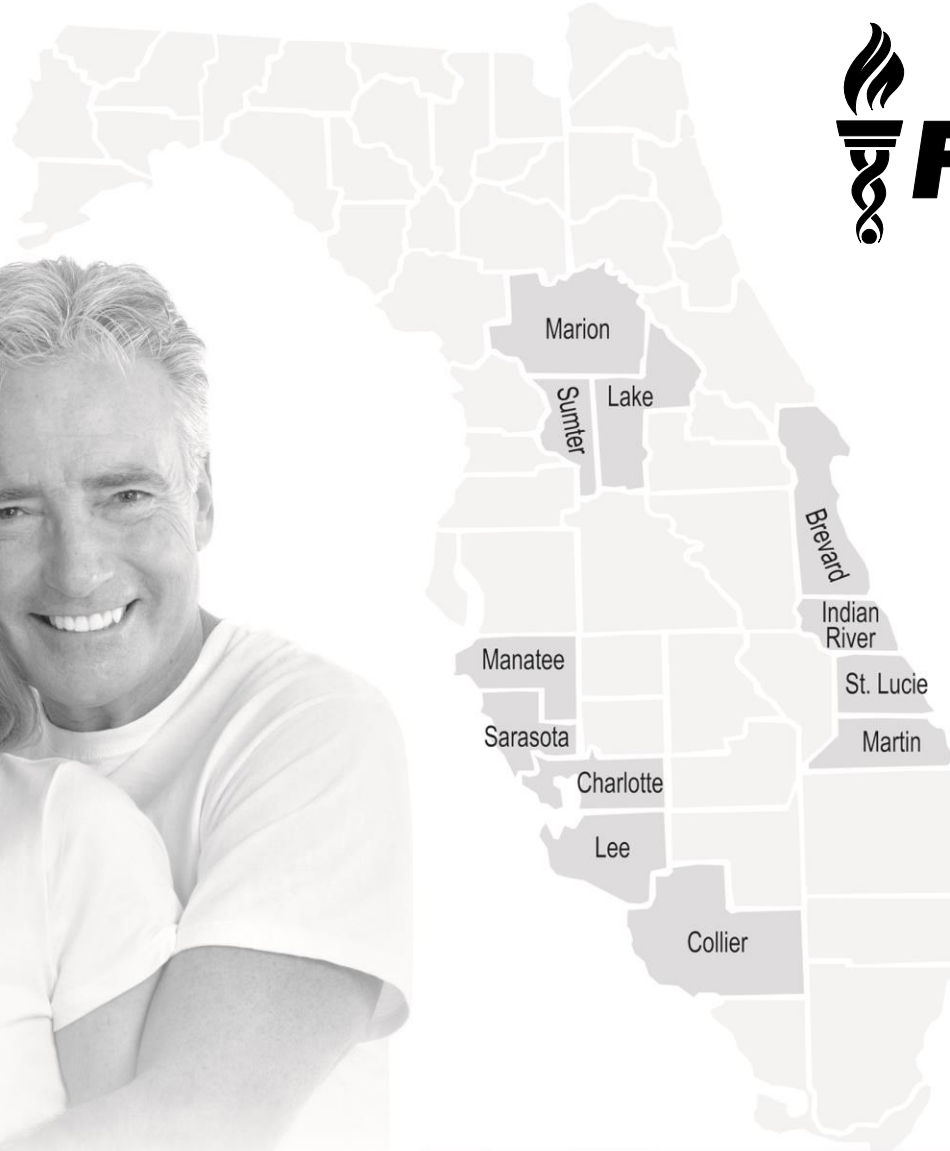


F24SBPLRX2



***SB Combo***  
***104 - 109 - 110 - 111***

**104 – Freedom Platinum Plus Plan Rx (HMO)**

**Counties:** Lake, Marion, and Sumter

**109 – Freedom Platinum Plus Plan Rx (HMO)**

**Counties:** Brevard, Indian River, Martin, and St. Lucie

**110 – Freedom Platinum Plus Plan Rx (HMO)**

**Counties:** Manatee and Sarasota

**111 – Freedom Platinum Plus Plan Rx (HMO)**

**Counties:** Charlotte, Collier, and Lee



# Summary of Benefits

January 1, 2024 - December 31, 2024

**Freedom Platinum Plus Plan Rx (HMO) H5427\_104**

**Freedom Platinum Plus Plan Rx (HMO) H5427\_109**

**Freedom Platinum Plus Plan Rx (HMO) H5427\_110**

**Freedom Platinum Plus Plan Rx (HMO) H5427\_111**

The purpose of the Summary of Benefits is to provide you with a summary of drug and health benefits covered by **Freedom Platinum Plus Plan Rx (HMO) H5427\_104, Freedom Platinum Plus Plan Rx (HMO) H5427\_109, Freedom Platinum Plus Plan Rx (HMO) H5427\_110** and **Freedom Platinum Plus Plan Rx (HMO) H5427\_111**, 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 Platinum Plus Plan Rx (HMO) H5427\_104, Freedom Platinum Plus Plan Rx (HMO) H5427\_109, Freedom Platinum Plus Plan Rx H5427\_110** and **Freedom Platinum Plus Plan Rx (HMO) H5427\_111**, 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 Plus Plan Rx (HMO) H5427\_104:**

Lake, Marion and Sumter

**Freedom Platinum Plus Plan Rx (HMO) H5427\_109:**

Brevard, Indian River, Martin and St. Lucie

**Freedom Platinum Plus Plan Rx H5427\_110:**

Manatee and Sarasota

**Freedom Platinum Plus Plan Rx (HMO) H5427\_111:**

Charlotte, Collier and Lee

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.

