

# 2018 Summary of Benefits

## Liberty Advantage (HMO SNP)

H6351, Plan 001

**This is a summary of drug and health services covered by Liberty Advantage (HMO SNP) January 1, 2018 - December 31, 2018**

Liberty Advantage is Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

This information is not a complete description of benefits. Contact the plan 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, please call Member Services and request the *Evidence of Coverage*.

### **To Reach our Member Services Representatives:**

- Toll-free 1-844-854-6884, TTY/TDD users should call 711.
- Hours of operation: 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.

### **To join Liberty Advantage (HMO SNP), you must:**

- be entitled to Medicare Part A,
- -- *and* -- be enrolled in Medicare Part B,
- -- *and* -- live in our service area,
- -- *and* -- reside in one of our participating assisted living communities and meet a nursing facility level of care, or nursing facilities for greater than 90 days. The plan's *Provider Directory* has a list of participating assisted living communities or nursing facilities, you can access this list on our website [www.libertyadvantageplan.com](http://www.libertyadvantageplan.com) or call Member Services and ask us to send you a list.

Our service area includes these counties in North Carolina: Alamance, Bertie, Brunswick, Chatham, Columbus, Cumberland, Davie, Forsyth, Halifax, Hyde, Johnston, Lee, New Hanover, Orange, Rowan, Sampson, and Warren.

Liberty Advantage (HMO SNP) has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at [www.libertyadvantageplan.com](http://www.libertyadvantageplan.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.

Limitations, copayments, and restrictions may apply.

You must continue to pay your Medicare Part B premium.

Liberty Advantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Liberty Advantage cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Liberty Advantage 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障 或性別而歧視任何人。

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 (HMO SNP)
Monthly Plan Premium	You pay \$30.10. You must continue to pay your Medicare Part B premium.
Deductible	\$183 per year Our plan charges the standard Medicare deductible. This cost may change in alignment with Original Medicare cost-sharing for 2018.
Maximum Out-of-Pocket Responsibility <i>(does not include prescription drugs)</i>	\$6,700 annually
Inpatient Hospital Coverage	<p>You pay:</p> <ul style="list-style-type: none"> <li>● \$1,316 deductible for each benefit period</li> <li>● Days 1-60: \$0 copay for each benefit period</li> <li>● Days 61-90: \$329 copay per day of each benefit period</li> <li>● Days 91 and beyond: \$658 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime)</li> </ul> <p>The above costs may change in alignment with Original Medicare cost-sharing for 2018.</p> <p>Prior authorization may be required.</p>
Outpatient Hospital Coverage	You pay 20% of the cost. Prior authorization may be required.
<p>Doctor Visits</p> <ul style="list-style-type: none"> <li>● Primary Care Providers</li> <li>● Specialists (referrals or prior authorization may be required)</li> </ul>	<p>You pay \$0 copay per visit.</p> <p>You pay 20% coinsurance per visit. Self referral: You have the right to go to a women's health specialist (such as a gynecologist) without a referral.</p>
Preventive Care	<p>You pay nothing.</p> <p>Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at \$0 cost.</p>

<b>Premiums and Benefits</b>	<b>Liberty Advantage (HMO SNP)</b>
Emergency Care	<p>You pay \$80 copay per visit.</p> <p>If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care.</p>
Urgently Needed Services	<p>You pay 20% coinsurance up to a maximum of \$65.</p> <p>If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for urgent care.</p>
<p>Diagnostic Services/Labs/Imaging</p> <ul style="list-style-type: none"> <li>● Diagnostic radiology services (<i>e.g., MRI</i>)</li> <li>● Therapeutic radiology services</li> <li>● Lab services</li> <li>● Diagnostic procedures and tests</li> <li>● Outpatient x-rays</li> </ul>	<p>0% coinsurance if the service is provided in a nursing facility or assisted living facility. 20% coinsurance applies in all other places of service. Deductible applies.</p> <p>Prior authorization may be required. Please contact the plan for more information.</p>
<p>Hearing Services</p> <ul style="list-style-type: none"> <li>● Hearing exam</li> </ul> <p><i>Supplemental Benefit</i></p> <ul style="list-style-type: none"> <li>● Routine hearing exam, fitting and evaluation for hearing aids</li> <li>● Hearing aids</li> </ul>	<p>You pay 20% of the cost for traditional Medicare-covered hearing services.</p> <p>You pay \$0 copay for one routine hearing exam, and fitting/evaluation for hearing aids per year.</p> <p>Allowance up to \$2000 for hearing aids every two years.</p>
Dental Service	<p>You pay 20% coinsurance for Medicare-covered services. Prior authorization may be required.</p>

