Dual Eligible Special Needs Plan 2024

F24SBDUAL

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

H5427_2024_SB_078_087_M

2024 Summary of Benefits

Summary of Benefits
January 1, 2024 - December 31, 2024

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. Benefits vary by plan.

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 Dual Special Needs Plan (D-SNP) through 2026 based on a review 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. covers emergency care and urgently needed services from Out-of-network providers. For routine care, you must use the Freedom Health network of providers, hospital, and pharmacies while in the plan's service area. Neither Medicare nor Freedom Health, Inc. will be responsible for the costs incurred of routine care received from out-of-network providers. 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 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 **$25.90**	You pay up to **$16.80**	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.
$500 annually	**$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
Ambulatory Surgery Center	You pay **$0** copay for Medicaid Covered Services.
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 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.
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. **$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 **$0** copay	You pay **$0** 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.

Premiums and Benefits	Medicaid Benefits
Diagnostic Services/Labs/Imaging • **Diagnostic Radiology Services *(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 Fitting-Evaluation** • **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 **$2,000** (**$1000 per hearing aid)** for hearing aid benefit every year. You are responsible for payment of any amount in excess of the maximum **$2,000 ($1000 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 of Tooth** • **Fillings** • **Debridement** • **Deep Cleaning (Scaling/Root Planing)** • **Crown** • **Dentures/Denture Reline** • **Periodontal Maintenance**	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, **$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. For all plans, you pay **$0** copay for Medicare-covered dental benefit.
You pay **$0** copay for fluoride treatment, 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 Dental X-rays	
You pay **$0** copay for extraction of tooth, 2 procedures per year	You pay **$0** copay for extraction of tooth, 2 procedures per year	
You pay **$0** copay for resin filling or restoration, 2 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 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	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 set every 5 years and **$0** copay for denture reline 1 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	
You pay **$0** copay for 2 procedures per year	You pay **$0** copay for 2 procedures per year	

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. Additional days may be available.

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 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 The Plan coverage limit is **$400** for eyewear (eyeglasses or contact lenses) every year for the total retail cost of up to 2 pairs combined.	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 The Plan coverage limit is **$400** for eyewear (eyeglasses or contact lenses) every year for the total retail cost of up to 2 pairs combined.	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. Services must be performed by a participating Vision provider. You will be responsible for any amount over the plan benefit maximum total retail cost of **$400** for eyewear up to 2 pairs combined.
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 for days 1-100	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 Visit** • **Speech Therapy Visit** • **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.
Medicare Part B Drugs	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	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 for Medicare-covered one-way air ambulance services	You pay **$0** copay for Medicare-covered one-way ground ambulance services and 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 unlimited 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 **20%** of the cost for chemotherapy drugs and for other Part B drugs For Part B insulins, you pay **$0** for a one-month supply	You pay **20%** of the cost for chemotherapy drugs and for other Part B drugs For Part B insulins, you pay **$0** for a one-month supply	The Plan may require authorization to determine whether certain drugs are covered by Medicare Part B or Part D. You may see lower out-of-pocket costs for certain chemotherapy and Part B drugs with prices that have increased faster than the rate of inflation. Please refer to your Evidence of Coverage for more details.

Premiums and Benefits	Medicaid Benefits
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)***	You pay **$0** copay for Medicaid Covered Services.
• **Prosthetics *(e.g., braces, artificial limbs)***	
• **Diabetes Supplies**	
Wellness	
• **Fitness**	Not Covered
• **24 Hour Nurse Advice 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	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.
$125 Monthly Allowance *The plan doesn't allow you to roll over any remaining OTC allowance into the next month*	**$125** 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

Premiums and Benefits	Medicaid Benefits
In-Home Support Service	Not Covered
Personal Emergency Response System (PERS)	Not Covered
Everyday Options Allowance	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** 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 light 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.	You pay **$0** copayment **for 1 Personal Emergency Response (PERS)** monitoring device and monitoring service.	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.
$175 Monthly allowance *Unused monthly amounts do not roll over to the next month or year.*	**$175** Monthly allowance *Unused monthly amounts do not roll over to the next month or year.*	This benefit provides a combined monthly spending allowance for eligible food items, home and pet care supplies, and utilities. You have a variety of convenient ways to use the benefit: • Shop in-store at participating retailers near you • Shop online on the approved vendor website • Shop on the approved vendor mobile app • Call to place an order • With your utility provider

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**.**
Because you receive "Extra Help" you pay **$0** copay for all covered drugs during the following Drug Payment Stages: Deductible Stage, Initial Coverage Stage, Coverage Gap Stage and Catastrophic Coverage Stage. *** Important Message About What You Pay for Vaccines and Insulin**- Our plan covers most Part D vaccines at no cost to you and because you receive "Extra Help" you won't pay more than **$0** for a one-month supply for any covered Insulin.

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**.**
Because you receive "Extra Help" you pay **$0** copay for all covered drugs during the following Drug Payment Stages: Deductible Stage, Initial Coverage Stage, Coverage Gap Stage and Catastrophic Coverage Stage. *** Important Message About What You Pay for Vaccines and Insulin**- Our plan covers most Part D vaccines at no cost to you and because you receive "Extra Help" you won't pay more than **$0** for a one-month supply for any covered Insulin.

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) H5427_078** and **Freedom Medi-Medi Full (HMO D-SNP) H5427_087** 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 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: https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/florida-medicaid-s-covered-services-and-hcbs-waivers.

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 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.

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 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. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at www.freedomhealth.com.

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/smartscreen/main.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 https://www.hhs.gov/ocr/complaints/index.html.

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-401-2740 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-401-2740 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-401-2740 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-401-2740 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-401-2740 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-401-2740 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-401-2740 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-401-2740 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-401-2740 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-401-2740 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic : إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-401-2740 (TTY:711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-401-2740 (TTY: 711)पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-401-2740 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-401-2740 (TTY: 711). Irá encontrar alguém que fale o idioma Portugués para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-401-2740 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer1-800-401-2740 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-401-2740 (TTY: 711)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Dual Eligible Special Needs Plan 2024

2024 Summary of Benefits

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

www.freedomhealth.com

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