H5427\_2024\_SB\_104\_109\_110\_111\_M

Premiums and Benefits	Freedom Platinum Plus Plan Rx (HMO)_104	Freedom Platinum Plus Plan Rx (HMO)_109
<b>Monthly Plan Premium</b>	You pay <b>\$23</b>	You pay <b>\$43</b>
<b>Deductible</b>	You pay <b>\$0</b>	You pay <b>\$0</b>
<b>Maximum Out-of-Pocket Responsibility</b> <i>(does not include prescription drugs)</i>	<b>\$1,500</b> annually	<b>\$1,500</b> annually
<b>Inpatient Hospital Coverage</b>	You pay <b>\$0</b> copayment each day per admission	You pay <b>\$0</b> copayment each day per admission
<b>Outpatient Hospital Coverage</b>	You pay <b>\$100</b> copay per visit	You pay <b>\$100</b> copay per visit

Freedom Platinum Plus Plan Rx (HMO)_110	Freedom Platinum Plus Plan Rx (HMO)_111	What you should know
You Pay <b>\$43</b>	You pay <b>\$43</b>	<p>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.</p> <p>You can have the plan premium taken out of your monthly Social Security check. Please contact the plan for more information.</p>
You pay <b>\$0</b>	You pay <b>\$0</b>	These plans do not have a deductible
<b>\$1,500</b> annually	<b>\$2,000</b> annually	<p>This is the most you pay for copays, coinsurance, and other costs for medical services for the year.</p> <p>Contact the Plan for details on what is covered in the Maximum Out-of-Pocket.</p>
You pay <b>\$0</b> copayment each day per admission	You pay <b>\$0</b> copayment each day 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 <b>\$100</b> copay per visit	You pay <b>\$100</b> copay per visit	<p>Prior authorization is required for some services by your doctor or other network provider. Please contact the Plan for more information.</p> <p>Services include but are not limited to Medicare-covered outpatient hospital facility visits, clinic, outpatient treatment room, observation room, or outpatient surgery services.</p>

Premiums and Benefits	Freedom Platinum Plus Plan Rx (HMO)_104	Freedom Platinum Plus Plan Rx (HMO)_109
<b>Ambulatory Surgery Center</b>	<p>You pay <b>\$0</b></p> <p>You pay <b>\$100</b> copay for each Medicare-covered outpatient hospital facility visit</p>	<p>You pay <b>\$0</b></p> <p>You pay <b>\$100</b> copay for each Medicare-covered outpatient hospital facility visit</p>
<b>Doctor's Visits</b> <ul style="list-style-type: none"> <li>• <b>Primary</b></li> <li>• <b>Specialists</b></li> </ul>	<p>You pay <b>\$0</b> copay per visit</p> <p>You pay <b>\$0</b> copay per visit</p>	<p>You pay <b>\$0</b> copay per visit</p> <p>You pay <b>\$0</b> copay per visit</p>
<b>Preventive Care</b>	You pay <b>\$0</b> copay	You pay <b>\$0</b> copay
<b>Emergency Care</b>	You pay <b>\$120</b> copay per visit	You pay <b>\$120</b> copay per visit

Freedom Platinum Plus Plan Rx (HMO)_110	Freedom Platinum Plus Plan Rx (HMO)_111	What you should know
<p>You pay <b>\$0</b></p> <p>You pay <b>\$100</b> copay for each Medicare-covered outpatient hospital facility visit</p>	<p>You pay <b>\$0</b></p> <p>You pay <b>\$100</b> copay for each Medicare-covered outpatient hospital facility visit</p>	<p>Prior authorization may be required. Contact the Plan for details.</p> <p>If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient.</p>
<p>You pay <b>\$0</b> copay per visit</p> <p>You pay <b>\$0</b> copay per visit</p>	<p>You pay <b>\$0</b> copay per visit</p> <p>You pay <b>\$0</b> copay per visit</p>	<p>Your primary care physician will coordinate the covered services you receive as a member of our plan.</p> <p>In order for you to see a specialist, you will need to have a referral from your PCP first.</p> <p>Separate copay may apply for each additional service received at an office visit.</p>
<p>You pay <b>\$0</b> copay</p>	<p>You pay <b>\$0</b> copay</p>	<p>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.</p>
<p>You pay <b>\$120</b> copay per visit</p>	<p>You pay <b>\$120</b> copay per visit</p>	<p><b>\$500</b> copay for each emergency service, urgent service and emergency transportation outside the U.S. <b>\$100,000</b> plan coverage limit for emergency services, urgent services and emergency transportation outside the U.S. every year. Contact the plan for details.</p>

