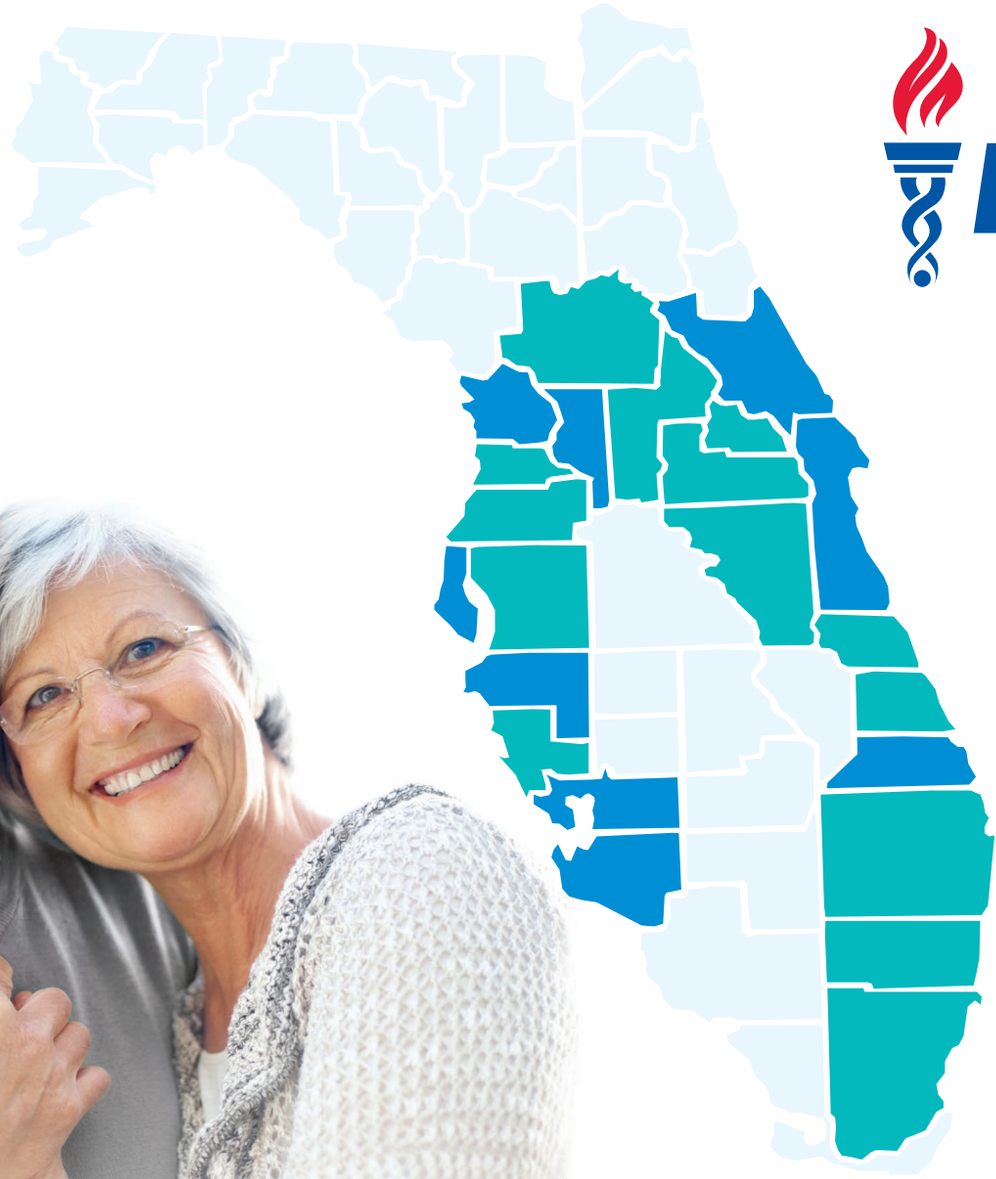
HMO

2014

FRH14SB596088



FREEDOM HEALTH

SB Combo 059 - 060 - 088

059 - Freedom Medicare Plan Rx (HMO)

Counties:
Brevard, Charlotte, Citrus, Lee, Manatee, Martin, Pinellas, Sumter, Volusia

060 - Freedom Medicare Plan Rx (HMO)

Counties:
Broward, Hernando, Hillsborough, Indian River, Lake, Marion, Miami-Dade, Orange, Osceola, Palm Beach, Pasco, Sarasota, Seminole, St. Lucie

088 - Freedom Medicare Plan Rx (HMO)

Counties:
Indian River, St. Lucie

HEALTH PLAN NCQA ACCREDITATION COMMENDABLE

Focused on You

H5427_SB_059_060_088_2014_CMS Accepted

2014 Summary of Benefits

Summary of Benefits

Freedom Medicare Plan Rx (HMO)

H5427 Florida Counties:

H5427_059
Brevard, Charlotte, Citrus, Lee, Manatee, Martin, Pinellas, Sumter, and Volusia

H5427_060
Broward, Hernando, Hillsborough, Indian River, Lake, Marion, Miami-Dade, Orange, Osceola, Palm Beach, Pasco, Sarasota, Seminole, and St. Lucie

H5427_088
Indian River and St. Lucie

SECTION I – INTRODUCTION TO SUMMARY OF BENEFITS

Thank you for your interest in Freedom Medicare Plan Rx (HMO). Our plan is offered by FREEDOM HEALTH PLAN, INC. which is also called Freedom Health, Inc., a Medicare Advantage Health Maintenance Organization (HMO) that contracts with the Federal government. This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Freedom Medicare Plan Rx (HMO) and ask for the "Evidence of Coverage".

YOU HAVE CHOICES IN YOUR HEALTH CARE
As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (Fee-for-Service) Medicare Plan. Another option is a Medicare health plan, like Freedom Medicare Plan Rx (HMO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call Freedom Medicare Plan Rx (HMO) at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?
You can compare Freedom Medicare Plan Rx (HMO) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

WHERE IS FREEDOM MEDICARE PLAN RX (HMO) AVAILABLE?
There is more than one plan listed in this Summary of Benefits. The service area for these plans include: Brevard, Broward, Charlotte, Citrus, Hernando, Hillsborough, Indian River, Lake, Lee, Manatee, Marion, Martin, Miami-Dade, Orange, Osceola, Palm Beach, Pasco, Pinellas, Sarasota, Seminole, St. Lucie, Sumter, Volusia Counties, FL. You must live in one of these areas to join the plan.

WHO IS ELIGIBLE TO JOIN FREEDOM MEDICARE PLAN RX (HMO)?
You can join Freedom Medicare Plan Rx (HMO) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End-Stage Renal Disease generally are not eligible to enroll in Freedom Medicare Plan Rx (HMO) unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?
Freedom Medicare Plan Rx (HMO) has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time.

You can ask for a current provider directory. For an updated list, visit us at http://www.FreedomHealth.com. Our customer service number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?
If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither the plan nor the Original Medicare Plan will pay for these services except in limited situations (for example, emergency care).

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?
Freedom Medicare Plan Rx (HMO) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at http://www.freedomhealth.com. Our customer service number is listed at the end of this introduction.

