# HMO – Point of Service (POS) 2024

F24SBMAX




FREEDOM HEALTH

## *SB Combo 112 - 113*

**112 - Freedom Máximo – (HMO-POS)**

**Counties:** Orange, Osceola, and Seminole

**113 - Freedom Máximo – (HMO-POS)**

**Counties:** Hillsborough and Polk

H5427_2024_SB_112_113_M

# *2024 Summary of Benefits*

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

## Freedom Máximo (HMO-POS) H5427_112
## Freedom Máximo (HMO-POS) H5427_113

The purpose of the Summary of Benefits is to provide you with a summary of drug and health benefits covered by **Freedom Máximo (HMO-POS) H5427_112** and **Freedom Máximo (HMO-POS) H5427_113,** 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. Enrollment in Freedom Health, Inc. depends on contract renewal.

To be eligible for **Freedom Máximo (HMO-POS) H5427_112** or **Freedom Máximo (HMO-POS) H5427_113,** 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 Máximo (HMO-POS) H5427_112:** Orange, Osceola, and Seminole
**Freedom Máximo (HMO-POS) H5427_113:** Hillsborough and Polk

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, and from a plan-approved provider network when using your Point-of-Service benefit in Puerto Rico. Neither Medicare nor Freedom Health, Inc. will be responsible for the costs incurred of routine care received from out-of-network providers except while utilizing your POS benefit with plan-approved providers while in Puerto Rico. 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 | Freedom Máximo (HMO-POS)_112 |
|---|---|
| **Monthly Plan Premium** | You pay **$0**<br><br>Freedom Health, Inc. will reduce your Medicare Part B premium by up to **$164.90** |
| **Deductible** | You pay **$0** |

| Premiums and Benefits | Freedom Máximo (HMO-POS)_112 In-Network Benefits | Freedom Máximo (HMO-POS)_112 Out-of-Network Benefits |
|---|---|---|
| **Maximum Out-of-Pocket Responsibility** *(does not include prescription drugs)* | **$3,400** annually | **$3,400** annually *(Combined In-Network and Out-of-Network)* |
| **Inpatient Hospital Coverage** | You pay **$195** copay each day for days 1 through 5 and **$0** copay each day for days 6 through 90 per admission | You pay **$195** copay each day for days 1 through 5 and **$0** copay each day for days 6 through 90 per admission |
| **Outpatient Hospital Coverage** | You pay **$195** copay per visit | You pay **$195** copay per visit |

| Freedom Máximo (HMO-POS)_113 | | What you should know |
|---|---|---|
| You pay **$0**<br><br>Freedom Health, Inc. will reduce your Medicare Part B premium by up to **$164.90** | | You must continue to pay your Medicare Part B Premium unless your Part B Premium is paid for you by Medicaid or another third party. |
| You pay **$0** | | These plans do not have a deductible. |
| **Freedom Máximo (HMO-POS)_113 In-Network Benefits** | **Freedom Máximo (HMO-POS)_113 Out-of-Network Benefits** | **What you should know** |
| **$1,900** annually | **$1,900** annually *(Combined In-Network and Out-of-Network)* | This is the most you pay for copays, coinsurance, and other costs for medical services for the year.<br><br>Contact the Plan for details on what is covered in the Maximum Out-of-Pocket. |
| You pay **$95** copay each day for days 1 through 5 and **$0** copay each day for days 6 through 90 per admission | You pay **$95** 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. |
| You pay **$95** copay per visit | You pay **$95** copay per visit | Prior authorization is required for some services by your doctor or other network provider. Please contact the Plan for more information.<br><br>Services include but are not limited to Medicare-covered outpatient hospital facility visits, clinic, outpatient treatment room, observation room, or outpatient surgery services. |

| Premiums and Benefits | Freedom Máximo (HMO-POS)_112 In-Network Benefits | Freedom Máximo (HMO-POS)_112 Out-of-Network Benefits |
|---|---|---|
| **Ambulatory Surgery Center** | You pay **$25**<br><br>You pay **$195** copay for each Medicare-covered outpatient hospital facility visit | You pay **$25**<br><br>You pay **$195** copay for each Medicare-covered outpatient hospital facility visit |
| **Doctor's Visits**<br><br>• **Primary**<br><br>• **Specialists** | <br><br>You pay **$0** copay per visit<br><br>You pay **$10** copay per visit | <br><br>You pay **$0** copay per visit<br><br>You pay **$10** copay per visit |
| **Preventive Care** | You pay **$0** copay | You pay **$0** copay |
| **Emergency Care** | You pay **$120** copay per visit | You pay **$120** copay per visit |

