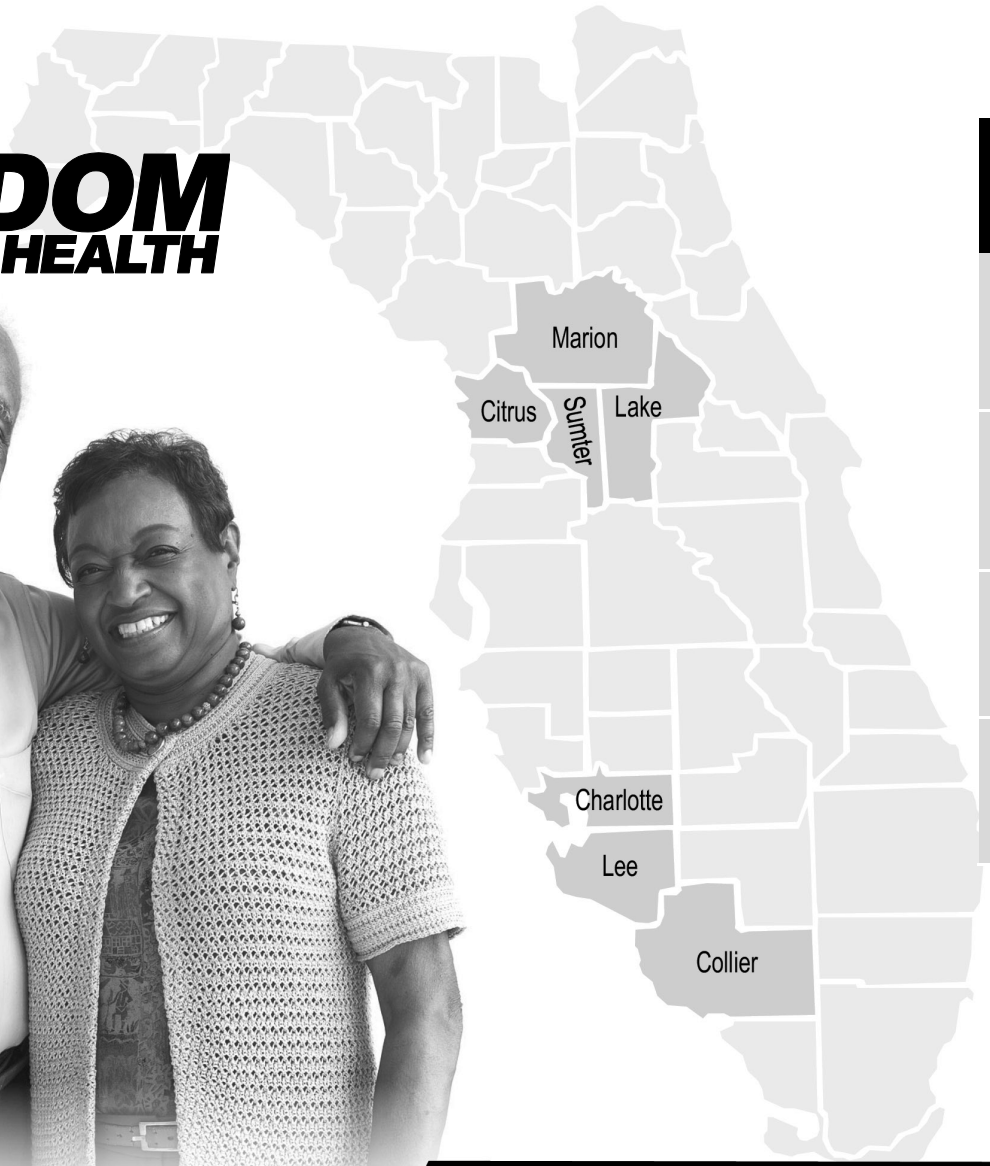
HMO 2022

F22SBPLRX

FREEDOM HEALTH



SB Combo
093 – 094 – 104 – 105

093 - Freedom Platinum Plan Rx (HMO)

Counties: Citrus

094 - Freedom Platinum Plan Rx (HMO)

