

Chronic Special Needs Plan

2019

F19SBCSNP



Focused on **You**



SB Combo

070 - 072 - 077 - 082 - 083

**070 - Freedom VIP Care
(HMO SNP)**

**072 - Freedom VIP Savings
(HMO SNP)**

**077 - Freedom VIP Savings COPD
(HMO SNP)**

Counties:

Citrus, Hernando, Hillsborough, Lake, Manatee, Marion, Miami-Dade, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole, Sumter (Volusia only in 070)

**082 - Freedom VIP Savings
(HMO SNP)**

**083 - Freedom VIP Savings COPD
(HMO SNP)**

Counties:

Broward, Charlotte, Collier, Indian River, Lee, Martin, St. Lucie, Volusia (Brevard only in 082)

H5427_2019_SB_070_072_077_082_083_M

2019 Summary of Benefits

Summary of Benefits

January 1, 2019 - December 31, 2019

Freedom VIP Care (HMO SNP) H5427_070

Freedom VIP Savings (HMO SNP) H5427_072

Freedom VIP Savings COPD (HMO SNP) H5427_077

Freedom VIP Savings (HMO SNP) H5427_082

Freedom VIP Savings COPD (HMO SNP) H5427_083

The purpose of the Summary of Benefits is to provide you with a summary of drug and health benefits covered by **Freedom VIP Care (HMO SNP) H5427_070, Freedom VIP Savings (HMO SNP) H5427_072, Freedom VIP Savings COPD (HMO SNP) H5427_077, Freedom VIP Savings (HMO SNP) H5427_082 and Freedom VIP Savings COPD (HMO SNP) H5427_083**, 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. Freedom Health, Inc. has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 2020 based on a review of Freedom Health, Inc.'s Model of Care.

To be eligible for **Freedom VIP Care (HMO SNP) H5427_070, Freedom VIP Savings (HMO SNP) H5427_072 and Freedom VIP Savings (HMO SNP) H5427_082** you must have both Medicare Part A and Medicare Part B. Our plans are designed to meet the specialized needs of people who have certain medical conditions. To be eligible for these plans, you must have cardiovascular disorders, chronic heart failure, and/or diabetes, and live in our service area.

To be eligible for **Freedom VIP Savings COPD (HMO SNP) H5427_077 and Freedom VIP Savings COPD (HMO SNP) H5427_083** you must have both Medicare Part A and Medicare Part B. Our plans are designed to meet the specialized needs of people who have certain medical conditions. To be eligible for these plans, you must have chronic lung disorders, and live in our service area.

Our service area includes the following counties in Florida:

Freedom VIP Care (HMO SNP) H5427_070: Citrus, Hernando, Hillsborough, Lake, Manatee, Marion, Miami-Dade, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole, Sumter and Volusia

Freedom VIP Savings (HMO SNP) H5427_072: Citrus, Hernando, Hillsborough, Lake, Manatee, Marion, Miami-Dade, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole and Sumter

Freedom VIP Savings COPD (HMO SNP) H5427_077: Citrus, Hernando, Hillsborough, Lake, Manatee, Marion, Miami-Dade, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole and Sumter

Freedom VIP Savings (HMO SNP) H5427_082: Brevard, Broward, Charlotte, Collier, Indian River, Lee, Martin, St. Lucie and Volusia

Freedom VIP Savings COPD (HMO SNP) H5427_083: Broward, Charlotte, Collier, Indian River, Lee, Martin, St. Lucie and Volusia

