Summary of Benefits

Thank you for your interest in our Medicare Advantage plans

Freedom Health, Inc. offers benefits to help support your health and help you manage your healthcare costs. This plan includes hospital and medical benefits, and prescription drug coverage.

Medicare Advantage and Part D

Plan year: January 1 – December 31, 2027

Florida

Orange, Osceola, Seminole counties

Freedom Máximo (HMO-POS)

Freedom Máximo (HMO-POS)

Our service area includes these counties in FL: Orange, Osceola, Seminole.

Do you have questions?

You can learn more on our website, **freedomhealth.com**. Or call us toll-free at **1-800-401-2740** (TTY: **711**). Hours of operation: 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

The Summary of Benefits does not list every covered service or rule. The Evidence of Coverage includes full details. Call us to request a copy.

Freedom Máximo (HMO-POS) is a Medicare Advantage plan. It includes hospital, medical, and prescription drug benefits. To join this plan, the following must apply to you:

- You're entitled to Medicare Part A.
- You're enrolled in Medicare Part B.
- You live in our service area.

Medicare coverage that goes beyond Original Medicare

- Medicare Advantage plans cover everything Original Medicare covers — Part A (hospital services) and Part B (medical services) — plus more.
- Medicare Advantage Prescription Drug Plans cover Medicare Part D drugs and Part B drugs.

This is a Health Maintenance Organization Point of Service (HMO-POS) plan. That means:

- Freedom Health, Inc. covers emergency care and urgently needed services from out-of-network providers. For routine care, you must use the Freedom Health, Inc. network of providers, hospitals, and pharmacies while in the plan's service area, and from a plan-approved provider network when using your Point-of-Service benefit in Puerto Rico. Neither Medicare nor Freedom Health, Inc. will be responsible for the costs incurred of routine care received from out-of-network providers except while utilizing your POS benefit with plan-approved providers while in Puerto Rico.
- Before you visit a specialist, talk with your PCP first. They know your health history and can help you find the right care.

Need to change your primary care provider (PCP)?

Call us. We can help you change your PCP.

Doctors can join or leave our network at any time. For the most current list, use the **Find Provider/Pharmacy** tool online.

Please call Member Services or see your Evidence of Coverage (EOC) for more information.

How to find a provider/PCP in our plan:

- Go to **freedomhealth.com**
  1. Select **Find Provider/Pharmacy**.
  2. Fill in the details (search by provider name, ZIP code, distance, specialty, etc.).
  3. Be sure to check that the doctor is "Accepting new patients."
- Or you can ask us for the Provider Directory. The phone number is on page 2.

Find a pharmacy

Our plans include many pharmacies in the U.S. Check the Pharmacy Directory to confirm your pharmacy is in-network. If your pharmacy is not in this plan, you could end up paying more for your drugs.

To confirm your pharmacy is in the plan (or to find a new one), use the **Quick Links** menu on our website at **freedomhealth.com**. Under **Quick Links,** choose **Provider Finder** to enter your location and search details. Select the type of pharmacy as the Specialty. Preferred pharmacies are noted under the pharmacy name. Or you can give us a call and we'll send you the directory.

Our plan offers preferred and standard pharmacies. You may go to either type of pharmacy to fill your covered prescription drugs.

How to check if your prescriptions (or an acceptable alternative) are covered:

- Visit **freedomhealth.com**
  1. Select **Quick Links** menu.
  2. Select **Drug Finder**.
  3. Select your **county** and **plan**.
  4. Enter **drug name**.
  5. Locate your prescription.
- You can also call us at the number on page 2 for a copy of the Formulary.

Don’t miss out on some Extra Help

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won’t have a late enrollment penalty.

To find out if you qualify for Extra Help, call:

- Our representatives at **1-800-401-2740** (TTY: **711**) 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.
- 1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048), 24 hours a day/7 days a week.
- The Social Security Administration at 1-800-772-1213 (TTY: 1-800-325-0778) Monday to Friday, 8 a.m. to 7 p.m.
- Your state Medicaid office.

For more information about Medicare, you can read the Medicare & You handbook. If you don't have a copy of this booklet, you can access it online at the Medicare website (medicare.gov/medicare-and-you) or request a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.



Summary of 2027 medical benefits

Freedom Máximo (HMO-POS)

How much is my premium (monthly payment)?

$0.00 per month

You must continue to pay your Medicare Part B premium.

Medicare Part B premium reduction

$202.90 per month

How much is my deductible?

This plan does not have a medical deductible.

This plan does not have a Part D deductible.

Freedom Máximo (HMO-POS)

Is there a limit on how much I will pay for my covered medical services? (does not include Part D drugs)

In-network and out-of-network providers combined: **$3,400.00** annually.

Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.