Counties: Lake, Marion, and Sumter

104 – Freedom Platinum Plus Plan Rx (HMO)

Counties: Lake, Marion, and Sumter

105 – Freedom Platinum Rewards Plan Rx (HMO)

Counties: Charlotte, Collier, and Lee

H5427_2022_SB_093_094_104_105_M

2022 Summary of Benefits

Summary of Benefits
January 1, 2022 - December 31, 2022

Freedom Platinum Plan Rx (HMO) H5427_093
Freedom Platinum Plan Rx (HMO) H5427_094
Freedom Platinum Plus Plan Rx (HMO) H5427_104
Freedom Platinum Rewards Plan Rx (HMO) H5427_105

The purpose of the Summary of Benefits is to provide you with a summary of drug and health benefits covered by **Freedom Platinum Plan Rx (HMO) H5427_093, Freedom Platinum Plan Rx (HMO) H5427_094, Freedom Platinum Plus Plan Rx (HMO) H5427_104** and **Freedom Platinum Rewards Plan Rx (HMO) H5427_105,** which describes what we cover and what you pay. This information is not a complete description of benefits. Call 1-866-245-5360 (TTY: 711) for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year.

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

To be eligible for **Freedom Platinum Plan Rx (HMO) H5427_093, Freedom Platinum Plan Rx (HMO) H5427_094**, **Freedom Platinum Plus Plan Rx H5427_104** and **Freedom Platinum Rewards Plan Rx (HMO) H5427_105,** you must have both Medicare Part A and Medicare Part B and live in our service area.

Our service area includes the following counties in Florida:

Freedom Platinum Plan Rx (HMO) H5427_093:
Citrus

Freedom Platinum Plan Rx (HMO) H5427_094:
Lake, Marion and Sumter

Freedom Platinum Plus Plan Rx H5427_104:
Lake, Marion and Sumter

Freedom Platinum Rewards Plan Rx (HMO) H5427_105:
Charlotte, Collier and Lee

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

Premiums and Benefits	Freedom Platinum Plan Rx (HMO)_093	Freedom Platinum Plan Rx (HMO)_094
Monthly Plan Premium	You pay **$0**	You pay **$0**
Deductible	You pay **$0**	You pay **$0**
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	**$2,000** annually	**$2,250** annually
Inpatient Hospital Coverage	You pay **$60** copay each day for days 1 through 7 and **$0** copay each day for days 8 through 90 per admission	You pay **$40** copay each day for days 1 through 5 and **$0** copay each day for days 6 through 90 per admission

Freedom Platinum Plus Plan Rx (HMO)_104	Freedom Platinum Rewards Plan Rx (HMO)_105	What you should know
You Pay **$50**	You pay **$0** Freedom Health, Inc. will reduce your Medicare Part B premium by up to **$75**	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 can have the plan premium taken out of your monthly Social Security check. Please contact the plan for more information.
You pay **$0**	You pay **$0**	These plan do not have a deductible
$1,500 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 **$0**	You pay **$195** copay each day for days 1 through 5 and **$0** copay each day for days 6 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.

Premiums and Benefits	Freedom Platinum Plan Rx (HMO)_093	Freedom Platinum Plan Rx (HMO)_094
Outpatient Hospital Coverage	You pay **$150** copay per visit	You pay **$100** copay per visit
Doctor's Visits • **Primary** • **Specialists**	 You pay **$0** copay per visit You pay **$10** copay per visit	 You pay **$0** copay per visit You pay **$5** copay per visit
Preventive Care	You pay **$0** copay	You pay **$0** copay
Emergency Care	You pay **$75** copay per visit	You pay **$75** copay per visit

Freedom Platinum Plus Plan Rx (HMO)_104	Freedom Platinum Rewards Plan Rx (HMO)_105	What you should know
You pay **$100** copay per visit	You pay **$195** 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.
You pay **$0** copay per visit You pay **$0** copay per visit	You pay **$0** copay per visit You pay **$25** copay per visit	Your primary care physician will coordinate the covered services you receive as a member of our plan. In order for you to see a specialist, you will need to have a referral from your PCP first. Separate copay may apply for each additional service received at an office visit.
You pay **$0** copay	You pay **$0** copay	Any additional preventive services approved by Medicare during the contract year will be covered. Preventive services in a hospital-based setting may require prior authorization.
You pay **$75** copay per visit	You pay **$75** copay per visit	**$500** copay for each emergency service, urgent service and emergency transportation outside the U.S. **$100,000** plan coverage limit for emergency services, urgent services and emergency transportation outside the U.S. every year. Contact the plan for details.