Premiums and Benefits	Freedom Platinum Plus Plan Rx (HMO)_104	Freedom Platinum Plus Plan Rx (HMO)_109
<b>Urgently Needed Services</b>	You pay <b>\$10</b> copay	You pay <b>\$10</b> copay
<b>Diagnostic Services/Labs/Imaging</b> <ul style="list-style-type: none"> <li>• <b>Diagnostic Radiology Service</b> <i>(e.g., MRI)</i></li> <li>• <b>Lab Services</b></li> <li>• <b>Diagnostic Tests and Procedures</b></li> <li>• <b>Outpatient X-rays</b></li> <li>• <b>Therapeutic Radiology</b></li> </ul>	<p>You pay <b>\$25-\$100</b> copay depending on the service</p> <p>You pay <b>\$0-\$50</b> copay depending on the place of service</p> <p>You pay <b>\$0-\$100</b> copay or <b>20%</b> coinsurance depending on the service</p> <p>You pay <b>\$0-\$100</b> copay depending on the service</p> <p>You pay <b>20%</b> coinsurance for Therapeutic Radiology</p>	<p>You pay <b>\$25-\$100</b> copay depending on the service</p> <p>You pay <b>\$0-\$50</b> copay depending on the place of service</p> <p>You pay <b>\$0-\$100</b> copay or <b>20%</b> coinsurance depending on the service</p> <p>You pay <b>\$0-\$100</b> copay depending on the service</p> <p>You pay <b>20%</b> coinsurance for Therapeutic Radiology</p>
<b>Hearing Services</b> <ul style="list-style-type: none"> <li>• <b>Hearing Exam/Hearing Aid Fitting-Evaluation</b></li> <li>• <b>Hearing Aid</b></li> </ul>	<p>You pay <b>\$0</b> copay for one routine hearing exam and one hearing aid fitting-evaluation every year</p> <p>You pay <b>\$0</b> copay for two hearing aids (1 per ear) per year</p>	<p>You pay <b>\$0</b> copay for one routine hearing exam and one hearing aid fitting-evaluation every year</p> <p>You pay <b>\$0</b> copay for two hearing aids (1 per ear) per year</p>



Freedom Platinum Plus Plan Rx (HMO)_110	Freedom Platinum Plus Plan Rx (HMO)_111	What you should know
You pay <b>\$10</b> copay	You pay <b>\$10</b> copay	<b>\$500</b> copay for each emergency service, urgent service and emergency transportation outside the U.S. <b>\$100,000</b> plan coverage limit for emergency services, urgent services and emergency transportation outside the U.S. every year. Contact the plan for details.
<p>You pay <b>\$25-\$100</b> copay depending on the service</p> <p>You pay <b>\$0-\$50</b> copay depending on the place of service</p> <p>You pay <b>\$0-\$100</b> copay or <b>20%</b> coinsurance depending on the service</p> <p>You pay <b>\$0-\$100</b> copay depending on the service</p> <p>You pay <b>20%</b> coinsurance for Therapeutic Radiology</p>	<p>You pay <b>\$25-\$100</b> copay depending on the service</p> <p>You pay <b>\$0-\$50</b> copay depending on the place of service</p> <p>You pay <b>\$0-\$100</b> copay or <b>20%</b> coinsurance depending on the service</p> <p>You pay <b>\$0-\$100</b> copay depending on the service</p> <p>You pay <b>20%</b> coinsurance for Therapeutic Radiology</p>	Prior authorization is required for some services by your doctor or other network provider. Please contact the plan for more information.
<p>You pay <b>\$0</b> copay for one routine hearing exam and one hearing aid fitting-evaluation every year</p> <p>You pay <b>\$0</b> copay for two hearing aids (1 per ear) per year</p>	<p>You pay <b>\$0</b> copay for one routine hearing exam and one hearing aid fitting-evaluation every year</p> <p>You pay <b>\$0</b> copay for two hearing aids (1 per ear) per year</p>	<p>Our plan pays up to a maximum of <b>\$2,000 (\$1,000 per hearing aid)</b> for hearing aid benefit every year.</p> <p>You are responsible for payment of any amount in excess of the maximum <b>\$2,000 (\$1,000 per hearing aid)</b>.</p> <p>For all plans, you pay <b>\$0</b> copay for Medicare-covered diagnostic hearing exam.</p>