Services you receive from both in-network and out-of-network providers go toward your yearly limit. If you reach the limit on out-of-pocket costs, you will not have to pay any out-of-pocket costs for covered Part A and Part B services (in-network or out-of-network) for the rest of the year.

Inpatient Hospital[1,2]

In-Network Benefits: Days 1-5: **$225.00** per day, per admission / Days 6-90: **$0.00** per day, per admission
Out-of-Network Benefits: Days 1-5: **$225.00** per day, per admission / Days 6-90: **$0.00** per day, per admission

Our plan covers 90 days for an inpatient hospital stay.

Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. Once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.

Freedom Máximo (HMO-POS)

Outpatient Hospital[1,2]

In-Network Benefits: **$195.00** copay
Out-of-Network Benefits: **$195.00** copay

Ambulatory Surgical Center[1,2]

In-Network Benefits: **$25.00** copay
Out-of-Network Benefits: **$25.00** copay

Doctor's Office Visits

Primary care physician (PCP) visit:

In-Network Benefits: **$0.00** copay
Out-of-Network Benefits: **$0.00** copay

Specialist visit:[1,2]

In-Network Benefits: **$20.00** copay
Out-of-Network Benefits: **$20.00** copay

Preventive Care Screenings

Preventive care screenings:[1,2]

In-Network Benefits: **$0.00** copay
Out-of-Network Benefits: **$0.00** copay

Freedom Máximo (HMO-POS)

Preventive Care Screenings

Covered preventive care screenings:

- Abdominal aortic aneurysm screening
- Annual wellness visit
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)
- Cardiovascular disease screening tests
- Cervical and vaginal cancer screening
- Colorectal cancer screenings
- Depression screening
- Diabetes screening
- Diabetes self-management training, diabetic services, and supplies
- Health and wellness education programs
- HIV screening
- Immunizations
- Medical nutrition therapy
- Medicare Diabetes Prevention Program (MDPP)
- Obesity screening and therapy to promote sustained weight loss
- Pre-exposure prophylaxis (PrEP) for HIV prevention
- Prostate cancer screening exams
- Screening and counseling to reduce alcohol misuse
- Screening for Hepatitis C Virus infection
- Screening for lung cancer with low dose computed tomography (LDCT)
- Screening for sexually transmitted infections (STIs) and counseling to prevent STIs
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)
- Vision care
- “Welcome to Medicare” preventive visit (one-time)

Any extra preventive services approved by Medicare during the contract year will be covered. When you use in-network or out-of-network plan-approved providers, **100%** of the cost of preventive care screenings will be covered.

Freedom Máximo (HMO-POS)

Emergency Care

In-Network Benefits: **$150.00** copay
Out-of-Network Benefits: **$150.00** copay

Emergency care copay may be waived upon admission. If you are admitted to the hospital within 72 hours for the same condition, you pay a **$0.00** copay for the emergency room visit.

Emergency and Urgent Care Worldwide Coverage
$500.00 copay

This plan covers urgent care and emergency services, including emergency transportation, when traveling outside of the United States for less than six months. This benefit is limited to **$100,000** per year.

Urgently Needed Services

In-Network Benefits: **$10.00** copay
Out-of-Network Benefits: **$10.00** copay

Diagnostic Services, Labs, and Imaging[1,2]

Diagnostic Radiology Services	
CT scans, MRI, MRA, PET	
In-Network Benefits:	
Physician's office or free-standing provider facilities:	**$50.00 copay - $150.00 copay**
Hospital outpatient facilities:	**$195.00 copay**

Freedom Máximo (HMO-POS)

Diagnostic Services, Labs, and Imaging[1,2]	
Out-of-Network Benefits:	
Physician's office or free-standing provider facilities:	**$50.00 copay - $150.00 copay**
Hospital outpatient facilities:	**$195.00 copay**
Ultrasounds	
In-Network Benefits:	
Physician's office or free-standing provider facilities:	**$25.00 copay**
Hospital outpatient facilities:	**$195.00 copay**
Out-of-Network Benefits:	
Physician's office or free-standing provider facilities:	**$25.00 copay**
Hospital outpatient facilities:	**$195.00 copay**
Diagnostic Tests and Procedures	
In-Network Benefits:	
Physician's office or free-standing provider facilities:	**$0.00 copay**
Hospital outpatient facilities:	**$195.00 copay**
Out-of-Network Benefits:	
Physician’s office or free-standing provider facilities:	**$0.00 copay**
Hospital outpatient facilities:	**$195.00 copay**

Freedom Máximo (HMO-POS)