| Freedom Máximo (HMO-POS)_113 In-Network Benefits | Freedom Máximo (HMO-POS)_113 Out-of-Network Benefits | What you should know |
|---|---|---|
| You pay **$25**<br><br>You pay **$95** copay for each Medicare-covered outpatient hospital facility visit | You pay **$25**<br><br>You pay **$95** copay for each Medicare-covered outpatient hospital facility visit | Prior authorization may be required. Contact the Plan for details.<br><br>If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. |
| You pay **$0** copay per visit<br><br>You pay **$10** copay per visit | You pay **$0** copay per visit<br><br>You pay **$10** copay per visit | Your primary care physician will coordinate the covered services you receive as a member of our plan.<br><br>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 **$120** copay per visit | You pay **$120** 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 Máximo (HMO-POS)_112 In-Network Benefits | Freedom Máximo (HMO-POS)_112 Out-of-Network Benefits |
|---|---|---|
| **Urgently Needed Services** | You pay **$10** copay | You pay **$10** copay |
| **Diagnostic Services/Labs/Imaging** | | |
| • **Diagnostic Radiology Service *(e.g., MRI)*** | You pay **$25-$195** copay depending on the service | You pay **$25-$195** copay depending on the service |
| • **Lab Services** | You pay **$0-$50** copay depending on the place of service | You pay **$0-$50** copay depending on the place of service |
| • **Diagnostic Tests and Procedures** | You pay **$0-$195** copay or **20%** coinsurance depending on the service | You pay **$0-$195** copay or **20%** coinsurance depending on the service |
| • **Outpatient X-rays** | You pay **$0-$195**copay depending on the service | You pay **$0-$195** copay depending on the service |
| • **Therapeutic Radiology** | You pay **20%** coinsurance for Therapeutic Radiology | You pay **20%** coinsurance for Therapeutic Radiology |
| **Hearing Services** | You pay **$0** copay for one routine hearing exam and one hearing aid fitting-evaluation every year | Not Covered |
| • **Hearing Exam/Hearing Aid Fitting-Evaluation** | | |
| • **Hearing Aid** | You pay **$0** copay for two hearing aids (1 per ear) per year | Not Covered |
| | Our Plan pays up to a maximum of **$1,500 ($750 per hearing aid)** for hearing aid benefit every year. | Not Covered |

| Freedom Máximo (HMO-POS)_113 In-Network Benefits | Freedom Máximo (HMO-POS)_113 Out-of-Network Benefits | 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-$95** copay depending on the service<br><br>You pay **$0-$50** copay depending on the place of service<br><br>You pay **$0-$95** copay or **20%** coinsurance depending on the service<br><br>You pay **$0-$95** copay depending on the service<br><br>You pay **20%** coinsurance for Therapeutic Radiology | You pay **$25-$95** copay depending on the service<br><br>You pay **$0-$50** copay depending on the place of service<br><br>You pay **$0-$95** copay or **20%** coinsurance depending on the service<br><br>You pay **$0-$95** copay depending on the service<br><br>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<br><br>You pay **$0** copay for two hearing aids (1 per ear) per year<br><br>Our Plan pays up to a maximum of **$1,500 ($750 per hearing aid)** for hearing aid benefit every year. | Not Covered<br><br>Not Covered<br><br>Not Covered | For all plans, you pay **$0** copay for Medicare-covered diagnostic hearing exam.<br><br>You are responsible for payment of any amount in excess of the maximum **$1,500 ($750 per hearing aid).** |

| Premiums and Benefits | Freedom Máximo (HMO-POS)_112 In-Network Benefits | Freedom Máximo (HMO-POS)_112 Out-of-Network Benefits |
|---|---|---|
| **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 | Not Covered |
| • **Fluoride Treatment** | You pay **$0** copay for fluoride treatment, 2 per year | Not Covered |
| • **Dental X-rays** | You pay **$0** copay for Dental X-rays | Not Covered |
| • **Extraction of Tooth** | You pay **$0** copay for extraction of tooth, 1 procedure per year | Not Covered |
| • **Fillings** | You pay **$0** copay for resin filling or restoration, 1 per year | Not Covered |
| • **Debridement** | You pay **$0** copay for full mouth debridement, 1 per 2 years | Not Covered |
| • **Deep Cleaning *(Scaling/Root Planing)*** | You pay **$0** copay for Scaling/Root Planing | Not Covered |
| • **Periodontal Maintenance** | You pay **$0** copay for 2 procedures per year | Not Covered |