Premiums and Benefits	Freedom Platinum Plus Plan Rx (HMO)_104	Freedom Platinum Plus Plan Rx (HMO)_109
<p><b>Dental Services</b></p> <ul style="list-style-type: none"> <li>• <b>Oral Exam &amp; Cleaning</b></li> <li>• <b>Fluoride Treatment</b></li> <li>• <b>Dental X-rays</b></li> <li>• <b>Extraction of Tooth</b></li> <li>• <b>Fillings</b></li> <li>• <b>Debridement</b></li> <li>• <b>Deep Cleaning (<i>Scaling/Root Planing</i>)</b></li> <li>• <b>Crown</b></li> <li>• <b>Periodontal Maintenance</b></li> <li>• <b>Dentures/Denture Reline</b></li> </ul>	<p>You pay <b>\$0</b> copay for Oral Exam, 2 per year, <b>\$0</b> copay for Problem Focused Exam, 2 per year and <b>\$0</b> copay for Cleaning, 2 per year</p> <p>You pay <b>\$0</b> copay for fluoride treatment, 2 per year</p> <p>You pay <b>\$0</b> copay for Dental X-rays</p> <p>You pay <b>\$0</b> copay for extraction of tooth, 2 procedures per year</p> <p>You pay <b>\$0</b> copay for resin filling or restoration, 2 per year</p> <p>You pay <b>\$0</b> copay for full mouth debridement, 1 per 2 years</p> <p>You pay <b>\$0</b> copay for Scaling/Root Planing</p> <p>You pay <b>\$0</b> copay for porcelain/ceramic or porcelain fused to high noble metal crown, 1 per year</p> <p>You pay <b>\$0</b> copay for 2 procedures per year</p> <p>You pay <b>\$0</b> copay for partial or full set of dentures, 1 set every 5 years and <b>\$0</b> copay for denture reline 1 per year</p>	<p>You pay <b>\$0</b> copay for Oral Exam, 2 per year, <b>\$0</b> copay for Problem Focused Exam, 2 per year and <b>\$0</b> copay for Cleaning, 2 per year</p> <p>You pay <b>\$0</b> copay for fluoride treatment, 2 per year</p> <p>You pay <b>\$0</b> copay for Dental X-rays</p> <p>You pay <b>\$0</b> copay for extraction of tooth, 2 procedures per year</p> <p>You pay <b>\$0</b> copay for resin filling or restoration, 2 per year</p> <p>You pay <b>\$0</b> copay for full mouth debridement, 1 per 2 years</p> <p>You pay <b>\$0</b> copay for Scaling/Root Planing</p> <p>You pay <b>\$0</b> copay for porcelain/ceramic or porcelain fused to high noble metal crown, 1 per year</p> <p>You pay <b>\$0</b> copay for 2 procedures per year</p> <p>You pay <b>\$0</b> copay for partial or full set of dentures, 1 set every 5 years and <b>\$0</b> copay for denture reline 1 per year</p>

Freedom Platinum Plus Plan Rx (HMO)_110	Freedom Platinum Plus Plan Rx (HMO)_111	What you should know
<p>You pay <b>\$0</b> copay for Oral Exam, 2 per year, <b>\$0</b> copay for Problem Focused Exam, 2 per year and <b>\$0</b> copay for Cleaning, 2 per year</p> <p>You pay <b>\$0</b> copay for fluoride treatment, 2 per year</p> <p>You pay <b>\$0</b> copay for Dental X-rays</p> <p>You pay <b>\$0</b> copay for extraction of tooth, 2 procedures per year</p> <p>You pay <b>\$0</b> copay for resin filling or restoration, 2 per year</p> <p>You pay <b>\$0</b> copay for full mouth debridement, 1 per 2 years</p> <p>You pay <b>\$0</b> copay for Scaling/Root Planing</p> <p>You pay <b>\$0</b> copay for porcelain/ceramic or porcelain fused to high noble metal crown, 1 per year</p> <p>You pay <b>\$0</b> copay for 2 procedures per year</p> <p>You pay <b>\$0</b> copay for partial or full set of dentures, 1 set every 5 years and <b>\$0</b> copay for denture reline 1 per year</p>	<p>You pay <b>\$0</b> copay for Oral Exam, 2 per year, <b>\$0</b> copay for Problem Focused Exam, 2 per year and <b>\$0</b> copay for Cleaning, 2 per year</p> <p>You pay <b>\$0</b> copay for fluoride treatment, 2 per year</p> <p>You pay <b>\$0</b> copay for Dental X-rays</p> <p>You pay <b>\$0</b> copay for extraction of tooth, 2 procedures per year</p> <p>You pay <b>\$0</b> copay for resin filling or restoration, 2 per year</p> <p>You pay <b>\$0</b> copay for full mouth debridement, 1 per 2 years</p> <p>You pay <b>\$0</b> copay for Scaling/Root Planing</p> <p>You pay <b>\$0</b> copay for porcelain/ceramic or porcelain fused to high noble metal crown, 1 per year</p> <p>You pay <b>\$0</b> copay for 2 procedures per year</p> <p>You pay <b>\$0</b> copay for partial or full set of dentures, 1 set every 5 years and <b>\$0</b> copay for denture reline 1 per year</p>	<p>Prior Authorization may be required, and services must be performed by a participating Dental provider.</p> <p>For more details or to get a complete list of services we cover, please refer to your Evidence of Coverage.</p> <p>For all plans, you pay <b>\$0</b> copay for Medicare-covered dental benefit.</p> <p>For Scaling/Root Planing, 4 procedures per year and limited to 1 procedure per quadrant per year.</p>