Premiums and Benefits	Freedom Platinum Plan Rx (HMO)_093	Freedom Platinum Plan Rx (HMO)_094
Urgently Needed Services	You pay **$10** copay	You pay **$10** copay
Diagnostic Services/Labs/Imaging • **Diagnostic Radiology Service *(e.g., MRI)*** • **Lab Services** • **Diagnostic Tests and Procedures** • **Outpatient X-rays** • **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	You pay **$25-$100** copay depending on the service You pay **$0-$50** copay depending on the place of service You pay **$0-$100** copay or **20%** coinsurance depending on the service You pay **$0-$100** copay depending on the service You pay **20%** coinsurance for Therapeutic Radiology
Hearing Services • **Hearing Exam/Hearing Aid Fitting-Evaluation** • **Hearing Aid**	You pay **$0** copay for one routine hearing exam and one hearing aid fitting-evaluation every year You pay **$0** copay for two hearing aids (1 per ear) per year You are responsible for payment of any amount in excess of the maximum **$1,000 ($500 per hearing aid).**	You pay **$0** copay for one routine hearing exam and one hearing aid fitting-evaluation every year You pay **$0** copay for two hearing aids (1 per ear) per year You are responsible for payment of any amount in excess of the maximum **$1,000 ($500 per hearing aid).**

Freedom Platinum Plus Plan Rx (HMO)_104	Freedom Platinum Rewards Plan Rx (HMO)_105	What you should know
You pay **$10** copay	You pay **$10** copay	**$500** copay for each emergency service, urgent service and emergency transportation outside the U.S. **$100,000** plan coverage limit for emergency services, urgent services and emergency transportation outside the U.S. every year. Contact the plan for details.
You pay **$25-$100** copay depending on the service You pay **$0-$50** copay depending on the place of service You pay **$0-$100** copay or **20%** coinsurance depending on the service You pay **$0-$100** 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	Prior authorization is required for some services by your doctor or other network provider. Please contact the plan for more information.
You pay **$0** copay for one routine hearing exam and one hearing aid fitting-evaluation every year You pay **$0** copay for two hearing aids (1 per ear) per year You are responsible for payment of any amount in excess of the maximum **$2,000 ($1000 per hearing aid).**	You pay **$0** copay for one routine hearing exam and one hearing aid fitting-evaluation every year You pay **$0** copay for two hearing aids (1 per ear) per year You 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. For Plans **093**, **094** and **105,** we pay up to a maximum of **$1,000 ($500 per hearing aid)** for hearing aid benefit every year. For Plan **104,** we pay up to a maximum of **$2,000 ($1000 per hearing aid)** for hearing aid benefit every year.

Premiums and Benefits	Freedom Platinum Plan Rx (HMO)_093	Freedom Platinum Plan Rx (HMO)_094
Dental Services		
• **Oral Exam & Cleaning**	You pay **$0** copay for Oral Exam, 2 per year, **$0** copay for Problem Focused Exam, 2 per year and **$0** copay for Cleaning, 2 per year	You pay **$0** copay for Oral Exam, 2 per year, **$0** copay for Problem Focused Exam, 2 per year and **$0** copay for Cleaning, 2 per year
• **Fluoride Treatment**	You pay **$0** copay for fluoride treatment, 2 per year	You pay **$0** copay for fluoride treatment, 2 per year
• **Dental X-rays**	You pay **$0** copay for Dental X-rays	You pay **$0** copay for Dental X-rays
• **Extraction of Tooth**	You pay **$0** copay for extraction of tooth, 1 procedure per year	You pay **$0** copay for extraction of tooth, 1 procedure per year
• **Fillings**	You pay **$0** copay for resin filling or restoration, 1 per year	You pay **$0** copay for resin filling or restoration, 1 per year
• **Debridement**	You pay **$0** copay for full mouth debridement, 1 per 2 years	You pay **$0** copay for full mouth debridement, 1 per 2 years
• **Deep Cleaning *(Scaling/Root Planing)***	You pay **$0** copay for Scaling/Root Planing	You pay **$0** copay for Scaling/Root Planing
• **Crown**	Not Covered	Not covered
• **Periodontal Maintenance**	You pay **$0** copay for 2 procedures per year	You pay **$0** copay for 2 procedures per year
• **Dentures/Denture Reline**	Not covered	Not covered

