ULTIMATE HEALTH PLANS

2021 Summary of Benefits

This Summary of Benefits is for the following counties:

Citrus
013 - 4 Premier by Ultimate (HMO)
014 - 2 Premier Plus by Ultimate (HMO)

Hernando
001 Premier by Ultimate (HMO)
014 - 1 Premier Plus by Ultimate (HMO)

Hillsborough
011 Premier by Ultimate (HMO)
012 Premier Plus by Ultimate (HMO)

Lake
028 Premier by Ultimate (HMO)
016 Premier Plus by Ultimate (HMO)

Marion
028 Premier by Ultimate (HMO)
016 Premier Plus by Ultimate (HMO)

Pasco
013 - 3 Premier by Ultimate (HMO)
014 - 1 Premier Plus by Ultimate (HMO)

Pinellas
011 Premier by Ultimate (HMO)
012 Premier Plus by Ultimate (HMO)

Sumter
028 Premier by Ultimate (HMO)
016 Premier Plus by Ultimate (HMO)

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HOW TO USE THIS BOOKLET

Thank you for taking the time to learn about Ultimate Health Plans. We hope you find this time well spent. Ultimate, as our members call us, is a local plan with operations and customer service based right here in Central Florida. Our main office is located in Spring Hill. We have a large (and growing) network of local doctors and hospitals conveniently located throughout Citrus, Hernando, Hillsborough, Lake, Marion, Pasco, Pinellas, and Sumter counties.

In a nutshell, we offer affordable, quality medical, hospital, and prescription drug benefits along with extra services not covered by Original Medicare. Browse through this booklet to get more details about our great benefits and affordable costs. We're confident you'll like what you see.

Sections in this Booklet

For questions or more information, call us at **1-888-657-4170 (TTY 711)**. We are open Monday through Sunday from 8 a.m. to 8 p.m. During certain times of the year we may use alternative technologies to answer your call on weekends and Federal holidays.

Who can join?

To join Ultimate Health Plans, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area for Premier and Premier Plus by Ultimate Health Care (HMO) includes the following counties in Florida:

- Citrus
- Hernando
- Hillsborough
- Lake
- Marion
- Pasco
- Pinellas
- Sumter

Which doctors, hospitals and pharmacies can I use?

We have a network of doctors, hospitals, pharmacies, and other providers. Except in an emergency, you must use network providers and pharmacies. If you use providers that are not in our network, the plan may not pay for these services. You can see our plan's Provider and Pharmacy Directory on our website www.chooseultimate.com. Or, call us and we will send you a copy of the Provider and Pharmacy Directory. The pharmacy network and/or provider network may change at any time. You will receive notice when necessary.

We cover everything that Original Medicare covers — and more!

Our plan members get all of the benefits covered by Original Medicare (like doctor visits, hospital stays and medical equipment) as well as extra benefits that Original Medicare doesn't cover (like dental, vision, hearing and SilverSneakers® Fitness program). Some of the extra benefits are outlined in this booklet.

We also cover Part D drugs and Over-the-Counter (OTC) Medicines and Supplies. To find out what drugs we cover, you can see the complete plan drug list (our formulary) and any restrictions on our website, www.chooseultimate.com. Or, call us and we will send you a copy of the drug list.

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, visit our website at www.chooseultimate.com or call us and ask for the "Evidence of Coverage."

Citrus

013 - 4 Premier by Ultimate
014 - 2 Premier Plus by Ultimate

Good health is where you live.

Citrus

Premium and Benefits	Citrus 013 - 4 Premier by Ultimate
Monthly Plan Premium	You pay $0
Part B Premium Reduction	Ultimate Health Plans will reduce your Medicare Part B premium by up to **$110.00 per month.**
Deductible	This plan **does not** have a deductible.
Maximum Out-of-Pocket Responsibility	**$2,800**
Inpatient Hospital Coverage	You pay **$125** copay per day for days 1 through 5 You pay **$0** copay per day for days 6 through 90
Outpatient Hospital Coverage	You pay **$25** copay per visit for **Ambulatory Surgical Center** services You pay **$195** copay per visit for **Outpatient Hospital** services
Doctor Visits *(Primary Care Providers and Providers)*	You pay **$0** copay per visit for **Primary Care Provider** You pay **$20** copay per visit for **Specialist**
Preventive Care	**You pay nothing**
Emergency Care	You pay **$75** copay per visit
Urgently Needed Services	You pay **$10** copay per visit

Citrus 014 - 2 Premier Plus by Ultimate	What You Should Know
You pay $0	
Not applicable for this plan	You must continue to pay your Medicare Part B premium.
This plan **does not** have a deductible.	
$1,500	This amount is the most you'll pay for copays, coinsurance and other costs for in-network medical services for the year. It does not include Part D drugs.
You pay **$0** copay	Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. A referral or prior authorization is required for some services. Please contact the plan for more information.
You pay **$25** copay per visit for **Ambulatory Surgical Center** services You pay **$150** copay per visit for **Outpatient Hospital** services	A referral or prior authorization is required for some services. Please contact the plan for more information.
You pay **$0** copay per visit for **Primary Care Provider** and **Specialist**	A referral or prior authorization is required for some services. Please contact the plan for more information.
You pay nothing	For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. Any additional preventive services approved by Medicare during the contract year will be covered. A referral or prior authorization is required for some services. Please contact the plan for more information. See page 89 for more information about the preventive services we cover.
You pay **$50** copay per visit	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. We also cover supplemental Emergency Care worldwide (See **Worldwide Emergency Care** on page 88.)
You pay **$10** copay per visit	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services.

Premium and Benefits	Citrus 013 - 4 Premier by Ultimate
Diagnostic Services Labs/Imaging • *Lab services* • *Outpatient X-Rays* • *Diagnostic tests and procedures* • *Diagnostic radiological services* • *Therapeutic radiological services*	**Lab Services** • You pay **$0** copay **Outpatient X-Rays** • You pay **$0** copay **Diagnostic Tests and Procedures** You pay the following: • **$25** copay for Colonoscopy, Endoscopy and other diagnostic "scopic" procedures, Pulmonary Function Tests and Thyroid Function Tests • **$75** copay for Sleep Study and Psychological Tests **Diagnostic Radiological Services** You pay the following in addition to the office visit copay: • **$25** copay for Ultrasounds and Echocardiography • **$50** copay for Stress, Nerve Conduction, CT, MRI • **$100** copay for CTA, MRA, PET, SPECT, other nuclear medicine tests **Therapeutic Radiological Services** (such as radiation treatment for cancer): • **20%** of the cost A referral or prior authorization is required for some services. Please contact the plan for more information. All services performed at an outpatient hospital facility are subject to the outpatient hospital copayment.
Hearing Services • *Exam to diagnose and treat hearing and balance issues* • *Routine hearing exam* • *Hearing aid fitting and evaluation* • *Hearing aids*	You pay **$0** copay for • 1 r**outine hearing exam** per year • **Exam to diagnose and treat hearing and balance issues** *Our plan pays up to $2,000 every two years for hearing aids.* You pay **$10** copay for • 1 hearing aid fitting/evaluation per year • Per hearing aid