Premiums and Benefits	Freedom Platinum Plus Plan Rx (HMO)_104	Freedom Platinum Plus Plan Rx (HMO)_109
<p><b>Vision Services</b></p> <ul style="list-style-type: none"> <li>• <b>Routine Eye Exam</b></li> <li>• <b>Eyeglasses (<i>Frames and Lenses</i>)</b></li> </ul>	<p>You pay <b>\$0</b> copay for routine eye exam 1 every year by an Optometrist</p> <p>You pay <b>\$0</b> copay for the plan coverage limit for 2 pair of eyeglasses or contact lenses per year</p> <p>You pay <b>\$0</b> copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery</p> <p>The plan coverage limit is <b>\$400</b> for eyewear (eyeglasses or contact lenses) per benefit year.</p>	<p>You pay <b>\$0</b> copay for routine eye exam 1 every year by an Optometrist</p> <p>You pay <b>\$0</b> copay for the plan coverage limit for 2 pair of eyeglasses or contact lenses per year</p> <p>You pay <b>\$0</b> copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery</p> <p>The plan coverage limit is <b>\$400</b> for eyewear (eyeglasses or contact lenses) per benefit year.</p>
<p><b>Mental Health Services</b></p> <ul style="list-style-type: none"> <li>• <b>Inpatient Visit</b></li> <li>• <b>Outpatient Group Therapy Visit</b></li> <li>• <b>Outpatient Individual Therapy Visit</b></li> </ul>	<p>You pay <b>\$0</b> copayment per admission</p> <p>You pay <b>\$0</b> copay for outpatient group/individual therapy visit</p>	<p>You pay <b>\$0</b> copayment per admission</p> <p>You pay <b>\$0</b> copay for outpatient group/individual therapy visit</p>

Freedom Platinum Plus Plan Rx (HMO)_110	Freedom Platinum Plus Plan Rx (HMO)_111	What you should know
<p>You pay <b>\$0</b> copay for routine eye exam 1 every year by an Optometrist</p> <p>You pay <b>\$0</b> copay for the plan coverage limit for 2 pair of eyeglasses or contact lenses per year</p> <p>You pay <b>\$0</b> copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery</p> <p>The plan coverage limit is <b>\$400</b> for eyewear (eyeglasses or contact lenses) per benefit year.</p>	<p>You pay <b>\$0</b> copay for routine eye exam 1 every year by an Optometrist</p> <p>You pay <b>\$0</b> copay for the plan coverage limit for 2 pair of eyeglasses or contact lenses per year</p> <p>You pay <b>\$0</b> copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery</p> <p>The plan coverage limit is <b>\$400</b> for eyewear (eyeglasses or contact lenses) per benefit year.</p>	<p>Eye exams to diagnose and treat diseases and conditions of the eye by an Ophthalmologist are subject to the Specialist copay.</p> <p>Contact the Plan for additional supplemental benefits. Services must be performed by a participating Vision provider.</p> <p>You pay nothing for exams to diagnose and treat diseases and conditions of the eye by an Optometrist.</p> <p>You will be responsible for any amount over the plan benefit maximum total retail cost of <b>\$400</b> for eyewear benefit</p>
<p>You pay <b>\$0</b> copayment per admission</p> <p>You pay <b>\$0</b> copay for outpatient group/individual therapy visit</p>	<p>You pay <b>\$0</b> copayment per admission</p> <p>You pay <b>\$0</b> copay for outpatient group/individual therapy visit</p>	<p>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.</p>

Premiums and Benefits	Freedom Platinum Plus Plan Rx (HMO)_104	Freedom Platinum Plus Plan Rx (HMO)_109
<b>Skilled Nursing Facility</b>	<p>You pay <b>\$0</b> copay each day for days 1-20</p> <p>You pay <b>\$150</b> copay each day for days 21-100</p>	<p>You pay <b>\$0</b> copay each day for days 1-20</p> <p>You pay <b>\$150</b> copay each day for days 21-100</p>
<b>Physical Therapy (Rehabilitation Services)</b> <ul style="list-style-type: none"> <li>• Occupational Therapy Visit</li> <li>• Physical Therapy Visit</li> <li>• Speech Therapy Visit</li> <li>• Language Therapy Visit</li> </ul>	<p>You pay <b>\$0</b> copay</p>	<p>You pay <b>\$0</b> copay</p>
<b>Ambulance</b>	<p>You pay <b>\$150</b> copay for Medicare-covered one-way ground ambulance services</p> <p>You pay <b>20%</b> coinsurance for Medicare-covered one-way air ambulance services</p>	<p>You pay <b>\$150</b> copay for Medicare-covered one-way ground ambulance services</p> <p>You pay <b>20%</b> coinsurance for Medicare-covered one-way air ambulance services</p>
<b>Transportation</b>	<p>You pay <b>\$0</b> copay for unlimited one-way trips every year</p>	<p>You pay <b>\$0</b> copay for unlimited one-way trips every year</p>