WHAT IF MY DOCTOR PRESCRIBES LESS THAN A MONTH'S SUPPLY?
In consultation with your doctor or pharmacist, you may receive less than a month's supply of certain drugs. Also, if you live in a long-term care facility, you will receive less than a month's supply of certain brand and generic drugs. Dispensing fewer drugs at a time can help reduce cost and waste in the Medicare Part D program, when this is medically appropriate.

The amount you pay in these circumstances will depend on whether you are responsible for paying coinsurance (a percentage of the cost of the drug) or a copay (a flat dollar amount for the drug). If you are responsible for coinsurance for the drug, you will continue to pay the applicable percentage of the drug cost. If you are responsible for a copay for the drug, a "daily cost-sharing rate" will be applied. If your doctor decides to continue the drug after a trial period, you should not pay more for a month's supply than you otherwise would have paid. Contact your plan if you have questions about cost-sharing when less than a one-month supply is dispensed.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?
Freedom Medicare Plan Rx (HMO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?
Freedom Medicare Plan Rx (HMO) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected members before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at http://www.freedomhealth.com.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?
You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

* 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week and see http://www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare & You.

* The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or

* Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?
All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Freedom Medicare Plan Rx (HMO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of Freedom Medicare Plan Rx (HMO), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Freedom Medicare Plan Rx (HMO) for more details.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Freedom Medicare Plan Rx (HMO) for more details.

-- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.

-- Osteoporosis Drugs: Injectable osteoporosis drugs for some women.

-- Erythropoietin: By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.

-- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.

-- Injectable Drugs: Most injectable drugs administered incident to a physician's service.

-- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant took place in a Medicare-certified facility and was paid for by Medicare or by a private insurance company that was the primary payer for Medicare Part A coverage.

-- Some Oral Cancer Drugs: If the same drug is available in injectable form.

-- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.

-- Inhalation and Infusion Drugs administered through Durable Medical Equipment.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you can find the Plan Ratings information by using the “Find health & drug plans” web tool on medicare.gov to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Please call Freedom Health, Inc. for more information about Freedom Medicare Plan Rx (HMO)

Visit us at http://www.FreedomHealth.com or, call us:

Customer Service Hours for October 1 through February 14:
Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. – 8:00 p.m. Eastern

Customer Service Hours for February 15 through September 30:
Monday, Tuesday, Wednesday, Thursday, Friday, 8:00 a.m. – 8:00 p.m. Eastern

Current and Prospective members should call toll-free (800) 401-2740 for questions related to Medicare Advantage and Part D Prescription Drug Programs. (TTY/TDD (800) 955-8771).

Current and Prospective members should call locally (800) 401-2740 for questions related to Medicare Advantage and Part D Prescription Drug Programs. (TTY/TDD (800) 955-8771).

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227).
TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.
Or, visit http://www.medicare.gov on the web.

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language.

For additional information, call customer service at the phone number listed above.

Este documento puede estar disponible en diferentes formatos o idiomas. Para más información, puede llamar al servicio al cliente al número listado. Si Usted tiene necesidades especiales, éste documento puede estar disponible en otro formato.

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	Freedom Medicare Plan Rx (HMO) 059
IMPORTANT INFORMATION		
1 – Premium and Other Important Information	In 2013 the monthly Part B Premium was $104.90 and may change for 2014 and the annual Part B deductible amount was $147 and may change for 2014. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	**General** $0 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. **In-Network** $3,400 out-of-pocket limit for Medicare-covered services.
2 – Doctor and Hospital Choice (For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	**In-Network** You must go to network doctors, specialist, and hospitals. Referral required for network hospitals and specialists (for certain benefits). *See page 52 for additional information about Doctor and Hospital Choice*

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
General $0 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. **In-Network** $3,400 out-of-pocket limit for Medicare-covered services.	**General** $0 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. **In-Network** $3,400 out-of-pocket limit for Medicare-covered services.
In-Network You must go to network doctors, specialist, and hospitals. Referral required for network hospitals and specialists (for certain benefits). *See page 53 for additional information about Doctor and Hospital Choice*	**In-Network** You must go to network doctors, specialist, and hospitals. Referral required for network hospitals and specialists (for certain benefits). *See page 53 for additional information about Doctor and Hospital Choice*

Benefit	Original Medicare	Freedom Medicare Plan Rx (HMO) 059
SUMMARY OF BENEFITS		
INPATIENT CARE		
3 – Inpatient Hospital Care (include Substance Abuse and Rehabilitation Services)	In 2013 the amounts for each benefit period were: Days 1 – 60: $1,184 deductible Days 61 – 90: $296 per day Days 91 – 150: $592 per lifetime reserve day These amounts may change for 2014. Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	**In Network** Plan covers 90 days each benefit period. For Medicare-covered hospital stays: - Days 1 – 7: $225 copay per day - Days 8 – 90: $0 copay per day Plan covers 60 lifetime reserve days. $0 copay per lifetime reserve day. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. *See page 52 for additional information about Inpatient Hospital Care*

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
In Network Plan covers 90 days each benefit period. For Medicare-covered hospital stays: - Days 1 – 7: $175 copay per day - Days 8 – 90: $0 copay per day Plan covers 60 lifetime reserve days. $0 copay per lifetime reserve day. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. *See page 53 for additional information about Inpatient Hospital Care*	**In Network** Plan covers 90 days each benefit period. For Medicare-covered hospital stays: - Days 1 – 7: $100 copay per day - Days 8 – 90: $0 copay per day Plan covers 60 lifetime reserve days. $0 copay per lifetime reserve day. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. *See page 53 for additional information about Inpatient Hospital Care*

Benefit	Original Medicare	Freedom Medicare Plan Rx (HMO) 059
4 – Inpatient Mental Health Care	In 2013 the amounts for each benefit period were: Days 1 – 60: $1,184 deductible Days 61 – 90: $296 per day Days 91 – 150: $592 per lifetime reserve day These amounts may change for 2014. You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. For Medicare-covered hospital stays: - Days 1 – 7: $225 copay per day - Days 8 – 90: $0 copay per day Plan covers 60 lifetime reserve days. $0 copay per lifetime reserve day. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. *See page 52 for additional information about Inpatient Mental Health Care*
5 – Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	In 2013 the amounts for each benefit period after at least a 3-day Medicare-covered hospital stay were: Days 1 – 20: $0 per day Days 21 – 100: $148 per day These amounts may change for 2014. 100 days for each benefit period. A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	**General** Authorization rules may apply**.** **In-Network** Plan covers up to 100 days each benefit period No prior hospital stay is required. For Medicare-covered SNF stays: - Days 1 – 4: $0 copay per day - Days 5 – 20: $50 copay per day - Days 21 – 100: $125 copay per day *See page 52 for additional information about Skilled Nursing Facility (SNF)*

