Dual Eligible Special Needs Plan 2020

F20SBDUAL

FREEDOM HEALTH

SB Combo 078 - 087

078 - Freedom Medi-Medi Partial (HMO D-SNP)

087 - Freedom Medi-Medi Full (HMO D-SNP)

Counties:

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

Focused on You

H5427_2020_SB_078_087_M

2020 Summary of Benefits

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

Freedom Medi-Medi Partial (HMO D-SNP) H5427_078
Freedom Medi-Medi Full (HMO D-SNP) H5427_087

The purpose of the Summary of Benefits is to provide you with a summary of drug and health benefits covered by **Freedom Medi-Medi Partial (HMO D-SNP) H5427_078** and **Freedom Medi-Medi Full (HMO D-SNP) H5427_087,** 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 and a contract with the State Medicaid Program. Enrollment in Freedom Health, Inc. depends on contract renewal.

Freedom Health Inc. offers Dual Eligible Special Needs Plans (D-SNPs) which are available to anyone who has both Medical Assistance from the State Plan under Medicaid (Title XIX) and Medicare (Title XVIII). Our Plan benefits are designed for people with special health care needs. 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 Medi-Medi Partial (HMO D-SNP) H5427_078** or **Freedom Medi-Medi Full (HMO D-SNP) H5427_087,** you must have Medicare Part A and Medicare Part B, live in our service area and are eligible for Medicare cost-sharing assistance under Medicaid. Depending on your level of Medicaid eligibility, benefits differ, and you may or not be subject to cost-sharing requirements.

To join **Freedom Medi-Medi Partial (HMO D-SNP) H5427_078**, you must be eligible for certain levels of financial assistance from Florida Medicaid, as one of the following: Specified Low-Income Medicare Beneficiary (SLMB or SLMB Plus), Qualified Individual (QI) or Qualified Disabled and Working Individual (QDWI) or other Full Benefit Dual Eligible (FBDE).

To join **Freedom Medi-Medi Full (HMO D-SNP) H5427_087**, you must be eligible for certain levels of financial assistance from Florida Medicaid, as a Qualified Medicare Beneficiary (QMB or QMB Plus).

Our service area includes the following counties in Florida:

Freedom Medi-Medi Partial (HMO D-SNP) H5427_078 and **Freedom Medi-Medi Full (HMO D-SNP) H5427_087:**
Brevard, Broward, Charlotte, Citrus, Collier, Hernando, Hillsborough, Indian River, Lake, Lee, Manatee, Marion, Martin, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole, St. Lucie, Sumter and Volusia.

Freedom Health, Inc. has a network of doctors, hospitals, pharmacies, and other providers. You must use network 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 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	Medicaid Benefits
Monthly Plan Premium	There is **no Premium** for Medicaid Covered Services.
Deductible	There is **no Deductible** for Medicaid Covered Services.
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	There is **no Maximum Out-of-Pocket** Responsibility for Medicaid Covered Services.
Inpatient Hospital Coverage	You pay **$0** copay for Medicaid Covered Services.
Outpatient Hospital Coverage	You pay **$0** copay for Medicaid Covered Services.

Freedom Medi-Medi Partial (HMO D-SNP)_078	Freedom Medi-Medi Full (HMO D-SNP)_087	What you should know
You pay up to **$28.50**	You pay up to **$28.50**	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. If you receive "Extra Help" this premium may be reduced or paid on your behalf.
You pay **$0**	You pay **$0**	These plans do not have a deductible.
$1,500 annually	**$1,500** 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 **$0** copay each day for days 1 – 90	You pay **$0** copay each day for days 1 – 90	Except in an emergency, you must get prior authorization before you are admitted to the facility or your stay may not be covered.
You pay **$0** copay per visit	You pay **$0** copay per visit	Prior authorization is required for some services by your doctor or other network provider. Please contact the Plan for more information.

Premiums and Benefits	Medicaid Benefits
Doctor's Visits • **Primary** • **Specialists**	You pay **$0** copay for Medicaid Covered Services.
Preventive Care	You pay **$0** copay for Medicaid Covered Services.
Emergency Care	You pay **$0** copay for Medicaid Covered Services.
Urgently Needed Services	You pay **$0** copay for Medicaid Covered Services.

Freedom Medi-Medi Partial (HMO D-SNP)_078	Freedom Medi-Medi Full (HMO D-SNP)_087	What you should know
You pay **$0** copay per visit You pay **$0** copay per visit	You pay **$0** copay per visit You pay **$0** copay per visit	Your Primary Care Physician (PCP) 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 **$0** copay per visit	You pay **$0** 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 **$0** copay	You pay **$0** 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	Medicaid Benefits
Diagnostic Services/Labs/Imaging • **Diagnostic Radiology Service *(e.g., MRI)*** • **Lab Services** • **Diagnostic Tests and Procedures** • **Outpatient X-rays** • **Therapeutic Radiology**	You pay **$0** copay for Medicaid Covered Services.
Hearing Services • **Hearing Exam** • **Hearing Aid**	You pay **$0** copay for Medicaid Covered Services.

