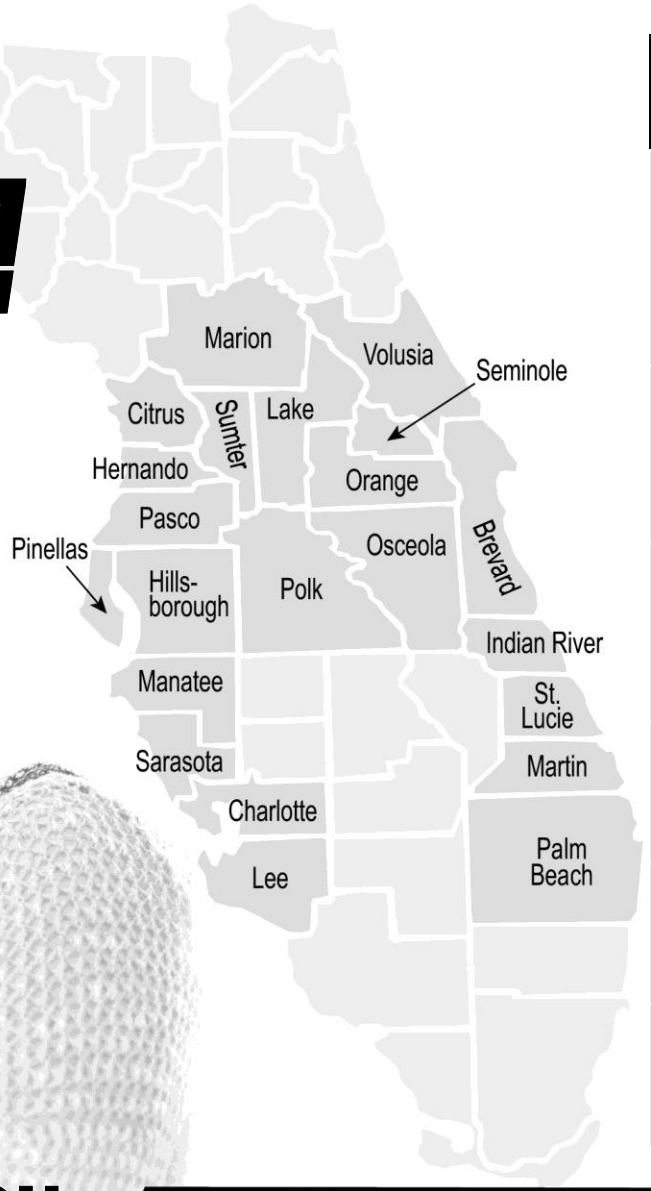
HMO 2020

F20SBSAVMEDPL

FREEDOM HEALTH



Focused on You

H5427_2020_SB_052_059_060_088_096_098_M

SB Combo 052 - 059 - 060 - 088 - 096 - 098

052 - Freedom Savings Plan (HMO)

Counties: Brevard, Citrus, Hernando, Hillsborough, Indian River, Lake, Lee, Manatee, Marion, Martin, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole, St. Lucie, Sumter, Volusia

059 - Freedom Medicare Plan Rx (HMO)

Counties: Brevard, Charlotte, Citrus, Lee, Martin, Pinellas, Sumter, Volusia

060 - Freedom Medicare Plan Rx (HMO)

Counties: Hillsborough, Lake, Marion, Orange, Osceola, Palm Beach, Pasco, Sarasota, Seminole

088 - Freedom Platinum Plan Rx (HMO)

Counties: Indian River, Martin, St. Lucie

096 - Freedom Platinum Rewards Plan Rx (HMO)

Counties: Lake, Marion, Sumter

098 - Freedom Platinum Rewards Plan Rx (HMO)