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
In-Network You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. For Medicare-covered hospital stays: - Days 1 – 7: $175 copay per day - Days 8 – 90: $0 copay per day Plan covers 60 lifetime reserve days. $0 copay per lifetime reserve day. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. *See page 53 for additional information about Inpatient Mental Health Care*	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. For Medicare-covered hospital stays: - Days 1 – 7: $100 copay per day - Days 8 – 90: $0 copay per day Plan covers 60 lifetime reserve days. $0 copay per lifetime reserve day. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. *See page 53 for additional information about Inpatient Mental Health Care*
General Authorization rules may apply**.** **In-Network** Plan covers up to 100 days each benefit period No prior hospital stay is required. For Medicare-covered SNF stays: - Days 1 – 4: $0 copay per day - Days 5 – 20: $50 copay per day - Days 21 – 100: $125 copay per day *See page 53 for additional information about Skilled Nursing Facility (SNF)*	**General** Authorization rules may apply**.** **In-Network** Plan covers up to 100 days each benefit period No prior hospital stay is required. For Medicare-covered SNF stays: - Days 1 – 4: $0 copay per day - Days 5 – 20: $50 copay per day - Days 21 – 100: $125 copay per day *See page 53 for additional information about Skilled Nursing Facility (SNF)*

Benefit	Original Medicare	Freedom Medicare Plan Rx (HMO) 059
6 – Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.	$0 copay.	**General** Authorization rules may apply. **In-Network** $15 copay for each Medicare-covered home health visit
7 – Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	**General** You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.
OUTPATIENT CARE		
8 – Doctor Office Visits	20% coinsurance	**General** Authorization rules may apply. **In-Network** $0 copay for each Medicare-covered primary care doctor visit. $32 copay for each Medicare-covered specialist visit.
9 – Chiropractic Services	Supplemental routine care not covered 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part).	**General** Authorization rules may apply. **In-Network** $20 copay for each Medicare-covered chiropractic visit Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part).

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
General Authorization rules may apply. **In-Network** $15 copay for each Medicare-covered home health visit	**General** Authorization rules may apply. **In-Network** $10 copay for each Medicare-covered home health visit
General You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.	**General** You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.
General Authorization rules may apply. **In-Network** $0 copay for each Medicare-covered primary care doctor visit. $30 copay for each Medicare-covered specialist visit.	**General** Authorization rules may apply. **In-Network** $0 copay for each Medicare-covered primary care doctor visit. $20 copay for each Medicare-covered specialist visit.
General Authorization rules may apply. **In-Network** $20 copay for each Medicare-covered chiropractic visit Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part).	**General** Authorization rules may apply. **In-Network** $15 copay for each Medicare-covered chiropractic visit Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part).

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Benefit	Original Medicare	Freedom Medicare Plan Rx (HMO) 059
10 – Podiatry Services	Supplemental routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	**General** Authorization rules may apply. **In-Network** $32 copay for each Medicare-covered podiatry visit Medicare-covered podiatry visits are for medically-necessary foot care.
11 – Outpatient Mental Health Care	20% coinsurance for most outpatient mental health services Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible. "Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	**General** Authorization rules may apply. **In-Network** $32 copay for each Medicare-covered individual therapy visit $32 copay for each Medicare-covered group therapy visit $32 copay for each Medicare-covered individual therapy visit with a psychiatrist $32 copay for each Medicare-covered group therapy visit with a psychiatrist $55 copay for Medicare-covered partial hospitalization program services

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
General Authorization rules may apply. **In-Network** $30 copay for each Medicare-covered podiatry visit Medicare-covered podiatry visits are for medically-necessary foot care.	**General** Authorization rules may apply. **In-Network** $20 copay for each Medicare-covered podiatry visit Medicare-covered podiatry visits are for medically-necessary foot care.
General Authorization rules may apply. **In-Network** $30 copay for each Medicare-covered individual therapy visit $30 copay for each Medicare-covered group therapy visit $30 copay for each Medicare-covered individual therapy visit with a psychiatrist $30 copay for each Medicare-covered group therapy visit with a psychiatrist $55 copay for Medicare-covered partial hospitalization program services	**General** Authorization rules may apply. **In-Network** $20 copay for each Medicare-covered individual therapy visit $20 copay for each Medicare-covered group therapy visit $20 copay for each Medicare-covered individual therapy visit with a psychiatrist $20 copay for each Medicare-covered group therapy visit with a psychiatrist $55 copay for Medicare-covered partial hospitalization program services

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Benefit	Original Medicare	Freedom Medicare Plan Rx (HMO) 059
12 – Outpatient Substance Abuse Care	20% coinsurance	**General** Authorization rules may apply **In-Network** $32 to $200 copay for Medicare-covered individual substance abuse outpatient treatment visits $32 to $200 copay for Medicare-covered group substance abuse outpatient treatment visits
13 – Outpatient Services	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility services. Copay cannot exceed the Part A inpatient hospital deductible. 20% coinsurance for ambulatory surgical center facility services	**General** Authorization rules may apply **In-Network** $50 copay for each Medicare-covered ambulatory surgical center visit $200 copay for each Medicare-covered outpatient hospital facility visit *See page 52 for additional information about Outpatient Services*
14 – Ambulance Services (medically necessary ambulance services)	20% coinsurance	**General** Authorization rules may apply **In-Network** $155 copay for Medicare-covered ambulance benefits.

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
General Authorization rules may apply **In-Network** $30 to $200 copay for Medicare-covered individual substance abuse outpatient treatment visits $30 to $200 copay for Medicare-covered group substance abuse outpatient treatment visits	**General** Authorization rules may apply **In-Network** $20 to $200 copay for Medicare-covered individual substance abuse outpatient treatment visits $20 to $200 copay for Medicare-covered group substance abuse outpatient treatment visits
General Authorization rules may apply **In-Network** $50 copay for each Medicare-covered ambulatory surgical center visit $200 copay for each Medicare-covered outpatient hospital facility visit *See page 53 for additional information about Outpatient Services*	**General** Authorization rules may apply **In-Network** $50 copay for each Medicare-covered ambulatory surgical center visit $200 copay for each Medicare-covered outpatient hospital facility visit *See page 53 for additional information about Outpatient Services*
General Authorization rules may apply **In-Network** $150 copay for Medicare-covered ambulance benefits.	**General** Authorization rules may apply **In-Network** $100 copay for Medicare-covered ambulance benefits.

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Benefit	Original Medicare	Freedom Medicare Plan Rx (HMO) 059
15 – Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility emergency services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit. Not covered outside the U.S. except under limited circumstances.	**General** $65 copay for Medicare-covered emergency room visits $25,000 plan coverage limit for supplemental emergency services outside the U.S. and its territories every year.
16 – Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance, or a set copay If you are admitted to the hospital within 3 days for the same condition, you pay $0 for the urgently-needed-care visit. NOT covered outside the U.S. except under limited circumstances.	**General** $10 copay for Medicare-covered urgently-needed-care visits

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
General $65 copay for Medicare-covered emergency room visits $25,000 plan coverage limit for supplemental emergency services outside the U.S. and its territories every year.	**General** $65 copay for Medicare-covered emergency room visits $25,000 plan coverage limit for supplemental emergency services outside the U.S. and its territories every year.
General $10 copay for Medicare-covered urgently-needed-care visits	**General** $10 copay for Medicare-covered urgently-needed-care visits

Benefit	Original Medicare	Freedom Medicare Plan Rx (HMO) 059
17 – Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered.	**General** Authorization rules may apply. Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered. **In-Network** $32 copay for Medicare-covered Occupational Therapy visits $32 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18 – Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered durable medical equipment
19 – Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance 20% coinsurance for Medicare-covered medical supplies related to prosthetics, splints, and other devices.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered prosthetic devices 20% of the cost for Medicare-covered medical supplies related to prosthetics, splints, and other devices

