HMO 2023

F23SBPLAT

FREEDOM HEALTH

SB Combo
088 - 089 - 091 - 092 - 098

088 - Freedom Platinum Plan Rx (HMO)

Counties: Brevard, Indian River, Martin, St. Lucie

089 - Freedom Platinum Plan Rx (HMO)

Counties: Orange, Osceola, Seminole, Volusia

091 - Freedom Platinum Plan Rx (HMO)

Counties: Manatee and Sarasota

092 - Freedom Platinum Plan Rx (HMO)

Counties: Polk

098 - Freedom Platinum Plan Rx (HMO)

Counties: Charlotte, Collier, Lee

H5427_2023_SB_088_089_091_092_098_M

2023 Summary of Benefits

Summary of Benefits
January 1, 2023 - December 31, 2023

Freedom Platinum Plan Rx (HMO) H5427_088
Freedom Platinum Plan Rx (HMO) H5427_089
Freedom Platinum Plan Rx (HMO) H5427_091
Freedom Platinum Plan Rx (HMO) H5427_092
Freedom Platinum Plan Rx (HMO) H5427_098

The purpose of the Summary of Benefits is to provide you with a summary of drug and health benefits covered by **Freedom Platinum Plan Rx (HMO) H5427_088, Freedom Platinum Plan Rx (HMO) H5427_089, Freedom Platinum Plan Rx (HMO) H5427_091, Freedom Platinum Plan Rx (HMO) H5427_092, Freedom Platinum Plan Rx (HMO) H5427_098,** which describes what we cover and what you pay. This information is not a complete description of benefits. Call 1-800-401-2740 (TTY: 711) for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year.

Freedom Health, Inc. is an HMO with a Medicare contract. Enrollment in Freedom Health, Inc. depends on contract renewal.

To be eligible for **Freedom Platinum Plan Rx (HMO) H5427_088, Freedom Platinum Plan Rx (HMO) H5427_089, Freedom Platinum Plan Rx (HMO) H5427_091, Freedom Platinum Plan Rx (HMO) H5427_092, Freedom Platinum Plan Rx (HMO) H5427_098,** you must have both Medicare Part A and Medicare Part B and live in our service area.

Our service area includes the following counties in Florida:

Freedom Platinum Plan Rx (HMO) H5427_088: Brevard, Indian River, Martin and St. Lucie
Freedom Platinum Plan Rx (HMO) H5427_089: Orange, Osceola, Seminole and Volusia
Freedom Platinum Plan Rx (HMO) H5427_091: Manatee and Sarasota
Freedom Platinum Plan Rx (HMO) H5427_092: Polk
Freedom Platinum Plan Rx (HMO) H5427_098: Charlotte, Collier and Lee

Freedom Health, Inc. has a network of doctors, hospitals, pharmacies, and other providers. You must use plan providers to get your medical care and services except in emergency or urgent needed services, when the network is not available, out-of-area dialysis services and in cases in which the plan authorizes use of out-of-network providers. If you obtain routine care from out-of-network providers neither Medicare nor Freedom Health, Inc. will be responsible for the costs. Out-of-network/non-contracted providers are under no obligation to treat Freedom Health, Inc. members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Premiums and Benefits	Freedom Platinum Plan Rx (HMO)_088	Freedom Platinum Plan Rx (HMO)_089	Freedom Platinum Plan Rx (HMO)_091
Monthly Plan Premium	You pay **$0**	You pay **$0**	You pay **$0**
Deductible	You pay **$0**	You pay **$0**	You pay **$0**
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	**$1,750** annually	**$2,000** annually	**$2,750** annually
Inpatient Hospital Coverage	You pay **$85** copay each day for days 1 through 7 and **$0** copay each for days 8 through 90 per admission	You pay **$25** copay each day for days 1 through 7 and **$0** copay each for days 8 through 90 per admission	You pay **$75** copay each day for days 1 through 7 and **$0** copay each day for days 8 through 90 per admission
Outpatient Hospital Coverage	You pay **$100** copay per visit	You pay **$100** copay per visit	You pay **$150** copay per visit

Freedom Platinum Plan Rx (HMO)_092	Freedom Platinum Plan Rx (HMO)_098	What you should know
You pay **$0**	You pay **$0**	You must continue to pay your Medicare Part B Premium unless your Part B Premium is paid for you by Medicaid or another third party.
You pay **$0**	You pay **$0**	These plans do not have a deductible
$1,750 annually	**$3,400** annually	This is the most you pay for copays, coinsurance and other costs for medical services for the year. Contact the Plan for details on what is covered in the Maximum Out-of-Pocket.
You pay **$40** copay each day for days 1 through 5 and **$0** copay each day for days 6 through 90 per admission	You pay **$150** copay each day for days 1 through 7 and **$0** copay each day for days 8 through 90 per admission	Except in an emergency, you must get prior authorization in advance before you are admitted to the facility or your stay may not be covered.
You pay **$75** copay per visit	You pay **$150** copay per visit	Prior authorization is required for some services by your doctor or other network provider. Please contact the Plan for more information. Services include but are not limited to Medicare-covered outpatient hospital facility visits, clinic, outpatient treatment room, observation room, or outpatient surgery services.