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 will be responsible for the costs. Out-of-network/non-contracted providers are under no obligation to treat Freedom Health 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 VIP Care (HMO SNP)_070	Freedom VIP Savings (HMO SNP)_072	Freedom VIP Savings COPD (HMO SNP)_077
Monthly Plan Premium	You pay \$0	You pay \$0 Freedom Health, Inc. will reduce your Medicare Part B premium by up to \$100	You pay \$0 Freedom Health, Inc. will reduce your Medicare Part B premium by up to \$85
Deductible	You pay \$0	You pay \$0	You pay \$0
Maximum Out-of-Pocket Responsibility <i>(does not include prescription drugs)</i>	\$3,400 annually	\$3,400 annually	\$3,400 annually
Inpatient Hospital Coverage	You pay \$75 copay each day for days 1 through 5 and \$0 copay each day for days 6 through 90 per admission	You pay \$195 copay each day for days 1 through 7 and \$0 copay each day for days 8 through 90 per admission	You pay \$195 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 \$150 copay per visit	You pay \$250 copay per visit	You pay \$200 copay per visit
Doctor's Visits			
<ul style="list-style-type: none"> • Primary • Specialists 	<p>You pay \$0 copay per visit</p> <p>You pay \$10 copay per visit</p>	<p>You pay \$0 copay per visit</p> <p>You pay \$30 copay per visit</p>	<p>You pay \$0 copay per visit</p> <p>You pay \$30 copay per visit</p>

Freedom VIP Savings (HMO SNP)_082	Freedom VIP Savings COPD (HMO SNP)_083	What you should know
<p>You pay \$0</p> <p>Freedom Health, Inc. will reduce your Medicare Part B premium by up to \$40</p>	<p>You pay \$0</p>	<p>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.</p>
<p>You pay \$0</p>	<p>You pay \$0</p>	<p>These plans do not have a deductible.</p>
<p>\$6,700 annually</p>	<p>\$6,700 annually</p>	<p>This is the most you pay for copays, coinsurance and other costs for medical services for the year.</p> <p>Contact the Plan for details on what is covered in the Maximum Out of Pocket.</p>
<p>You pay \$225 copay each day for days 1 through 7 and \$0 copay each day for days 8 through 90 per admission</p>	<p>You pay \$225 copay each day for days 1 through 7 and \$0 copay per day for days 8 through 90 per admission</p>	<p>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.</p>
<p>You pay \$250 copay per visit</p>	<p>You pay \$250 copay per visit</p>	<p>Prior authorization is required for some services by your doctor or other network provider. Please contact the Plan for more information.</p> <p>Services include but are not limited to Medicare-covered outpatient hospital facility visits, clinic, outpatient treatment room, observation room, or outpatient surgery services.</p>
<p>You pay \$0 copay per visit</p> <p>You pay \$40 copay per visit</p>	<p>You pay \$0 copay per visit</p> <p>You pay \$40 copay per visit</p>	<p>Your Primary Care Physician will coordinate the covered services you receive as a member of our plan.</p> <p>In order for you to see a specialist, you will need to have a referral from your PCP first.</p> <p>Separate copay may apply for each additional service received at an office visit.</p>

Premiums and Benefits	Freedom VIP Care (HMO SNP)_070	Freedom VIP Savings (HMO SNP)_072	Freedom VIP Savings COPD (HMO SNP)_077
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
Diagnostic Services/Labs/Imaging <ul style="list-style-type: none"> • Diagnostic Radiology service (e.g., MRI) • Lab services • Diagnostic Tests and Procedures • Outpatient X-rays • Therapeutic Radiology 	<p>You pay \$25-\$150 copay depending on the service</p> <p>You pay \$0-\$50 copay depending on the place of service</p> <p>You pay \$0-\$150 copay or 20% coinsurance depending on the service</p> <p>You pay \$0-\$150 copay depending on the service</p> <p>You pay 20% coinsurance for Therapeutic Radiology</p>	<p>You pay \$25-\$250 copay depending on the service</p> <p>You pay \$0-\$50 copay depending on the place of service</p> <p>You pay \$0-\$250 copay or 20% coinsurance depending on the service</p> <p>You pay \$0-\$250 copay depending on the service</p> <p>You pay 20% coinsurance for Therapeutic Radiology</p>	<p>You pay \$25-\$200 copay depending on the service</p> <p>You pay \$0-\$50 copay depending on the place of service</p> <p>You pay \$0-\$200 copay or 20% coinsurance depending on the service</p> <p>You pay \$0-\$200 copay depending on the service</p> <p>You pay 20% coinsurance for Therapeutic Radiology</p>