Diagnostic Services, Labs, and Imaging[1,2]	
Sleep Studies In-Network Benefits: Out-of-Network Benefits:	**20% coinsurance** **20% coinsurance**
Lab Services In-Network Benefits: Physician's office or free-standing provider facilities: Hospital outpatient facilities: Out-of-Network Benefits: Physician's office or free-standing provider facilities: Hospital outpatient facilities:	 **$0.00 copay** **$50.00 copay** **$0.00 copay** **$50.00 copay**
Outpatient X-rays In-Network Benefits: Physician's office or free-standing provider facilities: Hospital outpatient facilities: Out-of-Network Benefits: Physician's office or free-standing provider facilities: Hospital outpatient facilities:	 **$0.00 copay** **$195.00 copay** **$0.00 copay** **$195.00 copay**

Freedom Máximo (HMO-POS)

Diagnostic Services, Labs, and Imaging[1,2]	
Therapeutic Radiology Services (such as radiation treatment for cancer) In-Network Benefits: Out-of-Network Benefits:	 **20% coinsurance** **20% coinsurance**

Hearing Services

Medicare-covered hearing services (Exam to diagnose and treat hearing and balance issues):

In-Network Benefits: **$0.00** copay
Out-of-Network Benefits: **$0.00** copay

Routine hearing services:

In-Network Benefits: **$0.00** copay for routine hearing exam(s). **$0.00** copay for hearing aids up to the maximum plan benefit amount.

This plan covers 1 routine hearing exam every year. This plan covers 1 routine hearing aid fitting evaluation and a **$750** maximum plan benefit for prescribed hearing aids per ear every year.

Out-of-Network Benefits: Not Covered

Freedom Máximo (HMO-POS)

Dental Services

Medicare-covered dental services (this does not include services for care, treatment, filling, removal or replacement of teeth):[1]

In-Network Benefits: **$0.00** copay
Out-of-Network Benefits: **$0.00** copay

Preventive dental services:

In-Network Benefits: **$0.00** copay
This plan covers: 2 oral exams, 2 emergency exams, 2 prophylaxis cleanings, 2 fluoride treatments and dental X-rays every year.

Out-of-Network Benefits: Not Covered

Comprehensive dental services:

In-Network Benefits: **$0.00** copay
This plan covers up to: 2 simple or surgical extractions (in 1 or more visits) every year, 2 resin or amalgam fillings every year, 2 periodontal maintenance procedures every year, 1 periodontal scaling and root planing per quadrant every year, and 1 full mouth debridement every 2 years.

Please refer to the Dental section of your Evidence of Coverage for additional information, limitations and exclusions.

To find a dental provider in our plan, follow the same steps as the "How to find a provider/PCP in our plan" box at the beginning of this booklet. Then enter **Dental** under **Specialty**.

Out-of-Network Benefits: Not Covered

Vision Services

Medicare-covered vision services:

Exam to diagnose and treat diseases and conditions of the eye:

In-Network Benefits:
Optometrists: **$0.00** copay
Ophthalmologists: **$20.00** copay[1,2]

Out-of-Network Benefits:
Optometrists: **$0.00** copay
Ophthalmologists: **$20.00** copay[1,2]

Eyeglasses or contact lenses after cataract surgery:

In-Network Benefits: **$0.00** copay
Out-of-Network Benefits: **$0.00** copay

Routine vision services:

Routine vision exam:

In-Network Benefits: **$0.00** copay
This plan covers 1 routine eye exam(s) every year.

Out-of-Network Benefits: Not Covered

Freedom Máximo (HMO-POS)

Vision Services

Routine eyewear (lenses and frames)**:**

In-Network Benefits: **$0.00** copay and **$30** copay for CR-39 lenses
This plan covers up to **$300** for 1 pair(s) of eyeglasses or contact lenses every year.

To find a vision provider in our plan, please call the phone number on page 2 for assistance.

Out-of-Network Benefits: Not Covered

Mental Health Care

Inpatient visit:[1,2]

In-Network Benefits: Days 1-5: **$225.00** per day, per admission / Days 6-90: **$0.00** per day, per admission

Out-of-Network Benefits: Days 1-5: **$225.00** per day, per admission / Days 6-90: **$0.00** per day, per admission

Our plan covers 90 days for an inpatient hospital stay.

Our plan has a lifetime limit of 190 days for inpatient mental health care in a psychiatric hospital. This limit does not apply to inpatient mental health services provided in a general hospital.

Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. Once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.

Outpatient individual and group therapy services:[1,2]

In-Network Benefits: **$20.00** copay

Out-of-Network Benefits: **$20.00** copay

Freedom Máximo (HMO-POS)

Skilled Nursing Facility (SNF)[1,2]

In-Network Benefits: Days 1 - 20: **$0.00** per day / Days 21 - 100: **$218.00** per day

Out-of-Network Benefits: Days 1-20: **$0.00** per day / Days 21-100: **$218.00** per day

Our plan covers up to 100 days in a Skilled Nursing Facility (SNF).