Freedom Medi-Medi Partial (HMO D-SNP)_078	Freedom Medi-Medi Full (HMO D-SNP)_087	What you should know
You pay **$0** copay You pay **$0** copay You pay **$0** copay You pay **$0** copay For members with full Medicaid eligibility or those who are exempt from cost-share, you pay **0%** coinsurance for Medicare-covered Therapeutic Radiology services. For all other members, you pay **20%** coinsurance for Medicare-covered Therapeutic Radiology services.	You pay **$0** copay You pay **$0** copay You pay **$0** copay You pay **$0** copay You pay **0%** coinsurance for Medicare-covered Therapeutic Radiology services.	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 every year You pay **$0** copay for 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 every year You pay **$0** copay for 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	Medicaid Benefits
Dental Services • **Oral Exam** • **Fluoride Treatment** • **Dental X-rays** • **Extraction/Surgical Removal** • **Fillings** • **Debridement** • **Deep Cleaning (Scaling/Root Planing)** • **Crown** • **Dentures**	You pay **$0** copay for Medicaid Covered Services.

Freedom Medi-Medi Partial (HMO D-SNP)_078	Freedom Medi-Medi Full (HMO D-SNP)_087	What you should know
You pay **$0** copay for Oral Exam 2 per year and **$0** copay for Cleaning, 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 a simple extraction OR surgical removal of erupted tooth, 2 total procedures per year You pay **$0** copay for resin filling or restoration, 2 per year You pay **$0** copay for full mouth debridement, 1 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 Porcelain/ceramic or porcelain fused to high noble metal crown, 1 per year You pay **$0** copay for partial or full set of dentures, 1 complete set every 5 years	You pay **$0** copay for Oral Exam 2 per year and **$0** copay for Cleaning, 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 a simple extraction OR surgical removal of erupted tooth, 2 total procedures per year You pay **$0** copay for resin filling or restoration, 2 per year You pay **$0** copay for full mouth debridement, 1 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 Porcelain/ceramic or porcelain fused to high noble metal crown, 1 per year You pay **$0** copay for partial or full set of dentures, 1 complete set every 5 years	Dental services exclude periodontal maintenance. 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.

Premiums and Benefits	Medicaid Benefits
Vision Services • **Routine Eye Exam** • **Eyeglasses (Frames and Lenses)**	You pay **$0** copay for Medicaid Covered Services.
Mental Health Services • **Inpatient Visit** • **Outpatient Group and Individual Therapy Visits**	You pay **$0** copay for Medicaid Covered Services.
Skilled Nursing Facility	You pay **$0** copay for Medicaid Covered Services.

Freedom Medi-Medi Partial (HMO D-SNP)_078	Freedom Medi-Medi Full (HMO D-SNP)_087	What you should know
You pay **$0** copay for routine eye exam 1 every year by an Optometrist You pay **$0** copay for the plan coverage limit of 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 The Plan coverage limit is **$200** for eyewear (eyeglasses or contact lenses) per benefit year.	You pay **$0** copay for routine eye exam 1 every year by an Optometrist You pay **$0** 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 The Plan coverage limit is **$200** for eyewear (eyeglasses or contact lenses) per benefit year.	You pay nothing for exams to diagnose and treat diseases and conditions of the eye by an Optometrist or an Ophthalmologist (Specialist). Contact the Plan for additional supplemental benefits. You will be responsible for any amount over the plan benefit maximum of **$200** for eyewear benefit.
You pay **$0** copay each day for days 1 – 90 per admission You pay **$0** for outpatient group/individual therapy visit	You pay **$0** copay each day for days 1 – 90 per admission You pay **$0** 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.
You pay **$0** copay per admission	You pay **$0** copay per admission	Our plan covers up to 100 days in a SNF per benefit period. You must get prior authorization in advance before you are admitted to the facility or your stay may not be covered.

Premiums and Benefits	Medicaid Benefits
Physical Therapy (Rehabilitation Services) • **Occupational Therapy Visit** • **Physical Therapy and Speech Therapy and Language Therapy Visit**	You pay **$0** copay for Medicaid Covered Services.
Ambulance	You pay **$0** copay for Medicaid Covered Services.
Transportation	You pay **$0** copay for Medicaid Covered Services.
Ambulatory Surgery Center	You pay **$0** copay for Medicaid Covered Services.

