% coinsurance |

**Out-Patient Prescription Drugs**

| | **Standard Retail CostSharing – In-Network up to 30 day supply** | **Long term care (LTC) costsharing – up to 31 day supply** |
|---|---|---|
| Deductible for Part D Prescription Drugs | $505 | $505 |
| **Cost Sharing for Covered Drugs** | | |
| | 25% Coinsurance | 25% Coinsurance |
| **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% coinsurance for brand name drugs during the coverage gap. | $4,660 | $4,660 |
| **Catastrophic Coverage** | | |
| After your yearly out-ofpocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400 you pay the greater of:<br>• 5% coinsurance, or<br>• $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 |

**Part D Vaccines – Important Message for 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

*Liberty Medicare Advantage does not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact* Medicare.gov or 1-800-MEDICARE *to get information of all of your options.*