Freedom Platinum Plus Plan Rx (HMO)_110	Freedom Platinum Plus Plan Rx (HMO)_111	What you should know
<p>You pay <b>\$0</b> copay each day for days 1-20</p> <p>You pay <b>\$150</b> copay each day for days 21-100</p>	<p>You pay <b>\$0</b> copay each day for days 1-20</p> <p>You pay <b>\$150</b> copay each day for days 21-100</p>	<p>Our plan covers up to 100 days in a SNF per benefit plan.</p> <p>You must get prior authorization in advance before you are admitted to the facility, or your stay may not be covered.</p>
<p>You pay <b>\$0</b> copay</p>	<p>You pay <b>\$0</b> copay</p>	<p>For rehabilitative services, you will need a referral or authorization from your PCP first depending on the specific service.</p> <p>There may be limits on physical therapy, occupational therapy, and speech and language pathology services. Contact the plan for details.</p>
<p>You pay <b>\$150</b> copay for Medicare-covered one-way ground ambulance services</p> <p>You pay <b>20%</b> coinsurance for Medicare-covered one-way air ambulance services</p>	<p>You pay <b>\$150</b> copay for Medicare-covered one-way ground ambulance services</p> <p>You pay <b>20%</b> coinsurance for Medicare-covered one-way air ambulance services</p>	<p>Prior Authorization may be required. Contact the Plan for details.</p>
<p>You pay <b>\$0</b> copay for unlimited one-way trips every year</p>	<p>You pay <b>\$0</b> copay for unlimited one-way trips every year</p>	<p>Transportation is intended for rides to and/or from plan approved locations for medical appointments and health needs within your county.</p> <p>Call to schedule a ride at least 72 hours prior to scheduled medical appointment.</p>

Premiums and Benefits	Freedom Platinum Plus Plan Rx (HMO)_104	Freedom Platinum Plus Plan Rx (HMO)_109
<b>Medicare Part B Drugs</b>	You pay <b>20%</b> of the cost for chemotherapy drugs and <b>20%</b> of the cost for other Part B drugs  For Part B insulins, you pay <b>\$35</b> or less for a one-month supply	You pay <b>20%</b> of the cost for chemotherapy drugs and <b>20%</b> of the cost for other Part B drugs  For Part B insulins, you pay <b>\$35</b> or less for a one-month supply
<b>Foot Care (<i>Podiatry Services</i>)</b> <ul style="list-style-type: none"> <li>• <b>Foot Exams and Treatment</b></li> </ul>	You pay <b>\$0</b> copay	You pay <b>\$0</b> copay
<b>Medical Equipment/Supplies</b> <ul style="list-style-type: none"> <li>• <b>Durable Medical Equipment (<i>e.g., wheelchairs, oxygen</i>)</b></li> <li>• <b>Prosthetics (<i>e.g., braces, artificial limbs</i>)</b></li> <li>• <b>Diabetes Supplies</b></li> </ul>	You pay <b>20%</b> coinsurance  You pay <b>20%</b> coinsurance  You pay <b>0-20%</b> coinsurance	You pay <b>20%</b> coinsurance  You pay <b>20%</b> coinsurance  You pay <b>0-20%</b> coinsurance
<b>Wellness</b> <ul style="list-style-type: none"> <li>• <b>Fitness</b></li> <li>• <b>24 Hour Nurse Advice Line</b></li> </ul>	You pay <b>\$0</b> copay  You pay <b>\$0</b> copay	You pay <b>\$0</b> copay  You pay <b>\$0</b> copay



Freedom Platinum Plus Plan Rx (HMO)_110	Freedom Platinum Plus Plan Rx (HMO)_111	What you should know
<p>You pay <b>20%</b> of the cost for chemotherapy drugs and <b>20%</b> of the cost for other Part B drugs</p> <p>For Part B insulins, you pay <b>\$35</b> or less for a one-month supply</p>	<p>You pay <b>20%</b> of the cost for chemotherapy drugs and <b>20%</b> of the cost for other Part B drugs</p> <p>For Part B insulins, you pay <b>\$35</b> or less for a one-month supply</p>	<p>The Plan may require authorization to determine whether certain drugs are covered by Medicare Part B or Medicare Part D.</p> <p>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.</p> <p>Please refer to your Evidence of Coverage for more details.</p>
<p>You pay <b>\$0</b> copay</p>	<p>You pay <b>\$0</b> copay</p>	<p>Covered podiatry benefits are for medically necessary foot care.</p> <p>You will need to have a referral or authorization from your PCP first depending on the service.</p>
<p>You pay <b>20%</b> coinsurance</p> <p>You pay <b>20%</b> coinsurance</p> <p>You pay <b>0-20%</b> coinsurance</p>	<p>You pay <b>20%</b> coinsurance</p> <p>You pay <b>20%</b> coinsurance</p> <p>You pay <b>0-20%</b> coinsurance</p>	<p>We cover all medically necessary Durable Medical Equipment covered by Original Medicare.</p> <p>You will need to have a referral or authorization from your PCP first depending on the service.</p> <p>You pay <b>\$0</b> for Diabetic Monitors, Lancets and Test Strips when ordered through the Plan's Mail Order Program.</p> <p>You pay <b>20%</b> for all diabetic supplies from a retail pharmacy.</p>
<p>You pay <b>\$0</b> copay</p> <p>You pay <b>\$0</b> copay</p>	<p>You pay <b>\$0</b> copay</p> <p>You pay <b>\$0</b> copay</p>	<p>Health Club Memberships are limited to participating facilities.</p> <p>Health Advice from a nursing professional, available 24 hours a day, 7 days a week.</p>