Counties: Charlotte and Lee

2020 Summary of Benefits

Summary of Benefits
January 1, 2020 - December 31, 2020

Freedom Savings Plan (HMO) H5427_052
Freedom Medicare Plan Rx (HMO) H5427_059
Freedom Medicare Plan Rx (HMO) H5427_060
Freedom Platinum Plan Rx (HMO) H5427_088
Freedom Platinum Rewards Plan Rx (HMO) H5427_096
Freedom Platinum Rewards 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 Savings Plan (HMO) H5427_052, Freedom Medicare Plan Rx (HMO) H5427_059, Freedom Medicare Plan Rx (HMO) H5427_060, Freedom Platinum Plan Rx (HMO) H5427_088,** and **Freedom Platinum Rewards Plan Rx (HMO) H5427_096,** 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 Savings Plan (HMO) H5427_052, Freedom Medicare Plan Rx (HMO) H5427_059, Freedom Medicare Plan Rx (HMO) H5427_060, Freedom Platinum Plan RX (HMO) H5427_088** and **Freedom Platinum Rewards Plan Rx (HMO) H5427_096, and Freedom Platinum Rewards Plan Rx (HMO) H5427_098** you must have both Medicare Part A and Medicare Part B, and live in our service areas.

Our service area includes the following counties in Florida:

Freedom Savings Plan (HMO) H5427_052: Brevard, Citrus, Hernando, Hillsborough, Indian River, Lake, Lee, Manatee, Marion, Martin, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole, St. Lucie, Sumter and Volusia.

Freedom Medicare Plan RX (HMO) H5427_059: Brevard, Charlotte, Citrus, Lee, Martin, Pinellas, Sumter and Volusia.

Our service area includes the following counties in Florida:

Freedom Medicare Plan RX (HMO) H5427_060: Hillsborough, Lake, Marion, Orange, Osceola, Palm Beach, Pasco, Sarasota and Seminole.

Freedom Platinum Plan RX (HMO) H5427_088: Indian River, Martin and St. Lucie.

Freedom Platinum Rewards Plan RX (HMO) H5427_096: Lake, Marion, and Sumter

Freedom Platinum Rewards Plan Rx (HMO) H5427_098: Charlotte 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 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 Savings Plan (HMO)_052	Freedom Medicare Plan Rx (HMO)_059	Freedom Medicare Plan Rx (HMO)_060
Monthly Plan Premium	You pay **$0** Freedom Health, Inc. will reduce your Medicare Part B premium by up to **$65**	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)*	**$3,400** annually	**$3,400** annually	**$3,400** annually
Inpatient Hospital Coverage	You pay **$225** copay each day for days 1 through 7 and **$0** copay each day for days 8 through 90 per admission	You pay **$225** copay each day for days 1 through 7 and **$0** copay each day for days 8 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
Outpatient Hospital Coverage	You pay **$250** copay per visit	You pay **$200** copay per visit	You pay **$250** copay per visit