Premiums and Benefits	Freedom Platinum Plan Rx (HMO)_088	Freedom Platinum Plan Rx (HMO)_089	Freedom Platinum Plan Rx (HMO)_091
Ambulatory Surgery Center	You pay **$25** copay for each Medicare-covered ambulatory surgical center visit You pay **$100** copay for each Medicare-covered outpatient hospital facility visit	You pay **$25** copay for each Medicare-covered ambulatory surgical center visit You pay **$100** copay for each Medicare-covered outpatient hospital facility visit	You pay **$25** copay for each Medicare-covered ambulatory surgical center visit You pay **$150** copay for each Medicare-covered outpatient hospital facility visit
Doctor's Visits • **Primary** • **Specialists**	You pay **$0** copay per visit You pay **$15** copay per visit	You pay **$0** copay per visit You pay **$0** copay per visit	You pay **$0** copay per visit You pay **$15** copay per visit
Preventive Care	You pay **$0** copay	You pay **$0** copay	You pay **$0** copay
Emergency Care	You pay **$75** copay per visit	You pay **$75** copay per visit	You pay **$75** copay per visit
Urgently Needed Services	You pay **$10** copay	You pay **$10** copay	You pay **$10** copay

Freedom Platinum Plan Rx (HMO)_092	Freedom Platinum Plan Rx (HMO)_098	What you should know
You pay **$25** copay for each Medicare-covered ambulatory surgical center visit You pay **$75** copay for each Medicare-covered outpatient hospital facility visit	You pay **$25** copay for each Medicare-covered ambulatory surgical center visit You pay **$150** copay for each Medicare-covered outpatient hospital facility visit	Prior authorization may be required. Contact the Plan for details. If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient.
You pay **$0** copay per visit You pay **$0** copay per visit	You pay **$0** copay per visit You pay **$10** copay per visit	Your primary care physician will coordinate the covered services you receive as a member of our plan. In order for you to see a specialist, you will need to have a referral from your PCP first. Separate copay may apply for each additional service received at an office visit.
You pay **$0** copay	You pay **$0** copay	Any additional preventive services approved by Medicare during the contract year will be covered. Preventive services in a hospital-based setting may require prior authorization.
You pay **$75** copay per visit	You pay **$75** copay per visit	**$500** copay for each emergency service, urgent service and emergency transportation outside the U.S. **$100,000** plan coverage limit for emergency services, urgent services and emergency transportation outside the U.S. every year. Contact the plan for details.
You pay **$10** copay	You pay **$10** copay	**$500** copay for each emergency service, urgent service and emergency transportation outside the U.S. **$100,000** plan coverage limit for emergency services, urgent services and emergency transportation outside the U.S. every year. Contact the plan for details.

Premiums and Benefits	Freedom Platinum Plan Rx (HMO)_088	Freedom Platinum Plan Rx (HMO)_089	Freedom Platinum Plan Rx (HMO)_091
Diagnostic Services/Labs/Imaging			
• **Diagnostic Radiology Services *(e.g., MRI)***	You pay **$25-$100** copay depending on the service	You pay **$25-$100** copay depending on the service	You pay **$25-$150** copay depending on the service
• **Lab Services**	You pay **$0-$50** copay depending on the place of service	You pay **$0-$50** copay depending on the place of service	You pay **$0-$50** copay depending on the place of service
• **Diagnostic Tests and Procedures**	You pay **$0-$100** copay or **20%** coinsurance depending on the service	You pay **$0-$100** copay or **20%** coinsurance depending on the service	You pay **$0-$150** copay or **20%** coinsurance depending on the service
• **Outpatient X-rays**	You pay **$0-$100** copay depending on the service	You pay **$0-$100** copay depending on the service	You pay **$0-$150** copay depending on the service
• **Therapeutic Radiology**	You pay **20%** coinsurance for Therapeutic Radiology	You pay **20%** coinsurance for Therapeutic Radiology	You pay **20%** coinsurance for Therapeutic Radiology
Hearing Services			
• **Hearing Exam/Hearing Aid Fitting-Evaluation**	You pay **$0** copay for one routine hearing exam and one hearing aid fitting-evaluation every year	You pay **$0** copay for one routine hearing exam and one hearing aid fitting-evaluation every year	You pay **$0** copay for one routine hearing exam and one hearing aid fitting-evaluation every year
• **Hearing Aid**	You pay **$0** copay for two hearing aids (1 per ear) per year	You pay **$0** copay for two hearing aids (1 per ear) per year	You pay **$0** copay for two hearing aids (1 per ear) per year

