

**VISION PLAN BENEFITS**

COVERAGE	FREEDOM SAVINGS PLAN (HMO): 052 FREEDOM MEDICARE PLAN Rx (HMO): 059, 060	FREEDOM VIP CARE (HMO C-SNP): 070 FREEDOM VIP SAVINGS (HMO C-SNP): 072, 082 FREEDOM VIP SAVINGS COPD (HMO C-SNP): 077, 083 FREEDOM PLATINUM PLAN Rx (HMO): 088, 089, 091, 092, 093, 094, 098 FREEDOM PLATINUM REWARDS PLAN Rx (HMO): 096, 102, 103, 105, 106, 107 FREEDOM VIP REWARDS (HMO C-SNP): 099, 108	FREEDOM MEDI-MEDI PARTIAL (HMO D-SNP): 078 FREEDOM MEDI-MEDI FULL (HMO D-SNP): 087 FREEDOM PLATINUM PLUS PLAN Rx (HMO): 104
Comprehensive Eye Examination	\$0 co-pay	\$0 co-pay	\$0 co-pay
Frame and Eyeglass Lens (Standard plastic) This benefit may not be combined with any other discounts or promotional offers. For premium frames, progressive lenses, and additional lens treatment upgrades, the member receives vision vendor's discounted rate. (These are Value-Added Items and Services (VAIS) and are not plan benefits and are not part of the plan's benefit package).	<b>\$10 co-pay</b> includes CR-39 clear plastic lenses and standard frame. <b>\$100</b> benefit. Member pays any amount over <b>\$100</b> • Single vision • Lined bifocal (FT 28) • Lined trifocal (FT 7x28) <b>\$30 co-pay</b> for CR-39 clear plastic standard progressive lenses. <b>\$30 co-pay</b> for CR-39 plastic standard photochromic lenses. <b>Lens and Frames Upgrades:</b> Member pays Argus' discounted rate.	<b>\$10 co-pay</b> includes CR-39 clear plastic lenses and standard frame. <b>\$150</b> benefit. Member pays any amount over <b>\$150</b> . • Single vision • Lined bifocal (FT 28) • Lined trifocal (FT 7x28) <b>\$30 co-pay</b> for CR-39 clear plastic standard progressive lenses. <b>\$30 co-pay</b> for CR-39 plastic standard photochromic lenses. <b>Lens and Frames Upgrades:</b> Member pays Argus' discounted rate.	<b>\$0 co-pay</b> includes CR-39 clear plastic lenses and standard frame. <b>\$400</b> benefit. Member pays any amount over <b>\$400</b> . • Single vision • Lined bifocal (FT 28) • Lined trifocal (FT 7x28) <b>\$30 co-pay</b> for CR-39 clear plastic standard progressive lenses. <b>\$30 co-pay</b> for CR-39 plastic standard photochromic lenses. <b>Lens and Frames Upgrades:</b> Member pays Argus' discounted rate.
Contact Lenses (in lieu of eyeglasses) Conventional or Disposable	<b>\$10 co-pay</b> <b>\$100</b> benefit. Member pays any amount over <b>\$100</b> . Contact lens fitting fee is not a covered benefit.	<b>\$10 co-pay</b> <b>\$150</b> benefit. Member pays any amount over <b>\$150</b> . Contact lens fitting fee is not a covered benefit.	<b>\$0 co-pay</b> <b>\$400</b> benefit. Member pays any amount over <b>\$400</b> . Contact lens fitting fee is not a covered benefit.
Glasses or Contacts after Cataract Surgery	<b>\$0 co-pay</b> Medicare allowable benefit limit. Contact lens fitting fee is not a covered benefit. Progressives and photochromic lenses not covered.	<b>\$0 co-pay</b> Medicare allowable benefit limit. Contact lens fitting fee is not a covered benefit. Progressives and photochromic lenses not covered.	<b>\$0 co-pay</b> Medicare allowable benefit limit. Contact lens fitting fee is not a covered benefit. Progressives and photochromic lenses not covered.

BENEFIT FREQUENCIES	ALL PLANS EXCEPT MEDI-MEDI	FREEDOM MEDI-MEDI PARTIAL AND FULL (078 AND 087); and FREEDOM PLATINUM PLUS PLAN Rx (HMO): 104
Eye Examination	Once every 12 months	Once every 12 months
Eyeglass Lenses	Once every 12 months	Twice every 12 months
Eyeglass Frames	Once every 12 months	Twice every 12 months
Contact Lenses	Once every 12 months	Twice every 12 months
Glasses or Contacts (after Cataract Surgery)	Once after cataract Surgery	Once after cataract Surgery
LASIK	Not Covered	Not Covered

**EYE CARE NETWORK INCLUDES INDEPENDENT AND NATIONAL RETAIL PROVIDERS**

The Eye Care provider network is comprised of both independent and national retail optical locations. Please visit our website at [www.argusdentalvision.com](http://www.argusdentalvision.com) and choose Freedom Health Medicare Routine Vision.