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
General Authorization rules may apply. Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered. **In-Network** $30 copay for Medicare-covered Occupational Therapy visits $30 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits	**General** Authorization rules may apply. Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered. **In-Network** $20 copay for Medicare-covered Occupational Therapy visits $20 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits
General Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered durable medical equipment	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered durable medical equipment
General Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered prosthetic devices 20% of the cost for Medicare-covered medical supplies related to prosthetics, splints, and other devices	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered prosthetic devices 20% of the cost for Medicare-covered medical supplies related to prosthetics, splints, and other devices

Benefit	Original Medicare	Freedom Medicare Plan Rx (HMO) 059
20 – Diabetes Programs and Supplies	20% coinsurance for diabetes self-management training 20% coinsurance for diabetes supplies 20% coinsurance for diabetic therapeutic shoes or inserts	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered Diabetes self-management training 0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies 20% of the cost for Medicare-covered Therapeutic shoes or inserts *See page 54 for additional information about Diabetes Programs and Supplies*
21 – Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and x-rays $0 copay for Medicare-covered lab services Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered lab services $0 copay for Medicare-covered diagnostic procedures and tests $0 copay for Medicare-covered X-rays $25 to $100 copay for Medicare-covered diagnostic radiology services (not including X-rays) 20% of the cost for Medicare-covered therapeutic radiology services If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of $0 to $32 may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of $0 to $32 may apply *See page 54 for additional information about Diagnostic Tests, X-Rays, Lab Services, and Radiology Services*

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
General Authorization rules may apply. **In-Network** $0 copay for Medicare-covered Diabetes self-management training 0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies 20% of the cost for Medicare-covered Therapeutic shoes or inserts *See page 55 for additional information about Diabetes Programs and Supplies*	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered Diabetes self-management training 0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies 20% of the cost for Medicare-covered Therapeutic shoes or inserts *See page 55 for additional information about Diabetes Programs and Supplies*
General Authorization rules may apply. **In-Network** $0 copay for Medicare-covered lab services $0 copay for Medicare-covered diagnostic procedures and tests $0 copay for Medicare-covered X-rays $25 to $100 copay for Medicare-covered diagnostic radiology services (not including X-rays) 20% of the cost for Medicare-covered therapeutic radiology services If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of $0 to $30 may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of $0 to $30 may apply *See page 55 for additional information about Diagnostic Tests, X-Rays, Lab Services, and Radiology Services*	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered lab services $0 copay for Medicare-covered diagnostic procedures and tests $0 copay for Medicare-covered X-rays $25 to $100 copay for Medicare-covered diagnostic radiology services (not including X-rays) 20% of the cost for Medicare-covered therapeutic radiology services If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of $0 to $20 may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of $0 to $20 may apply *See page 55 for additional information about Diagnostic Tests, X-Rays, Lab Services, and Radiology Services*

Benefit	Original Medicare	Freedom Medicare Plan Rx (HMO) 059
22 – Cardiac and Pulmonary Rehabilitation Services	20% coinsurance for Cardiac Rehabilitation services 20% coinsurance for Pulmonary Rehabilitation services 20% coinsurance for Intensive Cardiac Rehabilitation services	**In-Network** $32 to $200 copay for Medicare-covered Cardiac Rehabilitation Services $32 to $200 copay for Medicare-covered Intensive Cardiac Rehabilitation Services $32 to $200 copay for Medicare-covered Pulmonary Rehabilitation Services
PREVENTIVE SERVICES		
23 – Preventive Services	No coinsurance, copayment or deductible for the following: - Abdominal Aortic Aneurysm Screening - Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. - Cardiovascular Screening - Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. - Colorectal Cancer Screening - Diabetes Screening - Influenza Vaccine - Hepatitis B Vaccine for people with Medicare who are at risk	**General** Authorization rules may apply. $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. Authorization rules may apply.

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
In-Network $30 to $200 copay for Medicare-covered Cardiac Rehabilitation Services $30 to $200 copay for Medicare-covered Intensive Cardiac Rehabilitation Services $30 to $200 copay for Medicare-covered Pulmonary Rehabilitation Services	**In-Network** $20 to $200 copay for Medicare-covered Cardiac Rehabilitation Services $20 to $200 copay for Medicare-covered Intensive Cardiac Rehabilitation Services $20 to $200 copay for Medicare-covered Pulmonary Rehabilitation Services
General Authorization rules may apply. $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. Authorization rules may apply.	**General** Authorization rules may apply. $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. Authorization rules may apply.

Benefit	Original Medicare	Freedom Medicare Plan Rx (HMO) 059
23 – Preventive Services *(continued)*	HIV Screening. $0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. - Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. - Medical Nutrition Therapy Services Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease - Personalized Prevention Plan Services (Annual Wellness Visits) - Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. - Prostate Cancer Screening - Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. - Smoking and Tobacco Use Cessation (counseling to stop smoking and tobacco use). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.	

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088

Benefit	Original Medicare	Freedom Medicare Plan Rx (HMO) 059
23 – Preventive Services *(continued)*	- Screening and behavioral counseling interventions in primary care to reduce alcohol misuse - Screening for depression in adults - Screening for sexually transmitted infections (STI) and high-intensity behavioral counseling to prevent STIs - Intensive behavioral counseling for Cardiovascular Disease (bi-annual) - Intensive behavioral therapy for obesity - Welcome to Medicare Preventive Visits (initial preventive physical exam) when you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Preventive Visit or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.	
24 – Kidney Disease and Conditions	20% coinsurance for renal dialysis 20% coinsurance for kidney disease education services	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered renal dialysis $0 copay for Medicare-covered kidney disease education services

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
General Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered renal dialysis $0 copay for Medicare-covered kidney disease education services	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered renal dialysis $0 copay for Medicare-covered kidney disease education services

Benefit	Original Medicare	Freedom Medicare Plan Rx (HMO) 059
PRESCRIPTION DRUG BENEFITS		
25 – Outpatient Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	**Drugs covered under Medicare Part B** **General** 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. **Drugs covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.freedomhealth.com on the web. Different out-of-pocket costs may apply for people who - have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Service) providers. The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Freedom Medicare Plan Rx (HMO) for certain drugs.