Freedom Platinum Plan Rx (HMO)_092	Freedom Platinum Plan Rx (HMO)_098	What you should know
You pay **$25-$75** copay depending on the service You pay **$0-$50** copay depending on the place of service You pay **$0-$75** copay or **20%** coinsurance depending on the service You pay **$0-$75** copay depending on the service You pay **20%** coinsurance for Therapeutic Radiology	You pay **$25-$150** copay depending on the service You pay **$0-$50** copay depending on the place of service You pay **$0-$150** copay or **20%** coinsurance depending on the service You pay **$0-$150** copay depending on the service You pay **20%** coinsurance for Therapeutic Radiology	Prior authorization is required for some services by your doctor or other network provider. Please contact the plan for more information.
You pay **$0** copay for one routine hearing exam and one hearing aid fitting-evaluation every year You pay **$0** copay for two hearing aids (1 per ear) per year	You pay **$0** copay for one routine hearing exam and one hearing aid fitting-evaluation every year You pay **$0** copay for two hearing aids (1 per ear) per year	Our Plan pays up to a maximum of **$1,000 ($500 per hearing aid)** for hearing aid benefit every year. You are responsible for payment of any amount in excess of the maximum **$1,000 ($500 per hearing aid)** For all plans, you pay **$0** copay for Medicare-covered diagnostic hearing exam.

Premiums and Benefits	Freedom Platinum Plan Rx (HMO)_088	Freedom Platinum Plan Rx (HMO)_089	Freedom Platinum Plan Rx (HMO)_091
Dental Services			
• **Oral Exam & Cleaning**	You pay **$0** copay for Oral Exam, 2 per year, **$0** copay for Problem Focused Exam, 2 per year and **$0** copay for Cleaning, 2 per year	You pay **$0** copay for Oral Exam, 2 per year, **$0** copay for Problem Focused Exam, 2 per year and **$0** copay for Cleaning, 2 per year	You pay **$0** copay for Oral Exam, 2 per year, **$0** copay for Problem Focused Exam, 2 per year and **$0** copay for Cleaning, 2 per year
• **Fluoride Treatment**	You pay **$0** copay for fluoride treatment, 2 per year	You pay **$0** copay for fluoride treatment, 2 per year	You pay **$0** copay for fluoride treatment, 2 per year
• **Dental X-rays**	You pay **$0** copay for Dental X-rays	You pay **$0** copay for Dental X-rays	You pay **$0** copay for Dental X-rays
• **Extraction of Tooth**	You pay **$0** copay for extraction of tooth, 1 procedure per year	You pay **$0** copay for extraction of tooth, 1 procedure per year	You pay **$0** copay for extraction of tooth, 1 procedure per year
• **Fillings**	You pay **$0** copay for resin filling or restoration, 1 per year	You pay **$0** copay for resin filling or restoration, 1 per year	You pay **$0** copay for resin filling or restoration, 1 per year
• **Debridement**	You pay **$0** copay for 1 full mouth debridement per 2 years	You pay **$0** copay for 1 full mouth debridement per 2 years	You pay **$0** copay for 1 full mouth debridement per 2 years
• **Deep Cleaning *(Scaling/Root Planing)***	You pay **$0** copay for Scaling/Root Planing	You pay **$0** copay for Scaling/Root Planing	You pay **$0** copay for Scaling/Root Planing
• **Periodontal Maintenance**	You pay **$0** copay for 2 procedures per year	You pay **$0** copay for 2 procedures per year	You pay **$0** copay for 2 procedures per year