Premiums and Benefits	Freedom Platinum Plus Plan Rx (HMO)_104	Freedom Platinum Plus Plan Rx (HMO)_109
<b>Active Fitness</b>	<b>\$500</b> Annual Allowance	Not covered
<b>Over The Counter (OTC)</b>	<b>\$75</b> Monthly Allowance  <i>The plan doesn't allow you to roll over any remaining OTC allowance into the next month</i>	<b>\$75</b> Monthly Allowance  <i>The plan doesn't allow you to roll over any remaining OTC allowance into the next month</i>
<b>In-Home Support Services</b>	You pay <b>\$0</b> copay for Up to <b>30 hours</b> of companion services per year	You pay <b>\$0</b> copay for Up to <b>30 hours</b> of companion services per year
<b>Personal Emergency Response System (PERS)</b>	You pay <b>\$0</b> copay for <b>1 Personal Emergency Response (PERS)</b> monitoring device and monitoring service	You pay <b>\$0</b> copay for <b>1 Personal Emergency Response (PERS)</b> monitoring device and monitoring service

Freedom Platinum Plus Plan Rx (HMO)_110	Freedom Platinum Plus Plan Rx (HMO)_111	What you should know
<p><b>\$500</b> Annual Allowance</p>	<p>Not covered</p>	<p>The plan covers a spending allowance of <b>\$500</b> per year towards the payment of facility access fees for golf, tennis or swimming. Any unused amounts do not carry forward to the next calendar year.</p> <p>For more information about this benefit please contact Member Services.</p>
<p><b>\$75</b> Monthly Allowance</p> <p><i>The plan doesn't allow you to roll over any remaining OTC allowance into the next month</i></p>	<p><b>\$75</b> Monthly Allowance</p> <p><i>The plan doesn't allow you to roll over any remaining OTC allowance into the next month</i></p>	<p>Please contact the plan or visit our website for specific instructions for using this benefit and our list of covered Over-the-Counter items.</p> <p>Call Member Services at 1-800-401-2740, TTY users call 711, or visit our website at <a href="http://www.freedomhealth.com">www.freedomhealth.com</a>.</p>
<p>You pay <b>\$0</b> copay for Up to <b>30 hours</b> of companion services per year</p>	<p>You pay <b>\$0</b> copay for Up to <b>30 hours</b> of companion services per year</p>	<p>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.</p>
<p>You pay <b>\$0</b> copay for <b>1 Personal Emergency Response (PERS)</b> monitoring device and monitoring service</p>	<p>You pay <b>\$0</b> copay for <b>1 Personal Emergency Response (PERS)</b> monitoring device and monitoring service</p>	<p>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.</p>

## Outpatient Prescription Drugs

### Freedom Platinum Plus Plan Rx (HMO)\_104

	<b>Standard Retail Rx 30 – day Supply</b>	<b>Standard Mail Order 90 – day Supply</b>	<b>What you should know</b>
<p><b>* Important Message About What You Pay for Vaccines and Insulin-</b> 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.</p>			
<b><i>Deductible Stage</i></b>	This stage does not apply to you		
<b><i>Initial Coverage Stage</i></b>			<p>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 <b>\$5,030</b>. 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.</p> <p>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.</p>
<b>Tier 1: Preferred Generic</b>	<b>\$0 Copay</b>	<b>\$0 Copay</b>	
<b>Tier 2: Preferred Brand</b>	<b>\$20 Copay</b>	<b>\$40 Copay</b>	
<b>Tier 3: Non-Preferred Drug</b>	<b>\$60 Copay</b>	<b>\$120 Copay</b>	
<b>Tier 4: Specialty Tier</b>	<b>33% of the Cost</b>	<b>Long Term Supply Not Available</b>	
<b><i>Coverage Gap Stage</i></b>			<p>For all other drugs, you pay <b>25%</b> of the price for brand drugs and <b>25%</b> 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 <b>\$8,000</b>.</p>
<b>Tier 1: Preferred Generic</b>	<b>\$0 Copay</b>	<b>\$0 Copay</b>	
<b><i>Catastrophic Coverage Stage</i></b>	<p>You won't have to pay any coinsurance or copayments during this phase for covered Medicare prescriptions drugs.</p>		<p>During this stage, the plan will pay the cost of your drugs for the rest of the calendar year.</p>

## Outpatient Prescription Drugs

### Freedom Platinum Plus Plan Rx (HMO)\_109

	Standard Retail Rx 30 – day Supply	Standard Mail Order 90 – day Supply	What you should know
<p><b>* Important Message About What You Pay for Vaccines and Insulin-</b> 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.</p>			
<b><i>Deductible Stage</i></b>	This stage does not apply to you		
<b><i>Initial Coverage Stage</i></b>			<p>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 <b>\$5,030</b>. 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.</p> <p>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.</p>
<b>Tier 1: Preferred Generic</b>	<b>\$0 Copay</b>	<b>\$0 Copay</b>	
<b>Tier 2: Preferred Brand</b>	<b>\$25 Copay</b>	<b>\$50 Copay</b>	
<b>Tier 3: Non-Preferred Drug</b>	<b>\$70 Copay</b>	<b>\$140 Copay</b>	
<b>Tier 4: Specialty Tier</b>	<b>33% of the Cost</b>	<b>Long Term Supply Not Available</b>	
<b><i>Coverage Gap Stage</i></b>			<p>For all other drugs, you pay <b>25%</b> of the price for brand drugs and <b>25%</b> 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 <b>\$8,000</b>.</p>
<b>Tier 1: Preferred Generic</b>	<b>\$0 Copay</b>	<b>\$0 Copay</b>	
<b><i>Catastrophic Coverage Stage</i></b>	<p>You won't have to pay any coinsurance or copayments during this phase for covered Medicare prescriptions drugs.</p>		<p>During this stage, the plan will pay the cost of your drugs for the rest of the calendar year.</p>