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
Drugs covered under Medicare Part B **General** 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs.	**Drugs covered under Medicare Part B** **General** 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs.
Drugs covered under Medicare Part D **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.freedomhealth.com on the web. Different out-of-pocket costs may apply for people who - have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Service) providers. The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Freedom Medicare Plan Rx (HMO) for certain drugs	**Drugs covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.freedomhealth.com on the web. Different out-of-pocket costs may apply for people who - have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Service) providers. The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Freedom Medicare Plan Rx (HMO) for certain drugs

Benefit	Original Medicare	Freedom Medicare Plan Rx (HMO) 059
25 – Outpatient Prescription Drugs *(continued)*		The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Freedom Medicare Plan Rx (HMO) approves the exception, you will pay Tier 3: Non-Preferred Brand cost sharing for that drug. **In-Network** $0 deductible. Supplemental drugs don't count toward your out-of-pocket drug costs. **Initial Coverage** You pay the following until total yearly drug costs reach $2,850: **Retail Pharmacy** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Freedom Medicare Plan Rx (HMO) approves the exception, you will pay Tier 3: Non-Preferred Brand cost sharing for that drug. **In-Network** $0 deductible. Supplemental drugs don't count toward your out-of-pocket drug costs. **Initial Coverage** You pay the following until total yearly drug costs reach $2,850: **Retail Pharmacy** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.	The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Freedom Medicare Plan Rx (HMO) approves the exception, you will pay Tier 3: Non-Preferred Brand cost sharing for that drug. **In-Network** $0 deductible. Supplemental drugs don't count toward your out-of-pocket drug costs. **Initial Coverage** You pay the following until total yearly drug costs reach $2,850: **Retail Pharmacy** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

Benefit	Original Medicare	Freedom Medicare Plan Rx (HMO) 059
25 – Outpatient Prescription Drugs *(continued)*		You can get drugs the following way(s): **Tier 1: Preferred Generic** - $0 copay for a one-month (30-day) supply of drugs in this tier - $0 copay for a three-month (90-day) supply of drugs in this tier **Tier 2: Preferred Brand** - $30 copay for a one-month (30-day) supply of drugs in this tier - $90 copay for a three-month (90-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** - $80 copay for a one-month (30-day) supply of drugs in this tier - $240 copay for a three-month (90-day) supply of drugs in this tier **Tier 4: Specialty Tier** - 33% coinsurance for a one-month (30-day) supply of drugs in this tier - 33% coinsurance for a three-month (90-day) supply of drugs in this tier **Long Term Care Pharmacy** Long term care pharmacies must dispense brand name drugs in amounts less than a 14 days' supply at a time. They may also dispense less than a month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
You can get drugs the following way(s): **Tier 1: Preferred Generic** - $0 copay for a one-month (30-day) supply of drugs in this tier - $0 copay for a three-month (90-day) supply of drugs in this tier **Tier 2: Preferred Brand** - $30 copay for a one-month (30-day) supply of drugs in this tier - $90 copay for a three-month (90-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** - $80 copay for a one-month (30-day) supply of drugs in this tier - $240 copay for a three-month (90-day) supply of drugs in this tier **Tier 4: Specialty Tier** - 33% coinsurance for a one-month (30-day) supply of drugs in this tier - 33% coinsurance for a three-month (90-day) supply of drugs in this tier **Long Term Care Pharmacy** Long term care pharmacies must dispense brand name drugs in amounts less than a 14 days' supply at a time. They may also dispense less than a month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.	You can get drugs the following way(s): **Tier 1: Preferred Generic** - $0 copay for a one-month (30-day) supply of drugs in this tier - $0 copay for a three-month (90-day) supply of drugs in this tier **Tier 2: Preferred Brand** - $20 copay for a one-month (30-day) supply of drugs in this tier - $60 copay for a three-month (90-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** - $65 copay for a one-month (30-day) supply of drugs in this tier - $195 copay for a three-month (90-day) supply of drugs in this tier **Tier 4: Specialty Tier** - 33% coinsurance for a one-month (30-day) supply of drugs in this tier - 33% coinsurance for a three-month (90-day) supply of drugs in this tier **Long Term Care Pharmacy** Long term care pharmacies must dispense brand name drugs in amounts less than a 14 days' supply at a time. They may also dispense less than a month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

Benefit	Original Medicare	Freedom Medicare Plan Rx (HMO) 059
25 – Outpatient Prescription Drugs *(continued)*		You can get drugs the following way(s): **Tier 1: Preferred Generic** - $0 copay for a one-month (31-day) supply of drugs in this tier **Tier 2: Preferred Brand** - $30 copay for a one-month (31-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** - $80 copay for a one-month (31-day) supply of drugs in this tier **Tier 4: Specialty Tier** - 33% coinsurance for a one-month (31-day) supply of drugs in this tier **Mail Order** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. You can get drugs the following way(s): **Tier 1: Preferred Generic** - $0 copay for a one-month (30-day) supply of drugs in this tier - $0 copay for a three-month (90-day) supply of drugs in this tier **Tier 2: Preferred Brand** - $30 copay for a one-month (30-day) supply of drugs in this tier - $60 copay for a three-month (90-day) supply of drugs in this tier

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
You can get drugs the following way(s): **Tier 1: Preferred Generic** - $0 copay for a one-month (31-day) supply of drugs in this tier **Tier 2: Preferred Brand** - $30 copay for a one-month (31-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** - $80 copay for a one-month (31-day) supply of drugs in this tier **Tier 4: Specialty Tier** - 33% coinsurance for a one-month (31-day) supply of drugs in this tier **Mail Order** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. You can get drugs the following way(s): **Tier 1: Preferred Generic** - $0 copay for a one-month (30-day) supply of drugs in this tier - $0 copay for a three-month (90-day) supply of drugs in this tier **Tier 2: Preferred Brand** - $30 copay for a one-month (30-day) supply of drugs in this tier - $60 copay for a three-month (90-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** - $80 copay for a one-month (30-day) supply of drugs in this tier - $160 copay for a three-month (90-day) supply of drugs in this tier	You can get drugs the following way(s): **Tier 1: Preferred Generic** - $0 copay for a one-month (31-day) supply of drugs in this tier **Tier 2: Preferred Brand** - $20 copay for a one-month (31-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** - $65 copay for a one-month (31-day) supply of drugs in this tier **Tier 4: Specialty Tier** - 33% coinsurance for a one-month (31-day) supply of drugs in this tier **Mail Order** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. You can get drugs the following way(s): **Tier 1: Preferred Generic** - $0 copay for a one-month (30-day) supply of drugs in this tier - $0 copay for a three-month (90-day) supply of drugs in this tier **Tier 2: Preferred Brand** - $20 copay for a one-month (30-day) supply of drugs in this tier - $40 copay for a three-month (90-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** - $65 copay for a one-month (30-day) supply of drugs in this tier - $130 copay for a three-month (90-day) supply of drugs in this tier

Benefit	Original Medicare	Freedom Medicare Plan Rx (HMO) 059
25 – Outpatient Prescription Drugs *(continued)*		**Tier 3: Non-Preferred Brand** - $80 copay for a one-month (30-day) supply of drugs in this tier - $160 copay for a three-month (90-day) supply of drugs in this tier **Tier 4: Specialty Tier** - 33% coinsurance for a one-month (30-day) supply of drugs in this tier - 33% coinsurance for a three-month (90-day) supply of drugs in this tier **Coverage Gap** After your total yearly drug costs reach $2,850, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 72% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,550. **Additional Coverage Gap** The plan covers many formulary generics (65% - 99% of formulary generic drugs) through the coverage gap. The plan offers additional coverage in the gap for the following tiers. You pay the following: **Retail Pharmacy** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
Tier 4: Specialty Tier - 33% coinsurance for a one-month (30-day) supply of drugs in this tier - 33% coinsurance for a three-month (90-day) supply of drugs in this tier	**Tier 4: Specialty Tier** - 33% coinsurance for a one-month (30-day) supply of drugs in this tier - 33% coinsurance for a three-month (90-day) supply of drugs in this tier
Coverage Gap After your total yearly drug costs reach $2,850, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 72% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,550.	**Coverage Gap** After your total yearly drug costs reach $2,850, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 72% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,550.
Additional Coverage Gap The plan covers many formulary generics (65% - 99% of formulary generic drugs) through the coverage gap. The plan offers additional coverage in the gap for the following tiers. You pay the following:	**Additional Coverage Gap** The plan covers many formulary generics (65% - 99% of formulary generic drugs) through the coverage gap. The plan offers additional coverage in the gap for the following tiers. You pay the following:
Retail Pharmacy Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.	**Retail Pharmacy** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.
Tier 1: Preferred Generic - $0 copay for a one-month (30-day) supply of all drugs covered within this tier - $0 copay for a three-month (90-day) supply of all drugs covered within this tier	**Tier 1: Preferred Generic** - $0 copay for a one-month (30-day) supply of all drugs covered within this tier - $0 copay for a three-month (90-day) supply of all drugs covered within this tier