Freedom Platinum Plus Plan Rx (HMO)_104	Freedom Platinum Rewards Plan Rx (HMO)_105	What you should know
You pay **$0** copay for Oral Exam, 2 per year, **$0** copay for Problem Focused Exam, 2 per year and **$0** copay for Cleaning, 2 per year	You pay **$0** copay for Oral Exam, 2 per year, **$0** copay for Problem Focused Exam, 2 per year and **$0** copay for Cleaning, 2 per year	Prior Authorization may be required, and services must be performed by a participating Dental provider. For more details or to get a complete list of services we cover, please refer to your Evidence of Coverage.
You pay **$0** copay for fluoride treatment, 2 per year	You pay **$0** copay for fluoride treatment, 2 per year	For all plans, you pay **$0** copay for Medicare-covered dental benefit.
You pay **$0** copay for Dental X-rays	You pay **$0** copay for Dental X-rays	
You pay **$0** copay for extraction of tooth, 2 procedures per year	You pay **$0** copay for extraction of tooth, 1 procedure per year	
You pay **$0** copay for resin filling or restoration, 2 per year	You pay **$0** copay for resin filling or restoration, 1 per year	
You pay **$0** copay for full mouth debridement, 1 per 2 years	You pay **$0** copay for full mouth debridement, 1 per 2 years	
You pay **$0** copay for Scaling/Root Planing	You pay **$0** copay for Scaling/Root Planing	For Scaling/Root Planing, 4 procedures per year and limited to 1 procedure per quadrant per year.
You pay **$0** copay for porcelain/ceramic or porcelain fused to high noble metal crown, 1 per year	Not Covered	
You pay **$0** copay for 2 procedures per year	You pay **$0** copay for 2 procedures per year	
You pay **$0** copay for partial or full set of dentures, 1 set every 5 years and **$0** copay for denture reline 1 per year	Not covered	

Premiums and Benefits	Freedom Platinum Plan Rx (HMO)_093	Freedom Platinum Plan Rx (HMO)_094
Vision Services • **Routine Eye Exam** • **Eyeglasses *(Frames and Lenses)***	You pay **$0** copay for routine eye exam 1 every year by an Optometrist You pay **$10** copay for the plan coverage limit for 1 pair of eyeglasses or contact lenses per year You pay **$0** copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery You will be responsible for the **$10** copay and any amount over the plan benefit maximum total retail cost of **$150** for eyewear benefit	You pay **$0** copay for routine eye exam 1 every year by an Optometrist You pay **$10** copay for the plan coverage limit for 1 pair of eyeglasses or contact lenses per year You pay **$0** copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery You will be responsible for the **$10** copay and any amount over the plan benefit maximum total retail cost of **$150** for eyewear benefit
Mental Health Services • **Inpatient Visit** • **Outpatient Group Therapy Visit** • **Outpatient Individual Therapy Visit**	You pay **$60** copay each day for days 1-7 and **$0** copay each day for days 8-90 per admission You pay **$10** copay for outpatient group/individual therapy visit	You pay **$40** copay each day for days 1-5 and **$0** copay each day for days 6-90 per admission You pay **$5** copay for outpatient group/individual therapy visit
Skilled Nursing Facility	You pay **$0** copay each day for days 1-20 You pay **$150** copay each day for days 21-100	You pay **$0** copay each day for days 1-20 You pay **$150** copay each day for days 21-100