**Freedom Health Customer Service**  
Toll Free: 1-800-401-2740 • TTY: 711  
[www.argusdentalvision.com](http://www.argusdentalvision.com)

**Freedom Health members receive these benefits through HearUSA:**

- **\$0 co-pay** routine hearing exam, one every year.
- All plans except Medi-Medi: **\$0 co-pay** for two hearing aids per year (1 per ear), \$1,000 limit on hearing aids (\$500 per hearing aid).
- **Freedom Medi-Medi Partial and Full** (078 and 087) and **Freedom Platinum Plus Plan Rx** (HMO): (104): **\$0 co-pay** for two hearing aids per year (1 per ear), \$2,000 limit on hearing aids (\$1,000 per hearing aid).
- **\$0 co-pay** for hearing aid evaluations/hearing aid fitting, one every year.
- Selection of quality digital products featuring choice of style and technologies.
- Annual cleaning and check of hearing aids.

You must go to a participating provider. If your plan has an out of network benefit, please review your evidence of coverage or call the plan's Member Services Department for details.

[www.hearusa.com](http://www.hearusa.com)

**Wellness and Health Care Planning Services: (Only in plan 078 and 087)**  
Members are eligible for advance care planning (ACP) services through MyDirectives®. To get started, access the link to MyDirectives® from the Member Portal on our website at [www.freedomhealth.com](http://www.freedomhealth.com). Click on Member Portal, log in to register.

**Personal Emergency Response System (PERS): (Only in plans 070, 072, 077, 078, 082, 087, 099, 104, 108)**  
With a Personal Emergency Response System (PERS), help is a button press away. PERS is a monitoring device that can provide you with confidence, knowing you have quick access to the help you need 24 hours a day in any situation. The device is a lightweight, discreet button that can be worn on the wrist or as a pendant (automatic fall detection and mobile options available). Must use the plan's contracted provider/vendor. For more information contact Member Services.

**Fitness**  
Freedom has partnered with SilverSneakers® to provide our fitness benefit which is available on all of our plans. Please visit their website at [www.silversneakers.com](http://www.silversneakers.com) or call our Member Services Department for the most updated participating network facilities and information on how to utilize the benefit. Please take your Freedom ID to the participating network facility on your first visit.

- Limitations/Restrictions:**
- Health Club Memberships are limited to participating providers. Please contact Member Services for details and to locate a participating provider. (Phone numbers are printed on the back cover of this booklet).
  - You should always consult your physician or other healthcare provider before changing your diet or starting an exercise program.

*Personal Trainers are not covered.*

**In Home Support (Papa's Pals): (Not in plan 052, 059, 060)**

- Assistance for services such as:**
- **Household chores:** light cleaning, organization, laundry
  - **Companionship:** conversation, board games, reading, hobbies
  - **Technical Guidance:** assist with learning telehealth services to connect with physician, help install devices
  - **Exercise and Activity:** walking or biking
  - **Assistance from a distance:** virtual services and companionship.
- For more information or schedule services please call 1-888-228-5958 (TTY: 711). Must use the plan's contracted provider/vendor.

**Special Supplemental Benefits for the Chronically Ill:**

**Healthy Food Groceries (Only in plans 070, 072, 077, 099, 108)**  
Eating healthy is an important part of managing a chronic medical condition and can help you maintain or improve your overall health. Healthy Groceries provides you with a monthly **\$25** benefit for the purchase of healthy groceries at participating retailers. The benefit is intended to assist with the purchase of healthy food items. Some items, including tobacco or alcohol products, are excluded. Any unused benefit will expire at the end of the month and cannot be rolled over into the following month. Unused Health Groceries amounts do not roll over to the next calendar year. After the plan pays benefits for Healthy Groceries you are responsible for any remaining cost. Please contact Member Services for further information or sign up on the member portal.

**Transportation**

Transportation by taxi, bus/subway, van, and other approved methods to Plan approved locations, see limitations below. Please contact Member Services for details and to locate a participating vendor. (Phone numbers are printed on the back cover of this booklet).