YOUR BENEFITS AND COST SHARING

Premium and Benefits	Citrus 014 - 2 Premier Plus by Ultimate
Diagnostic Services Labs/Imaging • *Lab services* • *Outpatient X-Rays* • *Diagnostic tests and procedures* • *Diagnostic radiological services* • *Therapeutic radiological services*	**Lab Services** • You pay **$0** copay **Outpatient X-Rays** • You pay **$0** copay **Diagnostic Tests and Procedures** You pay the following: • **$0** copay for Colonoscopy, Endoscopy and other diagnostic "scopic" procedures, Pulmonary Function Tests and Thyroid Function Tests • **$50** copay for Sleep Study and Psychological Tests **Diagnostic Radiological Services** You pay the following in addition to the office visit copay: • **$0** copay for Ultrasounds and Echocardiography • **$25** copay for Stress, Nerve Conduction, CT, MRI • **$75** copay for CTA, MRA, PET, SPECT, other nuclear medicine tests **Therapeutic Radiological Services** (such as radiation treatment for cancer): • **20%** of the cost A referral or prior authorization is required for some services. Please contact the plan for more information. All services performed at an outpatient hospital facility are subject to the outpatient hospital copayment.
Hearing Services • *Exam to diagnose and treat hearing and balance issues* • *Routine hearing exam* • *Hearing aid fitting and evaluation* • *Hearing aids*	You pay **$0** copay for • 1 r**outine hearing exam** per year • **Exam to diagnose and treat hearing and balance issues** *Our plan pays up to $2,000 every two years for hearing aids.* You pay **$5** copay for • 1 hearing aid fitting/evaluation per year • Per hearing aid

Premium and Benefits	Citrus 013 - 4 Premier by Ultimate
Dental Services • *Preventive dental services* • *Comprehensive dental services* • *Medicare-covered non-routine dental services*	You pay **$0** copay for: • 1 **oral evaluation** every 6 months • 1 **cleaning** every 6 months • 1 **fluoride treatment** every 6 months • 1 **dental X-Ray** per year • 1 **comprehensive oral exam** every 3 years • 1 **simple extraction** per year • 1 **filling** per year • **Scaling/root planing** limited to 1 procedure per quadrant per year. Scaling/root planing for 4 total procedures per year (deep cleaning) • Medicare-covered non-routine dental services

Citrus 014 - 2 Premier Plus by Ultimate	What You Should Know
You pay **$0** copay for: • 1 **oral evaluation** every 6 months • 1 **cleaning** every 6 months • 1 **fluoride treatment** every 6 months • 1 **dental X-Ray** per year • 1 **comprehensive oral exam** every 3 years • 1 **simple extraction** per year • 1 **filling** per year • 1 **full-mouth debridement** every 2 years • 1 **Denture** per arch every 3 years • **Scaling/root planing** limited to 1 procedure per quadrant per year. Scaling/root planing for 4 total procedures per year (deep cleaning) • Medicare-covered non-routine dental services	**X-Rays may include:** • Intraoral, complete series of radiographic images • Intraoral, periapical radiographic image • Bitewing, single radiographic image, or Bitewings, two, three or four radiographic images • Panoramic radiographic image • Full mouth and panoramic images covered every 3 years. **Simple Extraction may include:** • Extraction, erupted tooth or exposed root • Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth **Filling may include:** • Amalgam, one, or more surfaces, primary or permanent • Resin-based composite, one to three surfaces, anterior, four or more surfaces, involving incisal angle • Resin-based composite, one or more surfaces, posterior Services must be performed by a participating general dentist. Our plan covers non-routine dental services that are medically necessary prior to another Medicare-covered medical procedure. Periodontal maintenance, gingival irrigation, and localized delivery of antimicrobial agents, like Arestin®, are not covered, and the member is responsible for the additional charge, even though scaling/root planing is covered. Some services may require prior authorization. Please contact the plan for more information. *For plan 014-2 only* **Denture may include 1 of the following per arch per 3 years:** • Complete denture, maxillary or mandibular • Immediate denture, maxillary or mandibular • Maxillary or mandibular partial denture, resin base • Maxillary or mandibular partial denture, cast metal, resin base • Maxillary or mandibular partial denture, flexible base

Premium and Benefits	Citrus 013 - 4 Premier by Ultimate
Vision Services • *Eye exams* • *Eyewear and Contact Lenses*	**Our plan covers** • 1 **routine eye exam** per year • **Exam(s) to diagnose and treat diseases and conditions of the eye** You pay **$0** copay for: • Exam with optometrist You pay **$20** copay for: • Exam with ophthalmologist Our plan pays up to **$150** per year for eyewear. You pay **$0** copay for: • **Contact lenses** OR • 1 pair of standard CR-39 **eyeglass lenses** AND/OR • 1 **eyeglass frame** You pay **$50** copay for: • Upgrade to **progressive lenses** You pay **$40** copay for: • 1 additional pair of **prescription sunglasses** per year OR • **$30** copay for **photochromic lenses** **Post Cataract Surgery Benefit**: • 1 frame from special selection AND/OR • Standard CR-39 eyeglass lenses as medically necessary, no limit on lenses after cataract surgery • Instead of glasses, may select contact lenses up to the eyewear benefit limit of $150

YOUR BENEFITS AND COST SHARING

Citrus 014 - 2 Premier Plus by Ultimate	What You Should Know
Our plan covers • 1 **routine eye exam** per year • **Exam(s) to diagnose and treat diseases and conditions of the eye** You pay **$0** copay for: • Exam with optometrist You pay **$20** copay for: • Exam with ophthalmologist Our plan pays up to **$150** per year for eyewear. You pay **$0** copay for: • **Contact lenses** OR • 1 pair of standard CR-39 **eyeglass lenses** AND/OR • 1 **eyeglass frame** You pay **$50** copay for: • Upgrade to **progressive lenses** You pay **$40** copay for: • 1 additional pair of **prescription sunglasses** per year • **$30** copay for **photochromic lenses** **Post Cataract Surgery Benefit**: • 1 frame from special selection AND/OR • Standard CR-39 eyeglass lenses as medically necessary, no limit on lenses after cataract surgery • Instead of glasses, may select contact lenses up to the eyewear benefit limit of $150	• The per-year benefit amount may be applied to lenses only, frame only or to both. • Standard eyeglass lenses include: ▶ Single Vision, ▶ Bifocal (FT 28) or ▶ Trifocal (7X28) lenses • The upgrade to progressive lenses does not impact the per-year limit on eyewear. • The additional prescription sunglasses benefit is in addition to and does not impact the per-year benefit limit on eyewear. This benefit may be utilized once per year. • Additional Prescription Sunglasses OR Photochromic Lenses benefit allows: • Option to select Prescription Sunglasses with Polarized (Grey or Brown) Lenses from a special frame selection OR Photochromic Lenses. • The Prescription Sunglasses with Polarized (Grey or Brown) Lenses is subject to a $40 copay. • The Photochromic Lenses is subject to a $30 copay. • Contact lenses fitting is not covered benefit.