## Outpatient Prescription Drugs

### Freedom Platinum Plus Plan Rx (HMO)\_110

	<b>Standard Retail Rx 30 – day Supply</b>	<b>Standard Mail Order 90 – day Supply</b>	<b>What you should know</b>
<p><b>* Important Message About What You Pay for Vaccines and Insulin-</b> 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.</p>			
<b><i>Deductible Stage</i></b>	This stage does not apply to you		
<b><i>Initial Coverage Stage</i></b>			<p>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 <b>\$5,030</b>. 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.</p> <p>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.</p>
<b>Tier 1: Preferred Generic</b>	<b>\$0 Copay</b>	<b>\$0 Copay</b>	
<b>Tier 2: Preferred Brand</b>	<b>\$20 Copay</b>	<b>\$40 Copay</b>	
<b>Tier 3: Non-Preferred Drug</b>	<b>\$60 Copay</b>	<b>\$120 Copay</b>	
<b>Tier 4: Specialty Tier</b>	<b>33% of the Cost</b>	<b>Long Term Supply Not Available</b>	
<b><i>Coverage Gap Stage</i></b>			<p>For all other drugs, you pay <b>25%</b> of the price for brand drugs and <b>25%</b> 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 <b>\$8,000</b>.</p>
<b>Tier 1: Preferred Generic</b>	<b>\$0 Copay</b>	<b>\$0 Copay</b>	
<b><i>Catastrophic Coverage Stage</i></b>	<p>You won't have to pay any coinsurance or copayments during this phase for covered Medicare prescriptions drugs.</p>		<p>During this stage, the plan will pay the cost of your drugs for the rest of the calendar year.</p>

## Outpatient Prescription Drugs

### Freedom Platinum Plus Plan Rx (HMO)\_111

	<b>Standard Retail Rx 30 – day Supply</b>	<b>Standard Mail Order 90 – day Supply</b>	<b>What you should know</b>
<p><b>* Important Message About What You Pay for Vaccines and Insulin-</b> 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.</p>			
<b><i>Deductible Stage</i></b>	This stage does not apply to you		
<b><i>Initial Coverage Stage</i></b>			<p>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 <b>\$5,030</b>. 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.</p> <p>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.</p>
<b>Tier 1: Preferred Generic</b>	<b>\$0 Copay</b>	<b>\$0 Copay</b>	
<b>Tier 2: Preferred Brand</b>	<b>\$25 Copay</b>	<b>\$50 Copay</b>	
<b>Tier 3: Non-Preferred Drug</b>	<b>\$65 Copay</b>	<b>\$130 Copay</b>	
<b>Tier 4: Specialty Tier</b>	<b>33% of the Cost</b>	<b>Long Term Supply Not Available</b>	
<b><i>Coverage Gap Stage</i></b>			<p>For all other drugs, you pay <b>25%</b> of the price for brand drugs and <b>25%</b> 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 <b>\$8,000</b>.</p>
<b>Tier 1: Preferred Generic</b>	<b>\$0 Copay</b>	<b>\$0 Copay</b>	
<b><i>Catastrophic Coverage Stage</i></b>	<p>You won't have to pay any coinsurance or copayments during this phase for covered Medicare prescriptions drugs.</p>		<p>During this stage, the plan will pay the cost of your drugs for the rest of the calendar year.</p>

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](http://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

This document is available in alternate formats such as large print and Spanish. For more information, please call us at the phone number below or visit us at [www.freedomhealth.com](http://www.freedomhealth.com).

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

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

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](http://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>.



## Multi-Language Insert

### Multi-language Interpreter Services

Form Approved  
OMB# 0938-1421

**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 quý vị cần thông dịch viên xin gọi 1-800-401-2740 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý 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 대해 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.

Form CMS-10802  
(Expires 12/31/25)

**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 Português 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 numer 1-800-401-2740 (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。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。



# 2024 Summary of Benefits



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

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

## ***SB Combo***

***104 - 109 - 110 - 111***

**104 – Freedom Platinum Plus Plan Rx (HMO)**

**Counties:** Lake, Marion, and Sumter

**109 – Freedom Platinum Plus Plan Rx (HMO)**

**Counties:** Brevard, Indian River, Martin, and St. Lucie

**110 – Freedom Platinum Plus Plan Rx (HMO)**

**Counties:** Manatee and Sarasota

**111 – Freedom Platinum Plus Plan Rx (HMO)**

**Counties:** Charlotte, Collier, and Lee