Your copays for SNF benefits are based on benefit periods. A benefit period starts on the first day you go into a hospital or SNF and ends when you haven't had any inpatient hospital care or skilled nursing care for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period starts. There's no limit to the number of benefit periods you can have.

Physical Therapy[1,2]

In-Network Benefits: **$20.00** copay
Out-of-Network Benefits: **$20.00** copay

Ambulance[1]

Ground/Water Ambulance:

In-Network Benefits: **$200.00** copay per trip
Out-of-Network Benefits: **$200.00** copay per trip

Air Ambulance:

In-Network Benefits: **20%** coinsurance per trip
Out-of-Network Benefits: **20%** coinsurance per trip

Transportation

Plan approved health related locations
In-Network Benefits: **$0.00** copay. This plan offers coverage for 20, one-way, routine transportation services every year. Trips are limited to 50 miles.
Out-of-Network Benefits: Not Covered

Medicare Part B Drugs

Insulin furnished through an insulin pump:

In-Network Benefits: **$35.00** copay
Out-of-Network Benefits: **$35.00** copay

Other Part B Drugs:[1]

In-Network Benefits: **20%** coinsurance
Out-of-Network Benefits: **20%** coinsurance

Chemotherapy drugs:[1]

In-Network Benefits: **20%** coinsurance
Out-of-Network Benefits: **20%** coinsurance

You may pay less than the maximum coinsurance for certain Part B and chemotherapy rebatable drugs. The list and the cost of each rebatable drug changes every quarter.

Additional benefits

Freedom Máximo (HMO-POS)

Acupuncture

Medicare-covered acupuncture services:[1,2]

In-Network Benefits: **$20.00** copay
Out-of-Network Benefits: **$20.00** copay

Available for people with chronic low back pain under certain circumstances. Please see the Evidence of Coverage for more information.

Chiropractic Care[1,2]

Medicare-covered chiropractic services:

In-Network Benefits: **$20.00** copay
Out-of-Network Benefits: **$20.00** copay

Medicare coverage includes manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position).

Diabetic Monitors, Supplies, and Services[1]

Continuous glucose monitors (CGMs) and sensors:
In-Network Benefits: **20%** coinsurance
Out-of-Network Benefits: **20%** coinsurance

Blood glucose monitors:
In-Network Benefits: **$0.00** copay through the plan mail order program or **20%** coinsurance through a network pharmacy
Out-of-Network Benefits: **$0.00** copay through the plan mail order program or **20%** coinsurance through a plan-approved pharmacy

Blood glucose test strips and lancets:
In-Network Benefits: **$0.00** copay through the plan mail order program or **20%** coinsurance through a network pharmacy
Out-of-Network Benefits: **$0.00** copay through the plan mail order program or **20%** coinsurance through a plan-approved pharmacy

Coverage limitations may apply. Please refer to your Evidence of Coverage for complete coverage details.

Freedom Máximo (HMO-POS)

Enhanced Drug Coverage

Our plan offers additional coverage of some prescription drugs not normally covered in a Medicare prescription drug plan. Covered drugs include:

- A drug used for the relief of cough and cold symptoms.
- Some prescription vitamins, such as folic acid and Vitamin D 50000 IU.
- Erectile dysfunction drugs, like sildenafil, tadalafil, and vardenafil - limit 10 tablets per month.

Please refer to the Tier 1 and Tier 2 copay later in this Summary of Benefits for how much you will pay. You pay your Initial Coverage Limit (ICL) cost-sharing for excluded drugs covered in Tier 1 and Tier 2 during all the drug stages.
For more information about the drugs covered under this benefit, please refer to the plan's Formulary.

Active Fitness

In-Network Benefits:
This benefit provides a spending allowance of **$500** every year on your Benefits Prepaid Card for the payment of access fees or lesson/clinic costs at sports facilities for golf, swimming, and tennis. The allowance cannot be applied to merchandise or other services.

Unused amounts expire at the end of the plan year.

Out-of-Network Benefits: Not Covered

Freedom Máximo (HMO-POS)

Foot Care (podiatry services)[1,2]

Medicare-covered podiatry:

In-Network Benefits: **$20.00** copay
Out-of-Network Benefits: **$20.00** copay

Foot exams and treatment are covered if you have diabetes-related nerve damage and/or meet certain conditions.

Healthy Meals - Post Discharge[1,2]

In-Network Benefits: **$0.00** copay for up to one week of meals (maximum 10 meals) following your discharge from a hospital or skilled nursing facility (SNF).