Freedom Platinum Plan Rx (HMO)_092	Freedom Platinum Plan Rx (HMO)_098	What you should know
You pay **$0** copay for Oral Exam, 2 per year, **$0** copay for Problem Focused Exam, 2 per year and **$0** copay for Cleaning, 2 per year	You pay **$0** copay for Oral Exam, 2 per year, **$0** copay for Problem Focused Exam, 2 per year and **$0** copay for Cleaning, 2 per year	Prior Authorization may be required, and services must be performed by a participating Dental provider. For more details or to get a complete list of services we cover, please refer to your Evidence of Coverage. For all plans, you pay **$0** copay for Medicare-covered dental benefit.
You pay **$0** copay for fluoride treatment, 2 per year	You pay **$0** copay for fluoride treatment, 2 per year	
You pay **$0** copay for Dental X-rays	You pay **$0** copay for Dental X-rays	
You pay **$0** copay for extraction of tooth, 1 procedure per year	You pay **$0** copay for extraction of tooth, 1 procedure per year	
You pay **$0** copay for resin filling or restoration, 1 per year	You pay **$0** copay for resin filling or restoration, 1 per year	
You pay **$0** copay for 1 full mouth debridement per 2 years	You pay **$0** copay for full mouth debridement, per 2 years	
You pay **$0** copay for Scaling/Root Planing	You pay **$0** copay for Scaling/Root Planing	For Scaling/Root Planing, 4 procedures per year and limited to 1 procedure per quadrant per year.
You pay **$0** copay for 2 procedures per year	You pay **$0** copay for 2 procedures per year	

Premiums and Benefits	Freedom Platinum Plan Rx (HMO)_088	Freedom Platinum Plan Rx (HMO)_089	Freedom Platinum Plan Rx (HMO)_091
Vision Services			
• **Routine Eye Exam**	You pay **$0** copay for 1 routine eye exam every year by an Optometrist	You pay **$0** copay for 1 routine eye exam every year by an Optometrist	You pay **$0** copay for 1 routine eye exam every year by an Optometrist
• **Eyeglasses** ***(Frames and Lenses)***	You pay **$10** copay for the plan coverage limit for 1 pair of eyeglasses or contact lenses per year You pay **$0** copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery	You pay **$10** copay for the plan coverage limit for 1 pair of eyeglasses or contact lenses per year You pay **$0** copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery	You pay **$10** copay for the plan coverage limit for 1 pair of eyeglasses or contact lenses per year You pay **$0** copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery
Mental Health Services			
• **Inpatient Visit**	You pay **$85** copay each day for days 1-7 and **$0** copay each day for days 8-90 per admission	You pay **$25** copay each day for days 1-7 and **$0** copay each day for days 8-90 per admission	You pay **$75** copay each day for days 1-7 and **$0** copay each day for days 8-90 per admission
• **Outpatient Group Therapy Visit** • **Outpatient Individual Therapy Visit**	You pay **$15** copay for outpatient group/individual therapy visit	You pay **$0** copay for outpatient group/individual therapy visit	You pay **$15** copay for outpatient group/individual therapy visit

Freedom Platinum Plan Rx (HMO)_092	Freedom Platinum Plan Rx (HMO)_098	What you should know
You pay **$0** copay for 1 routine eye exam every year by an Optometrist You pay **$10** copay for the plan coverage limit for 1 pair of eyeglasses or contact lenses per year You pay **$0** copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery	You pay **$0** copay for routine eye exam 1 every year by an Optometrist You pay **$10** copay for the plan coverage limit for 1 pair of eyeglasses or contact lenses per year You pay **$0** copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery	Eye exams to diagnose and treat diseases and conditions of the eye by an Ophthalmologist are subject to the Specialist copay. Contact the Plan for additional supplemental benefits. Services must be performed by a participating Vision provider. You pay nothing for exams to diagnose and treat diseases and conditions of the eye by an Optometrist For all plans, the coverage limit is **$150** for eyewear (eyeglasses or contact lenses) per benefit year. You will be responsible for the **$10** copay and any amount over the plan benefit maximum total retail cost of **$150** for eyewear benefit.
You pay **$40** copay each day for days 1-5 and **$0** copay each day for days 6-90 per admission You pay **$0** copay for outpatient group/individual therapy visit	You pay **$150** copay each day for days 1-7 and **$0** copay each day for days 8-90 per admission You pay **$10** copay for outpatient group/individual therapy visit	Prior Authorization may be required. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

Premiums and Benefits	Freedom Platinum Plan Rx (HMO)_088	Freedom Platinum Plan Rx (HMO)_089	Freedom Platinum Plan Rx (HMO)_091
Skilled Nursing Facility	You pay **$0** copay each day for days 1 - 20 You pay **$150** copay each day for days 21 - 100	You pay **$0** copay each day for days 1 - 20 You pay **$150** copay each day for days 21 - 100	You pay **$0** copay each day for days 1 - 20 You pay **$150** copay each day for days 21 - 100
Physical Therapy ***(Rehabilitation Services)*** • **Occupational Therapy Visit** • **Physical Therapy Visit** • **Speech Therapy Visit** • **Language Therapy Visit**	You pay **$15** copay	You pay **$0** copay	You pay **$15** copay
Ambulance	You pay **$175** copay for Medicare-covered one-way Ground Ambulance services You pay **20%** coinsurance for Medicare-covered one-way Air Ambulance services	You pay **$150** copay for Medicare-covered one-way Ground Ambulance services You pay **20%** coinsurance for Medicare-covered one-way Air Ambulance services	You pay **$150** copay for Medicare-covered one-way Ground Ambulance services You pay **20%** coinsurance for Medicare-covered one-way Air Ambulance services