Premium and Benefits	Citrus 013 - 4 Premier by Ultimate
Mental Health Services • *Inpatient hospital stay* • *Outpatient group therapy visits* • *Outpatient individual therapy visits*	**Inpatient hospital stay** • You pay **$125** copay per day for days 1 through 5 • You pay **$0** copay per day for days 6 through 90 **Outpatient group therapy visits** • You pay **$10** copay per session **Outpatient individual therapy visits** • You pay **$20** copay per session
Skilled Nursing Facility	You pay **$0** copay per day for days 1 through 20 You pay **$150** copay per day for days 21 through 40 You pay **$0** copay per day for days 41 through 100

Citrus 014 - 2 Premier Plus by Ultimate	What You Should Know
Inpatient hospital stay • You pay **$0** copay **Outpatient group therapy visits** • You pay **$0** copay per session **Outpatient individual therapy visits** • You pay **$0** copay per session	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. A referral or prior authorization is required for some services. Please contact the plan for more information.
You pay **$0** copay per day for days 1 through 20 You pay **$150** copay per day for days 21 through 31 You pay **$0** copay per day for days 32 through 100	Our plan covers up to 100 days in a SNF. The copays for skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any skilled care in a SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods. A referral or prior authorization is required for some services. Please contact the plan for more information.

Premium and Benefits	Citrus 013 - 4 Premier by Ultimate
Physical Therapy • *Physical therapy visit* • *Speech-language pathology services* • *Occupational therapy visit*	You pay **$20** copay per visit • Physical therapy • Speech-language pathology You pay **$20** copay per visit • Occupational therapy
Ambulance	You pay **$150** copay for Medicare-covered one-way **ground ambulance** benefit You pay **20%** of the cost for Medicare-covered one-way **air ambulance** benefit
Transportation	You pay **$0** copay for up to **20 trips**: • 8 one-way trips (4 round trips) to Primary Care Provider office, eye doctor, specialist or dialysis, AND • 12 one-way trips (6 roundtrips) to physical therapy
Medicare Part B Drugs	You pay **20%** of the cost for • Medicare Part B chemotherapy drugs • Part B medications and contrast agents injected during a service • Other Part B drugs For covered IV Antibiotics, you pay **$0** copay when the service is bundled with Home Health services.

Citrus 014 - 2 Premier Plus by Ultimate	What You Should Know
You pay **$5** copay per visit • Physical therapy • Speech-language pathology You pay **$0** copay per visit • Occupational therapy	A referral and prior authorization may be required for some services. Please contact the plan for more information. Services performed at an outpatient hospital facility are subject to the outpatient hospital copayment.
You pay **$150** copay for Medicare-covered one-way **ground ambulance** benefit You pay **20%** of the cost for Medicare-covered one-way **air ambulance** benefit	Except in an emergency, this service may require prior authorization. Please contact the plan for more information.
You pay **$0** copay for up to **20 trips**: • 8 one-way trips (4 round trips) to Primary Care Provider office, eye doctor, specialist or dialysis, AND • 12 one-way trips (6 roundtrips) to physical therapy	Trips must be to a plan approved health related location via taxi, rideshare service, bus, van or medical transport (as arranged by plan). A referral or prior authorization is required for some services. Please contact the plan for more information.
You pay **20%** of the cost for • Medicare Part B chemotherapy drugs • Part B medications and contrast agents injected during a service • Other Part B drugs For covered IV Antibiotics, you pay **$0** copay when the service is bundled with Home Health services.	The applicable specialist copay applies when provided during a Physician/Specialist office visit. A referral or prior authorization is required for some services. Please contact the plan for more information.

Premium and Benefits	Citrus 013 - 4 Premier by Ultimate	Citrus 014 - 2 Premier Plus by Ultimate	What You Should Know
Foot Care (podiatry services) • *Medicare-covered foot exams and treatment*	You pay **$20** copay per visit	You pay **$0** per visit	A referral is required. Contact the plan for more information.
Worldwide Emergency Care	You pay **$75** per visit	You pay **$100** per visit	We pay up to $50,000 for covered emergency services received outside the U.S. and its territories. See page 88 for more information.
Wellness Program • *SilverSneakers® Fitness Program* • *Health Education* • *Additional Smoking and Tobacco Use Cessation*	**You pay nothing**	**You pay nothing**	See page 87 for a description of the Wellness Programs we offer.
Chiropractic Care Services	You pay **$20** copay per visit for: • **Medicare-covered** chiropractic services	You pay **$0** copay per visit for: • **Medicare-covered** chiropractic services	Medicare-covered Chiropractic Services include manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position).
Over-the-Counter (OTC)	**You pay nothing for OTC** items, medications and products up to **$35** every month for a total yearly benefit of **$420**	**You pay nothing for OTC** items, medications and products up to **$35** every month for a total yearly benefit of **$420**	The benefit amount does not accumulate from month to month. See page 85 for more information.

YOUR BENEFITS AND COST SHARING

Premium and Benefits	Citrus 013 - 4 Premier by Ultimate
Telehealth Services	You pay **$0** copay per visit for: • **Primary care** telehealth services, including 24 Hour Nurse Advice Line You pay **$20** copay per visit for: • **Specialist** telehealth services • **Mental health** telehealth services
Meal Benefits	You pay a **$0** copay for **meals** immediately following a hospital stay.
Medical Equipment/Supplies • *Durable Medical Equipment (e.g., wheelchairs, oxygen)* • *Prosthetics (e.g., braces. artificial limbs)* • *Diabetes supplies*	You pay **20%** of the cost for • **Durable Medical Equipment** (DME) • **Prosthetics** You pay **$0** copay for • Diabetes **monitoring supplies** • Diabetes **self-management training** • Diabetic **shoes**

YOUR BENEFITS AND COST SHARING

Citrus 014 - 2 Premier Plus by Ultimate	What You Should Know
You pay **$0** copay per visit for: • **Primary care** telehealth services, including 24 Hour Nurse Advice Line • **Specialist** telehealth services • **Mental health** telehealth services	A referral is required for specialist telehealth services. Please contact the plan for more information.
You pay a **$0** copay for **meals** immediately following a hospital stay.	Two meals per day are offered for 7 days, provided they are ordered by a physician or case manager.
You pay **20%** of the cost for • **Durable Medical Equipment** (DME) • **Prosthetics** You pay **$0** copay for • Diabetes **monitoring supplies** • Diabetes **self-management training** • Diabetic **shoes**	Authorization is required for some services. Please contact the plan for more information.

How Much Do I Pay in Each Stage?

WHAT YOU SHOULD KNOW

What you pay for a drug depends on which "drug payment stage" you are in when you get the drug. Because these plans do not have a deductible, you begin in the Initial Coverage stage.

During this stage, our plan also covers select insulins. You pay a $25-35 copay for select insulins. To find out which drugs are select insulins, review our plan's drug list (also called the formulary).

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. Not everyone will enter the coverage gap.

If you enter the coverage gap, our plans continue to cover drugs in Tier 1 Preferred Generic. For drugs in Tier 1 you pay the copay amounts shown below or 25% of the plan's cost, whichever is less. Additionally, during the coverage gap stage, your out-of-pocket costs for select insulins will be $25-35.

For covered brand name drugs you pay 25% of the price (plus a portion of the dispensing fee) while in the coverage gap. You stay in the coverage gap stage until your costs total $6,550, which is the end of the coverage gap and the beginning of the catastrophic coverage stage, during which the plan pays most of the cost for your drugs.