Benefit	Original Medicare	Freedom Medicare Plan Rx (HMO) 059
25 – Outpatient Prescription Drugs *(continued)*		**Tier 1: Preferred Generic** - $10 copay for a one-month (30-day) supply of all drugs covered within this tier - $30 copay for a three-month (90-day) supply of all drugs covered within this tier **Long Term Care Pharmacy** Long term care pharmacies must dispense brand name drugs in amounts less than a 14 days' supply at a time. They may also dispense less than a month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. **Tier 1: Preferred Generic** - $10 copay for a one-month (31-day) supply of all drugs covered within this tier **Mail Order** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. **Tier 1: Preferred Generic** - $10 copay for a one-month (30-day) supply of all drugs covered within this tier - $20 copay for a three-month (90-day) supply of all drugs covered within this tier **Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: - 5% coinsurance, or - $2.55 copay for generic (including brand drugs treated as generic) and a $6.35 copay for all other drugs.

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
Long Term Care Pharmacy Long term care pharmacies must dispense brand name drugs in amounts less than a 14 days' supply at a time. They may also dispense less than a month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. **Tier 1: Preferred Generic** - $0 copay for a one-month (31-day) supply of all drugs covered within this tier **Mail Order** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. **Tier 1: Preferred Generic** - $0 copay for a one-month (30-day) supply of all drugs covered within this tier - $0 copay for a three-month (90-day) supply of all drugs covered within this tier **Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: - 5% coinsurance, or - $2.55 copay for generic (including brand drugs treated as generic) and a $6.35 copay for all other drugs. **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Freedom Medicare Plan Rx (HMO).	**Long Term Care Pharmacy** Long term care pharmacies must dispense brand name drugs in amounts less than a 14 days' supply at a time. They may also dispense less than a month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. **Tier 1: Preferred Generic** - $0 copay for a one-month (31-day) supply of all drugs covered within this tier **Mail Order** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. **Tier 1: Preferred Generic** - $0 copay for a one-month (30-day) supply of all drugs covered within this tier - $0 copay for a three-month (90-day) supply of all drugs covered within this tier **Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: - 5% coinsurance, or - $2.55 copay for generic (including brand drugs treated as generic) and a $6.35 copay for all other drugs. **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Freedom Medicare Plan Rx (HMO).

Benefit	Original Medicare	Freedom Medicare Plan Rx (HMO) 059
25 – Outpatient Prescription Drugs *(continued)*		**Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Freedom Medicare Plan Rx (HMO). You can get out-of-network drugs the following way: **Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,850: **Tier 1: Preferred Generic** - $0 copay for a one-month (30-day) supply of drugs in this tier **Tier 2: Preferred Brand** - $30 copay for a one-month (30-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** - $80 copay for a one-month (30-day) supply of drugs in this tier **Tier 4: Specialty Tier** - 33% coinsurance for a one-month (30-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
You can get out-of-network drugs the following way: **Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,850: **Tier 1: Preferred Generic** - $0 copay for a one-month (30-day) supply of drugs in this tier **Tier 2: Preferred Brand** - $30 copay for a one-month (30-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** - $80 copay for a one-month (30-day) supply of drugs in this tier **Tier 4: Specialty Tier** - 33% coinsurance for a one-month (30-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Out-of-Network Coverage Gap** You will be reimbursed up to 28% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for the drug(s). You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).	You can get out-of-network drugs the following way: **Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,850: **Tier 1: Preferred Generic** - $0 copay for a one-month (30-day) supply of drugs in this tier **Tier 2: Preferred Brand** - $20 copay for a one-month (30-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** - $65 copay for a one-month (30-day) supply of drugs in this tier **Tier 4: Specialty Tier** - 33% coinsurance for a one-month (30-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Out-of-Network Coverage Gap** You will be reimbursed up to 28% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for the drug(s). You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).

Benefit	Original Medicare	Freedom Medicare Plan Rx (HMO) 059
25 – Outpatient Prescription Drugs *(continued)*		**Out-of-Network Coverage Gap** You will be reimbursed up to 28% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for the drug(s). You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). **Additional Out-of-Network Coverage Gap** You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following: **Tier 1: Preferred Generic** - $10 copay for a one-month (30-day) supply of all drugs covered within this tier **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: - 5% coinsurance, or - $2.55 copay for generic (including brand drugs treated as generic) and a $6.35 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. *See page 56 for additional information about Outpatient Prescription Drugs*

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
Additional Out-of-Network Coverage Gap You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following: **Tier 1: Preferred Generic** - $0 copay for a one-month (30-day) supply of all drugs covered within this tier **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: - 5% coinsurance, or - $2.55 copay for generic (including brand drugs treated as generic) and a $6.35 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. *See page 57 for additional information about Outpatient Prescription Drugs*	**Additional Out-of-Network Coverage Gap** You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following: **Tier 1: Preferred Generic** - $0 copay for a one-month (30-day) supply of all drugs covered within this tier **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: - 5% coinsurance, or - $2.55 copay for generic (including brand drugs treated as generic) and a $6.35 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. *See page 57 for additional information about Outpatient Prescription Drugs*

Benefit	Original Medicare	Freedom Medicare Plan Rx (HMO) 059
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
26 – Dental Services	Preventive dental services (such as cleaning) not covered.	**In-Network** $0 copay for Medicare-covered dental benefits $0 copay for up to 1 supplemental oral exam(s) every year $0 copay for up to 2 supplemental cleaning(s) every year $0 copay for up to 1 supplemental fluoride treatment(s) every year $5 to $75 copay for up to 1 supplemental dental x-ray(s) every year
27 – Hearing Services	Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	**In-Network** $0 copay for: Medicare-covered diagnostic hearing exams $0 copay for: - up to 1 supplemental routine hearing exam(s) every two years $0 copay for up to 1 supplemental hearing aid fitting-evaluation(s) every two years $0 copay each for up to 1 supplemental hearing aid(s) every two years $500 plan coverage limit for supplemental hearing aids every two years.