<b>Premiums and Benefits</b>	<b>Liberty Advantage (HMO SNP)</b>
<p>Vision Services</p> <ul style="list-style-type: none"> <li>● Yearly eye exam for diabetic retinopathy</li> </ul> <p><i>Supplemental Benefit</i></p> <ul style="list-style-type: none"> <li>● Routine eye exam</li> <li>● Glaucoma screening</li> <li>● Eyeglasses, lenses, frames, contacts</li> </ul>	<p>You pay 0% coinsurance applies when services provided in Nursing Home; 20% coinsurance applies when services are provided in professional provider's office. Deductible applies.</p> <p>You pay \$0 copay for one routine eye exam visit and one glaucoma screening per year.</p> <p>Allowance of up to \$300 per year.</p>
<p>Mental Health Services</p> <ul style="list-style-type: none"> <li>● Inpatient visit</li> <li>● Outpatient group therapy visit</li> <li>● Outpatient individual therapy visit</li> </ul>	<p>You pay:</p> <ul style="list-style-type: none"> <li>● \$1,316 deductible for each benefit period</li> <li>● Days 1-60: \$0 copay for each benefit period</li> <li>● Days 61-90: \$329 copay per day of each benefit period</li> <li>● Days 91 and beyond: \$658 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime)</li> </ul> <p>The above costs may change in alignment with Original Medicare cost-sharing for 2018.</p> <p>You pay 20% of the cost group/individual therapy visit.</p> <p>Prior authorization may be required.</p>
<p>Skilled Nursing Facility</p>	<p>You pay:</p> <ul style="list-style-type: none"> <li>● Days 1-20: \$0 copay</li> <li>● Days 21-100: \$164.50 copay per day of benefit period.</li> <li>● Days 101 and beyond: all costs</li> </ul> <p>The above costs may change in alignment with Original Medicare cost-sharing for 2018. No prior hospital stay required. Prior authorization may be required.</p>
<p>Rehabilitation Services</p> <ul style="list-style-type: none"> <li>● Occupational therapy visit</li> <li>● Physical therapy and speech and language therapy visit</li> </ul>	<p>You pay 20% of the cost.</p> <p>You pay 20% of the cost.</p> <p>Prior authorization may be required.</p>

<b>Premiums and Benefits</b>	<b>Liberty Advantage (HMO SNP)</b>
Ambulance	You pay 20% of the cost one way. Prior authorization may be required for non-emergency services.
Non-Emergency Transportation	You pay 0% of the total cost for transportation services to a medical appointment for up to 24 one-way trips per year.
Medicare Part B Drugs	20% of the cost for chemotherapy and other Part B drugs.
Foot Care (podiatry services) <ul style="list-style-type: none"> <li>● Foot exams and treatment</li> </ul> <i>Supplemental Benefit</i> <ul style="list-style-type: none"> <li>● Routine foot care</li> </ul>	You pay 20% of the cost.  You pay \$0 for 6 routine foot care visits per year.
Medical Equipment/Supplies <ul style="list-style-type: none"> <li>● Durable Medical Equipment (e.g., wheelchairs, oxygen)</li> <li>● Prosthetics (e.g., braces, artificial limbs)</li> <li>● Diabetic supplies</li> <li>● Diabetic Therapeutic Shoes and Inserts</li> </ul>	You pay 20% of the cost.  You pay 20% of the cost.  You pay 20% of the cost.  You pay 20% of the cost. Prior authorization may be required.

<b>Outpatient Prescription Drugs</b>		
	<b>Retail Pharmacy (in network) (up to a 30-day supply)</b>	<b>Long-term care (LTC) cost-sharing (up to a 31-day supply)</b>
Initial Coverage Stage (After you pay your \$405 deductible)		
Cost sharing (All formulary Drugs)	25%	25%
Cost-Sharing may change depending on the pharmacy you choose and when you enter another stage of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the stages of the benefit, please call us or access our <i>Evidence of Coverage</i> online.		

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

You can see the *Pharmacy Directory* and complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at [www.libertyadvantageplan.com](http://www.libertyadvantageplan.com).

There are four phases to prescription drug coverage under Part D.

- **Deductible Stage:** During this stage, you pay the full cost of your drugs. You stay in this stage until you have paid \$405 for your drugs (\$405 is the amount of your deductible).
- **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. You stay in this stage until your year-to-date “total drug costs” (your payments plus any Part D plan’s payments) total \$3,750.
- **Gap Coverage Stage:** During this stage, you pay 35% of the price for brand name drugs plus a portion of the dispensing fee) and 44% of the price for generic drugs. You stay in this stage until your year-to-date “out-of-pocket costs” (your payments) reach a total of \$5,000.
- **Catastrophic Coverage Stage:** During this stage, the plan will pay most of the cost for your drugs. You pay the greater of:
  - --either-- coinsurance of 5% of the cost of the drug,
  - --or-- \$3.35 for a generic drug or a drug that is treated like a generic and \$8.35 for all other drugs.