Freedom Platinum Plan Rx (HMO)_088	Freedom Platinum Rewards Plan Rx (HMO)_096	Freedom Platinum Rewards Plan Rx (HMO)_098	What you should know
You pay **$0**	You pay **$0** Freedom Health, Inc. will reduce your Medicare Part B premium by up to **$80**	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**	You pay **$0**	These plans do not have a deductible.
$3,000 annually	**$3,400** 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 **$85** 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 per day for days 8 through 90 per admission	You pay **$175** 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 **$150** copay per visit	You pay **$195** 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 Savings Plan (HMO)_052	Freedom Medicare Plan Rx (HMO)_059	Freedom Medicare Plan Rx (HMO)_060
Doctor's Visits • **Primary** • **Specialists**	You pay **$0** copay per visit You pay **$40** copay per visit	You pay **$0** copay per visit You pay **$30** copay per visit	You pay **$0** copay per visit You pay **$35** 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)_088	Freedom Platinum Rewards Plan Rx (HMO)_096	Freedom Platinum Rewards Plan Rx (HMO)_098	What you should know
You pay **$0** copay per visit You pay **$25** copay per visit	You pay **$0** copay per visit You pay **$20** copay per visit	You pay **$0** copay per visit You pay **$20** 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	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	You pay **$75** copay per visit	**$500** copay for each emergency service, urgent service and emergency transportation outside the U.S. **$25,000** 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	You pay **$10** copay	**$500** copay for each emergency service, urgent service and emergency transportation outside the U.S. **$25,000** 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 Savings Plan (HMO)_052	Freedom Medicare Plan Rx (HMO)_059	Freedom Medicare Plan Rx (HMO)_060
Diagnostic Services/Labs/Imaging			
• **Diagnostic Radiology Service *(e.g., MRI)***	You pay **$25-$250** copay depending on the service	You pay **$25-$200** copay depending on the service	You pay **$25-$250** 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-$250** copay or **20%** coinsurance depending on the service	You pay **$0-$200** copay or **20%** coinsurance depending on the service	You pay **$0-$250** copay or **20%** coinsurance depending on the service
• **Outpatient X-rays**	You pay **$0-$250** copay depending on the service	You pay **$0-$200** copay depending on the service	You pay **$0-$250** 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**	You pay **$0** copay for one routine hearing exam and one hearing aid fitting every year	You pay **$0** copay for one routine hearing exam and one hearing aid fitting every year	You pay **$0** copay for one routine hearing exam and one hearing aid fitting 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)_088	Freedom Platinum Rewards Plan Rx (HMO)_096	Freedom Platinum Rewards Plan Rx (HMO)_098	What you should know
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	You pay **$25-$195** copay depending on the service You pay **$0-$50** copay depending on the place of service You pay **$0-$195** copay or **20%** coinsurance depending on the service You pay **$0-$195** 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 every year You pay **$0** copay for two hearing aids (1 per ear) every year	You pay **$0** copay for one routine hearing exam and one hearing aid fitting every year You pay **$0** copay for two hearing aids (1 per ear) every year	You pay **$0** copay for one routine hearing exam and one hearing aid fitting 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 Savings Plan (HMO)_052	Freedom Medicare Plan Rx (HMO)_059	Freedom Medicare Plan Rx (HMO)_060
Dental Services			
• **Oral Exam & Cleaning**	You pay **$0** copay for Oral exam, 2 per year and **$0** copay for 2 cleanings per year	You pay **$0** copay for Oral exam, 2 per year and **$0** copay for 2 cleanings per year	You pay **$0** copay for Oral exam, 2 per year and **$0** copay for 2 cleanings per year
• **Fluoride Treatment**	You pay **$0** copay for 2 fluoride treatments per year	You pay **$0** copay for 2 fluoride treatments per year	You pay **$0** copay for 2 fluoride treatments 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/Surgical Removal**	You pay **$0** copay for simple extraction OR surgical removal of erupted tooth, 1 procedure per year	You pay **$0** copay for simple extraction OR surgical removal of erupted tooth, 1 procedure per year	You pay **$0** copay for simple extraction OR surgical removal of erupted tooth, 1 procedure per year
• **Fillings**	Not Covered	Not Covered	Not Covered
• **Debridement**	Not Covered	Not Covered	Not Covered
• **Deep Cleaning (Scaling/Root Planing)**	Not Covered	Not Covered	Not Covered

Freedom Platinum Plan Rx (HMO)_088	Freedom Platinum Rewards Plan Rx (HMO)_096	Freedom Platinum Rewards Plan Rx (HMO)_098	What you should know
You pay **$0** copay for Oral exam, 2 per year and **$0** copay for 2 cleanings per year You pay **$0** copay for 2 fluoride treatments per year You pay **$0** copay for Dental X-rays You pay **$0** copay for simple extraction OR surgical removal of erupted tooth, 1 procedure 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 Scaling/Root Planing, 4 procedures per year and limited to 1 procedure per quadrant per year	You pay **$0** copay for Oral exam, 2 per year and **$0** copay for 2 cleanings per year You pay **$0** copay for 2 fluoride treatments per year You pay **$0** copay for Dental X-rays You pay **$0** copay for simple extraction OR surgical removal of erupted tooth, 1 procedure 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 Scaling/Root Planing, 4 procedures per year and limited to 1 procedure per quadrant per year	You pay **$0** copay for Oral exam, 2 per year and **$0** copay for 2 cleanings per year You pay **$0** copay for 2 fluoride treatments per year You pay **$0** copay for Dental X-rays You pay **$0** copay for simple extraction OR surgical removal of erupted tooth, 1 procedure 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 Scaling/Root Planing, 4 procedures per year and limited to 1 procedure per quadrant per year	Dental services exclude periodontal maintenance. Prior Authorization may be required, and services must be performed by a participating dental provider. For plans **052, 059** and **060**, Dental Services exclude periodontal scaling, root planing, fillings, debridement and periodontal maintenance. 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.