Freedom VIP Savings (HMO SNP)_082	Freedom VIP Savings COPD (HMO SNP)_083	What you should know
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	\$25,000 plan coverage limit for emergency services, urgent services and emergency transportation outside the U.S. every year. Contact the plan for details. \$500 copayment for each emergency service, urgent service and emergency transportation outside the U.S.
You pay \$10 copay	You pay \$10 copay	\$25,000 plan coverage limit for emergency services, urgent services and emergency transportation outside the U.S. every year. Contact the plan for details. \$500 copayment for each emergency service, urgent service and emergency transportation outside the U.S.
<p>You pay \$25-\$250 copay depending on the service</p> <p>You pay \$0-\$50 copay depending on the place of service</p> <p>You pay \$0-\$250 copay or 20% coinsurance depending on the service</p> <p>You pay \$0-\$250 copay depending on the service</p> <p>You pay 20% coinsurance for Therapeutic Radiology</p>	<p>You pay \$25-\$250 copay depending on the service</p> <p>You pay \$0-\$50 copay depending on the place of service</p> <p>You pay \$0-\$250 copay or 20% coinsurance depending on the service</p> <p>You pay \$0-\$250 copay depending on the service</p> <p>You pay 20% coinsurance for Therapeutic Radiology</p>	<p>Prior authorization is required for some services by your doctor or other network provider. Please contact the plan for more information.</p>

Premiums and Benefits	Freedom VIP Care (HMO SNP)_070	Freedom VIP Savings (HMO SNP)_072	Freedom VIP Savings COPD (HMO SNP)_077
Hearing Services <ul style="list-style-type: none"> • Hearing exam • Hearing aid 	<p>You pay \$0 copay for one routine hearing exam and one hearing aid fitting every year</p> <p>You pay \$0 copay for two hearing aids (1 per ear) per year</p>	<p>You pay \$0 copay for one routine hearing exam and one hearing aid fitting every year</p> <p>You pay \$0 copay for two hearing aids (1 per ear) per year</p>	<p>You pay \$0 copay for one routine hearing exam and one hearing aid fitting every year</p> <p>You pay \$0 copay for two hearing aids (1 per ear) per year</p>
Dental Services <ul style="list-style-type: none"> • Oral Exam & Cleaning • Fluoride Treatment • Dental X-rays • Extraction/Surgical Removal • Fillings • Debridement 	<p>You pay \$0 copay for 1 oral exam per year and \$0 copay for 2 cleanings per year</p> <p>You pay \$0 copay for 2 fluoride treatments per year</p> <p>You pay \$0 copay</p> <p>You pay \$0 copay for simple extraction OR surgical removal of erupted tooth, 1 procedure per year</p> <p>You pay \$0 copay for anterior teeth (incisor or canine) one or two surface resin filling or restoration OR posterior teeth (premolar or molar) one, two, or three surface resin filling or restoration, 1 per year</p> <p>You pay \$0 copay for 1 full mouth debridement per 2 years</p>	<p>You pay \$0 copay for 1 oral exam per year and \$0 copay for 2 cleanings per year</p> <p>You pay \$0 copay for 2 fluoride treatments per year</p> <p>You pay \$0 copay</p> <p>You pay \$0 copay for simple extraction OR surgical removal of erupted tooth, 1 procedure per year</p> <p>You pay \$0 copay for anterior teeth (incisor or canine) one or two surface resin filling or restoration OR posterior teeth (premolar or molar) one, two, or three surface resin filling or restoration, 1 per year</p> <p>You pay \$0 copay for 1 full mouth debridement per 2 years</p>	<p>You pay \$0 copay for 1 oral exam per year and \$0 copay for 2 cleanings per year</p> <p>You pay \$0 copay for 2 fluoride treatments per year</p> <p>You pay \$0 copay</p> <p>You pay \$0 copay for simple extraction OR surgical removal of erupted tooth, 1 procedure per year</p> <p>You pay \$0 copay for anterior teeth (incisor or canine) one or two surface resin filling or restoration OR posterior teeth (premolar or molar) one, two, or three surface resin filling or restoration, 1 per year</p> <p>You pay \$0 copay for 1 full mouth debridement per 2 years</p>