Freedom Medi-Medi Partial (HMO D-SNP)_078	Freedom Medi-Medi Full (HMO D-SNP)_087	What you should know
You pay **$0** copay You pay **$0** copay	You pay **$0** copay You pay **$0** 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 **$0** copay for Medicare-covered one-way ground ambulance services and pay **$0** copay for Medicare-covered one-way air ambulance services	You pay **$0** copay for Medicare-covered one-way ground ambulance services and pay **$0** copay for Medicare-covered one-way air ambulance services	Prior Authorization may be required. Contact the Plan for details.
You pay **$0** copay for up to **24** one way trips every year For members with full Medicaid eligibility you pay **$0** copay for unlimited one-way trips to plan approved locations.	You pay **$0** copay for up to **24** one way trips every year For members with full Medicaid eligibility you pay **$0** copay for unlimited one-way trips to plan approved locations.	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 **$0** copay for each Medicare-covered ambulatory surgical center visit You pay **$0** copay for each Medicare-covered outpatient hospital facility visit	You pay **$0** copay for each Medicare-covered ambulatory surgical center visit You pay **$0** 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.

Premiums and Benefits	Medicaid Benefits
Medicare Part B Drugs	You pay **$0** copay for Medicaid Covered Services.
Foot Care *(Podiatry Services)* • **Foot Exams and Treatment**	You pay **$0** copay for Medicaid Covered Services.
Medical Equipment/Supplies • **Durable Medical Equipment *(e.g., wheelchairs, oxygen)*** • **Prosthetics *(e.g., braces, artificial limits)*** • **Diabetes Supplies**	You pay **$0** copay for Medicaid Covered Services.
Wellness • **Fitness** • **24 Hour Nurse Advise Line**	Not Covered
Over The Counter (OTC)	Not Covered

Freedom Medi-Medi Partial (HMO D-SNP)_078	Freedom Medi-Medi Full (HMO D-SNP)_087	What you should know
You pay **$0** copay for Medicare Part B-covered chemotherapy drugs and other Medicare Part B covered drugs	You pay **$0** copay for Medicare Part B-covered chemotherapy drugs and other Medicare Part B covered 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 **$0** copay	Covered podiatry benefits are for medically necessary foot care. You will need to have a referral or prior authorization from your PCP first depending on the service.
You pay **$0** You pay **$0** You pay **$0**	You pay **$0** You pay **$0** You pay **$0**	We cover all medically necessary durable medical equipment covered by Original Medicare. You will need to have a referral or prior authorization from your PCP first depending on the service.
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.
$100 Monthly Allowance *The plan doesn't allow you to roll over any remaining OTC allowance into the next month.*	**$100** 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

Outpatient Prescription Drugs			
Freedom Medi-Medi Partial (HMO D-SNP) H5427_078			
Medicaid - You pay **$0** copay for Medicaid covered prescription drugs not covered by a Medicare Prescription Drug Plan**.**			
	Standard Retail Rx 30 – day Supply	**Standard Mail Order 90 – day Supply**	**What you should Know**
Deductible Stage	If you receive "Extra Help" to pay for your prescription drugs, your deductible amount will be either **$0** or **$89** depending on the level of "Extra Help" you receive. If you do not receive "Extra Help" during this stage you pay the full cost of your Tier 2 Preferred Brand, Tier 3 Non-Preferred Drug and Tier 4 Specialty Tier drugs up to **$435.** The Plan will cover cost of Tier 1 Preferred Generic Drugs.		
Initial Coverage Stage **Tier 1: Preferred Generic** **Tier 2: Preferred Brand** **Tier 3: Non-Preferred Drug** **Tier 4: Specialty Tier**	If you receive 'Extra Help" you pay: For generic drugs including drugs treated as generic, either: • **$0** copay • **15%** coinsurance • **$1.30** copay or • **$3.60** copay For all other drugs, either: • **$0** copay • **15%** coinsurance, • **$3.90** copay or • **$8.95** copay If you do not receive "Extra Help" you pay: • **$0** copay • **$45** copay • **$95** copay • **25%** coinsurance	If you receive 'Extra Help" you pay: For generic drugs including drugs treated as generic, either: • **$0** copay • **15%** coinsurance • **$1.30** copay or • **$3.60** copay For all other drugs, either: • **$0** copay • **15%** coinsurance, • **$3.90** copay or • **$8.95** copay If you do not receive "Extra Help" you pay: • **$0** copay • **$135** copay • **$285** copay • **A Long-Term Supply is Not Available**	Cost Sharing may change depending on your LIS level and when you enter another phase of the 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. If you do not receive "Extra Help," you may be charged more when you get drugs from an out-of-network pharmacy than from an in-network pharmacy.

Outpatient Prescription Drugs	
Freedom Medi-Medi Partial (HMO D-SNP) H5427_078	
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	During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year.
	