Freedom Platinum Plan Rx (HMO)_092	Freedom Platinum Plan Rx (HMO)_098	What you should know
You pay **$0** copay each day for days 1 - 20 You pay **$150** copay each day for days 21 - 100	You pay **$0** copay each day for days 1- 20 You pay **$150** copay each day for days 21-100	Our plan covers up to 100 days in a SNF per benefit plan. You must get prior authorization in advance before you are admitted to the facility or your stay may not be covered.
You pay **$0** copay	You pay **$10** copay	For rehabilitative services, you will need a referral or authorization from your PCP first depending on the specific service. There may be limits on physical therapy, occupational therapy, and speech and language pathology services. Contact the plan for details.
You pay **$150** copay for Medicare-covered one-way Ground Ambulance services You pay **20%** coinsurance for Medicare-covered one-way Air Ambulance services	You pay **$150** copay for Medicare-covered one-way ground ambulance services You pay **20%** coinsurance for Medicare-covered one-way air ambulance services	Prior authorization may be required. Contact the Plan for details.

Premiums and Benefits	Freedom Platinum Plan Rx (HMO)_088	Freedom Platinum Plan Rx (HMO)_089	Freedom Platinum Plan Rx (HMO)_091
Transportation	You pay **$0** copay for up to **12** one-way trips every year	You pay **$0** copay for up to **12** one-way trips every year	You pay **$0** copay for up to **12** one-way trips every year
Medicare Part B Drugs	You pay **20%** of the cost for chemotherapy drugs You pay **20%** of the cost for other Part B drugs	You pay **20%** of the cost for chemotherapy drugs You pay **20%** of the cost for other Part B drugs	You pay **20%** of the cost for chemotherapy drugs You pay **20%** of the cost for other Part B drugs
Foot Care ***(Podiatry Services)*** • **Foot Exams and Treatment**	You pay **$15** copay	You pay **$0** copay	You pay **$15** copay
Medical Equipment/ Supplies • **Durable Medical Equipment** ***(e.g., wheelchairs, oxygen)***	You pay **20%** coinsurance	You pay **20%** coinsurance	You pay **20%** coinsurance
• **Prosthetics** ***(e.g., braces, artificial limbs)***	You pay **20%** coinsurance	You pay **20%** coinsurance	You pay **20%** coinsurance
• **Diabetes Supplies**	You pay **0-20%** coinsurance	You pay **0-20%** coinsurance	You pay **0-20%** coinsurance

Freedom Platinum Plan Rx (HMO)_092	Freedom Platinum Plan Rx (HMO)_098	What you should know
You pay **$0** copay for up to **12** one-way trips every year	You pay **$0** copay for up to **12** one-way trips every year	Transportation is intended for rides to and/or from plan approved locations for medical appointments and health needs within your county. Call to schedule a ride at least 72 hours prior to scheduled medical appointment.
You pay **20%** of the cost for chemotherapy drugs You pay **20%** of the cost for other Part B drugs	You pay **20%** of the cost for chemotherapy drugs You pay **20%** of the cost for other Part B drugs	The Plan may require authorization to determine whether certain drugs are covered by Medicare Part B or Part D. Please refer to your Evidence of Coverage for more details.
You pay **$0** copay	You pay **$10** copay	Covered podiatry benefits are for medically necessary foot care. You will need to have a referral or authorization from your PCP first depending on the service.
You pay **20%** coinsurance You pay **20%** coinsurance You pay **0-20%** coinsurance	You pay **20%** coinsurance You pay **20%** coinsurance You pay **0-20%** coinsurance	We cover all medically necessary Durable Medical Equipment covered by Original Medicare. You will need to have a referral or authorization from your PCP first depending on the service. You pay **$0** for Diabetic Monitors, Lancets and Test Strips ordered through the Plan's Mail Order Program. You pay **20%** for all diabetic supplies from a retail pharmacy.