Cost-Sharing may change depending on the pharmacy you choose (i.e. network, out of network, mail order, LTC, home infusion, etc.), the days supply (i.e. 30 days or 90 days) and when you enter another stage of the Part D benefit. If you reside in a long-term care facility and use a Long Term Care (LTC) pharmacy, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy. For more information on the additional pharmacy-specific cost-sharing and the stages of the benefit, please call us or access our Evidence of Coverage online.

Citrus

013 - 4 Premier by Ultimate		
Initial	***RETAIL PHARMACY*** Your cost for a one-month supply filled at a network retail pharmacy: Tier 1: Generic • You pay: **$0** per prescription Tier 2: Preferred Brand • You pay: **$35** per prescription Tier 3: Non-Preferred Brand • You pay: **$60** per prescription Tier 4: Specialty Tier • You pay: **33%** of the cost	***MAIL ORDER PHARMACY*** Your cost for a 90-day supply filled at a network mail order pharmacy: Tier 1: Generic • You pay: **$0** per prescription Tier 2: Preferred Brand • You pay: **$70** per prescription Tier 3: Non-Preferred Brand • You pay: **$120** per prescription
Coverage Gap	***RETAIL PHARMACY*** Your cost for a one-month supply filled at a network retail pharmacy: Tier 1: Preferred Generic • You pay: **$0** per prescription	***MAIL ORDER PHARMACY*** Your cost for a 90-day supply filled at a network mail order pharmacy: Tier 1: Preferred Generic • You pay: **$0** per prescription

Citrus

014 - 2 Premier Plus by Ultimate		
Initial	***RETAIL PHARMACY*** Your cost for a one-month supply filled at a network retail pharmacy: Tier 1: Generic • You pay: **$0** per prescription Tier 2: Preferred Brand • You pay: **$25** per prescription Tier 3: Non-Preferred Brand • You pay: **$50** per prescription Tier 4: Specialty Tier • You pay: **33%** of the cost	***MAIL ORDER PHARMACY*** Your cost for a 90-day supply filled at a network mail order pharmacy: Tier 1: Generic • You pay: **$0** per prescription Tier 2: Preferred Brand • You pay: **$50** per prescription Tier 3: Non-Preferred Brand • You pay: **$100** per prescription
Coverage Gap	***RETAIL PHARMACY*** Your cost for a one-month supply filled at a network retail pharmacy: Tier 1: Preferred Generic • You pay: **$0** per prescription	***MAIL ORDER PHARMACY*** Your cost for a 90-day supply filled at a network mail order pharmacy: Tier 1: Preferred Generic • You pay: **$0** per prescription

Hernando

Pasco

Hernando

001 Premier by Ultimate
014 - 1 Premier Plus by Ultimate

Pasco

013 - 3 Premier by Ultimate
014 - 1 Premier Plus by Ultimate

Good health is where you live.

Premium and Benefits	Hernando Pasco 001 Premier by Ultimate —Hernando 013 - 3 Premier by Ultimate—Pasco
Monthly Plan Premium	You pay $0
Part B Premium Reduction	Ultimate Health Plans will reduce your Medicare Part B premium by up to **$130.00 per month.**
Deductible	This plan **does not** have a deductible.
Maximum Out-of-Pocket Responsibility	**$2,800**
Inpatient Hospital Coverage	You pay **$125** copay per day for days 1 through 5 You pay **$0** copay per day for days 6 through 90
Outpatient Hospital Coverage	You pay **$25** copay per visit for **Ambulatory Surgical Center** services You pay **$150** copay per visit for **Outpatient Hospital** services
Doctor Visits *(Primary Care Providers and Providers)*	You pay **$0** copay per visit for **Primary Care Provider** You pay **$20** copay per visit for **Specialist**
Preventive Care	**You pay nothing**
Emergency Care	You pay **$75** copay per visit
Urgently Needed Services	You pay **$10** copay per visit

Hernando Pasco 014 - 1 Premier Plus by Ultimate —Hernando & Pasco	What You Should Know
You pay $0	
Not applicable for this plan	You must continue to pay your Medicare Part B premium.
This plan **does not** have a deductible.	
$1,500	This amount is the most you'll pay for copays, coinsurance and other costs for in-network medical services for the year. It does not include Part D drugs.
You pay **$0** copay	Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. A referral or prior authorization is required for some services. Please contact the plan for more information.
You pay **$25** copay per visit for **Ambulatory Surgical Center** services You pay **$100** copay per visit for **Outpatient Hospital** services	A referral or prior authorization is required for some services. Please contact the plan for more information.
You pay **$0** copay per visit for **Primary Care Provider** and **Specialist**	A referral or prior authorization is required for some services. Please contact the plan for more information.
You pay nothing	For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. Any additional preventive services approved by Medicare during the contract year will be covered. A referral or prior authorization is required for some services. Please contact the plan for more information. See page 89 for more information about the preventive services we cover.
You pay **$50** copay per visit	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. We also cover supplemental Emergency Care worldwide (See **Worldwide Emergency Care** on page 88.)
You pay **$10** copay per visit	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services.

Premium and Benefits	Hernando Pasco 001 Premier by Ultimate—Hernando 013 - 3 Premier by Ultimate—Pasco
Diagnostic Services Labs/Imaging • *Lab services* • *Outpatient X-Rays* • *Diagnostic tests and procedures* • *Diagnostic radiological services* • *Therapeutic radiological services*	**Lab Services** • You pay **$0** copay **Outpatient X-Rays** • You pay **$0** copay **Diagnostic Tests and Procedures** You pay the following: • **$25** copay for Colonoscopy, Endoscopy and other diagnostic "scopic" procedures, Pulmonary Function Tests and Thyroid Function Tests • **$75** copay for Sleep Study and Psychological Tests **Diagnostic Radiological Services** You pay the following in addition to the office visit copay: • **$25** copay for Ultrasounds and Echocardiography • **$50** copay for Stress, Nerve Conduction, CT, MRI • **$100** copay for CTA, MRA, PET, SPECT, other nuclear medicine tests **Therapeutic Radiological Services** (such as radiation treatment for cancer): • **20%** of the cost A referral or prior authorization is required for some services. Please contact the plan for more information. All services performed at an outpatient hospital facility are subject to the outpatient hospital copayment.
Hearing Services • *Exam to diagnose and treat hearing and balance issues* • *Routine hearing exam* • *Hearing aid fitting and evaluation* • *Hearing aids*	You pay **$0** copay for • 1 **routine hearing exam** per year • **Exam to diagnose and treat hearing and balance issues** *Our plan pays up to $2,000 every two years for hearing aids.* You pay **$10** copay for • 1 hearing aid fitting/evaluation per year • Per hearing aid