Freedom VIP Savings (HMO SNP)_082	Freedom VIP Savings COPD (HMO SNP)_083	What you should know
<p>You pay \$0 copay for one routine hearing exam and one hearing aid fitting every year</p> <p>You pay \$0 copay for two hearing aids (1 per ear) every year</p>	<p>You pay \$0 copay for one routine hearing exam and one hearing aid fitting every year</p> <p>You pay \$0 copay for two hearing aids (1 per ear) every year</p>	<p>You are responsible for payment of any amount in excess of the maximum \$1,000 (\$500 per hearing aid)</p> <p>Our Plan pays up to a maximum of \$1,000 (\$500 per hearing aid) for hearing aid benefit every year.</p> <p>For all plans, you pay \$0 copayment for Medicare-covered diagnostic hearing exam.</p>
<p>You pay \$0 copay for 1 oral exam per year and \$0 copay for 2 cleanings per year</p> <p>You pay \$0 copay for 2 fluoride treatments per year</p> <p>You pay \$0 copay</p> <p>You pay \$0 copay for simple extraction OR surgical removal of erupted tooth, 1 procedure per year</p> <p>You pay \$0 copay for anterior teeth (incisor or canine) one or two surface resin filling or restoration OR posterior teeth (premolar or molar) one, two, or three surface resin filling or restoration, 1 per year</p> <p>You pay \$0 copay for 1 full mouth debridement per 2 years</p>	<p>You pay \$0 copay for 1 oral exam per year and \$0 copay for 2 cleanings per year</p> <p>You pay \$0 copay for 2 fluoride treatments per year</p> <p>You pay \$0 copay</p> <p>You pay \$0 copay for simple extraction OR surgical removal of erupted tooth, 1 procedure per year</p> <p>You pay \$0 copay for anterior teeth (incisor or canine) one or two surface resin filling or restoration OR posterior teeth (premolar or molar) one, two, or three surface resin filling or restoration, 1 per year</p> <p>You pay \$0 copay for 1 full mouth debridement per 2 years</p>	<p>Dental services exclude periodontal scaling, root planing and periodontal maintenance. Services must be performed by a participating general dentist.</p> <p>For more details or to get a complete list of services we cover, please refer to your Evidence of Coverage.</p> <p>For all plans, you pay \$0 copayment for Medicare-covered dental benefit</p>

Premiums and Benefits	Freedom VIP Care (HMO SNP)_070	Freedom VIP Savings (HMO SNP)_072	Freedom VIP Savings COPD (HMO SNP)_077
<p>Vision Services</p> <ul style="list-style-type: none"> • Routine Eye Exam • Eyeglasses (Frames and Lenses) 	<p>You pay \$0 copay for 1 routine eye exam every year by an Optometrist</p> <p>You pay \$10 copay for the plan coverage limit for 1 pair of eye glasses or contact lenses per year</p> <p>You pay \$0 copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery</p>	<p>You pay \$0 copay for 1 routine eye exam every year by an Optometrist</p> <p>You pay \$10 copay for the plan coverage limit for 1 pair of eye glasses or contact lenses per year</p> <p>You pay \$0 copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery</p>	<p>You pay \$0 copay for 1 routine eye exam every year by an Optometrist</p> <p>You pay \$10 copay for the plan coverage limit for 1 pair of eye glasses or contact lenses per year</p> <p>You pay \$0 copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery</p>
<p>Mental Health Services</p> <ul style="list-style-type: none"> • Inpatient visit • Outpatient Group Therapy visit • Outpatient Individual Therapy visit 	<p>You pay \$75 copay each day for days 1-5 and \$0 copay each day for days 6-90 per admission</p> <p>You pay \$10 copay for outpatient group/individual therapy visit</p>	<p>You pay \$195 copay each day for days 1-7 and \$0 copay each day for days 8-90 per admission</p> <p>You pay \$30 copay for outpatient group/individual therapy visit</p>	<p>You pay \$195 copay each day for days 1-7 and \$0 copay each day for days 8-90 per admission</p> <p>You pay \$30 copay for outpatient group/individual therapy visit</p>