Premiums and Benefits	Freedom Platinum Plan Rx (HMO)_088	Freedom Platinum Plan Rx (HMO)_089	Freedom Platinum Plan Rx (HMO)_091
Wellness • **Fitness** • **24 Hour Nurse Advice Line**	You pay **$0** copay You pay **$0** copay	You pay **$0** copay You pay **$0** copay	You pay **$0** copay You pay **$0** copay
Flex Account – Active Fitness	Not covered	**$500** Annual Allowance	**$500** Annual Allowance
Over The Counter (OTC)	**$50** Monthly Allowance *The plan doesn't allow you to roll over any remaining OTC allowance into the next month*	**$50** Monthly Allowance *The plan doesn't allow you to roll over any remaining OTC allowance into the next month*	**$50** Monthly Allowance *The plan doesn't allow you to roll over any remaining OTC allowance into the next month*
In-Home Support Service (Papa's Pals)	You pay **$0** copay for Up to **30 hours** of companion services per year	You pay **$0** copay for Up to **30 hours** of companion services per year	You pay **$0** copay for Up to **30 hours** of companion services per year

Freedom Platinum Plan Rx (HMO)_092	Freedom Platinum Plan Rx (HMO)_098	What you should know
You pay **$0** copay You pay **$0** copay	You pay **$0** copay You pay **$0** copay	Health Club Memberships are limited to participating facilities. Health Advice from a nursing professional, available 24 hours a day, 7 days a week.
$500 Annual Allowance	Not covered	The plan covers a spending allowance of **$500** per year towards the payment of facility access fees for golf, tennis or swimming. Any unused amounts do not carry forward to the next calendar year. For more information about this benefit please contact Member Services.
$75 Monthly Allowance *The plan doesn't allow you to roll over any remaining OTC allowance into the next month*	**$50** Monthly Allowance *The plan doesn't allow you to roll over any remaining OTC allowance into the next month*	Please contact the plan or visit our website for specific instructions for using this benefit and our list of covered Over-the-Counter items. Call Member Services at 1-800-401-2740, TTY users call 711, or visit our website at www.freedomhealth.com.
You pay **$0** copay for Up to **30 hours** of companion services per year	You pay **$0** copay for Up to **30 hours** of companion services per year	Services include but are not limited to Household Chores, Companionship and Technical Guidance. Services are scheduled in 1-hour increments. Please call 1-888-228-5958 for specific instructions for using this benefit. TTY users call 711.

Outpatient Prescription Drugs			
Freedom Platinum Plan Rx (HMO)_088			
	Standard Retail Rx 30 – day Supply	**Standard Mail Order 90 – day Supply**	**What you should know**
*** Important Message About What You Pay for Vaccines and Insulin**- Our plan covers most Part D vaccines at no cost to you and you won't pay more than $35 for a one-month supply for any covered Insulin.			
Deductible Stage	This stage does not apply to you		
Initial Coverage Stage **Tier 1: Preferred Generic** **Tier 2: Preferred Brand** **Tier 3: Non-Preferred Drug** **Tier 4: Specialty Tier**	 **$0 Copay** **$30 Copay** **$75 Copay** **33% of the Cost**	 **$0 Copay** **$60 Copay** **$150 Copay** **Long Term Supply Not Available**	Cost Sharing may change depending on the pharmacy you choose and when you enter another phase of Part D benefit. You pay your cost share until your total yearly drug costs reach **$4,660**. Not all drugs qualify for a 90-day supply. Some Tier 1 medications allow up to a 100-day supply. For more information, please call us or access our Evidence of Coverage online. If you reside in a long-term care facility, you pay the same as a Standard Retail one-month supply for a 34-day supply.
Coverage Gap Stage **Tier 1: Preferred Generic**	 **$0 Copay**	 **$0 Copay**	For all other drugs, you pay **25%** of the price for brand drugs and **25%** of the price for all generic drugs (plus a portion of the dispensing fee). You stay in this stage until your out-of-pocket costs reach a total of **$7,400**.
Catastrophic Coverage Stage	You pay the greater of: • **5%** of the cost of the drug, or • **$4.15** copay for generic (including drugs treated as generic) and **$10.35** copay for all other drugs • Our Plan pays the rest of the cost		During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year.