Freedom Platinum Plus Plan Rx (HMO)_104	Freedom Platinum Rewards Plan Rx (HMO)_105	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 for 2 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 any amount over the plan benefit maximum total retail cost of **$400** for eyewear benefit	You pay **$0** copay for routine eye exam 1 every year by an Optometrist You pay **$10** copay for the plan coverage limit for 1 pair of eyeglasses or contact lenses per year You pay **$0** copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery You will be responsible for the **$10** copay and any amount over the plan benefit maximum total retail cost of **$150** 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. Services must be performed by a participating Vision provider. You pay nothing for exams to diagnose and treat diseases and conditions of the eye by an Optometrist. For Plans **093, 094** and **105,** the coverage limit is **$150** for eyewear (eyeglasses or contact lenses) per benefit year. For plan **104** the coverage limit is **$400** for eyewear (eyeglasses or contact lenses) per benefit year.
You pay **$0** You pay **$0**	You pay **$195** copay each day for days 1-5 and **$0** copay each day for days 6-90 per admission You pay **$25** 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.
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.

Premiums and Benefits	Freedom Platinum Plan Rx (HMO)_093	Freedom Platinum Plan Rx (HMO)_094
Physical Therapy ***(Rehabilitation Services)*** • **Occupational Therapy Visit** • **Physical Therapy Visit** • **Speech Therapy Visit** • **Language Therapy Visit**	You pay **$10** copay	You pay **$5** copay
Ambulance	You pay **$150** copay for Medicare-covered one-way ground ambulance services You pay **20%** coinsurance for Medicare-covered one-way air ambulance services	You pay **$150** copay for Medicare-covered one-way ground ambulance services You pay **20%** coinsurance for Medicare-covered one-way air ambulance services
Transportation	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
Ambulatory Surgery Center	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 **$25** copay for each Medicare-covered ambulatory surgical center visit You pay **$100** copay for each Medicare-covered outpatient hospital facility visit

Freedom Platinum Plus Plan Rx (HMO)_104	Freedom Platinum Rewards Plan Rx (HMO)_105	What you should know
You pay **$0** copay	You pay **$25** copay	For rehabilitative services, you will need a referral or authorization from your PCP first depending on the specific service. There may be limits on physical therapy, occupational therapy, and speech and language pathology services. Contact the plan for details.
You pay **$150** copay for Medicare-covered one-way ground ambulance services You pay **20%** coinsurance for Medicare-covered one-way air ambulance services	You pay **$175** copay for Medicare-covered one-way ground ambulance services You pay **20%** coinsurance for Medicare-covered one-way air ambulance services	Prior Authorization may be required. Contact the Plan for details.
You pay **$0** copay for unlimited one-way trips every year	You pay **$0** copay for up to **12** one-way trips every year	Transportation is intended for rides to and/or from plan approved locations for medical appointments and health needs within your county. Call to schedule a ride at least 72 hours prior to scheduled medical appointment.
You pay **$0** copay for each Medicare-covered ambulatory surgical center visit You pay **$100** copay for each Medicare-covered outpatient hospital facility visit	You pay **$25** copay for each Medicare-covered ambulatory surgical center visit You pay **$195** 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	Freedom Platinum Plan Rx (HMO)_093	Freedom Platinum Plan Rx (HMO)_094
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
Foot Care *(Podiatry Services)* • **Foot Exams and Treatment**	You pay **$10** copay	You pay **$5** copay
Medical Equipment/Supplies • **Durable Medical Equipment *(e.g., wheelchairs, oxygen)*** • **Prosthetics *(e.g., braces, artificial limbs)*** • **Diabetes Supplies**	You pay **20%** coinsurance You pay **20%** coinsurance You pay **0-20%** coinsurance	You pay **20%** coinsurance You pay **20%** coinsurance You pay **0-20%** coinsurance