Freedom VIP Savings (HMO SNP)_082	Freedom VIP Savings COPD (HMO SNP)_083	What you should know
<p>You pay \$0 copay for 1 routine eye exam every year by an Optometrist</p> <p>You pay \$10 copay for the plan coverage limit for 1 pair of eye glasses or contact lenses per year</p> <p>You pay \$0 copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery</p>	<p>You pay \$0 copay for 1 routine eye exam every year by an Optometrist</p> <p>You pay \$10 copay for the plan coverage limit for 1 pair of eye glasses or contact lenses per year</p> <p>You pay \$0 copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery</p>	<p>Eye exams to diagnose and treat diseases and conditions of the eye by an Ophthalmologist are subject to the Specialist copay.</p> <p>Contact the Plan for additional supplemental benefits.</p> <p>You pay nothing for exams to diagnose and treat diseases and conditions of the eye by an Optometrist.</p> <p>The Plan coverage limit is \$125 for eyewear (eyeglasses or contact lenses) per benefit year.</p> <p>You will be responsible for the \$10 copayment and any amount over the plan benefit maximum of \$125 for eyewear benefit.</p>
<p>You pay \$225 copay each day for days 1-7 and \$0 copay each day for days 8-90 per admission</p> <p>You pay \$40 copay for outpatient group/individual therapy visit</p>	<p>You pay \$225 copay each day for days 1-7 and \$0 copay each day for days 8-90 per admission</p> <p>You pay \$40 copay for outpatient group/individual therapy visit</p>	<p>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.</p>

Premiums and Benefits	Freedom VIP Care (HMO SNP)_070	Freedom VIP Savings (HMO SNP)_072	Freedom VIP Savings COPD (HMO SNP)_077
Skilled Nursing Facility	<p>You pay \$0 copay each day for days 1 - 20</p> <p>You pay \$150 copay each day for days 21 - 100</p>	<p>You pay \$0 copay each day for days 1 - 20</p> <p>You pay \$150 copay each day for days 21 - 100</p>	<p>You pay \$0 copay each day for days 1 - 20</p> <p>You pay \$150 copay each day for days 21 - 100</p>
Physical Therapy (Rehabilitation) Services <ul style="list-style-type: none"> • Occupational Therapy visit • Physical Therapy and Speech Therapy and Language Therapy visit 	<p>You pay \$10 copay</p> <p>You pay \$10 copay</p>	<p>You pay \$30 copay</p> <p>You pay \$30 copay</p>	<p>You pay \$30 copay</p> <p>You pay \$30 copay</p>
Ambulance	<p>You pay \$150 copay for Medicare-covered one-way Ground Ambulance services</p> <p>You pay 20% coinsurance for Medicare-covered one-way Air Ambulance services</p>	<p>You pay \$150 copay for Medicare-covered one-way Ground Ambulance services</p> <p>You pay 20% coinsurance for Medicare-covered one-way Air Ambulance services</p>	<p>You pay \$150 copay for Medicare-covered one-way Ground Ambulance services</p> <p>You pay 20% coinsurance for Medicare-covered one-way Air Ambulance services</p>
Transportation	<p>You pay \$0 copay for up to 12 one-way trips every year</p>	<p>You pay \$0 copay for up to 12 one-way trips every year</p>	<p>You pay \$0 copay for up to 12 one-way trips every year</p>

Freedom VIP Savings (HMO SNP)_082	Freedom VIP Savings COPD (HMO SNP)_083	What you should know
<p>You pay \$0 copay each day for days 1 - 20</p> <p>You pay \$150 copay each day for days 21 - 100</p>	<p>You pay \$0 copay each day for days 1 - 20</p> <p>You pay \$150 copay each day for days 21 - 100</p>	<p>Our plan covers up to 100 days in a SNF per benefit period.</p> <p>You must get prior authorization in advance before you are admitted to the facility or your stay may not be covered.</p>
<p>You pay \$40 copay</p> <p>You pay \$40 copay</p>	<p>You pay \$40 copay</p> <p>You pay \$40 copay</p>	<p>For rehabilitative services, you will need a referral or authorization from your PCP first depending on the specific service.</p> <p>There may be limits on physical therapy, occupational therapy, and speech and language pathology services. Contact the plan for details.</p>
<p>You pay \$150 copay for Medicare-covered one-way Ground Ambulance services</p> <p>You pay 20% coinsurance for Medicare-covered one-way Air Ambulance services</p>	<p>You pay \$150 copay for Medicare-covered one-way Ground Ambulance services</p> <p>You pay 20% coinsurance for Medicare-covered one-way Air Ambulance services</p>	<p>Prior authorization may be required. Contact the Plan for details.</p>
<p>You pay \$0 copay for up to 8 one-way trips every year</p>	<p>You pay \$0 copay for up to 8 one-way trips every year</p>	<p>Transportation is intended for rides to and/or from plan approved locations for medical appointments and health needs within your county.</p> <p>Call to schedule a ride at least 72 hours prior to scheduled medical appointment.</p>