| Freedom Máximo (HMO-POS)_113 In-Network Benefits | Freedom Máximo (HMO-POS)_113 Out-of-Network Benefits | 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 | Not Covered | Prior Authorization may be required, and services must be performed by a participating Dental provider.<br><br>For more details or to get a complete list of services we cover, please refer to your Evidence of Coverage.<br><br>For all plans, you pay **$0** copay for Medicare-covered dental services. |
| You pay **$0** copay for fluoride treatment, 2 per year | Not Covered | |
| You pay **$0** copay for Dental X-rays | Not Covered | |
| You pay **$0** copay for extraction of tooth, 1 procedure per year | Not Covered | |
| You pay **$0** copay for resin filling or restoration, 1 per year | Not Covered | |
| You pay **$0** copay for full mouth debridement, 1 per 2 years | Not Covered | |
| You pay **$0** copay for Scaling/Root Planing | Not Covered | For Plans that cover Scaling/Root Planing, coverage includes 4 procedures per year and is limited to 1 procedure per quadrant per year. |
| You pay **$0** copay for 2 procedures per year | Not Covered | |

| Premiums and Benefits | Freedom Máximo (HMO-POS)_112 In-Network Benefits | Freedom Máximo (HMO-POS)_112 Out-of-Network Benefits |
|---|---|---|
| **Vision Services**<br>• **Routine Eye Exam**<br>• **Eyeglasses *(Frames and Lenses)*** | You pay **$0** copay for routine eye exam 1 every year by an Optometrist<br><br>You pay **$0** copay for the plan coverage limit for 1 pair of eyeglasses or contact lenses per year<br><br>You pay **$0** copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery<br><br>You will be responsible for any amount over the plan benefit maximum total retail cost of **$300** for eyewear benefit<br><br>The coverage limit is **$300** for eyewear (eyeglasses or contact lenses) per year | Not Covered<br><br>Not Covered<br><br>You pay **$0** copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery<br><br>Not Covered<br><br>Not Covered |
| **Mental Health Services**<br>• **Inpatient Visit**<br><br>• **Outpatient Group Therapy Visit**<br>• **Outpatient Individual Therapy Visit** | You pay **$195** copay each day for days 1-5 and **$0** copay each day for days 6**-**90 per admission<br><br>You pay **$10** copay for outpatient group/individual therapy visit | You pay **$195** copay each day for days 1-5 and **$0** copay each day for days 6**-**90 per admission<br><br>You pay **$10** copay for outpatient group/individual therapy visit |

| Freedom Máximo (HMO-POS)_113 In-Network Benefits | Freedom Máximo (HMO-POS)_113 Out-of-Network Benefits | What you should know |
|---|---|---|
| You pay **$0** copay for routine eye exam 1 every year by an Optometrist | Not Covered | Eye exams to diagnose and treat diseases and conditions of the eye by an Ophthalmologist are subject to the Specialist copay. |
| You pay **$0** copay for the plan coverage limit for 1 pair of eyeglasses or contact lenses per year | Not Covered | Contact the Plan for additional supplemental benefits. Services must be performed by a participating Vision provider. |
| You pay **$0** copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery | You pay **$0** copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery | You pay nothing for exams to diagnose and treat diseases and conditions of the eye by an Optometrist. |
| You will be responsible for any amount over the plan benefit maximum total retail cost of **$300** for eyewear benefit | Not Covered | |
| The coverage limit is **$300** for eyewear (eyeglasses or contact lenses) per year | Not Covered | |
| You pay **$95** copay each day for days 1-5 and **$0** copay each day for days 6**-**90 per admission | You pay **$95** copay each day for days 1-5 and **$0** copay each day for days 6**-**90 per admission | 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 **$10** copay for outpatient group/individual therapy visit | You pay **$10** copay for outpatient group/individual therapy visit | |

