2025 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, 2025 – December 31, 2025.

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 Dual Plan, is offered by Liberty Advantage, LLC dba Liberty Medicare Advantage. Advantage Dual Plan (HMO-D-SNP).

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
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---be enrolled in NC Medicaid
- ---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, Haywood, Hyde, Johnston, Lee, Mecklenburg, New Hanover, Orange, Person, Polk, 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)
Monthly plan premium	$51.00 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. **Authorization is Required**	**$1,632.00*** per admission deductible is applied once during the defined benefit period. • Days 1 – 60: **$0*** coinsurance • Days 61 – 90: **$408.00*** coinsurance per day • Days > 90: **$816.00*** coinsurance per each lifetime reserve day after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserved days: all costs *These are 2024 cost-sharing amounts and may change for 2025. Liberty Medicare Advantage will provide updated rates as soon as they are released.
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. 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** (Blood transfusions do not require authorization)	• 20% coinsurance for Medicare-covered services. • Amounts are paid until out-of-pocket max is reached.

Ambulatory Surgical Center **Authorization may be required**	• 20% Coinsurance
Preventive Care	
Examples Include: • Annual Mammogram • Colonoscopy per Medicare guidelines • Annual Wellness Exam	• $0
Primary Care Providers	• 20% coinsurance
Specialists **Authorization may be required**	• 20% coinsurance

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.	• 20% coinsurance* for each Medicare-covered service, up to a maximum of $45 per visit. *Coinsurance is waived if you are admitted to a hospital within 3 days of a visit.
Diagnostic Services/Labs/Imaging	
• Diagnostic tests and procedures • Diagnostic radiology services (e.g. MRI, CAT Scan) • Laboratory tests	• 0-20% coinsurance for Medicare-covered services.

• 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.**	• 0 – 20% coinsurance for Medicare covered services. No Authorization required when services are rendered in a Nursing Facility or Physician Office.
Hearing Services	
• Hearing exam	• $0 coinsurance for annual routine exam
• Hearing Aids **Authorization is Required**	• We provide up to $2,500 for both ears combined every two years
Vision Services	
• Yearly eye exam	• $0 copayment/coinsurance, 0% if service provided in the nursing facility, 20% if services are provided in the office setting. •
• Eyeglasses, lenses, frames, contacts	• We provide up to $300 every year. Limit to one frame and set of lenses or contacts
Mental Health Services	
• Inpatient Visit	**$1,632.00*** per admission deductible is applied once during the defined benefit period. • Days 1 – 60: **$0*** coinsurance • Days 61 – 90: **$408.00*** coinsurance per day • Days > 90: **$816.00*** coinsurance per each lifetime reserve day after day 90 for each benefit period (up to 60 days over your lifetime).

	Beyond lifetime reserved days: all costs *These are 2024 cost-sharing amounts and may change for 2025. Liberty Medicare Advantage will provide updated rates as soon as they are released.
• Outpatient Psychiatric Group Therapy Visit	• 20% coinsurance for Medicare-covered services.
• Outpatient Psychiatric Individual Therapy Visit	• 20% coinsurance for Medicare-covered services.
Therapies	
Includes: • Occupational Therapy • Speech Pathology, and • Occupational Therapy **Prior authorization required**	• 20% coinsurance
Ambulance Services	
• Ground Ambulance **Prior authorization required**	• 20% coinsurance
• Air Ambulance **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. **Authorization is required**	• $0
Medicare Part B Prescription Drugs	
• Part B Part B Chemotherapy/Radiation Drugs	• 0-20% coinsurance* * The minimum coinsurance is set at 0% to reflect the lowest possible coinsurance for a Medicare Part B Chemotherapy/Radiation drugs. Maximum coinsurance is 20%. The initial administration of chemotherapy is all that requires authorization.
• Other Part B drugs **Authorization may be required**	• 0-20% coinsurance, the minimum coinsurance is set at 0% to reflect the lowest possible coinsurance for a Part B rebatable drug. Maximum coinsurance is 20%
Ambulatory Surgical Center	
• 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 Limit to blood glucose monitors and diabetic test strips from specific manufacturers **Authorization is Required**	• 20% coinsurance
Pulmonary Rehabilitation Services	
• Medicare covered Cardiac Rehabilitation Services	• 20% coinsurance
Supervised Exercise Therapy	
• Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) **Authorization is Required**	• 20%

Skilled Nursing Facility	

• Inpatient Skilled Nursing Facility
 	
Prior Authorization is Required
	• Follows Original Medicare Fee for Service:
	  • Days 1 – 20 - **$0*** coinsurance per day
	  • Days 21 – 100 - **$204.00** coinsurance per day
	  • Days 101 and Beyond all costs.
	
	*Above benefit amounts are based on 2024 rates and can change in 2025 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

Deductible Stage				
Deductible for Part D Prescription Drugs	$590	$590	$590	$590
Initial Coverage Stage				
You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled reaches the $2000 limit for the Initial Coverage Stage.	25%	25%	25%	25%
Catastrophic Coverage				
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy reach $2,000 your plan pays in full.	Plan pays in full for covered Part D drugs. You pay nothing	Plan pays in full for covered Part D drugs. You pay nothing	Plan pays in full for covered Part D drugs. You pay nothing	Plan pays in full for covered Part D drugs. You pay nothing