Premiums and Benefits	Freedom VIP Care (HMO SNP)_070	Freedom VIP Savings (HMO SNP)_072	Freedom VIP Savings COPD (HMO SNP)_077
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 \$10 copay	You pay \$30 copay	You pay \$30 copay
Medical Equipment/Supplies • Durable Medical Equipment (e.g., wheelchairs, oxygen) • Prosthetics (e.g., braces, artificial limbs) • Diabetes supplies	You pay 20% coinsurance You pay 20% coinsurance You pay 0% coinsurance	You pay 20% coinsurance You pay 20% coinsurance You pay 0% coinsurance	You pay 0% coinsurance for Oxygen and 20% coinsurance for all other DME You pay 20% coinsurance You pay 0-20% coinsurance
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
Over The Counter (OTC)	\$50 Monthly Allowance	\$50 Monthly Allowance	\$50 Monthly Allowance

Freedom VIP Savings (HMO SNP)_082	Freedom VIP Savings COPD (HMO SNP)_083	What you should know
<p>You pay 20% of the cost for chemotherapy drugs</p> <p>You pay 20% of the cost for other Part B drugs</p>	<p>You pay 20% of the cost for chemotherapy drugs</p> <p>You pay 20% of the cost for other Part B drugs</p>	<p>The Plan may require authorization to determine whether certain drugs are covered by Medicare Part B or Medicare Part D.</p> <p>Please refer to your Evidence of Coverage for more details.</p>
<p>You pay \$40 copay</p>	<p>You pay \$40 copay</p>	<p>Covered podiatry benefits are for medically-necessary foot care.</p> <p>You will need to have a referral or authorization from your PCP first depending on the service.</p>
<p>You pay 20% coinsurance</p> <p>You pay 20% coinsurance</p> <p>You pay 0% coinsurance</p>	<p>You pay 0% coinsurance for Oxygen and 20% coinsurance for all other DME</p> <p>You pay 20% coinsurance</p> <p>You pay 0-20% coinsurance</p>	<p>We cover all medically necessary durable medical equipment covered by Original Medicare.</p> <p>You will need to have a referral or authorization from your PCP first depending on the service.</p> <p>You pay nothing for Diabetic Monitors, Lancets and Test Strips ordered through the Plan's mail order program. For plans 077 and 083 you pay 20% for retail and all other diabetic supplies. For Plans 070, 072, and 082, you pay 0% for retail and all other diabetic supplies.</p>
<p>You pay \$0 copay</p> <p>You pay \$0 copay</p>	<p>You pay \$0 copay</p> <p>You pay \$0 copay</p>	<p>Health Club Memberships are limited to participating facilities.</p> <p>Health Advice from a nursing professional, available 24 hours a day, 7 days a week</p>
<p>\$50 Monthly Allowance</p>	<p>\$50 Monthly Allowance</p>	<p>Please contact the plan or visit our website for specific instructions for using this benefit and our list of covered Over-the-Counter items.</p> <p>Call Member Services at 1-800-401-2740, TTY users call 711, or visit our website at www.freedomhealth.com.</p>

