2025 SUMMARY OF BENEFITS LIBERTY

MEDICARE ADVANTAGE NURSING HOME PLAN (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, Haywood, Henderson, Hyde, Johnston, Lee, Lenoir, Martin, Mecklenburg, Moore, New Hanover, Orange, Pender, Person, Pitt, Polk, 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- 877-486-2048.

Premiums and Benefits	Liberty Advantage Nursing Home Plan (HMO I-SNP)
Monthly plan premium	**$51.00**
Deductible	**Medicare Fee-For-Service**
Maximum out-of-pocket (does not include Part D prescription drugs)	**$6,800**
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 Required**	**$1,676.00** per admission deductible is applied once during the defined benefit period. • Days 1 – 60: **$0** coinsurance • Days 61 – 90: **$419.00** coinsurance per day • Days > 90: **$838.00** coinsurance per each lifetime reserve day after day 90 for each benefit period (up to 60 days over your lifetime). After day 150 you pay all costs

Outpatient Observation 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**	• **20%** coinsurance for Medicare-covered services
Doctor Visits	
Primary Care Providers	• **0%** coinsurance
Specialists	• **20%** coinsurance
Preventative Care	
Examples Include: • Annual Mammogram • Colonoscopy per Medicare guidelines • Annual Wellness Exam	• **0%** coinsurance

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.	• 20% per visit, $110 maximum Coinsurance waived if hospital admission occurs within three (3) days of a visit
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 **$45** per visit Coinsurance waived if hospital admission occurs within three (3) days of a visit

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.	
Diagnostic Services/Labs/Imaging	
• Diagnostic tests and procedures • Diagnostic radiology services (e.g. MRI, CAT Scan) **No Authorization required when services are rendered in a Nursing Facility or Physician Office.**	• **0 – 20%** coinsurance for Medicare-covered services 0% coinsurance if the service is provided in a nursing facility or assisted living facility. 20% coinsurance applies in all other places of service.
• X-Rays and Radiation (radium and isotope) therapy including technician materials and supplies **Prior authorization will be required with the exceptions of X-rays, Ultra Sounds, Labs, and CT 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.	
• Routine Hearing Exam **Authorization is Required**	• **$0** coinsurance for annual routine exam, 1 per year
• Hearing Aids **Authorization is Required**	• Up to **$3,450** for both ears combined every two years
Vision Services	
• Routine Eye Exam	• **20%** in office, **$0** if performed in nursing facility
• Eyeglasses, lenses, frames, contacts	• **$450** annually Limit to one frame and set of lenses or contacts
Mental Health Services	
• Inpatient Visit	$**1,676** per admission deductible is applied once during the defined benefit period. • Days 1 – 60: **$0** coinsurance • Days 61 – 90: **$419.00** coinsurance per day • Days 91 – 150: **$838.00** coinsurance per each lifetime reserve day after day 90 for each benefit period • After day 150: You pay all costs.
• Outpatient Group Therapy Visit	• **20%** coinsurance for Medicare-covered services.
• Outpatient Individual Therapy	• **20%** coinsurance for Medicare-covered services.

visit	
Therapies	
Includes: • Occupational Therapy • Speech Pathology, and • Physical Therapy **Auth not required if services are provided at a facility with a capitated contract.**	• **20%** coinsurance
Ambulance Services	
• Ground Ambulance **Prior Authorization Required for Non-Emergency**	• **20%** coinsurance
• Air Ambulance **Prior Authorization Required for Non-Emergency**	• **20%** coinsurance
Transportation (Non-Emergency)	
Benefit allows 55 one-way trips for approved health-related locations **Authorization is required**	• **$0** **Limit 55 one-way trips - not to exceed 25 miles per trip.**
Medicare Part B Prescription Drugs	
• Chemotherapy drugs **Prior Authorization Required** (the initial administration of chemotherapy is all that requires authorization.	• **0-20%** coinsurance The minimum coinsurance is set at 0% to reflect the lowest possible coinsurance for a Medicare Part B Chemotherapy/Radiation drug.
• Other Part B Drugs	• **0-20%** coinsurance 0% to reflect the lowest possible coinsurance for a Part B

Prior Authorization Required	rebatable drug. Maximum coinsurance is 20%.
Ambulatory Surgical Center	
• Ambulatory Surgical Center Services **Prior Authorization 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 Limited to blood glucose monitors and diabetic test strips from specific manufacturers.
• Diabetic Therapeutic Shoes and Inserts **Authorization is Required**	• **20%** coinsurance
Medical Supplies • Surgical supplies such as dressings • Splints, casts and other devices used to reduce fractures and dislocations **Authorization is Required**	• **20%** coinsurance for Medicare-covered services
Medicare covered Cardiac Rehabilitation Services	• 20% coinsurance

Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) **Authorization is Required**	• **20%** coinsurance

Out-Patient Prescription Drugs

Cost Sharing for Covered Drugs	Standard Retail Cost Sharing – In-Network up to 30-day supply	Long term care (LTC) Cost Sharing – up to 31 day supply
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Part D drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.	$590	$590
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost**.	25%	25%
Stage 3: Catastrophic Stage Once you have paid $2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	Plan pays in full for covered Part D drugs. You pay nothing	Plan pays in full for covered Part D drugs. You pay nothing

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, 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.