Out-of-Network Benefits: Not Covered

Home Health Care[1,2]

In-Network Benefits: **$0.00** copay
Out-of-Network Benefits: **$0.00** copay

Medical Equipment/Supplies

Durable Medical Equipment (wheelchairs, oxygen, etc.):[1]

In-Network Benefits:
Oxygen: **20%** coinsurance every billing cycle (rental period)
Other durable medical equipment: **20%** coinsurance

Out-of-Network Benefits:
Oxygen: **20%** coinsurance every billing cycle (rental period)
Other durable medical equipment: **20%** coinsurance

Medical supplies and prosthetic devices (braces, artificial limbs, etc.):[1]

In-Network Benefits: **20%** coinsurance
Out-of-Network Benefits: **20%** coinsurance

Outpatient Rehabilitation

Cardiac (heart) rehab services (with a limit of two, one-hour sessions per day and a maximum of 36 sessions within a 36-week period):[1,2]

In-Network Benefits: **$20.00** copay
Out-of-Network Benefits: **$20.00** copay

Pulmonary (lung) rehab services (with a limit of two, one-hour sessions per day and a maximum of 36 sessions):[1,2]

In-Network Benefits: **$20.00** copay
Out-of-Network Benefits: **$20.00** copay

Occupational therapy visit:[1,2]

In-Network Benefits: **$20.00** copay
Out-of-Network Benefits: **$20.00** copay

Outpatient Substance Abuse[1,2]

Individual & Group therapy visit:

In-Network Benefits: **$20.00** copay - **$195.00** copay
Out-of-Network Benefits: **$20.00** copay - **$195.00** copay

Freedom Máximo (HMO-POS)

Over-the-Counter Products

In-Network/Out-of-Network Benefits
This plan covers certain approved, non-prescription, over-the-counter drugs and health-related items, up to a **$40** combined in-network/out-of-network allowance every month. Unused OTC amounts expire at the end of every month.

Please contact the plan or visit our website for specific instructions for using this benefit and our list of covered over-the-counter items.

Renal Dialysis

In-Network Benefits: **20%** coinsurance
Out-of-Network Benefits: **20%** coinsurance

SilverSneakers®†† Fitness program

In-Network Benefits: **$0.00** copay
When you become our member, you can sign up for SilverSneakers. It's included in our plan. To learn more details, go to **silversneakers.com** or call SilverSneakers at 1-855-741-4985 (TTY: 711), Monday to Friday, 8 a.m. to 8 p.m. ET.

†† SilverSneakers is a registered trademark of Tivity Health, Inc. All rights reserved. Tivity Health, Inc. is an independent company providing a fitness program on behalf of this plan.

Out-of-Network Benefits: Not Covered

Freedom Máximo (HMO-POS)

24/7 Nurseline

In-Network Benefits: **$0.00** copay

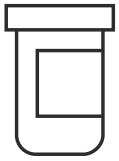
24-hour access to a nurse line, seven days a week, 365 days a year

Out-of-Network Benefits: Not Covered

Footnotes

Services with a 1 may need prior authorization (preapproval) from the plan.

Services with a 2 may need a referral from your doctor or Primary Care Physician (PCP).



Summary of 2027 prescription drug coverage

Ways to save

1. Choose generic drugs on tier 1 when available.
2. Use mail order.
3. Use a preferred pharmacy. To find a preferred pharmacy in this plan:
   - Visit **freedomhealth.com** (select **Quick Links** Choose **Provider Finder** to enter your location and search details. Select the type of pharmacy as the Specialty. Preferred pharmacies are noted.
   - Give us a call and we will send you a copy of the Pharmacy Directory.

Freedom Máximo (HMO-POS)

Stage 1: Yearly Deductible

This plan does not have a Part D deductible.

Stage 2: Initial Coverage

After you pay your yearly deductible (if your plan has one), you move to the Initial Coverage Stage. In this stage, you pay the amounts listed in the table on the following pages, until your total year-to-date out-of-pocket costs reach **$2,400**.

The amount you pay is determined by the covered Part D prescription and if you receive Extra Help low-income subsidy coverage. Please refer to your 2027 LIS Rider for the specific amount if you receive Extra Help.

You may get your covered drugs at retail pharmacies and mail-order pharmacies in our plan. Generally, you may get your covered drugs from pharmacies not in our plan only when you are unable to get your prescription drugs from a pharmacy that is in our plan. If you live in a long-term care facility, you pay the same as at a standard retail pharmacy.

Important message about what you pay for vaccines and insulin: This plan covers most Part D vaccines at no cost to you and you will not pay more than **$35** for a one-month supply for any covered Insulin.

Stage 2: Initial Coverage

Cost Sharing	Freedom Máximo (HMO-POS)
Tier 1: Preferred Generic	
Preferred retail one-month supply	**$0.00**
Standard retail one-month supply	**$0.00**
Mail order three-month supply[100]	**$0.00**
Tier 2: Preferred Brand	
Preferred retail one-month supply	**$30.00**
Standard retail one-month supply	**$30.00**
Mail order three-month supply	**$60.00**
Tier 3: Non-preferred Drug	
Preferred retail one-month supply	**$85.00**
Standard retail one-month supply	**$90.00**
Mail order three-month supply	**$170.00**
Tier 4: Specialty Tier	
Preferred retail one-month supply	**33%**
Standard retail one-month supply	**33%**
Mail order three-month supply	**Not available**

[100] Up to a 100-day supply is available for select medications.