Outpatient Prescription Drugs

Freedom VIP Care (HMO SNP) H5427_070

	Standard Retail Rx 30 – day Supply	Standard Mail Order 90 – day Supply	What you should know
<i>Deductible Stage</i>	This stage does not apply to you		
<i>Initial Coverage Stage</i>			<p>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 \$3,820. Not all drugs qualify for a 90-day supply. Please call us or access our Evidence of Coverage online.</p> <p>If you reside in a long term care facility, you pay the same for a Standard Retail 30 day supply and the Standard Mail Order 90 day supply.</p>
Tier 1: Preferred Generic	\$0 Copay	\$0 Copay	
Tier 2: Preferred Brand	\$20 Copay	\$40 Copay	
Tier 3: Non-Preferred Drug	\$60 Copay	\$120 Copay	
Tier 4: Specialty Tier	33% of the Cost	Long Term Supply Not Available	
Tier 5: Select Diabetic Drugs	\$0 Copay	\$0 Copay	
<i>Coverage Gap Stage</i>			<p>For all other drugs, you pay 25% of the price for brand drugs and 37% 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 \$5,100.</p>
Tier 1: Preferred Generic	\$0 Copay	\$0 Copay	
Tier 5: Select Diabetic Drugs	\$10 Copay	\$20 Copay	
<i>Catastrophic Coverage Stage</i>	<p>You pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost of the drug, or • \$3.40 copay for generic (including drugs treated as generic) and \$8.50 copay for all other drugs • Our Plan pays the rest of the cost 		<p>During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year.</p>

Outpatient Prescription Drugs

Freedom VIP Savings (HMO SNP) H5427_072

	Standard Retail Rx 30 – day Supply	Standard Mail Order 90 – day Supply	What you should know
<i>Deductible Stage</i>	This stage does not apply to you		
<i>Initial Coverage Stage</i>			<p>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 \$3,820. Not all drugs qualify for a 90-day supply. Please call us or access our Evidence of Coverage online.</p> <p>If you reside in a long term care facility, you pay the same for a Standard Retail 30 day supply and the Standard Mail Order 90 day supply.</p>
Tier 1: Preferred Generic	\$0 Copay	\$0 Copay	
Tier 2: Preferred Brand	\$30 Copay	\$60 Copay	
Tier 3: Non-Preferred Drug	\$80 Copay	\$160 Copay	
Tier 4: Specialty Tier	33% of the Cost	Long Term Supply Not Available	
Tier 5: Select Diabetic Drugs	\$10 Copay	\$20 Copay	
<i>Coverage Gap Stage</i>			<p>For all other drugs, you pay 25% of the price for brand drugs and 37% 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 \$5,100.</p>
Tier 1: Preferred Generic	\$0 Copay	\$0 Copay	
<i>Catastrophic Coverage Stage</i>	<p>You pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost of the drug, or • \$3.40 copay for generic (including drugs treated as generic) and \$8.50 copay for all other drugs • Our Plan pays the rest of the cost 		<p>During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year.</p>

Outpatient Prescription Drugs

Freedom VIP Savings COPD (HMO SNP) H5427_077

	Standard Retail Rx 30 – day Supply	Standard Mail Order 90 – day Supply	What you should know
<i>Deductible Stage</i>	This stage does not apply to you		
<i>Initial Coverage Stage</i>			<p>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 \$3,820. Not all drugs qualify for a 90-day supply. Please call us or access our Evidence of Coverage online.</p> <p>If you reside in a long term care facility, you pay the same for a Standard Retail 30 day supply and the Standard Mail Order 90 day supply.</p>
Tier 1: Preferred Generic	\$0 Copay	\$0 Copay	
Tier 2: Preferred Brand	\$30 Copay	\$60 Copay	
Tier 3: Non-Preferred Drug	\$80 Copay	\$160 Copay	
Tier 4: Specialty Tier	33% of the Cost	Long Term Supply Not Available	
<i>Coverage Gap Stage</i>			<p>For all other drugs, you pay 25% of the price for brand drugs and 37% 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 \$5,100.</p>
Tier 1: Preferred Generic	\$0 Copay	\$0 Copay	
<i>Catastrophic Coverage Stage</i>	<p>You pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost of the drug, or • \$3.40 copay for generic (including drugs treated as generic) and \$8.50 copay for all other drugs • Our Plan pays the rest of the cost 		<p>During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year.</p>