Outpatient Prescription Drugs			
Freedom Platinum Plan Rx (HMO)_089			
	Standard Retail Rx 30 – day Supply	**Standard Mail Order 90 – day Supply**	**What you should know**
*** Important Message About What You Pay for Vaccines and Insulin**- Our plan covers most Part D vaccines at no cost to you and you won't pay more than $35 for a one-month supply for any covered Insulin.			
Deductible Stage	This stage does not apply to you		
Initial Coverage Stage **Tier 1: Preferred Generic** **Tier 2: Preferred Brand** **Tier 3: Non-Preferred Drug** **Tier 4: Specialty Tier**	 **$0 Copay** **$25 Copay** **$65 Copay** **33% of the Cost**	 **$0 Copay** **$50 Copay** **$130 Copay** **Long Term Supply Not Available**	Cost Sharing may change depending on the pharmacy you choose and when you enter another phase of Part D benefit. You pay your cost share until your total yearly drug costs reach **$4,660**. Not all drugs qualify for a 90-day supply. Some Tier 1 medications allow up to a 100-day supply. For more information, please call us or access our Evidence of Coverage online. If you reside in a long-term care facility, you pay the same as a Standard Retail one-month supply for a 34-day supply.
Coverage Gap Stage **Tier 1: Preferred Generic**	 **$0 Copay**	 **$0 Copay**	For all other drugs, you pay **25%** of the price for brand drugs and **25%** of the price for all generic drugs (plus a portion of the dispensing fee). You stay in this stage until your out-of-pocket costs reach a total of **$7,400**.
Catastrophic Coverage Stage	You pay the greater of: • **5%** of the cost of the drug, or • **$4.15** copay for generic (including drugs treated as generic) and **$10.35** copay for all other drugs • Our Plan pays the rest of the cost		During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year.

Outpatient Prescription Drugs			
Freedom Platinum Plan Rx (HMO)_091			
	Standard Retail Rx 30 – day Supply	**Standard Mail Order 90 – day Supply**	**What you should know**
*** Important Message About What You Pay for Vaccines and Insulin**- Our plan covers most Part D vaccines at no cost to you and you won't pay more than $35 for a one-month supply for any covered Insulin.			
Deductible Stage	This stage does not apply to you		
Initial Coverage Stage **Tier 1: Preferred Generic** **Tier 2: Preferred Brand** **Tier 3: Non-Preferred Drug** **Tier 4: Specialty Tier**	 **$0 Copay** **$25 Copay** **$70 Copay** **33% of the Cost**	 **$0 Copay** **$50 Copay** **$140 Copay** **Long Term Supply Not Available**	Cost Sharing may change depending on the pharmacy you choose and when you enter another phase of Part D benefit. You pay your cost share until your total yearly drug costs reach **$4,660**. Not all drugs qualify for a 90-day supply. Some Tier 1 medications allow up to a 100-day supply. For more information, please call us or access our Evidence of Coverage online. If you reside in a long-term care facility, you pay the same as a Standard Retail one-month supply for a 34-day supply.
Coverage Gap Stage **Tier 1: Preferred Generic**	 **$0 Copay**	 **$0 Copay**	For all other drugs, you pay **25%** of the price for brand drugs and **25%** of the price for all generic drugs (plus a portion of the dispensing fee). You stay in this stage until your out-of-pocket costs reach a total of **$7,400**.
Catastrophic Coverage Stage	You pay the greater of: • **5%** of the cost of the drug, or • **$4.15** copay for generic (including drugs treated as generic) and **$10.35** copay for all other drugs • Our Plan pays the rest of the cost		During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year.

Outpatient Prescription Drugs			
Freedom Platinum Plan Rx (HMO)_092			
	Standard Retail Rx 30 – day Supply	**Standard Mail Order 90 – day Supply**	**What you should know**
*** Important Message About What You Pay for Vaccines and Insulin**- Our plan covers most Part D vaccines at no cost to you and you won't pay more than $35 for a one-month supply for any covered Insulin.			
Deductible Stage	This stage does not apply to you		
Initial Coverage Stage **Tier 1: Preferred Generic** **Tier 2: Preferred Brand** **Tier 3: Non-Preferred Drug** **Tier 4: Specialty Tier**	**$0 Copay** **$10 Copay** **$55 Copay** **33% of the Cost**	**$0 Copay** **$20 Copay** **$110 Copay** **Long Term Supply Not Available**	Cost Sharing may change depending on the pharmacy you choose and when you enter another phase of Part D benefit. You pay your cost share until your total yearly drug costs reach **$4,660**. Not all drugs qualify for a 90-day supply. Some Tier 1 medications allow up to a 100-day supply. For more information, please call us or access our Evidence of Coverage online. If you reside in a long-term care facility, you pay the same as a Standard Retail one-month supply for a 34-day supply.
Coverage Gap Stage **Tier 1: Preferred Generic**	**$0 Copay**	**$0 Copay**	For all other drugs, you pay **25%** of the price for brand drugs and **25%** of the price for all generic drugs (plus a portion of the dispensing fee). You stay in this stage until your out-of-pocket costs reach a total of **$7,400**.
Catastrophic Coverage Stage	You pay the greater of: • **5%** of the cost of the drug, or • **$4.15** copay for generic (including drugs treated as generic) and **$10.35** copay for all other drugs • Our Plan pays the rest of the cost		During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year.