Stage 3: Catastrophic Coverage

During this stage, you pay nothing for your covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit.

Out-of-network/non-contracted providers are under no obligation to treat Freedom Máximo (HMO-POS) members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Member Services number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

If you need emergency or urgent care, call 911 or go to the nearest doctor or facility that can help you. Most times, you must use doctors in our plan to receive covered medical care, except for emergencies and urgently needed care when doctors in our plan are not available, or dialysis services when you are out of the service area. If you receive routine care from doctors outside our plan, neither Medicare nor Freedom Health, Inc. will pay for it.

Discrimination is against the law. That's why we comply with applicable Federal civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, sex, age or disability.

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

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

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English – ATTENTION: If you need help in your language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **1-800-401-2740** (TTY: **711)**. Hours of operation are 8 a.m. to 8 p.m. local time, seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

Español (Spanish) – ATENCIÓN: Si necesita ayuda en su idioma, tiene a su disposición servicios gratuitos de asistencia en otros idiomas. También puede obtener ayudas y servicios auxiliares adecuados gratuitos para proporcionar información en formatos accesibles. Llame al número de teléfono indicado anteriormente. El horario de atención es de 8 a.m. a 8 p.m. hora local, los siete días de la semana (excepto el Día de Acción de Gracias y Navidad) desde el 1.º de octubre hasta el 31 de marzo, y de lunes a viernes (excepto los días feriados) desde el 1.º de abril hasta el 30 de septiembre.

العربية (Arabic) – تنبيه: إذا كنت تحتاج إلى المساعدة بلغتك، فإن خدمات المساعدة اللغوية المجانية متاحة لك. كما تتوفر مساعدات وخدمات مساعدة مناسبة لتوفير المعلومات بأشكال يسهل الوصول إليها مجانا. اتصل على رقم الهاتف المذكور أعلاه. ساعات العمل من الساعة 8 صباحًا حتى الساعة 8 مساءً على مدار الأسبوع (ما عدا أيام عيد الشكر وعيد الميلاد) بدايةً من 1 أكتوبر حتى 31 مارس، ومن الاثنين حتى الجمعة (ما عدا أيام العطلات) من 1 أبريل حتى 30 سبتمبر.

简体中文 (Chinese Simplified) – 注意：如果您在您的语言方面需要帮助，我们可以为您提供免费的语言协助服务。我们还免费提供适当的辅助工具和服务，以可访问的格式提供信息。请拨打上面列出的电话号码。营业时间：10 月 1 日至 3 月 31 日，每周七天（感恩节和圣诞节除外），4 月 1 日至 9 月 30 日，周一至周五（节假日除外），当地时间上午 8 时至晚上 8 时。

繁體中文 (Chinese Traditional) – 注意：如果您在您的語言方面需要協助，我們可以為您提供免費的語言協助服務。我們還免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請撥打上面列出的電話號碼。營業時間：10 月 1 日至 3 月 31 日，每週七天（感恩節和耶誕節除外），4 月 1 日至 9 月 30 日，週一至週五（節假日除外），當地時間上午 8 時至晚上 8 時。

Français (French) – ATTENTION : Si vous avez besoin d'aide dans votre langue, des services gratuits d'assistance linguistique sont disponibles. Des aides et services auxiliaires appropriés permettant de fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le numéro de téléphone mentionné ci-dessus. Les heures d'ouverture sont de 8h à 20h, heure locale, sept jours sur sept (sauf Thanksgiving et Noël) du 1er octobre au 31 mars, et du lundi au vendredi (sauf jours fériés) du 1er avril au 30 septembre.

Deutsch (German) – ACHTUNG: Wenn Sie Hilfe in Ihrer Sprache benötigen, stehen Ihnen kostenlose Dienste zur sprachlichen Unterstützung zur Verfügung. Außerdem sind kostenlose Hilfsmittel und Dienste verfügbar, um Informationen in zugänglichen Formaten bereitzustellen. Rufen Sie die oben aufgeführte Telefonnummer an. Die Geschäftszeiten sind 8 Uhr bis 20 Uhr lokaler Zeit an sieben Tagen in der Woche (außer Thanksgiving und Weihnachten) vom 1. Oktober bis zum 31. März, und Montag bis Freitag (außer an Feiertagen) vom 1. April bis zum 30. September.