Premiums and Benefits	Freedom Savings Plan (HMO)_052	Freedom Medicare Plan Rx (HMO)_059	Freedom Medicare Plan Rx (HMO)_060
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 **$10** copay for the plan coverage limit for 1 pair of eyeglasses or contact lenses per year	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 Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery	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 will be responsible for the **$10** copay and any amount over the plan benefit maximum of **$100** for eyewear benefit.	You will be responsible for the **$10** copay and any amount over the plan benefit maximum of **$100** for eyewear benefit.	You will be responsible for the **$10** copay and any amount over the plan benefit maximum of **$100** for eyewear benefit.
Mental Health Services • **Inpatient Visit**	You pay **$225** copay each day for days 1-7 and **$0** copay each day for days 8-90 per admission	You pay **$225** copay each day for days 1-7 and **$0** copay each day for days 8-90 per admission	You pay **$150** 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 **$40** copay for outpatient group/individual therapy visit	You pay **$30** copay for outpatient group/individual therapy visit	You pay **$35** copay for outpatient group/individual therapy visit

Freedom Platinum Plan Rx (HMO)_088	Freedom Platinum Rewards Plan Rx (HMO)_096	Freedom Platinum Rewards 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 will be responsible for the **$10** copay and any amount over the plan benefit maximum of **$125** for eyewear benefit.	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 will be responsible for the **$10** copay and any amount over the plan benefit maximum of **$125** for eyewear benefit.	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 will be responsible for the **$10** copay and any amount over the plan benefit maximum of **$125** for eyewear benefit.	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. You pay nothing for exams to diagnose and treat diseases and conditions of the eye by an Optometrist. For plans **052**, **059**, and **060**, the coverage limit is **$100** for eyewear (eyeglasses or contact lenses) per benefit year. For plans **088**, **096**, and **098**, the coverage limit is **$125** for eyewear (eyeglasses or contact lenses) per benefit year.
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 for outpatient group/individual therapy visit	You pay **$195** copay each day for days 1-7 and **$0** copay each day for days 8-90 per admission You pay **$20** copay for outpatient group/individual therapy visit	You pay **$175** copay each day for days 1-7 and **$0** copay each day for days 8-90 per admission You pay **$20** 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 Savings Plan (HMO)_052	Freedom Medicare Plan Rx (HMO)_059	Freedom Medicare Plan Rx (HMO)_060
Skilled Nursing Facility	You pay **$0** copay each day for days 1 - 5 You pay **$20** copay each day for days 6 - 20 You pay **$125** copay each day for days 21 - 100	You pay **$0** copay each day for days 1 - 5 You pay **$20** copay each day for days 6 - 20 You pay **$150** copay each day for days 21 - 100	You pay **$0** copay each day for days 1 - 5 You pay **$20** copay each day for days 6 - 20 You pay **$150** copay each day for days 21 - 100
Physical Therapy (Rehabilitation Services) • **Occupational Therapy Visit** • **Physical Therapy and Speech Therapy and Language Therapy Visit**	 You pay **$40** copay You pay **$40** copay	 You pay **$30** copay You pay **$30** copay	 You pay **$35** copay You pay **$35** copay
Ambulance	You pay **$150** copay for Medicare-covered one-way ground ambulance benefit You pay **20%** coinsurance for Medicare-covered one-way air ambulance benefit	You pay **$175** copay for Medicare-covered one-way ground ambulance benefit You pay **20%** coinsurance for Medicare-covered one-way air ambulance benefit	You pay **$175** copay for Medicare-covered one-way ground ambulance benefit You pay **20%** coinsurance for Medicare-covered one-way air ambulance benefit