Premium and Benefits	Hernando Pasco 014 - 1 Premier Plus by Ultimate —Hernando & Pasco
Diagnostic Services Labs/Imaging • *Lab services* • *Outpatient X-Rays* • *Diagnostic tests and procedures* • *Diagnostic radiological services* • *Therapeutic radiological services*	**Lab Services** • You pay **$0** copay **Outpatient X-Rays** • You pay **$0** copay **Diagnostic Tests and Procedures** You pay the following: • **$0** copay for Colonoscopy, Endoscopy and other diagnostic "scopic" procedures, Pulmonary Function Tests and Thyroid Function Tests • **$50** copay for Sleep Study and Psychological Tests **Diagnostic Radiological Services** You pay the following in addition to the office visit copay: • **$0** copay for Ultrasounds and Echocardiography • **$25** copay for Stress, Nerve Conduction, CT, MRI • **$50** copay for CTA, MRA, PET, SPECT, other nuclear medicine tests **Therapeutic Radiological Services** (such as radiation treatment for cancer): • **20%** of the cost A referral or prior authorization is required for some services. Please contact the plan for more information. All services performed at an outpatient hospital facility are subject to the outpatient hospital copayment.
Hearing Services • *Exam to diagnose and treat hearing and balance issues* • *Routine hearing exam* • *Hearing aid fitting and evaluation* • *Hearing aids*	You pay **$0** copay for • 1 **routine hearing exam** per year • **Exam to diagnose and treat hearing and balance issues** *Our plan pays up to $2,000 every two years for hearing aids.* You pay **$5** copay for • 1 hearing aid fitting/evaluation per year • Per hearing aid

Premium and Benefits	Hernando Pasco 001 Premier by Ultimate—Hernando 013 - 3 Premier by Ultimate—Pasco
Dental Services • *Preventive dental services* • *Comprehensive dental services* • *Medicare-covered non-routine dental services*	You pay **$0** copay for: • 1 **oral evaluation** every 6 months • 1 **cleaning** every 6 months • 1 **fluoride treatment** every 6 months • 1 **dental X-Ray** per year • 1 **comprehensive oral exam** every 3 years • 1 **simple extraction** per year • 1 **filling** per year • **Scaling/root planing** limited to 1 procedure per quadrant per year. Scaling/root planing for 4 total procedures per year (deep cleaning) • Medicare-covered non-routine dental services

Hernando Pasco 014 - 1 Premier Plus by Ultimate—Hernando & Pasco	What You Should Know
You pay **$0** copay for: • 1 **oral evaluation** every 6 months • 1 **cleaning** every 6 months • 1 **fluoride treatment** every 6 months • 1 **dental X-Ray** per year • 1 **comprehensive oral exam** every 3 years • 1 **simple extraction** per year • 1 **filling** per year • 1 **full-mouth debridement** every 2 years • 1 **Bridge/Denture** per arch every 3 years • **Scaling/root planing** limited to 1 procedure per quadrant per year. Scaling/root planing for 4 total procedures per year (deep cleaning) • Medicare-covered non-routine dental services	**X-Rays may include:** • Intraoral, complete series of radiographic images • Intraoral, periapical radiographic image • Bitewing, single radiographic image, or Bitewings, two, three or four radiographic images • Panoramic radiographic image • Full mouth and panoramic images covered every 3 years. **Simple Extraction may include:** • Extraction, erupted tooth or exposed root • Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth **Filling may include:** • Amalgam, one, or more surfaces, primary or permanent • Resin-based composite, one to three surfaces, anterior, four or more surfaces, involving incisal angle • Resin-based composite, one or more surfaces, posterior Services must be performed by a participating general dentist. Our plan covers non-routine dental services that are medically necessary prior to another Medicare-covered medical procedure. Periodontal maintenance, gingival irrigation, and localized delivery of antimicrobial agents, like Arestin®, are not covered, and the member is responsible for the additional charge, even though scaling/root planing is covered. Some services may require prior authorization. Please contact the plan for more information. *For plan 014-1 only* **Denture may include 1 of the following per arch per 3 years:** • Complete denture, maxillary or mandibular • Immediate denture, maxillary or mandibular • Maxillary or mandibular partial denture, resin base • Maxillary or mandibular partial denture, cast metal, resin base • Maxillary or mandibular partial denture, flexible base

Premium and Benefits	Hernando Pasco 001 Premier by Ultimate—Hernando 013 - 3 Premier by Ultimate—Pasco	What You Should Know
Vision Services • *Eye exams* • *Eyewear and Contact Lenses*	**Our plan covers** • 1 **routine eye exam** per year • **Exam(s) to diagnose and treat diseases and conditions of the eye** You pay **$0** copay for: • Exam with optometrist You pay **$20** copay for: • Exam with ophthalmologist Our plan pays up to **$200** per year for eyewear. You pay **$0** copay for: • **Contact lenses** OR • 1 pair of standard CR-39 **eyeglass lenses** AND/OR • 1 **eyeglass frame** You pay **$50** copay for: • Upgrade to **progressive lenses** You pay **$40** copay for: • 1 additional pair of **prescription sunglasses** per year OR • **$30** copay for **photochromic lenses** **Post Cataract Surgery Benefit**: • 1 frame from special selection AND/OR • Standard CR-39 eyeglass lenses as medically necessary, no limit on lenses after cataract surgery • Instead of glasses, may select contact lenses up to the eyewear benefit limit of $200	

YOUR BENEFITS AND COST SHARING

Hernando Pasco 014 - 1 Premier Plus by Ultimate—Hernando & Pasco	What You Should Know
Our plan covers • 1 **routine eye exam** per year • **Exam(s) to diagnose and treat diseases and conditions of the eye** You pay **$0** copay for: • Exam with optometrist You pay **$0** copay for: • Exam with ophthalmologist Our plan pays up to **$200** per year for eyewear. You pay **$0** copay for: • **Contact lenses** OR • 1 pair of standard CR-39 **eyeglass lenses** AND/OR • 1 **eyeglass frame** You pay **$50** copay for: • Upgrade to **progressive lenses** You pay **$40** copay for: • 1 additional pair of **prescription sunglasses** per year • **$30** copay for **photochromic lenses** **Post Cataract Surgery Benefit**: • 1 frame from special selection AND/OR • Standard CR-39 eyeglass lenses as medically necessary, no limit on lenses after cataract surgery • Instead of glasses, may select contact lenses up to the eyewear benefit limit of $200	• The per-year benefit amount may be applied to lenses only, frame only or to both. • Standard eyeglass lenses include: ▶ Single Vision, ▶ Bifocal (FT 28) or ▶ Trifocal (7X28) lenses • The upgrade to progressive lenses does not impact the per-year limit on eyewear. • The additional prescription sunglasses benefit is in addition to and does not impact the per-year benefit limit on eyewear. This benefit may be utilized once per year. • Additional Prescription Sunglasses OR Photochromic Lenses benefit allows: • Option to select Prescription Sunglasses with Polarized (Grey or Brown) Lenses from a special frame selection OR Photochromic Lenses. • The Prescription Sunglasses with Polarized (Grey or Brown) Lenses is subject to a $40 copay. • The Photochromic Lenses is subject to a $30 copay. • Contact lenses fitting is not covered benefit.