| Premiums and Benefits | Freedom Máximo (HMO-POS)_112 In-Network Benefits | Freedom Máximo (HMO-POS)_112 Out-of-Network Benefits |
|---|---|---|
| **Skilled Nursing Facility** | You pay **$0** copay each day for days 1-20<br><br>You pay **$150** copay each day for days 21-100 | You pay **$0** copay each day for days 1-20<br><br>You pay **$150** copay each day for days 21-100 |
| **Physical Therapy** ***(Rehabilitation Services)***<br><br>• **Occupational Therapy Visit**<br>• **Physical Therapy Visit**<br>• **Speech Therapy Visit**<br>• **Language Therapy Visit** | You pay **$10** copay | You pay **$10** copay |
| **Ambulance** | You pay **$175** copay for Medicare-covered one-way ground ambulance services<br><br>You pay **20%** coinsurance for Medicare-covered one-way air ambulance services | You pay **$175** copay for Medicare-covered one-way ground ambulance services<br><br>You pay **20%** coinsurance for Medicare-covered one-way air ambulance services |
| **Transportation** | You pay **$0** copay for up to **20** one-way trips every year | Not Covered |

| Freedom Máximo (HMO-POS)_113 In-Network Benefits | Freedom Máximo (HMO-POS)_113 Out-of-Network Benefits | What you should know |
|---|---|---|
| You pay **$0** copay each day for days 1-20<br><br>You pay **$172** copay each day for days 21-100 | You pay **$0** copay each day for days 1-20<br><br>You pay **$172** copay each day for days 21-100 | Our plan covers up to 100 days in a SNF per benefit plan.<br><br>You must get prior authorization in advance before you are admitted to the facility, or your stay may not be covered. |
| You pay **$10** copay | You pay **$10** copay | For rehabilitative services, you will need a referral or authorization from your PCP first depending on the specific service.<br><br>There may be limits on physical therapy, occupational therapy, and speech and language pathology services. Contact the plan for details. |
| You pay **$175** copay for Medicare-covered one-way ground ambulance services<br><br>You pay **20%** coinsurance for Medicare-covered one-way air ambulance services | You pay **$175** copay for Medicare-covered one-way ground ambulance services<br><br>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 up to **20** one-way trips every year | Not Covered | Transportation is intended for rides to and/or from plan approved locations for medical appointments and health needs within your county.<br><br>Call to schedule a ride at least 72 hours prior to scheduled medical appointment. |

| Premiums and Benefits | Freedom Máximo (HMO-POS)_112 In-Network Benefits | Freedom Máximo (HMO-POS)_112 Out-of-Network Benefits |
|---|---|---|
| **Medicare Part B Drugs** | You pay **20%** of the cost for chemotherapy drugs and **20%** of the cost for other Part B drugs<br><br>For Part B insulins, you pay **$35** or less for a one-month supply | You pay **20%** of the cost for chemotherapy drugs and **20%** of the cost for other Part B drugs<br><br>For Part B insulins, you pay **$35** or less for a one-month supply |
| **Foot Care *(Podiatry Services)***<br><br>• **Foot Exams and Treatment** | You pay **$10** copay | You pay **$10** copay |
| **Medical Equipment/Supplies**<br><br>• **Durable Medical Equipment *(e.g., wheelchairs, oxygen)***<br><br>• **Prosthetics *(e.g., braces, artificial limbs)***<br><br>• **Diabetes Supplies** | You pay **20%** coinsurance<br><br>You pay **20%** coinsurance<br><br>You pay **0-20%** coinsurance | You pay **20%** coinsurance<br><br>You pay **20%** coinsurance<br><br>You pay **0-20%** coinsurance |
| **Wellness**<br><br>• **Fitness**<br><br>• **24 Hour Nurse Advice Line** | You pay **$0** copay<br><br>You pay **$0** copay | Not Covered<br><br>Not Covered |

