**2023 SUMMARY OF BENEFITS**

**LIBERTY MEDICARE DUAL PLAN (HMO D-SNP)**

**H6351, PLAN 005**

This summary of drug and health services covered by Liberty Medicare Dual Plan (HMO D-SNP) January 1, 2023 – December 31, 2023.

Liberty Medicare Dual Plan (HMO D-SNP) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) with a Medicare contract. This plan, Liberty Medicare Advantage Nursing Home Plan, is offered by Liberty Advantage, LLC dba Liberty Medicare Advantage. Advantage Nursing Home Plan (HMO-ISNP).

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.libertymedicareadvantage.com, or call Member Services and request the Evidence of Coverage.

**Key Contact Information**

| Service | Phone Number/Website | Hours of Operation |
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| Member Services | 1-844-854-6884 TTY/TDD should call 711 | 8 a.m. to 8 p.m. |
| Member Website | www.libertymedicareadvantage.com | 24/7 |

To join Liberty Medicare Dual Plan (HMO D-SNP), you must:

- Be entitled to Medicare Part A,
- ---and---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, 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 Medicare Dual Plan (HMO D-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. Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

| **Premiums and Benefits** | **Liberty Medicare Dual Plan (HMO D-SNP)** |
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| ***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)*** | $7,550 |
| **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>***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 life-time).<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 | • 20% coinsurance for Medicare-covered services.<br>• Amounts are paid until out-of-pocket max is reached. |

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| to the hospital or order outpatient tests.<br><br>***Prior Authorization is required*** | |
| **Ambulatory Surgical Center** | |
| ***Authorization is required*** | • 20% coinsurance |
| Primary Care Providers | • 20% coinsurance |
| Specialists<br>***Authorization may be required*** | • 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><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><br>Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.<br><br>Coverage is only covered within the U.S. | • 20% coinsurance for each Medicare-covered service, up to a maximum of $95 per visit.<br>• Coinsurance is waived if you are admitted to a hospital within 3 days of a visit. |

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| ***Authorization is required if the result is an inpatient stay*** | |
| **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.<br><br>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 out-of-network.<br>• Coverage within the U.S. only. | • 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. |
| **Diagnostic Services/Labs/Imaging** | |
| • Diagnostic tests and procedures<br>• Diagnostic radiology services (e.g. MRI, CAT Scan) | • 20% coinsurance for Medicare-covered services. |
| • Surgical supplies such as dressings<br>• Splints, casts and other devices used to reduce fractures and dislocations | • 20% coinsurance for Medicare covered services. |

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| • Laboratory tests | |
| • 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 Physician's Office.*** | • 0 – 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*** | • We provide up to $2,500 for both ears every three years |
| **Vision Services** | |
| • Yearly eye exam | • $0 copayment/coinsurance |
| • Eyeglasses, lenses, frames, contacts | • We provide up to $300 every two years |
| **Mental Health Services** | |
| • Inpatient Visit | • $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 life-time).<br>• Beyond lifetime reserved days: all costs |
| • Outpatient Psychiatric Group Therapy Visit | • 20% coinsurance for Medicare-covered services. |
| • Outpatient Psychiatric Individual Therapy Visit | • 20% coinsurance for Medicare-covered services. |
| **Therapies** | |

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| Includes:<br>• Occupational Therapy<br>• Speech Pathology, and<br>• Occupational Therapy<br><br>***Prior authorization required*** | • 20% coinsurance |
| **Ambulance Services** | |
| • Ground Ambulance<br>***Prior authorization required*** | • 20% coinsurance |
| • Air Ambulance<br><br>***Prior authorization required*** | • 20% coinsurance |
| **Transportation (non-emergency)** | |
| Benefit allows 20 one-way trips for approved health-related locations not to exceed 25 miles per trip.<br><br>**Authorization is required** | • $0 |
| **Medicare Part B Prescription Drugs** | |
| • Chemotherapy drugs<br>***Authorization may be required*** | • 20% coinsurance |
| • Other Part B drugs<br>***Authorization may be required*** | • 20% coinsurance |
| **Ambulatory Surgical Center** | |
| <br><br>***Authorization is required*** | • 20% coinsurance |
| **Medical Equipment/Supplies** | |
| • Durable Medical Equipment (e.g. wheelchairs, oxygen)<br>***Authorization is Required*** | • 20% coinsurance |
| • Prosthetics (e.g., braces, artificial limbs)<br>***Authorization is Required*** | • 20% coinsurance |
| • Diabetic Supplies<br>• Limit to blood glucose monitors and diabetic test strips<br>***Authorization is Required*** | • 20% coinsurance |
| **Pulmonary Rehabilitation Services** | |
| • Medicare covered Cardiac Rehabilitation Services | • 20% coinsurance |

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| • Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)<br>***Authorization is Required*** | |
| **Skilled Nursing Facility** | |
| | • Follows Original Medicare Fee for Service:<br>○ Days 1 – 20 - $0 coinsurance per day<br>○ Days 21 – 100 - $194.50 coinsurance per day<br>○ Days 101 and Beyond all costs.<br>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 |
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| Deductible for Part D Prescription Drugs | $505 | $505 | $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 | $4,660 | $4,660 |
| **Catastrophic Coverage** | | | | |

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| 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:<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 | $7,400 | $7,400 |
| Cost Sharing may change depending on the pharmacy you choose. | | | | |

## Optional Supplemental Benefits

| **Optional Benefits** | |
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| The following Optional benefits are at no cost to you. Some benefits are listed above but here is a complete list:<br><br>• Vision<br>• Dental<br>• Hearing<br>• Non-Emergent Transportation<br>• Meal Benefit<br>• Personal Emergency Response | |