2024 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 Medicare Advantage (HMO C-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, Cabarrus, Caldwell, Catawba, Chatham, Columbus, Cumberland, Davidson, Davie, Durham, Forsyth, Franklin, Granville, Greene, Guilford, Halifax, Harnett, Haywood, Henderson, Hyde, Johnston, Lee, Lenoir, Martin, Mecklenburg, Moore, New Hanover, Orange, Person, Pitt, Polk, 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 https://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 • **$0*** days 6 – 90 • Days 91 and beyond: **$800.00*** coinsurance per each lifetime reserve day after day 90 for each benefit period (up to 60 days over your life-time) *These are 2023 cost-sharing amounts and may change for 2024. Liberty Medicare Advantage will provide updated rates

	as soon as they are released.
Outpatient Hospital Observation 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**	• **15%** 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, Podiatrists, and Endocrinologist (Pathology and Labs if part of Service) • **$30** per visit for all other specialists • **20%** for Specialists while in a Facility

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

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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. 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.**	• **$0** copay, coinsurance & deductible
Diagnostic Services/Labs/Imaging	
• Diagnostic tests and procedures • Diagnostic radiology services (e.g., MRI, CAT Scan)	• **10%** 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.**	• **10%** 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**	• $2,000 Allowance to be used for Vision, Dental or Hearing benefit with Liberty Medicare Advantage Freedom Flex card.
Vision Services	
• Yearly eye exam	• **$0** copayment/coinsurance
• Eyeglasses, lenses, frames, contacts	• $2,000 Allowance to be used for Vision, Dental or Hearing benefit with Liberty Medicare Advantage Freedom Flex card.
Dental	
• Annual Exam	• **$0**

• Comprehensive and Preventative Services	• $2,000 Allowance to be used for Vision, Dental or Hearing benefit with Liberty Medicare Advantage Freedom Flex card.
Mental Health Services	

• Inpatient Visit **Prior Authorization is Required**	• **$1,600.00*** deductible is applied once during the defined benefit period** • Days 1 – 60: **$0*** coinsurance • Days 61- 90: $**400.00*** coinsurance per day • Days 91 and beyond: **$800.00*** 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. *These are 2023 cost-sharing amounts and may change for 2024. Liberty Medicare Advantage will provide updated rates as soon as they are released. **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	• **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)	
• Non-Emergency Transportation	• $20 allowance per month to be used for non-emergency transportation or fitness using the Liberty Medicare Advantage Freedom flex card.
Medicare Part B Prescription Drugs	

• Chemotherapy drugs **Authorization is required for initial administration of chemotherapy only**	• **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	
• Ambulatory Surgical Center Services **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**	• **15%** 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 from specific manufacturers **Prior Authorization is Required**	• **0%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	
Inpatient Skill Nursing care **Prior Authorization is Required**	• Follows Original Medicare Fee for Service: o Days 1 – 20 - **$0*** coinsurance per day o Days 21 – 100 - **$200.00*** coinsurance per day o Days 101 and beyond **all costs**. *These are 2023 cost-sharing amounts and may change for 2024. Liberty Medicare Advantage will provide updated rates as soon as they are released.

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	$0	$0	$0	$0	$0
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	$70	$70
Cost Sharing Tier 4 – Non-Preferred Brand	$95	$190	$285	$95	$95
Cost Sharing Tier 4 – Non-Preferred Brand Mail Order	$90	$180	$270	$95	$95
Cost Sharing Tier 5 – Specialty Tier and Mail Order	33%	33%	33%	33%	33%
Cost Sharing Tier 6 – Formulary Insulin	$0	$0	$0	$0	$0
Coverage GAP					
After your total drug costs (including what our plan has paid and what you have paid) reaches $5,030 you will pay no more than 25% coinsurance for generic drugs and 25%	$5,030	$5,030	$5,030	$5,030	$5,030

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 the plan pays the full cost for your covered Part D drugs	$7,400	$7,400	$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

Combined Additional Services*

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

- Liberty Medicare Advantage offers a **"Freedom Flex Card"** to be used for certain services that are important to you – we have 3 different allowances with a variety of services. 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 Vision, Dental or Hearing services.
    - **Fitness and Transportation** Flex Card
        - Allows you to spend $20 per month with can be rolled over monthly. You choose between either fitness or transportation
    - **OTC Drugs and Groceries Flex Card**
        - Allows you to spend $ 70 per month with no rollover. You choose between either OTC or Groceries
- **Meal Services** are also provided
    - **Post-Acute** – provides **two meals** per day for **up to 7 days** following an inpatient stay (14 meals in total)
    - **Chronic** – provides up to **two meals** per day for **up to 90 days**. Applicable to **2 events per year** (360 meals in total). RN referral required.
- **Personal Emergency Response**

A PERS monitoring device that can help provide you with confidence of knowing that, in an emergency, you can get help quickly, 24 hours a day, at no additional cost.

*These additional services/items are not part of the plan benefit package or the Medicare benefit.

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.