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
In-Network $0 copay for Medicare-covered dental benefits $0 copay for up to 1 supplemental oral exam(s) every year $0 copay for up to 2 supplemental cleaning(s) every year $0 copay for up to 1 supplemental fluoride treatment(s) every year $5 to $75 copay for up to 1 supplemental dental x-ray(s) every year	**In-Network** $0 copay for Medicare-covered dental benefits $0 copay for up to 1 supplemental oral exam(s) every year $0 copay for up to 2 supplemental cleaning(s) every year $0 copay for up to 1 supplemental fluoride treatment(s) every year $5 to $75 copay for up to 1 supplemental dental x-ray(s) every year
In-Network $0 copay for: Medicare-covered diagnostic hearing exams $0 copay for: - up to 1 supplemental routine hearing exam(s) every two years $0 copay for up to 1 supplemental hearing aid fitting-evaluation(s) every two years $0 copay each for up to 1 supplemental hearing aid(s) every two years $500 plan coverage limit for supplemental hearing aids every two years.	**In-Network** $0 copay for: Medicare-covered diagnostic hearing exams $0 copay for: - up to 1 supplemental routine hearing exam(s) every two years $0 copay for up to 1 supplemental hearing aid fitting-evaluation(s) every two years $0 copay each for up to 1 supplemental hearing aid(s) every two years $500 plan coverage limit for supplemental hearing aids every two years.

Benefit	Original Medicare	Freedom Medicare Plan Rx (HMO) 059
28 – Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye, including an annual glaucoma screening for people at risk. Supplemental routine eye exams and eyeglasses (lenses and frames) not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.	**In-Network** $0 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening for people at risk $0 copay for up to 1 supplemental routine eye exam(s) every year $15 copay for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery. $15 copay for up to 1 pair(s) of eyeglasses (lenses and frames) every year. $15 copay for up to 1 pair(s) of contact lenses every year $100 plan coverage limit for supplemental eyewear every year. Plan offers additional vision benefits. Contact plan for details. *See page 56 for additional information about Vision Services*
Wellness/ Education and Other Supplemental Benefits & Services	Not covered.	**In-Network** The plan covers the following supplemental education/wellness programs: - Health Club Membership/Fitness Classes
Over-the-Counter Items	Not covered.	**General** Please visit our plan website to see our list of covered Over-the-Counter items. OTC items may be purchased only for the enrollee. Please contact the plan for specific instructions for using this benefit.

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
In-Network $0 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening for people at risk $0 copay for up to 1 supplemental routine eye exam(s) every year $15 copay for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery. $15 copay for up to 1 pair(s) of eyeglasses (lenses and frames) every year. $15 copay for up to 1 pair(s) of contact lenses every year $100 plan coverage limit for supplemental eyewear every year. Plan offers additional vision benefits. Contact plan for details. *See page 57 for additional information about Vision Services*	**In-Network** $0 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening for people at risk $0 copay for up to 1 supplemental routine eye exam(s) every year $15 copay for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery. $15 copay for up to 1 pair(s) of eyeglasses (lenses and frames) every year. $15 copay for up to 1 pair(s) of contact lenses every year $100 plan coverage limit for supplemental eyewear every year. Plan offers additional vision benefits. Contact plan for details. *See page 57 for additional information about Vision Services*
In-Network The plan covers the following supplemental education/wellness programs: - Health Club Membership/Fitness Classes	**In-Network** The plan covers the following supplemental education/wellness programs: - Health Club Membership/Fitness Classes
General Please visit our plan website to see our list of covered Over-the-Counter items. OTC items may be purchased only for the enrollee. Please contact the plan for specific instructions for using this benefit.	**General** Please visit our plan website to see our list of covered Over-the-Counter items. OTC items may be purchased only for the enrollee. Please contact the plan for specific instructions for using this benefit.

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Benefit	Original Medicare	Freedom Medicare Plan Rx (HMO) 059
Transportation (Routine)	Not covered.	**In-Network** $0 copay for up to 4 one-way trip(s) to plan-approved location every year
Acupuncture and Other Alternative Therapies	Not covered.	**In-Network** This plan does not cover Acupuncture and other alternative therapies.

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
In-Network $0 copay for up to 4 one-way trip(s) to plan-approved location every year	**In-Network** $0 copay for up to 4 one-way trip(s) to plan-approved location every year
In-Network This plan does not cover Acupuncture and other alternative therapies.	**In-Network** This plan does not cover Acupuncture and other alternative therapies.

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

SECTION III – Additional Information Regarding Your Benefits

This section further explains some of the benefits of our plan. To get a complete list of benefits, limitations, and exclusions, call Freedom Health and ask for the "Evidence of Coverage."

Benefit	Freedom Medicare Plan Rx (HMO) 059
2 – Doctor and Hospital Choice	Services rendered by a physician or medical professional within the physician's office are subject to the physician specialist copay.
3 – Inpatient Hospital Care	You pay the amounts shown in Section II each time you're admitted to a hospital, no matter how many days have passed since your last admission.
4 – Inpatient Mental Health Care	You pay the amounts shown in Section II each time you're admitted to a hospital, no matter how many days have passed since your last admission.
5 – Skilled Nursing Facility (SNF)	You pay the amounts shown in Section II each time you're admitted to a SNF, no matter how many days have passed since your last admission. No prior hospital stay is required.
13 – Outpatient Services	20% of the cost for Medicare-covered Therapeutic Radiology services in a physician's office or freestanding facility. 20% of the cost for Medicare-covered Therapeutic Radiology services in an outpatient hospital 20% of the cost for Medicare-covered renal dialysis in a physician's office or freestanding facility. 20% of the cost for Medicare-covered renal dialysis in in an outpatient hospital. 20% of the cost for Medicare Part B chemo therapy drugs and other Part B drugs $50 copay for all other outpatient services received at an office or freestanding facility $200 copay for all other outpatient services received at a hospital facility

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
Services rendered by a physician or medical professional within the physician's office are subject to the physician specialist copay.	Services rendered by a physician or medical professional within the physician's office are subject to the physician specialist copay.
You pay the amounts shown in Section II each time you're admitted to a hospital, no matter how many days have passed since your last admission.	You pay the amounts shown in Section II each time you're admitted to a hospital, no matter how many days have passed since your last admission.
You pay the amounts shown in Section II each time you're admitted to a hospital, no matter how many days have passed since your last admission.	You pay the amounts shown in Section II each time you're admitted to a hospital, no matter how many days have passed since your last admission.
You pay the amounts shown in Section II each time you're admitted to a SNF, no matter how many days have passed since your last admission. No prior hospital stay is required.	You pay the amounts shown in Section II each time you're admitted to a SNF, no matter how many days have passed since your last admission. No prior hospital stay is required.
20% of the cost for Medicare-covered Therapeutic Radiology services in a physician's office or freestanding facility. 20% of the cost for Medicare-covered Therapeutic Radiology services in an outpatient hospital 20% of the cost for Medicare-covered renal dialysis in a physician's office or freestanding facility. 20% of the cost for Medicare-covered renal dialysis in in an outpatient hospital. 20% of the cost for Medicare Part B chemo therapy drugs and other Part B drugs $50 copay for all other outpatient services received at an office or freestanding facility $200 copay for all other outpatient services received at a hospital facility	20% of the cost for Medicare-covered Therapeutic Radiology services in a physician's office or freestanding facility. 20% of the cost for Medicare-covered Therapeutic Radiology services in an outpatient hospital 20% of the cost for Medicare-covered renal dialysis in a physician's office or freestanding facility. 20% of the cost for Medicare-covered renal dialysis in in an outpatient hospital. 20% of the cost for Medicare Part B chemo therapy drugs and other Part B drugs $50 copay for all other outpatient services received at an office or freestanding facility $200 copay for all other outpatient services received at a hospital facility