| Freedom Máximo (HMO-POS)_113 In-Network Benefits | Freedom Máximo (HMO-POS)_113 Out-of-Network Benefits | What you should know |
|---|---|---|
| You pay **20%** of the cost for chemotherapy drugs and **20%** of the cost for other Part B drugs<br><br>For Part B insulins, you pay **$35** or less for a one-month supply | You pay **20%** of the cost for chemotherapy drugs and **20%** of the cost for other Part B drugs<br><br>For Part B insulins, you pay **$35** or less for a one-month supply | The Plan may require authorization to determine whether certain drugs are covered by Medicare Part B or Part D.<br><br>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. |
| You pay **$10** copay | You pay **$10** copay | Covered podiatry benefits are for medically necessary foot care.<br><br>You will need to have a referral or authorization from your PCP first depending on the service. |
| You pay **20%** coinsurance<br><br>You pay **20%** coinsurance<br><br>You pay **0-20%** coinsurance | You pay **20%** coinsurance<br><br>You pay **20%** coinsurance<br><br>You pay **0-20%** coinsurance | We cover all medically necessary Durable Medical Equipment covered by Original Medicare.<br><br>You will need to have a referral or authorization from your PCP first depending on the service.<br><br>You pay **$0** for Diabetic Monitors, Lancets and Test Strips when ordered through the Plan's Mail Order Program.<br><br>You pay **20%** for all diabetic supplies from a retail pharmacy. |
| You pay **$0** copay<br><br>You pay **$0** copay | Not Covered<br><br>Not Covered | Health Club Memberships are limited to participating facilities.<br><br>Health Advice from a nursing professional, available 24 hours a day, 7 days a week. |

| Premiums and Benefits | Freedom Máximo (HMO-POS)_112<br>In-Network Benefits | Freedom Máximo (HMO-POS)_112<br>Out-of-Network Benefits |
|---|---|---|
| **Active Fitness** | **$500** Annual Allowance | Not covered |
| **Over The Counter (OTC)** | **$50** Monthly Allowance<br><br>*The plan doesn't allow you to roll over any remaining OTC allowance into the next month* | **$50** Monthly Allowance<br><br>*The plan doesn't allow you to roll over any remaining OTC allowance into the next month* |
| **In-Home Support Services** | You pay **$0** copay for Up to **30 hours** of companion services per year | Not Covered |

| Freedom Máximo (HMO-POS)_113 In-Network Benefits | Freedom Máximo (HMO-POS)_113 Out-of-Network Benefits | What you should know |
|---|---|---|
| **$500** Annual Allowance | Not covered | The Active Fitness benefit provides a spending allowance of **$500** on your Benefits Prepaid Card. This spending allowance may be used for access fees or lesson/clinic costs at sports facilities for golf, swimming and tennis. The allowance cannot be applied to merchandise or other services. Any unused amounts do not carry forward to the next calendar year.<br><br>For more information about this benefit please contact Member Services. |
| **$50** Monthly Allowance<br><br>*The plan doesn't allow you to roll over any remaining OTC allowance into the next month* | **$50** Monthly Allowance<br><br>*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.<br><br>Call Member Services at 1-800-401-2740, TTY users call 711, or visit our website at www.freedomhealth.com. |
| You pay **$0** copay for Up to **30 hours** of companion services per year | Not Covered | 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. |

| Outpatient Prescription Drugs | | | |
|---|---|---|---|
| **Freedom Máximo (HMO-POS)_112 In-Network Benefits** | | | |
| | **Standard Retail Rx 30 – day Supply** | **Standard Mail Order 90 – day Supply** | **What you should know** |
| *** Important Message About What You Pay for Vaccines and Insulin**- Our plan covers most Part D vaccines at no cost to you and you won't pay more than $35 for a one-month supply for any covered Insulin. | | | |
| ***Deductible Stage*** | This stage does not apply to you | | |
| ***Initial Coverage Stage***<br><br>**Tier 1: Preferred Generic**<br><br>**Tier 2: Preferred Brand**<br><br>**Tier 3: Non-Preferred Drug**<br><br>**Tier 4: Specialty Tier** | <br><br>**$0 Copay**<br><br>**$35 Copay**<br><br>**$85 Copay**<br><br>**33% of the Cost** | <br><br>**$0 Copay**<br><br>**$70 Copay**<br><br>**$170 Copay**<br><br>**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 **$5,030**. 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.<br><br>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).<br><br>You stay in this stage until your out-of-pocket costs reach a total of **$8,000.** | | |
| ***Catastrophic Coverage Stage*** | You won't have to pay any coinsurance or copayments during this phase for covered Medicare prescriptions drugs. | | During this stage, the plan will pay the cost of your drugs for the rest of the calendar year. |