Kreyòl Ayisyen (Haitian Creole) – ATANSYON: Si w bezwen èd nan lang ou, sèvis asistans lenguistik gratis disponib pou ou. Èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòma ki aksesib disponib tou san w p ap peye. Rele nimewo telefòn yo bay anwo a. Orè fonksyònman yo se 8 a.m. rive 8 p.m., sèt jou sou sèt (eksepte Jou Thanksgiving ak Nwèl) soti 1ye Oktòb rive 31 Mas, ak Lendi pou rive Vandredi (eksepte jou ferye) soti 1ye Avril rive 30 Septanm.

Italiano (Italian) –ATTENZIONE: se hai bisogno di supporto nella tua lingua, sono disponibili servizi di assistenza linguistica gratuita. Sono inoltre disponibili gratuitamente adeguati supporti e servizi per ottenere informazioni in formato accessibile. Chiama il numero di telefono riportato sopra. Il servizio è attivo dalle 8.00 alle 20.00 ora locale, sette giorni su sette (eccetto il Giorno del Ringraziamento e Natale) dal 1° ottobre al 31 marzo, e dal lunedì al venerdì (eccetto i giorni festivi) dal 1° aprile al 30 settembre.

한국어(Korean) – 주의: 귀하의 언어로 도움이 필요하신 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 대체 형식으로 정보를 제공하기 위한 적절한 보조 장치 및 서비스도 무료로 제공됩니다. 위의 전화 번호로 전화해 주십시오. 운영 시간은 현지 시간 오전 8시부터 오후 8시까지이며 10월 1일부터 3월 31일까지는 주 7일(추수 감사절과 성탄절은 제외) 내내, 4월 1일부터 9월 30일까지는 월요일부터 금요일까지(휴일은 제외)입니다.

ພາສາລາວ (Laotian) – ເອົາໃຈໃສ່: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ນອກຈາກນີ້ຍັງມີການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມທີ່ເໝາະສົມໃນການໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີໂທລະສັບທີ່ລະບຸໄວ້ຂ້າງເທິງ. ເວລາເຮັດວຽກແມ່ນ 8 ໂມງເຊົ້າ ຫາ 8 ໂມງແລງ ຕາມເວລາໃນທ້ອງຖິ່ນ, ເຈັດມື້ຕໍ່ອາທິດ (ຍົກເວັ້ນວັນຂອບໃຈພະເຈົ້າ ແລະ ວັນຄຣິດສມາດ) ຕັ້ງແຕ່ວັນທີ 1 ຕຸລາ ຫາ ວັນທີ 31 ມີນາ, ແລະ ວັນຈັນ ເຖິງ ວັນສຸກ (ຍົກເວັ້ນວັນພັກ) ຕັ້ງແຕ່ວັນທີ 1 ເມສາ ຫາ 30 ກັນຍາ.

Polski (Polish) – UWAGA: Jeśli potrzebujesz pomocy w swoim języku, możesz skorzystać z bezpłatnych usług pomocy językowej. Dostępne są również nieodpłatnie odpowiednie pomoce i usługi zapewniające informacje w dostępnych formatach. Zadzwoń pod numer telefonu podany powyżej. Czynne od 8:00 rano do 8:00 wieczorem czasu lokalnego, siedem dni w tygodniu (oprócz Święta Dziękczynienia i Bożego Narodzenia) od 1 października do 31 marca oraz od poniedziałku do piątku (oprócz świąt) od 1 kwietnia do 30 września.

Português (Portuguese) – ATENÇÃO: Se necessita de ajuda no seu idioma, tem à sua disposição serviços de assistência linguística gratuitos. Estão também disponíveis, a título gratuito, ajudas e erviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para o número de telefone acima indicado. Horário de expediente: das 8h às 20h, (hora local), sete dias por semana (exceto Dia de Ação de Graças e Natal) de 1 de outubro até 31 de março, e de segunda a sexta-feira (exceto feriados) de 1 de abril até 30 de setembro.

Русский (Russian) – ВНИМАНИЕ: Если вам нужна помощь на вашем языке, вам могут предоставить бесплатные услуги переводчика. Также бесплатно предоставляются вспомогательные средства и услуги, позволяющие получать информацию в доступных форматах. Позвоните по вышеуказанному номеру телефона. Часы работы: с 08:00 до 20:00 в любой день недели (кроме Дня благодарения и Рождества) с 1 октября по 31 марта и с понедельника по пятницу (кроме праздничных дней) с 1 апреля по 30 сентября.

Tagalog (Tagalog) – PAUNAWA: Kung kailangan mo ng tulong sa iyong wika, mayroong available na mga libreng serbisyo sa tulong sa wika para sa iyo. Ang naaangkop na mga karagdagang tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format ay available rin nang walang bayad. Tawagan ang numero ng telepono na nakalista sa itaas. Ang mga oras ng opisina ay 8 a.m. hanggang 8 p.m., lokal na oras, pitong araw sa isang linggo (maliban sa Thanksgiving at Pasko) mula Oktubre 1 hanggang Marso 31, at Lunes hanggang Biyernes (maliban sa mga holiday) mula Abril 1 hanggang Setyembre 30.