Freedom Platinum Plan Rx (HMO)_088	Freedom Platinum Rewards Plan Rx (HMO)_096	Freedom Platinum Rewards 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	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 **$25** copay You pay **$25** copay	You pay **$20** copay You pay **$20** copay	You pay **$20** copay You pay **$20** 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 **$175** copay for Medicare-covered one-way ground ambulance benefit You pay **20%** coinsurance for Medicare-covered one-way air ambulance benefit	You pay **$175** copay for Medicare-covered one-way ground ambulance benefit You pay **20%** coinsurance for Medicare-covered one-way air ambulance benefit	You pay **$150** copay for Medicare-covered one-way ground ambulance benefit You pay **20%** coinsurance for Medicare-covered one-way air ambulance benefit	Prior authorization may be required. Contact the Plan for details.

Premiums and Benefits	Freedom Savings Plan (HMO)_052	Freedom Medicare Plan Rx (HMO)_059	Freedom Medicare Plan Rx (HMO)_060
Transportation	You pay **$0** copay for up to **6** one-way trips every year	You pay **$0** copay for up to **6** one-way trips every year	You pay **$0** copay for up to **6** one-way trips every year
Ambulatory Surgery Center	You pay **$75** copay for each Medicare-covered ambulatory surgical center visit You pay **$250** copay for each Medicare-covered outpatient hospital facility visit	You pay **$75** copay for each Medicare-covered ambulatory surgical center visit You pay **$200** copay for each Medicare-covered outpatient hospital facility visit	You pay **$75** copay for each Medicare-covered ambulatory surgical center visit You pay **$250** copay for each Medicare-covered outpatient hospital facility visit
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 **$40** copay	You pay **$30** copay	You pay **$35** copay

Freedom Platinum Plan Rx (HMO)_088	Freedom Platinum Rewards Plan Rx (HMO)_096	Freedom Platinum Rewards Plan Rx (HMO)_098	What you should know
You pay **$0** copay for up to **8** 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 **8** 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 **$25** copay for each Medicare-covered ambulatory surgical center visit You pay **$150** copay for each Medicare-covered outpatient hospital facility visit	You pay **$100** copay for each Medicare-covered ambulatory surgical center visit You pay **$195** 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 **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	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 **$25** copay	You pay **$20** copay	You pay **$20** 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.

Premiums and Benefits	Freedom Savings Plan (HMO)_052	Freedom Medicare Plan Rx (HMO)_059	Freedom Medicare Plan Rx (HMO)_060
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 limits)**	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
Wellness			
• **Fitness**	You pay **$0** copay	You pay **$0** copay	You pay **$0** copay
• **24 Hour Nurse Advice Line**	You pay **$0** copay	You pay **$0** copay	You pay **$0** copay
Over-The-Counter (OTC)	**$25** Monthly Allowance *The plan doesn't allow you to roll over any remaining OTC allowance into the next month.*	**$35** Monthly Allowance *The plan doesn't allow you to roll over any remaining OTC allowance into the next month.*	**$35** Monthly Allowance *The plan doesn't allow you to roll over any remaining OTC allowance into the next month.*

Freedom Platinum Plan Rx (HMO)_088	Freedom Platinum Rewards Plan Rx (HMO)_096	Freedom Platinum Rewards Plan Rx (HMO)_098	What you should know
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	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 at a retail pharmacy.
You pay **$0** copay You pay **$0** copay	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.
$45 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.*	**$45** 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

This plan does <u>not</u> include Part D prescription drug coverage.