| Outpatient Prescription Drugs | | | |
|---|---|---|---|
| **Freedom Máximo (HMO-POS)_112 Out of Network Benefits** | | | |
| | **Standard Retail Rx 30 – day Supply** | **Standard Mail Order 90 – day Supply** | **What you should know** |
| *** Important Message About What You Pay for Vaccines and Insulin**- Our plan covers most Part D vaccines at no cost to you and you won't pay more than $35 for a one-month supply for any covered Insulin. | | | |
| ***Deductible Stage*** | This stage does not apply to you | | |
| ***Initial Coverage Stage***<br><br>**Tier 1: Preferred Generic**<br><br>**Tier 2: Preferred Brand**<br><br>**Tier 3: Non-Preferred Drug**<br><br>**Tier 4: Specialty Tier** | <br><br>**$0 Copay**<br><br>**$35 Copay**<br><br>**$85 Copay**<br><br>**33% of the Cost** | <br><br>**$0 Copay**<br><br>**$70 Copay**<br><br>**$170 Copay**<br><br>**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 **$5,030**. 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.<br><br>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).<br><br>You stay in this stage until your out-of-pocket costs reach a total of **$8,000.** | | |
| ***Catastrophic Coverage Stage*** | You won't have to pay any coinsurance or copayments during this phase for covered Medicare prescriptions drugs. | | During this stage, the plan will pay the cost of your drugs for the rest of the calendar year. |

| Outpatient Prescription Drugs | | | |
|---|---|---|---|
| **Freedom Máximo (HMO-POS)_113 In-Network Benefits** | | | |
| | **Standard Retail Rx 30 – day Supply** | **Standard Mail Order 90 – day Supply** | **What you should know** |
| *** Important Message About What You Pay for Vaccines and Insulin**- Our plan covers most Part D vaccines at no cost to you and you won't pay more than $35 for a one-month supply for any covered Insulin. | | | |
| ***Deductible Stage*** | This stage does not apply to you | | |
| ***Initial Coverage Stage***<br><br>**Tier 1: Preferred Generic**<br><br>**Tier 2: Preferred Brand**<br><br>**Tier 3: Non-Preferred Drug**<br><br>**Tier 4: Specialty Tier** | <br><br>**$0 Copay**<br><br>**$30 Copay**<br><br>**$70 Copay**<br><br>**33% of the Cost** | <br><br>**$0 Copay**<br><br>**$60 Copay**<br><br>**$140 Copay**<br><br>**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 **$5,030**. 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.<br><br>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***<br><br>**Tier 1: Preferred Generic** | <br><br>**$0 Copay** | <br><br>**$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 **$8,000**. |
| ***Catastrophic Coverage Stage*** | You won't have to pay any coinsurance or copayments during this phase for covered Medicare prescriptions drugs. | | During this stage, the plan will pay the cost of your drugs for the rest of the calendar year. |

| Outpatient Prescription Drugs | | | |
|---|---|---|---|
| **Freedom Máximo (HMO-POS)_113 Out of Network Benefits** | | | |
| | **Standard Retail Rx 30 – day Supply** | **Standard Mail Order 90 – day Supply** | **What you should know** |
| *** Important Message About What You Pay for Vaccines and Insulin**- Our plan covers most Part D vaccines at no cost to you and you won't pay more than $35 for a one-month supply for any covered Insulin. | | | |
| ***Deductible Stage*** | This stage does not apply to you | | |
| ***Initial Coverage Stage***<br><br>**Tier 1: Preferred Generic**<br><br>**Tier 2: Preferred Brand**<br><br>**Tier 3: Non-Preferred Drug**<br><br>**Tier 4: Specialty Tier** | <br><br>**$0 Copay**<br><br>**$30 Copay**<br><br>**$70 Copay**<br><br>**33% of the Cost** | <br><br>**$0 Copay**<br><br>**$60 Copay**<br><br>**$140 Copay**<br><br>**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 **$5,030**. 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.<br><br>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***<br><br>**Tier 1: Preferred Generic** | <br><br>**$0 Copay** | <br><br>**$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 **$8,000**. |
| ***Catastrophic Coverage Stage*** | You won't have to pay any coinsurance or copayments during this phase for covered Medicare prescriptions drugs. | | During this stage, the plan will pay 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.

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。

# HMO – Point of Service (POS) 2024

# *2024 Summary of Benefits*

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

www.freedomhealth.com

| *SB Combo 112 - 113* |
| --- |
| **112 - Freedom Máximo – (HMO-POS)**<br>**Counties:** Orange, Osceola, and Seminole |
| **113 - Freedom Máximo – (HMO-POS)**<br>**Counties:** Hillsborough and Polk |