ภาษาไทย (Thai) – หมายเหตุ: หากคุณต้องการความช่วยเหลือในภาษาของคุณ เรามีบริการช่วยเหลือด้านภาษาฟรีสำหรับคุณ นอกจากนี้ยังมีความช่วยเหลือและบริการเสริมที่เหมาะสม เพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่ายอีกด้วย โทรไปยังหมายเลขโทรศัพท์ที่ระบุไว้ด้านบน เวลาทำการคือ 08.00 น. ถึง 20.00 น. ตามเวลาท้องถิ่น เจ็ดวันต่อสัปดาห์ (ยกเว้นวันขอบคุณพระเจ้าและวันคริสต์มาส) ตั้งแต่วันที่ 1 ตุลาคม ถึง 31 มีนาคม และวันจันทร์ถึงวันศุกร์ (ยกเว้นวันหยุด) ตั้งแต่วันที่ 1 เมษายน ถึง 30 กันยายน

Українська (Ukrainian) – УВАГА. Якщо вам потрібна допомога рідною мовою, ви можете скористатися безкоштовними послугами мовної підтримки. Відповідні допоміжні засоби й послуги для надання інформації в доступних форматах також можна отримати безкоштовно. Зателефонуйте за вказаним вище номером. Графік роботи: з 08:00 до 20:00 за місцевим часом, без вихідних (крім Дня подяки й Різдва) з 1 жовтня по 31 березня й із понеділка по п’ятницю (крім святкових днів) з 1 квітня по 30 вересня.

Tiếng Việt (Vietnamese) – CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của quý vị, các dịch vụ hỗ trợ ngôn ngữ miễn phí luôn sẵn sàng phục vụ quý vị. Các dịch vụ và hỗ trợ phụ trợ thích hợp cung cấp thông tin ở các định dạng có thể truy cập cũng được cung cấp miễn phí. Gọi số điện thoại nêu trên. Giờ làm việc từ 8 giờ sáng đến 8 giờ tối, giờ địa phương, bảy ngày một tuần (trừ Lễ Tạ ơn và Giáng sinh) từ ngày 1 Tháng Mười đến 31 Tháng Ba, và Thứ Hai đến Thứ Sáu (trừ các ngày lễ), từ ngày 1 Tháng Tư đến 30 Tháng Chín.

IMPORTANT INFORMATION:
2026 Medicare Star Ratings

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Freedom Health, Inc. - H5427

For 2026, Freedom Health, Inc. - H5427 received the following Star Ratings from Medicare:

Overall Star Rating: ★★★★½

Health Services Rating: ★★★★★

Drug Services Rating: ★★★★½

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

The number of stars show how well a plan performs.

★★★★★ EXCELLENT

★★★★☆ ABOVE AVERAGE

★★★☆☆ AVERAGE

★★☆☆☆ BELOW AVERAGE

★☆☆☆☆ POOR

More stars mean a better plan – for example, members may get better care and better, faster customer service.

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at **Medicare.gov/plan-compare.**

Questions about this plan?

Contact Freedom Health, Inc. 7 days a week from 8 a.m. to 8 p.m., (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30 at 1-800-401-2740 (toll-free) or 711 (TTY).
Current members please call 1-800-401-2740 (toll-free) or 711 (TTY).

Freedom Health, Inc. is an HMO plan with a Medicare contract and a Medicaid contract with the State of Florida Agency for Health Care Administration. Enrollment in Freedom Health, Inc. depends on contract renewal.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-800-401-2740** TTY: **711**. 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **www.freedomhealth.com** or call **1-800-401-2740** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ ***For plans with Part D benefits:*** Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions. Review the Evidence of Coverage (EOC) to verify whether you have Part D benefits.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2027.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
    - Out-of-network/non-contracted providers are under no obligation to treat members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

☐ ***For C-SNP Plans Only:*** This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.

☐ ***For D-SNP Plans Only:*** This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

☐ ***For D-SNP Plans Only:*** In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party). This premium is normally taken out of your Social Security check each month. If you receive “Extra Help” this premium may be reduced or paid on your behalf.

☐ ***For All Non-D-SNP Plans:*** You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

- As a member of our plan you may be eligible for a reduction in your Medicare Part B premium. The reduction is set up by Medicare and administered through the Social Security Administration (SSA). Review the Chapter 1, Section 7 in the Evidence of Coverage (EOC) to verify.

Freedom Health, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Freedom Health, Inc. cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Freedom Health, Inc. konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks. Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-401-2740 (TTY: 711). Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-401-2740 (TTY: 711).