	If you receive "Extra Help" to pay for your prescription drugs, your costs for covered drugs will depend on the level of "Extra Help" you receive. During this stage, your share of the cost for a covered drug will be either:
	
	• **$0;** or
	• A coinsurance or a copay, whichever is the larger amount:
	  ○ either coinsurance of **5%** of the cost of the drug
	  ○ or **$3.60** copay for a generic drug or a drug that is treated like a generic and **$8.95** copay for all other drugs
	  ○ Our Plan pays the rest of the cost
	
	Look at your LIS Rider for information about your drug costs during the Catastrophic Coverage Stage

Outpatient Prescription Drugs			
Freedom Medi-Medi Full (HMO D-SNP) H5427_087			
Medicaid - You pay **$0** copay for Medicaid covered prescription drugs not covered by a Medicare Prescription Drug Plan**.**			
	Standard Retail Rx 30 – day Supply	**Standard Mail Order 90 – day Supply**	**What you should Know**
Deductible Stage	If you receive "Extra Help" to pay for your prescription drugs, your deductible amount will be either **$0** or **$89** depending on the level of "Extra Help" you receive. If you do not receive "Extra Help" during this stage you pay the full cost of your Tier 2 Preferred Brand, Tier 3 Non-Preferred Drug and Tier 4 Specialty Tier drugs up to **$435.** The Plan will cover cost of Tier 1 Preferred Generic Drugs.		
Initial Coverage Stage **Tier 1: Preferred Generic** **Tier 2: Preferred Brand** **Tier 3: Non-Preferred Drug** **Tier 4: Specialty Tier**	If you receive 'Extra Help" you pay: For generic drugs including drugs treated as generic, either: • **$0** copay • **15%** coinsurance • **$1.30** copay or • **$3.60** copay For all other drugs, either: • **$0** copay • **15%** coinsurance, • **$3.90** copay or • **$8.95** copay If you do not receive "Extra Help" you pay: • **$0** copay • **$45** copay • **$95** copay • **25%** coinsurance	If you receive 'Extra Help" you pay: For generic drugs including drugs treated as generic, either: • **$0** copay • **15%** coinsurance • **$1.30** copay or • **$3.60** copay For all other drugs, either: • **$0** copay • **15%** coinsurance, • **$3.90** copay or • **$8.95** copay If you do not receive "Extra Help" you pay: • **$0** copay • **$135** copay • **$285** copay • **A Long-Term Supply is Not Available**	Cost Sharing may change depending on your LIS level and when you enter another phase of the 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. If you do not receive "Extra Help," you may be charged more when you get drugs from an out-of-network pharmacy than you would from an in-network pharmacy.

Outpatient Prescription Drugs	
Freedom Medi-Medi Full (HMO D-SNP) H5427_087	
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	During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year.
	
	If you receive "Extra Help" to pay for your prescription drugs, your costs for covered drugs will depend on the level of "Extra Help" you receive. During this stage, your share of the cost for a covered drug will be either:
	
	• **$0;** or
	• A coinsurance or a copay, whichever is the larger amount:
	  ○ either coinsurance of **5%** of the cost of the drug
	  ○ or **$3.60** copay for a generic drug or a drug that is treated like a generic and **$8.95** copay for all other drugs
	  ○ Our Plan pays the rest of the cost
	
	Look at your LIS Rider for information about your drug costs during the Catastrophic Coverage Stage

Comprehensive Written Statement for Prospective Enrollees

The benefits described in the Premium and Benefit section of the Summary of Benefits are covered by our Medicare Advantage plan. For each benefit listed, you can see what our plan covers. What you pay for covered services may depend on your level of Medicaid eligibility.

Coverage of the benefits described above depends upon your level of Medicaid eligibility. No matter what your level of Medicaid eligibility is, **Freedom Medi-Medi Partial (HMO D-SNP)** and **Freedom Medi-Medi Full (HMO D-SNP)** will cover the benefits described in the Premium and Benefit section of the Summary of Benefits. If you have questions about your Medicaid eligibility and what benefits you are entitled to, call the Florida Agency for Health Care Administration toll-free at 1-888-419-3456 or the Florida Department of Children and Families (DCF) ACCESS Program toll free at 1-866-762-2237.

Our source of information for Medicaid benefits is the Florida Agency for Health Care Administration (Medicaid) website. All Medicaid covered services are subject to change at any time. For the most current Florida Medicaid coverage information, please visit the Florida Medicaid website at http://ahca.myflorida.com or call Member Services for assistance. A detailed explanation of Florida Medicaid benefits can be found in the Florida Summary of Services online at: http://ahca.myflorida.com/Medicaid/flmedicaid.shtml.

Premiums, co-pays, coinsurance and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details. 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. 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).

Dual Eligible Special Needs Plan 2020

2020 Summary of Benefits

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