Outpatient Prescription Drugs			
Freedom Medicare Plan Rx (HMO) H5427_059			
	Standard Retail Rx 30 – day Supply	**Standard Mail Order 90 – day Supply**	**What you should know**
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** **$35 Copay** **$85 Copay** **33% of the Cost**	 **$0 Copay** **$70 Copay** **$170 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 **$4,020**. 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 **$6,350**.
Catastrophic Coverage Stage	You pay the greater of: • **5%** of the cost of the drug, or • **$3.60** copay for generic (including drugs treated as generic) and **$8.95** 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 Medicare Plan Rx (HMO) H5427_060			
	Standard Retail Rx 30 – day Supply	**Standard Mail Order 90 – day Supply**	**What you should know**
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** **$35 Copay** **$85 Copay** **33% of the Cost**	**$0 Copay** **$70 Copay** **$170 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 **$4,020**. 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 **$6,350**.
Catastrophic Coverage Stage	You pay the greater of: • **5%** of the cost of the drug, or • **$3.60** copay for generic (including drugs treated as generic) and **$8.95** 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) H5427_088			
	Standard Retail Rx 30 – day Supply	**Standard Mail Order 90 – day Supply**	**What you should know**
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** **$35 Copay** **$85 Copay** **33% of the Cost**	**$0 Copay** **$70 Copay** **$170 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 **$4,020**. 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 **$6,350**.
Catastrophic Coverage Stage	You pay the greater of: • **5%** of the cost of the drug, or • **$3.60** copay for generic (including drugs treated as generic) and **$8.95** 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 Rewards Plan Rx (HMO) H5427_096			
	Standard Retail Rx 30 – day Supply	**Standard Mail Order 90 – day Supply**	**What you should know**
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** **$35 Copay** **$85 Copay** **33% of the Cost**	**$0 Copay** **$70 Copay** **$170 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 **$4,020**. 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	If you receive "Extra Help", you pay the same copay and coinsurance amounts as you would in the Initial Coverage Stage. If you do not receive "Extra Help", you pay **25%** of the price for brand name drugs and **25%** of the price for all generic drugs (plus a portion of the dispensing fee). You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of **$6,350**. If you receive "Extra Help" the cost of your drugs depends upon your level of "Extra Help".		
Catastrophic Coverage Stage	You pay the greater of: • **5%** of the cost of the drug, or • **$3.60** copay for generic (including drugs treated as generic) and **$8.95** 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 Rewards Plan Rx (HMO) H5427_098			
	Standard Retail Rx 30 – day Supply	**Standard Mail Order 90 – day Supply**	**What you should know**
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** **$35 Copay** **$85 Copay** **33% of the Cost**	**$0 Copay** **$70 Copay** **$170 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 **$4,020**. 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 **$6,350**.
Catastrophic Coverage Stage	You pay the greater of: • **5%** of the cost of the drug, or • **$3.60** copay for generic (including drugs treated as generic) and **$8.95** 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 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).

ΠΡΟΣΟΧΗ (Greek): Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-401-2740 (TTY: 711).

2020 Summary of Benefits

FREEDOM HEALTH

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

www.freedomhealth.com

Focused on You

SB Combo
052 - 059 - 060 - 088 - 096 - 098

052 - Freedom Savings Plan (HMO)
Counties:
Brevard, Citrus, Hernando, Hillsborough, Indian River, Lake, Lee, Manatee, Marion, Martin, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole, St. Lucie, Sumter, Volusia

059 - Freedom Medicare Plan Rx (HMO)
Counties:
Brevard, Charlotte, Citrus, Lee, Martin, Pinellas, Sumter, Volusia

060 - Freedom Medicare Plan Rx (HMO)
Counties:
Hillsborough, Lake, Marion, Orange, Osceola, Palm Beach, Pasco, Sarasota, Seminole

088 - Freedom Platinum Plan Rx (HMO)
Counties: Indian River, Martin, St. Lucie

096 - Freedom Platinum Rewards Plan Rx (HMO)
Counties: Lake, Marion, Sumter

098 - Freedom Platinum Rewards Plan Rx (HMO)
Counties: Charlotte and Lee