Outpatient Prescription Drugs			
Freedom Platinum Plan Rx (HMO)_098			
	Standard Retail Rx 30 – day Supply	**Standard Mail Order 90 – day Supply**	**What you should know**
*** Important Message About What You Pay for Vaccines and Insulin**- Our plan covers most Part D vaccines at no cost to you and you won't pay more than $35 for a one-month supply for any covered Insulin.			
Deductible Stage	This stage does not apply to you		
Initial Coverage Stage **Tier 1: Preferred Generic** **Tier 2: Preferred Brand** **Tier 3: Non-Preferred Drug** **Tier 4: Specialty Tier**	 **$0 Copay** **$30 Copay** **$70 Copay** **33% of the Cost**	 **$0 Copay** **$60 Copay** **$140 Copay** **Long Term Supply Not Available**	Cost Sharing may change depending on the pharmacy you choose and when you enter another phase of Part D benefit. You pay your cost share until your total yearly drug costs reach **$4,660**. Not all drugs qualify for a 90-day supply. Some Tier 1 medications allow up to a 100-day supply. For more information, please call us or access our Evidence of Coverage online. If you reside in a long-term care facility, you pay the same as a Standard Retail one-month supply for a 34-day supply.
Coverage Gap Stage **Tier 1: Preferred Generic**	 **$0 Copay**	 **$0 Copay**	For all other drugs, you pay **25%** of the price for brand drugs and **25%** of the price for all generic drugs (plus a portion of the dispensing fee). You stay in this stage until your out-of-pocket costs reach a total of **$7,400**.
Catastrophic Coverage Stage	You pay the greater of: • **5%** of the cost of the drug, or • **$4.15** copay for generic (including drugs treated as generic) and **$10.35** copay for all other drugs • Our Plan pays the rest of the cost		During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar 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 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.

To get a complete list of services we cover, please review the "Evidence of Coverage" online at www.freedomhealth.com or get a copy by calling 1-800-401-2740 (TTY: 711).

This document is available in alternate formats such as large print and Spanish. For more information, please call us at the phone number below or visit us at www.freedomhealth.com**.**

Please call our Member Services number at 1-800-401-2740 for additional information. TTY users should call 711. From October 1 to March 31, we are open 7 days a week from 8 a.m. to 8 p.m. EST. From April 1 to September 30, we are open Monday through Friday, 8 a.m. – 8 p.m. EST.

You can see our plan's provider and pharmacy directories at our website www.freedomhealth.com or call us and we will send you a copy of the directories. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

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 complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at www.freedomhealth.com.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

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

Freedom Health, Inc. cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Freedom Health, Inc. konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks. Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-401-2740 (TTY: 711). Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-401-2740 (TTY: 711).

Discrimination Is Against the Law

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Freedom Health, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Freedom Health, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Freedom Health, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Freedom Health Civil Rights Coordinator.

If you believe that Freedom Health, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Freedom Health Civil Rights Coordinator
P.O. Box 152727
Tampa, FL 33684
Phone: 1-800-401-2740, TTY: 711
Fax: 813-506-6235

You can file a grievance by mail, fax, or phone. If you need help filing a grievance, the Freedom Health Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-401-2740 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-401-2740 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-401-2740 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-401-2740 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-401-2740 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-401-2740 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-401-2740 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-401-2740 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-401-2740 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-401-2740 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-401-2740 (TTY: 711). سيقوم شخص ما يتحدث العربية. هذه خدمة مجانية بمساعدتك.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-401-2740 (TTY: 711)पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-401-2740 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-401-2740 (TTY: 711). Irá encontrar alguém que fale o idioma Portugués para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-401-2740 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer1-800-401-2740 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-401-2740 (TTY: 711)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

2023 Summary of Benefits

Freedom Health, Inc.
P.O. BOX 151137
Tampa, FL 33684

www.freedomhealth.com

SB Combo *088 - 089 - 091 - 092 - 098*
088 - Freedom Platinum Plan Rx (HMO) **Counties:** Brevard, Indian River, Martin, St. Lucie
089 - Freedom Platinum Plan Rx (HMO) **Counties:** Orange, Osceola, Seminole, Volusia
091 - Freedom Platinum Plan Rx (HMO) **Counties:** Manatee and Sarasota
092 - Freedom Platinum Plan Rx (HMO) **Counties:** Polk
098 - Freedom Platinum Plan Rx (HMO) **Counties:** Charlotte, Collier, Lee