**Limitations/Restrictions:**  
**Consult your Evidence of Coverage for the number of rides you are allowed.**

- This benefit is not intended for Medical emergencies. For Medical emergencies, ambulance co-pay applies.
- Plan approved locations are only for medical appointments and health needs; such as PCP and specialist visits or drop off and pick up for planned medical procedures (i.e. routine blood draw, surgery, x-rays, routine eye exams).
- Transportation is intended for rides within your county.
- Call to schedule a ride at least 72 hours prior to scheduled medical appointment. Have the following information ready: Address of appointment, office phone number, appointment date and time.

To utilize this benefit for facility transportation, advance notice may be required. Please contact member services for additional information.

FRH22DVH

**FREEDOM HEALTH**

# Make the Most of Your Benefits

Freedom Health partners with specific companies to offer you better value through added benefits. Knowing how to access your services is the most important step. This booklet tells you how.

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. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Freedom Health, Inc. cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Freedom Health, Inc. konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks. Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-401-2740 (TTY: 711). Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-401-2740 (TTY: 711). H5427\_2022\_DVH Flyer\_M

**Dental Plan Benefits**

Freedom Savings Plan (HMO): 052 Freedom Medicare Plan Rx (HMO): 059, 060	Freedom VIP Care (HMO C-SNP): 070 Freedom VIP Savings (HMO C-SNP): 072, 082 Freedom VIP Savings COPD (HMO C-SNP): 077, 083 Freedom Platinum Plan Rx (HMO): 088, 089, 091, 092, 093, 094, 098 Freedom Platinum Rewards Plan Rx (HMO): 096, 102, 103, 105, 106, 107 Freedom VIP Rewards (HMO C-SNP): 099, 108	Freedom Medi-Medi Partial (HMO D-SNP): 078 Freedom Medi-Medi Full (HMO D-SNP): 087 Freedom Platinum Plus Plan Rx (HMO): 104
<p><b>Covered Services:</b></p> <ul style="list-style-type: none"> <li>Routine Preventive Dental Care (member must use network dental provider). Problem focused exams are not considered routine</li> <li>Dental cleaning as determined necessary by treating provider</li> <li>Limited Oral Exam - Problem Focused exam</li> <li>Fluoride Treatment</li> <li>Dental X-rays</li> <li>Oral Exams</li> <li>Limited Extractions</li> <li><i>- Prior Authorization may be required and must be received by a participating dental provider</i></li> <li><i>- *excludes periodontal scaling and root planing and periodontal maintenance</i></li> <li><b>*You must go to a participating general dentist for all services.</b></li> </ul> <p><b>You Pay:</b></p> <ul style="list-style-type: none"> <li>\$0 for routine comprehensive or periodic exam up to 2 visit each year.</li> <li>\$0 for Limited Oral exam - Problem Focused exam up to 2 visits each year.</li> <li>\$0 for each cleaning up to 2 visits every year.</li> <li>\$0 for each fluoride treatment up to 2 visits every year.</li> <li>X-ray: \$0 co-pay for Occlusal Film 2 per year.</li> <li>X-ray: \$0 co-pay for Temporomandibular joint film one per year.</li> <li>X-ray: \$0 co-pay for Complete Series including bitewings single film one every 36 months, bitewings 2 film one per year, bitewings 4 film one per year and panoramic film one per 36 months.</li> <li>\$0 co-pay extraction of tooth, one procedure per year by a general dentist.</li> <li>\$0 co-pay for resin Filling up to 1 per year.</li> <li>\$0 co-pay full mouth debridement one every two years.</li> <li>\$0 co-pay for 4 total scaling and root planing procedures per year - Limited to 1 procedure per quadrant per year.</li> <li>\$0 co-pay periodontal maintenance - up to 2 procedures per year.</li> </ul>	<p><b>Covered Services:</b></p> <ul style="list-style-type: none"> <li>Routine Preventive Dental Care (member must use network dental provider). Problem focused exams are not considered routine</li> <li>Dental cleaning or periodontal scaling and root planing, as determined necessary by treating provider</li> <li>Limited Oral Exam - Problem Focused exam</li> <li>Fluoride Treatment</li> <li>Dental X-rays</li> <li>Oral Exams</li> <li>Diagnostic Services</li> <li>Limited Prosthodontics</li> <li>Limited Extractions</li> <li>Limited Periodontal Services</li> <li>Limited Restorative Services</li> <li><i>- Prior Authorization may be required and must be received by a participating dental provider</i></li> <li><i>- Gingival irrigation (D4921), and localized delivery of antimicrobial agents (D4391), like Arestin®, are not covered and the member is responsible for the additional charge, even though scaling/root planing (D4341 and D4342) and Periodontal Maintenance (D4910) are covered.