Outpatient Prescription Drugs

Freedom VIP Savings (HMO SNP) H5427_082

	Standard Retail Rx 30 – day Supply	Standard Mail Order 90 – day Supply	What you should know
<i>Deductible Stage</i>	This stage does not apply to you		
<i>Initial Coverage Stage</i>			<p>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 \$3,820. Not all drugs qualify for a 90-day supply. Please call us or access our Evidence of Coverage online.</p> <p>If you reside in a long term care facility, you pay the same for a Standard Retail 30 day supply and the Standard Mail Order 90 day supply.</p>
Tier 1: Preferred Generic	\$0 Copay	\$0 Copay	
Tier 2: Preferred Brand	\$30 Copay	\$60 Copay	
Tier 3: Non-Preferred Drug	\$80 Copay	\$160 Copay	
Tier 4: Specialty Tier	33% of the Cost	Long Term Supply Not Available	
Tier 5: Select Diabetic Drugs	\$10 Copay	\$20 Copay	
<i>Coverage Gap Stage</i>			<p>For all other drugs, you pay 25% of the price for brand drugs and 37% 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 \$5,100.</p>
Tier 1: Preferred Generic	\$0 Copay	\$0 Copay	
<i>Catastrophic Coverage Stage</i>	<p>You pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost of the drug, or • \$3.40 copay for generic (including drugs treated as generic) and \$8.50 copay for all other drugs • Our Plan pays the rest of the cost 		<p>During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year.</p>

Outpatient Prescription Drugs

Freedom VIP Savings COPD (HMO SNP) H5427_083

	Standard Retail Rx 30 – day Supply	Standard Mail Order 90 – day Supply	What you should know
<i>Deductible Stage</i>	This stage does not apply to you		
<i>Initial Coverage Stage</i>			<p>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 \$3,820. Not all drugs qualify for a 90-day supply. Please call us or access our Evidence of Coverage online.</p> <p>If you reside in a long term care facility, you pay the same for a Standard Retail 30 day supply and the Standard Mail Order 90 day supply.</p>
Tier 1: Preferred Generic	\$0 Copay	\$0 Copay	
Tier 2: Preferred Brand	\$30 Copay	\$60 Copay	
Tier 3: Non-Preferred Drug	\$80 Copay	\$160 Copay	
Tier 4: Specialty Tier	33% of the Cost	Long Term Supply Not Available	
<i>Coverage Gap Stage</i>			<p>For all other drugs, you pay 25% of the price for brand drugs and 37% 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 \$5,100.</p>
Tier 1: Preferred Generic	\$0 Copay	\$0 Copay	
<i>Catastrophic Coverage Stage</i>	<p>You pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost of the drug, or • \$3.40 copay for generic (including drugs treated as generic) and \$8.50 copay for all other drugs • Our Plan pays the rest of the cost 		<p>During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year.</p>

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 <http://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 <http://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 <http://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.

For accommodations of persons with special needs at meetings call 1-800-401-2740 (TTY: 711).

You can see our plan's provider and pharmacy directories at our website <http://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 <http://www.freedomhealth.com>.

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.

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 / Inserción de varios idiomas

Multi-language Interpreter Services / Servicios de interpretación en varios idiomas

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-401-2740 (TTY: 711).

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).

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-401-2740 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-401-2740 (TTY: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-401-2740 (TTY: 711)。

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-401-2740 (ATS: 711).

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-401-2740 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-401-2740 (телетайп: 711).

العربية (Arabic):

العربية ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-401-2740 (رقم هاتف الصم والبكم: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-401-2740 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-401-2740 (TTY: 711).

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-401-2740 (TTY: 711) 번으로 전화해 주십시오.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-401-2740 (TTY: 711).

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-401-2740 (TTY: 711).

ภาษาไทย (Thai): เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-401-2740 (TTY: 711).

2019 Summary of Benefits



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

www.freedomhealth.com

Focused on **You**

SB Combo

070 - 072 - 077 - 082 - 083

**070 - Freedom VIP Care
(HMO SNP)**

**072 - Freedom VIP Savings
(HMO SNP)**

**077 - Freedom VIP Savings COPD
(HMO SNP)**

Counties:

Citrus, Hernando, Hillsborough, Lake, Manatee,
Marion, Miami-Dade, Orange, Osceola, Palm
Beach, Pasco, Pinellas, Polk, Sarasota, Seminole,
Sumter

(Volusia only in plan 070)

**082 - Freedom VIP Savings
(HMO SNP)**

**083 - Freedom VIP Savings COPD
(HMO SNP)**

Counties:

Broward, Charlotte, Collier, Indian River, Lee,
Martin, St. Lucie, Volusia

(Brevard only in plan 082)