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Benefit	Freedom Medicare Plan Rx (HMO) 059
20 – Diabetes Programs and Supplies	0%for Diabetic Monitors, Lancets, and Test Strips through mail order program 20% for retail and all other diabetic supplies
21 – Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	This section includes Diagnostic tests, lab services, X-Ray services, Diagnostic Radiological services, and Therapeutic Radiological services furnished to patients under Medicare Part B who are **not** hospital outpatients. Services rendered in an outpatient hospital setting will be charged the outpatient hospital copay. **You pay the following for Medicare-covered services:** $0 copay for Medicare-covered lab services $0 copay for Medicare-covered diagnostic procedures and tests $0 copay for Medicare-covered X-rays Radiological Services: $25 copay for Medicare-covered Ultrasound $50 copay for Medicare-covered CAT Scan $75 copay for Medicare-covered MRI, MRA, Angiogram $75 copay for Medicare-covered Nuclear Medicine $100 copay for Medicare-covered PET Scan 20% of the cost for Medicare-covered therapeutic radiology services Separate copay applies in addition to this specific service copay if it is part of the same encounter. $0 for a Primary Care Physician visit and $32 for a Specialist Physician visit. You pay $200 for outpatient services received at a hospital facility.

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
0%for Diabetic Monitors, Lancets, and Test Strips through mail order program 20% for retail and all other diabetic supplies	0%for Diabetic Monitors, Lancets, and Test Strips through mail order program 20% for retail and all other diabetic supplies
This section includes Diagnostic tests, lab services, X-Ray services, Diagnostic Radiological services, and Therapeutic Radiological services furnished to patients under Medicare Part B who are **not** hospital outpatients. Services rendered in an outpatient hospital setting will be charged the outpatient hospital copay. **You pay the following for Medicare-covered services:** $0 copay for Medicare-covered lab services $0 copay for Medicare-covered diagnostic procedures and tests $0 copay for Medicare-covered X-rays Radiological Services: $25 copay for Medicare-covered Ultrasound $50 copay for Medicare-covered CAT Scan $75 copay for Medicare-covered MRI, MRA, Angiogram $75 copay for Medicare-covered Nuclear Medicine $100 copay for Medicare-covered PET Scan 20% of the cost for Medicare-covered therapeutic radiology services Separate copay applies in addition to this specific service copay if it is part of the same encounter. $0 for a Primary Care Physician visit and $30 for a Specialist Physician visit. You pay $200 for outpatient services received at a hospital facility.	This section includes Diagnostic tests, lab services, X-Ray services, Diagnostic Radiological services, and Therapeutic Radiological services furnished to patients under Medicare Part B who are **not** hospital outpatients. Services rendered in an outpatient hospital setting will be charged the outpatient hospital copay. **You pay the following for Medicare-covered services:** $0 copay for Medicare-covered lab services $0 copay for Medicare-covered diagnostic procedures and tests $0 copay for Medicare-covered X-rays Radiological Services: $25 copay for Medicare-covered Ultrasound $50 copay for Medicare-covered CAT Scan $75 copay for Medicare-covered MRI, MRA, Angiogram $75 copay for Medicare-covered Nuclear Medicine $100 copay for Medicare-covered PET Scan 20% of the cost for Medicare-covered therapeutic radiology services Separate copay applies in addition to this specific service copay if it is part of the same encounter. $0 for a Primary Care Physician visit and $20 for a Specialist Physician visit. You pay $200 for outpatient services received at a hospital facility.

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Benefit	Freedom Medicare Plan Rx (HMO) 059
25 – Outpatient Prescription Drugs	**Drugs covered under Medicare Part B** You pay 20% of the cost for Medicare-covered Part B drugs. You pay 20% of the cost for Medicare-covered chemotherapy drugs Certain drugs for dialysis are covered under the Part B drug benefit. Certain drugs and biological that you can't give yourself are covered under the Part B drug benefit. **Drugs covered under Medicare Part D** The plan does not cover all prescription drugs. In some cases, the law does not allow any Medicare plan to cover certain types of drugs. In other cases, we have decided not to include a particular drug on the Drug List (Formulary). The plan may require authorization to determine whether certain drugs are covered by Medicare Part B or Medicare Part D.
28 – Vision Services	$0 copayment for exams to diagnose and treat diseases and conditions of the eye by an Optometrist. $32 copayment for exams to diagnose and treat diseases and conditions of the eye by an Ophthalmologist.

If you have any questions about this plan's benefits or costs, please contact Freedom Health, Inc. for details.

Freedom Medicare Plan Rx (HMO) 060	Freedom Medicare Plan Rx (HMO) 088
Drugs covered under Medicare Part B You pay 20% of the cost for Medicare-covered Part B drugs. You pay 20% of the cost for Medicare-covered chemotherapy drugs Certain drugs for dialysis are covered under the Part B drug benefit. Certain drugs and biological that you can't give yourself are covered under the Part B drug benefit. **Drugs covered under Medicare Part D** The plan does not cover all prescription drugs. In some cases, the law does not allow any Medicare plan to cover certain types of drugs. In other cases, we have decided not to include a particular drug on the Drug List (Formulary). The plan may require authorization to determine whether certain drugs are covered by Medicare Part B or Medicare Part D.	**Drugs covered under Medicare Part B** You pay 20% of the cost for Medicare-covered Part B drugs. You pay 20% of the cost for Medicare-covered chemotherapy drugs Certain drugs for dialysis are covered under the Part B drug benefit. Certain drugs and biological that you can't give yourself are covered under the Part B drug benefit. **Drugs covered under Medicare Part D** The plan does not cover all prescription drugs. In some cases, the law does not allow any Medicare plan to cover certain types of drugs. In other cases, we have decided not to include a particular drug on the Drug List (Formulary). The plan may require authorization to determine whether certain drugs are covered by Medicare Part B or Medicare Part D.
$0 copayment for exams to diagnose and treat diseases and conditions of the eye by an Optometrist. $30 copayment for exams to diagnose and treat diseases and conditions of the eye by an Ophthalmologist.	$0 copayment for exams to diagnose and treat diseases and conditions of the eye by an Optometrist. $20 copayment for exams to diagnose and treat diseases and conditions of the eye by an Ophthalmologist.

2014 Summary of Benefits

FREEDOM HEALTH

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

www.freedomhealth.com

Focused on You

SB Combo 059 - 060 - 088

059 - Freedom Medicare Plan Rx (HMO)

Counties:
Brevard, Charlotte, Citrus, Lee, Manatee, Martin, Pinellas, Sumter, Volusia

060 - Freedom Medicare Plan Rx (HMO)

Counties:
Broward, Hernando, Hillsborough, Indian River, Lake, Marion, Miami-Dade, Orange, Osceola, Palm Beach, Pasco, Sarasota, Seminole, St. Lucie

088 - Freedom Medicare Plan Rx (HMO)

Counties:
Indian River, St. Lucie