</i></li> <li><i>- Core build-up (D2950) is excluded, even though 1 crown is covered</i></li> <li><b>*You must go to a participating general dentist for all services.</b></li> </ul> <p><b>You Pay:</b></p> <ul style="list-style-type: none"> <li>\$0 for routine comprehensive or periodic exam up to 2 visit each year.</li> <li>\$0 for Limited Oral Exam - Problem Focused exam up to 2 visits each year.</li> <li>\$0 for each cleaning up to 2 visits every year.</li> <li>\$0 for each fluoride treatment up to 2 visits every year.</li> <li>X-ray: \$0 co-pay for Occlusal Film 2 per year.</li> <li>X-ray: \$0 co-pay for Temporomandibular joint film one per year.</li> <li>X-ray: \$0 co-pay for Complete Series including bitewings single film one every 36 months, bitewings 2 film one per year, bitewings 4 film one per year and panoramic film one per 36 months.</li> <li>\$0 co-pay extraction of tooth, one procedure per year by a general dentist.</li> <li>\$0 co-pay for resin Filling up to 1 per year.</li> <li>\$0 co-pay full mouth debridement one every two years.</li> <li>\$0 co-pay for 4 total scaling and root planing procedures per year - Limited to 1 procedure per quadrant per year.</li> <li>\$0 co-pay periodontal maintenance - up to 2 procedures per year.</li> </ul>	<p><b>Covered Services:</b></p> <ul style="list-style-type: none"> <li>Routine Preventive Dental Care (member must use network dental provider). Problem focused exams are not considered routine</li> <li>Dental cleaning or periodontal scaling and root planing, as determined necessary by treating provider</li> <li>Limited Oral Exam - Problem Focused exam</li> <li>Fluoride Treatment</li> <li>Dental X-rays</li> <li>Oral Exams</li> <li>Diagnostic Services</li> <li>Limited Prosthodontics</li> <li>Limited Extractions</li> <li>Limited Periodontal Services</li> <li>Limited Restorative Services</li> <li><i>- Prior Authorization may be required and must be received by a participating dental provider</i></li> <li><i>- Gingival irrigation (D4921), and localized delivery of antimicrobial agents (D4391), like Arestin®, are not covered and the member is responsible for the additional charge, even though scaling/root planing (D4341 and D4342) and Periodontal Maintenance (D4910) are covered.</i></li> <li><i>- Core build-up (D2950) is excluded, even though 1 crown is covered</i></li> <li><b>*You must go to a participating general dentist for all services.</b></li> </ul> <p><b>You Pay:</b></p> <ul style="list-style-type: none"> <li>\$0 for routine comprehensive or periodic exam up to 2 visit each year.</li> <li>\$0 for Limited Oral Exam - Problem Focused exam up to 2 visits each year.</li> <li>\$0 for each cleaning up to 2 visits every year.</li> <li>\$0 for each fluoride treatment up to 2 visits every year.</li> <li>X-ray: \$0 co-pay for Occlusal Film 2 per year.</li> <li>X-ray: \$0 co-pay for Temporomandibular joint film one per year.</li> <li>X-ray: \$0 co-pay for Complete Series including bitewings single film one every 36 months, bitewings 2 film one per year, bitewings 4 film one per year and panoramic film one per 36 months.</li> <li>\$0 co-pay for resin Filling up to 2 per year.</li> <li>\$0 co-pay full mouth debridement one every two years.</li> <li>\$0 co-pay extraction of tooth two procedures per year by a general dentist.</li> <li>\$0 co-pay for one porcelain/ceramic or porcelain fused to high noble metal crown per year</li> <li>\$0 co-pay Partial or full set of Dentures; 1 set every 5 years.</li> <li>\$0 co-pay for Denture relines (upper or lower) - 1 per year</li> <li>\$0 co-pay for 4 total scaling and root planing procedures per year.</li> <li>- Limited to 1 procedure per quadrant per year.</li> <li>\$0 co-pay periodontal maintenance - up to 2 procedures per year.</li> </ul>

Dental benefits are provided through Argus Dental & Vision, Inc. If you have any questions about your benefits or need additional information, please contact Member Services at 1-855-445-9757 (TTD/TTY: 1-800-955-8771)