Premium and Benefits	Hernando Pasco 001 Premier by Ultimate—Hernando 013 - 3 Premier by Ultimate—Pasco	What You Should Know
Mental Health Services • *Inpatient hospital stay* • *Outpatient group therapy visits* • *Outpatient individual therapy visits*	**Inpatient hospital stay** • You pay **$125** copay per day for days 1 through 5 • You pay **$0** copay per day for days 6 through 90 **Outpatient group therapy visits** • You pay **$10** copay per session **Outpatient individual therapy visits** • You pay **$20** copay per session	
Skilled Nursing Facility	You pay **$0** copay per day for days 1 through 20 You pay **$150** copay per day for days 21 through 40 You pay **$0** copay per day for days 41 through 100	

Hernando Pasco 014 - 1 Premier Plus by Ultimate—Hernando & Pasco	What You Should Know
Inpatient hospital stay • You pay **$0** copay **Outpatient group therapy visits** • You pay **$0** copay per session **Outpatient individual therapy visits** • You pay **$0** copay per session	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. A referral or prior authorization is required for some services. Please contact the plan for more information.
You pay **$0** copay per day for days 1 through 20 You pay **$150** copay per day for days 21 through 31 You pay **$0** copay per day for days 32 through 100	Our plan covers up to 100 days in a SNF. The copays for skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any skilled care in a SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods. A referral or prior authorization is required for some services. Please contact the plan for more information.

Premium and Benefits	Hernando Pasco 001 Premier by Ultimate—Hernando 013 - 3 Premier by Ultimate—Pasco	Hernando Pasco 014 - 1 Premier Plus by Ultimate—Hernando & Pasco	What You Should Know
Physical Therapy • *Physical therapy visit* • *Speech-language pathology services* • *Occupational therapy visit*	You pay **$20** copay per visit • Physical therapy • Speech-language pathology You pay **$20** copay per visit • Occupational therapy	You pay **$5** copay per visit • Physical therapy • Speech-language pathology You pay **$0** copay per visit • Occupational therapy	A referral and prior authorization may be required for some services. Please contact the plan for more information. Services performed at an outpatient hospital facility are subject to the outpatient hospital copayment.
Ambulance	You pay **$150** copay for Medicare-covered one-way **ground ambulance** benefit You pay **20%** of the cost for Medicare-covered one-way **air ambulance** benefit	You pay **$150** copay for Medicare-covered one-way **ground ambulance** benefit You pay **20%** of the cost for Medicare-covered one-way **air ambulance** benefit	Except in an emergency, this service may require prior authorization. Please contact the plan for more information.
Transportation	You pay **$0** copay for up to **20 trips**: • 8 one-way trips (4 round trips) to Primary Care Provider office, eye doctor, specialist or dialysis, AND • 12 one-way trips (6 roundtrips) to physical therapy	You pay **$0** copay for **unlimited** trips to Primary Care Provider office, eye doctor, specialist, dialysis or physical therapy	Trips must be to a plan approved health related location via taxi, rideshare service, bus, van or medical transport (as arranged by plan). A referral or prior authorization is required for some services. Please contact the plan for more information.
Medicare Part B Drugs	You pay **20%** of the cost for • Medicare Part B chemotherapy drugs • Part B medications and contrast agents injected during a service • Other Part B drugs For covered IV Antibiotics, you pay **$0** copay when the service is bundled with Home Health services.	You pay **20%** of the cost for • Medicare Part B chemotherapy drugs • Part B medications and contrast agents injected during a service • Other Part B drugs For covered IV Antibiotics, you pay **$0** copay when the service is bundled with Home Health services.	The applicable specialist copay applies when provided during a Physician/Specialist office visit. A referral or prior authorization is required for some services. Please contact the plan for more information.

YOUR BENEFITS AND COST SHARING

Premium and Benefits	Hernando Pasco 001 Premier by Ultimate—Hernando 013 - 3 Premier by Ultimate—Pasco	Hernando Pasco 014 - 1 Premier Plus by Ultimate—Hernando & Pasco	What You Should Know
Foot Care (podiatry services) • *Medicare-covered foot exams and treatment*	You pay **$20** copay per visit	You pay **$0** per visit	A referral is required. Contact the plan for more information.
Worldwide Emergency Care	You pay **$75** per visit	You pay **$100** per visit	We pay up to $50,000 for covered emergency services received outside the U.S. and its territories. See page 88 for more information.
Wellness Program • *SilverSneakers® Fitness Program* • *Health Education* • *Additional Smoking and Tobacco Use Cessation*	**You pay nothing**	**You pay nothing**	See page 87 for a description of the Wellness Programs we offer.
Chiropractic Care Services	You pay **$20** copay per visit for: • **Medicare-covered** chiropractic services You pay **$20** copay per visit for: • Up to 12 **Routine** chiropractic care visits per year	You pay **$0** copay per visit for: • **Medicare-covered** chiropractic services You pay **$10** copay per visit for: • Up to 12 **Routine** chiropractic care visits per year	Medicare-covered Chiropractic Services include manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position).
Acupuncture	You pay **$20** copay per visit for: • Up to 6 **visits** per year	You pay **$10** copay per visit for: • Up to 6 **visits** per year	A referral is required. Please contact the plan for more information.
Therapeutic Massage	You pay **$20** copay per visit for: • Up to 4 **visits** per year	You pay **$10** copay per visit for: • Up to 4 **visits** per year	Therapeutic massage sessions must be furnished by a state licensed massage therapist. Massage must be referred by a physician or medical professional as defined by the plan and be health related.
Over-the-Counter (OTC)	**You pay nothing for OTC** items, medications and products up to **$50** every month for a total yearly benefit of **$600**	**You pay nothing for OTC** items, medications and products up to **$50** every month for a total yearly benefit of **$600**	The benefit amount does not accumulate from month to month. See page 85 for more information.

YOUR BENEFITS AND COST SHARING

Premium and Benefits	Hernando Pasco 001 Premier by Ultimate—Hernando 013 - 3 Premier by Ultimate—Pasco
Telehealth Services	You pay **$0** copay per visit for: • **Primary care** telehealth services, including 24 Hour Nurse Advice Line You pay **$20** copay per visit for: • **Specialist** telehealth services • **Mental health** telehealth services
Meal Benefits	You pay a **$0** copay for **meals** immediately following a hospital stay.
Medical Equipment/Supplies • *Durable Medical Equipment (e.g., wheelchairs, oxygen)* • *Prosthetics (e.g., braces. artificial limbs)* • *Diabetes supplies*	You pay **20%** of the cost for • **Durable Medical Equipment** (DME) • **Prosthetics** You pay **$0** copay for • Diabetes **monitoring supplies** • Diabetes **self-management training** • Diabetic **shoes**

YOUR BENEFITS AND COST SHARING

Hernando Pasco 014 - 1 Premier Plus by Ultimate—Hernando & Pasco	What You Should Know
You pay **$0** copay per visit for: • **Primary care** telehealth services, including 24 Hour Nurse Advice Line • **Specialist** telehealth services • **Mental health** telehealth services	A referral is required for specialist telehealth services. Please contact the plan for more information.
You pay a **$0** copay for **meals** immediately following a hospital stay.	Two meals per day are offered for 7 days, provided they are ordered by a physician or case manager.
You pay **20%** of the cost for • **Durable Medical Equipment** (DME) • **Prosthetics** You pay **$0** copay for • Diabetes **monitoring supplies** • Diabetes **self-management training** • Diabetic **shoes**	Authorization is required for some services. Please contact the plan for more information.