Freedom Platinum Plus Plan Rx (HMO)_104	Freedom Platinum Rewards Plan Rx (HMO)_105	What you should know
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 Medicare Part D. Please refer to your Evidence of Coverage for more details.
You pay **$0** copay	You pay **$25** copay	Covered podiatry benefits are for medically necessary foot care. You will need to have a referral or authorization from your PCP first depending on the service.
You pay **20%** coinsurance You pay **20%** coinsurance You pay **0-20%** coinsurance	You pay **20%** coinsurance You pay **20%** coinsurance You pay **0-20%** coinsurance	We cover all medically necessary Durable Medical Equipment covered by Original Medicare. You will need to have a referral or authorization from your PCP first depending on the service. You pay **$0** for Diabetic Monitors, Lancets and Test Strips when ordered through the Plan's Mail Order Program. You pay **20%** for all diabetic supplies from a retail pharmacy.

Premiums and Benefits	Freedom Platinum Plan Rx (HMO)_093	Freedom Platinum Plan Rx (HMO)_094
Wellness • **Fitness** • **24 Hour Nurse Advice Line**	You pay **$0** copay You pay **$0** copay	You pay **$0** copay You pay **$0** copay
Over The Counter *(OTC)*	**$60** Monthly Allowance *The plan doesn't allow you to roll over any remaining OTC allowance into the next month*	**$50** Monthly Allowance *The plan doesn't allow you to roll over any remaining OTC allowance into the next month*
In-Home Support Services *(Papa's Pals)*	You pay **$0** copayment for Up to **30 hours** of companion services per year	You pay **$0** copayment for Up to **30 hours** of companion services per year
Personal Emergency Response System *(PERS)*	Not covered	Not covered

Freedom Platinum Plus Plan Rx (HMO)_104	Freedom Platinum Rewards Plan Rx (HMO)_105	What you should know
You pay **$0** copay You pay **$0** copay	You pay **$0** copay You pay **$0** copay	Health Club Memberships are limited to participating facilities. Health Advice from a nursing professional, available 24 hours a day, 7 days a week.
$75 Monthly Allowance *The plan doesn't allow you to roll over any remaining OTC allowance into the next month*	**$50** Monthly Allowance *The plan doesn't allow you to roll over any remaining OTC allowance into the next month*	Please contact the plan or visit our website for specific instructions for using this benefit and our list of covered Over-the-Counter items. Call Member Services at 1-800-401-2740, TTY users call 711, or visit our website at www.freedomhealth.com.
You pay **$0** copayment for Up to **30 hours** of companion services per year	You pay **$0** copayment for Up to **30 hours** of companion services per year	Services include but are not limited to Household Chores, Companionship and Technical Guidance. Services are scheduled in 1-hour increments. Please call 1-888-228-5958 for specific instructions for using this benefit. TTY users call 711.
You pay **$0** copayment for **1 Personal Emergency Response (PERS)** monitoring device and monitoring service	Not covered	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. You must use the plan's contracted provider/vendor. For more details contact Member Services at 1-800-401-2740, TTY users call 711.