**Freedom Health • 1-800-401-2740 • TTY: 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. to 8 p.m. EST.

**FREEDOM HEALTH PLANS  
2022 COVERED CODE BENEFITS**

Code	Procedure Description	Freedom Savings Plan (HMO): 052 Freedom Medicare Plan Rx (HMO): 059, 060	Freedom VIP Care (HMO C-SNP): 070 Freedom VIP Savings (HMO C-SNP): 072, 082 Freedom VIP Savings COPD (HMO C-SNP): 077, 083 Freedom Platinum Plan Rx (HMO): 088, 089, 091, 092, 093, 094, 098 Freedom Platinum Rewards Plan Rx (HMO): 096, 102, 103, 105, 106, 107 Freedom VIP Rewards (HMO C-SNP): 099, 108	Freedom Medi-Medi Partial (HMO D-SNP): 078 Freedom Medi-Medi Full (HMO D-SNP): 087 Freedom Platinum Plus Plan Rx (HMO): 104
<b>Diagnostic (exams and x-rays)**</b>		<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>
D0120	Periodic Oral Evaluation - Established Patient			
D0140	Limited Oral Evaluation - Problem Focused	\$0	\$0	\$0
D0150	Comprehensive Oral Evaluation - New Or Established Patient			
D0210	Intraoral - Complete Series Of Radiographic Images	\$0	\$0	\$0
D0330	Panoramic Radiographic Image			
D0220	Intraoral - Periapical First Radiographic Image			
D0230	Intraoral - Periapical Each Additional Radiographic Image	\$0	\$0	\$0
D0240	Intraoral - Occlusal Radiographic Image			
D0270	Bitewing - Single Radiographic Image			
D0272	Bitewings - Two Radiographic Images			
D0274	Bitewings - Four Radiographic Images			
D0321	Other Temporomandibular Joint Radiographic Images, By Report	\$0	\$0	\$0
<b>Preventive**</b>		<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>
D1110	Prophylaxis - Adult	\$0	\$0	\$0
D1206	Topical Application Of Fluoride Varnish			
D1208	Topical Application Of Fluoride - Excluding Varnish	\$0	\$0	\$0
<b>Restorative**</b>		<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>
D2330	Resin - Based Composite - One Surface, Anterior			
D2331	Resin-Based Composite - Two Surfaces, Anterior			
D2332	Resin - Based Composite - Three Surfaces, Anterior			
D2335	Resin - Four Surfaces, Anterior			
D2391	Resin-Based Composite - One Surface, Posterior	Not Covered	\$0	\$0
D2392	Resin-Based Composite - Two Surfaces, Posterior			
D2393	Resin-Based Composite - Three Surfaces, Posterior			
D2394	Resin-Based Composite - Four Surfaces, Posterior			
<b>Restorative** cont.</b>		<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>
D2740	Crown Porcelain/Ceramic Substrate*			
D2750	Crown Porcelain Fused to High Noble Metal*	Not Covered	Not Covered	\$0

**FREEDOM HEALTH PLANS  
2022 COVERED CODE BENEFITS**

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<b>Periodontics**</b>		<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>
D4341	Periodontal Scaling and Root Planing - Per Quadrant (4 or More Teeth)	Not Covered	\$0	\$0
D4342	Periodontal Scaling and Root Planing - Per Quadrant (1 to 3 Teeth)			
D4355	Full Mouth Debridement To Enable Comprehensive Evaluation And Diagnosis On A Subsequent Visit	Not Covered	\$0	\$0
D4910	Periodontal Maintenance Procedures - Following Active Surgery	Not Covered	\$0	\$0
<b>Removable Prosthodontics**</b>		<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>
D5110	Complete Denture - Maxillary*			
D5120	Complete Denture - Mandibular*			
D5130	Immediate Denture - Maxillary*			
D5140	Immediate Denture - Mandibular*			
D5211	Maxillary Partial Denture - Resin Base (Including Any Conventional Clasps, Rests And Teeth)*			
D5212	Mandibular Partial Denture - Resin Base (Including Any Conventional Clasps, Rests And Teeth)*	Not Covered	Not Covered	\$0
D5213	Maxillary Partial Denture - Cast Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rests And Teeth)*			
D5214	Mandibular Partial Denture - Cast Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rests And Teeth)*			
D5730	Chairside Reline Complete Upper Denture			
D5731	Chairside Reline Complete Lower Denture	Not Covered	Not Covered	\$0
D5740	Chairside Reline Upper Partial			
D5741	Chairside Reline Lower Partial			
<b>Oral and Maxillofacial Surgery**</b>		<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>
D7140	Extraction, Erupted Tooth Or Exposed Root (Elevation And/Or Forceps Removal)	\$0	\$0	\$0
D7210	Extraction, Erupted Tooth Requiring Removal Of Bone And/Or Sectioning Of Tooth, And Including Elevation Of Mucoperiosteal Flap If Indicated*			

\* Requires a pre-authorization

\*\* Please reference your Explanation of Coverage (EOC) for benefit limitations

\*\*\* All services must be rendered by a general dentist