How Much Do I Pay in Each Stage?

WHAT YOU SHOULD KNOW

What you pay for a drug depends on which "drug payment stage" you are in when you get the drug. Because these plans do not have a deductible, you begin in the Initial Coverage stage.

During this stage, our plan also covers select insulins. You pay a $25-35 copay for select insulins. To find out which drugs are select insulins, review our plan's drug list (also called the formulary).

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. Not everyone will enter the coverage gap.

If you enter the coverage gap, our plans continue to cover drugs in Tier 1 Preferred Generic. For drugs in Tier 1 you pay the copay amounts shown below or 25% of the plan's cost, whichever is less. Additionally, during the coverage gap stage, your out-of-pocket costs for select insulins will be $25-35.

For covered brand name drugs you pay 25% of the price (plus a portion of the dispensing fee) while in the coverage gap. You stay in the coverage gap stage until your costs total $6,550, which is the end of the coverage gap and the beginning of the catastrophic coverage stage, during which the plan pays most of the cost for your drugs.

Cost-Sharing may change depending on the pharmacy you choose (i.e. network, out of network, mail order, LTC, home infusion, etc.), the days supply (i.e. 30 days or 90 days) and when you enter another stage of the Part D benefit. If you reside in a long-term care facility and use a Long Term Care (LTC) pharmacy, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy. For more information on the additional pharmacy-specific cost-sharing and the stages of the benefit, please call us or access our Evidence of Coverage online.

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		RETAIL PHARMACY	***MAIL ORDER PHARMACY***
Pasco	Initial	Your cost for a one-month supply filled at a network retail pharmacy: Tier 1: Generic • You pay: **$0** per prescription Tier 2: Preferred Brand • You pay: **$35** per prescription Tier 3: Non-Preferred Brand • You pay: **$60** per prescription Tier 4: Specialty Tier • You pay: **33%** of the cost	Your cost for a 90-day supply filled at a network mail order pharmacy: Tier 1: Generic • You pay: **$0** per prescription Tier 2: Preferred Brand • You pay: **$70** per prescription Tier 3: Non-Preferred Brand • You pay: **$120** per prescription
Hernando	Coverage Gap	***RETAIL PHARMACY*** Your cost for a one-month supply filled at a network retail pharmacy: Tier 1: Generic • You pay: **$0** per prescription	***MAIL ORDER PHARMACY*** Your cost for a 90-day supply filled at a network mail order pharmacy: Tier 1: Generic • You pay: **$0** per prescription

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		RETAIL PHARMACY	***MAIL ORDER PHARMACY***
Pasco	Initial	Your cost for a one-month supply filled at a network retail pharmacy: Tier 1: Generic • You pay: **$0** per prescription Tier 2: Preferred Brand • You pay: **$25** per prescription Tier 3: Non-Preferred Brand • You pay: **$50** per prescription Tier 4: Specialty Tier • You pay: **33%** of the cost	Your cost for a 90-day supply filled at a network mail order pharmacy: Tier 1: Generic • You pay: **$0** per prescription Tier 2: Preferred Brand • You pay: **$50** per prescription Tier 3: Non-Preferred Brand • You pay: **$100** per prescription
Hernando	Coverage Gap	***RETAIL PHARMACY*** Your cost for a one-month supply filled at a network retail pharmacy: Tier 1: Generic • You pay: **$0** per prescription	***MAIL ORDER PHARMACY*** Your cost for a 90-day supply filled at a network mail order pharmacy: Tier 1: Generic • You pay: **$0** per prescription

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Sumter

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Good health is where you live.

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Premium and Benefits	Marion Lake Sumter 028 - Premier by Ultimate
Monthly Plan Premium	You pay $0
Part B Premium Reduction	Ultimate Health Plans will reduce your Medicare Part B premium by up to **$110.00 per month.**
Deductible	This plan **does not** have a deductible.
Maximum Out-of-Pocket Responsibility	**$2,800**
Inpatient Hospital Coverage	You pay **$170** copay per day for days 1 through 5 You pay **$0** copay per day for days 6 through 90
Outpatient Hospital Coverage	You pay **$25** copay per visit for **Ambulatory Surgical Center** services You pay **$150** copay per visit for **Outpatient Hospital** services
Doctor Visits *(Primary Care Providers and Providers)*	You pay **$0** copay per visit for **Primary Care Provider** You pay **$20** copay per visit for **Specialist**
Preventive Care	**You pay nothing**
Emergency Care	You pay **$75** copay per visit
Urgently Needed Services	You pay **$10** copay per visit

Marion Lake Sumter 016 - Premier Plus by Ultimate	What You Should Know
You pay $0	
Not applicable for this plan	You must continue to pay your Medicare Part B premium.
This plan **does not** have a deductible.	
$3,400	This amount is the most you'll pay for copays, coinsurance and other costs for in-network medical services for the year. It does not include Part D drugs.
You pay **$0** copay per day for days 1 through 5 You pay **$0** copay per day for days 6 through 90	Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. A referral or prior authorization is required for some services. Please contact the plan for more information.
You pay **$25** copay per visit for **Ambulatory Surgical Center** services You pay **$150** copay per visit for **Outpatient Hospital** services	A referral or prior authorization is required for some services. Please contact the plan for more information.
You pay **$0** copay per visit for **Primary Care Provider** You pay **$20** copay per visit for **Specialist**	A referral or prior authorization is required for some services. Please contact the plan for more information.
You pay nothing	For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. Any additional preventive services approved by Medicare during the contract year will be covered. A referral or prior authorization is required for some services. Please contact the plan for more information. See page 89 for more information about the preventive services we cover.
You pay **$100** copay per visit	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. We also cover supplemental Emergency Care worldwide (See **Worldwide Emergency Care** on page 88.)
You pay **$10** copay per visit	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services.

Premium and Benefits	Marion Lake Sumter 028 - Premier by Ultimate
Diagnostic Services Labs/Imaging • *Lab services* • *Outpatient X-Rays* • *Diagnostic tests and procedures* • *Diagnostic radiological services* • *Therapeutic radiological services*	**Lab Services** • You pay **$0** copay **Outpatient X-Rays** • You pay **$0** copay **Diagnostic Tests and Procedures** You pay the following: • **$25** copay for Colonoscopy, Endoscopy and other diagnostic "scopic" procedures, Pulmonary Function Tests and Thyroid Function Tests • **$150** copay for Sleep Study and Psychological Tests **Diagnostic Radiological Services** You pay the following in addition to the office visit copay: • **$25** copay for Ultrasounds and Echocardiography • **$50** copay for Stress, Nerve Conduction, CT, MRI • **$150** copay for CTA, MRA, PET, SPECT, other nuclear medicine tests **Therapeutic Radiological Services** (such as radiation treatment for cancer): • **20%** of the cost A referral or prior authorization is required for some services. Please contact the plan for more information. All services performed at an outpatient hospital facility are subject to the outpatient hospital copayment.
Hearing Services • *Exam to diagnose and treat hearing and balance issues* • *Routine hearing exam* • *Hearing aid fitting and evaluation* • *Hearing aids*	You pay **$0** copay for • 1 **routine hearing exam** per year • **Exam to diagnose and treat hearing and balance issues** *Our plan pays up to $2,000 every two years for hearing aids.* You pay **$10** copay for • 1 hearing aid fitting/evaluation per year • Per hearing aid