Outpatient Prescription Drugs			
Freedom Platinum Plan Rx (HMO)_093			
	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** **$30 Copay** **$70 Copay** **33% of the Cost**	 **$0 Copay** **$60 Copay** **$140 Copay** **Long Term Supply Not Available**	Cost Sharing may change depending on the pharmacy you choose and when you enter another phase of Part D benefit. You pay your cost share until your total yearly drug costs reach **$4,430**. Not all drugs qualify for a 90-day supply. Some Tier 1 medications allow up to a 100-day supply. For more information, please call us or access our Evidence of Coverage online. If you reside in a long-term care facility, you pay the same as a Standard Retail one-month supply for a 34-day supply.
Coverage Gap Stage **Tier 1: Preferred Generic**	 **$0 Copay**	 **$0 Copay**	For all other drugs, you pay **25%** of the price for brand drugs and **25%** of the price for all generic drugs (plus a portion of the dispensing fee). You stay in this stage until your out-of-pocket costs reach a total of **$7,050**.
Catastrophic Coverage Stage	You pay the greater of: • **5%** of the cost of the drug, or • **$3.95** copay for generic (including drugs treated as generic) and **$9.85** 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)_094			
	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** **$25 Copay** **$70 Copay** **33% of the Cost**	 **$0 Copay** **$50 Copay** **$140 Copay** **Long Term Supply Not Available**	Cost Sharing may change depending on the pharmacy you choose and when you enter another phase of Part D benefit. You pay your cost share until your total yearly drug costs reach **$4,430**. Not all drugs qualify for a 90-day supply. Some Tier 1 medications allow up to a 100-day supply. For more information, please call us or access our Evidence of Coverage online. If you reside in a long-term care facility, you pay the same as a Standard Retail one-month supply for a 34-day supply.
Coverage Gap Stage **Tier 1: Preferred Generic**	 **$0 Copay**	 **$0 Copay**	For all other drugs, you pay **25%** of the price for brand drugs and **25%** of the price for all generic drugs (plus a portion of the dispensing fee). You stay in this stage until your out-of-pocket costs reach a total of **$7,050**.
Catastrophic Coverage Stage	You pay the greater of: • **5%** of the cost of the drug, or • **$3.95** copay for generic (including drugs treated as generic) and **$9.85** 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 Plus Plan Rx (HMO)_104			
	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** **$20 Copay** **$60 Copay** **33% of the Cost**	 **$0 Copay** **$40 Copay** **$120 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 **$4,430**. Not all drugs qualify for a 90-day supply. Some Tier 1 medications allow up to a 100-day supply. For more information, please call us or access our Evidence of Coverage online. If you reside in a long-term care facility, you pay the same as a Standard Retail one-month supply for a 34-day supply.
Coverage Gap Stage **Tier 1: Preferred Generic**	 **$0 Copay**	 **$0 Copay**	For all other drugs, you pay **25%** of the price for brand drugs and **25%** of the price for all generic drugs (plus a portion of the dispensing fee). You stay in this stage until your out-of-pocket costs reach a total of **$7,050**.
Catastrophic Coverage Stage	You pay the greater of: • **5%** of the cost of the drug, or • **$3.95** copay for generic (including drugs treated as generic) and **$9.85** 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)_105			
	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 **$4,430**. 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	During this stage, you pay **25%** of the price for brand drugs and **25%** of the price for all generic drugs (plus a portion of the dispensing fee). You stay in this stage until your out-of-pocket costs reach a total of **$7,050**.		
Catastrophic Coverage Stage	You pay the greater of: • **5%** of the cost of the drug, or • **$3.95** copay for generic (including drugs treated as generic) and **$9.85** copay for all other drugs • Our Plan pays the rest of the cost		During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year.

If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

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

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

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at www.freedomhealth.com.

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

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

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

Discrimination Is Against the Law

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

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

Freedom Health, Inc.:

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

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

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

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

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

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

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

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

Multi-Language Insert / 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 1-866-245-5360 (TTY: 711).

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-245-5360 (TTY: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-245-5360 (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 1-866-245-5360 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-245-5360 (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 1-866-245-5360 (TTY: 711) 。

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-245-5360 (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 1-866-245-5360 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-245-5360 (телетайп: 711).

العربية (Arabic):

العربية ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-245-5360 (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 1-866-245-5360 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-245-5360 (TTY: 711).

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-245-5360 (TTY: 711) 번으로 전화해 주십시오.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-245-5360 (TTY: 711).

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-245-5360 (TTY: 711).

ภาษาไทย (Thai): เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-866-245-5360 (TTY: 711).

ΠΡΟΣΟΧΗ (Greek): Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-866-245-5360 (TTY: 711).

2022 Summary of Benefits

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

www.freedomhealth.com

SB Combo *093 – 094 – 104 – 105*
093 - Freedom Platinum Plan Rx (HMO) **Counties:** Citrus
094 - Freedom Platinum Plan Rx (HMO) **Counties:** Lake, Marion, and Sumter
104 – Freedom Platinum Plus Plan Rx (HMO) **Counties:** Lake, Marion, and Sumter
105 – Freedom Platinum Rewards Plan Rx (HMO) **Counties:** Charlotte, Collier, and Lee