Premium and Benefits	Marion Lake Sumter 016 - Premier Plus by Ultimate
Diagnostic Services Labs/Imaging • *Lab services* • *Outpatient X-Rays* • *Diagnostic tests and procedures* • *Diagnostic radiological services* • *Therapeutic radiological services*	**Lab Services** • You pay **$0** copay **Outpatient X-Rays** • You pay **$0** copay **Diagnostic Tests and Procedures** You pay the following: • **$25** copay for Colonoscopy, Endoscopy and other diagnostic "scopic" procedures, Pulmonary Function Tests and Thyroid Function Tests • **$50** copay for Pulmonary Function Tests, Thyroid Function Tests • **$150** copay for Sleep Study and Psychological Tests **Diagnostic Radiological Services** You pay the following in addition to the office visit copay: • **$25** copay for Ultrasounds and Echocardiography • **$50** copay for Stress, Nerve Conduction • **$75** copay for CT, MRI, CTA, MRA • **$150** copay for PET, SPECT, other nuclear medicine tests **Therapeutic Radiological Services** (such as radiation treatment for cancer): • **20%** of the cost A referral or prior authorization is required for some services. Please contact the plan for more information. All services performed at an outpatient hospital facility are subject to the outpatient hospital copayment.
Hearing Services • *Exam to diagnose and treat hearing and balance issues* • *Routine hearing exam* • *Hearing aid fitting and evaluation* • *Hearing aids*	You pay **$0** copay for • 1 **routine hearing exam** per year • **Exam to diagnose and treat hearing and balance issues** *Our plan pays up to $2,000 every two years for hearing aids.* You pay **$5** copay for • 1 hearing aid fitting/evaluation per year • Per hearing aid

Premium and Benefits	Marion Lake Sumter 028 - Premier by Ultimate
Dental Services • *Preventive dental services* • *Comprehensive dental services* • *Medicare-covered non-routine dental services*	You pay **$0** copay for: • 1 **oral evaluation** every 6 months • 1 **cleaning** every 6 months • 1 **fluoride treatment** every 6 months • 1 **dental X-Ray** per year • 1 **comprehensive oral exam** every 3 years • 1 **simple extraction** per year • 1 **filling** per year • **Scaling/root planing** limited to 1 procedure per quadrant per year. Scaling/root planing for 4 total procedures per year (deep cleaning) • Medicare-covered non-routine dental services

Marion Lake Sumter 016 - Premier Plus by Ultimate	What You Should Know
You pay **$0** copay for: • 1 **oral evaluation** every 6 months • 1 **cleaning** every 6 months • 1 **fluoride treatment** every 6 months • 1 **dental X-Ray** per year • 1 **comprehensive oral exam** every 3 years • 1 **simple extraction** per year • 1 **filling** per year • 1 **full-mouth debridement** every 2 years • **Scaling/root planing** limited to 1 procedure per quadrant per year. Scaling/root planing for 4 total procedures per year (deep cleaning) • Medicare-covered non-routine dental services	**X-Rays may include:** • Intraoral, complete series of radiographic images • Intraoral, periapical radiographic image • Bitewing, single radiographic image, or Bitewings, two, three or four radiographic images • Panoramic radiographic image • Full mouth and panoramic images covered every 3 years. **Simple Extraction may include:** • Extraction, erupted tooth or exposed root • Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth **Filling may include:** • Amalgam, one, or more surfaces, primary or permanent • Resin-based composite, one to three surfaces, anterior, four or more surfaces, involving incisal angle • Resin-based composite, one or more surfaces, posterior Services must be performed by a participating general dentist. Our plan covers non-routine dental services that are medically necessary prior to another Medicare-covered medical procedure. Periodontal maintenance, gingival irrigation, and localized delivery of antimicrobial agents, like Arestin®, are not covered, and the member is responsible for the additional charge, even though scaling/root planing is covered. Some services may require prior authorization. Please contact the plan for more information.

Premium and Benefits	Marion Lake Sumter 028 - Premier by Ultimate
Vision Services • *Eye exams* • *Eyewear and Contact Lenses*	**Our plan covers** • 1 **routine eye exam** per year • **Exam(s) to diagnose and treat diseases and conditions of the eye** You pay **$0** copay for: • Exam with optometrist You pay **$20** copay for: • Exam with ophthalmologist Our plan pays up to **$200** per year for eyewear. You pay **$0** copay for: • **Contact lenses** OR • 1 pair of standard CR-39 **eyeglass lenses** AND/OR • 1 **eyeglass frame** You pay **$50** copay for: • Upgrade to **progressive lenses** You pay **$40** copay for: • 1 additional pair of **prescription sunglasses** per year OR • **$30** copay for **photochromic lenses** **Post Cataract Surgery Benefit**: • 1 frame from special selection AND/OR • Standard CR-39 eyeglass lenses as medically necessary, no limit on lenses after cataract surgery • Instead of glasses, may select contact lenses up to the eyewear benefit limit of $200

YOUR BENEFITS AND COST SHARING

Marion Lake Sumter 016 - Premier Plus by Ultimate	What You Should Know
Our plan covers • 1 **routine eye exam** per year • **Exam(s) to diagnose and treat diseases and conditions of the eye** You pay **$0** copay for: • Exam with optometrist You pay **$20** copay for: • Exam with ophthalmologist Our plan pays up to **$200** per year for eyewear. You pay **$0** copay for: • **Contact lenses** OR • 1 pair of standard CR-39 **eyeglass lenses** AND/OR • 1 **eyeglass frame** You pay **$50** copay for: • Upgrade to **progressive lenses** You pay **$40** copay for: • 1 additional pair of **prescription sunglasses** per year • **$30** copay for **photochromic lenses** **Post Cataract Surgery Benefit**: • 1 frame from special selection AND/OR • Standard CR-39 eyeglass lenses as medically necessary, no limit on lenses after cataract surgery • Instead of glasses, may select contact lenses up to the eyewear benefit limit of $200	• The per-year benefit amount may be applied to lenses only, frame only or to both. • Standard eyeglass lenses include: ▶ Single Vision, ▶ Bifocal (FT 28) or ▶ Trifocal (7X28) lenses • The upgrade to progressive lenses does not impact the per-year limit on eyewear. • The additional prescription sunglasses benefit is in addition to and does not impact the per-year benefit limit on eyewear. This benefit may be utilized once per year. • Additional Prescription Sunglasses OR Photochromic Lenses benefit allows: • Option to select Prescription Sunglasses with Polarized (Grey or Brown) Lenses from a special frame selection OR Photochromic Lenses. • The Prescription Sunglasses with Polarized (Grey or Brown) Lenses is subject to a $40 copay. • The Photochromic Lenses is subject to a $30 copay. • Contact lenses fitting is not covered benefit.

Premium and Benefits	Marion Lake Sumter 028 - Premier by Ultimate
Mental Health Services • *Inpatient hospital stay* • *Outpatient group therapy visits* • *Outpatient individual therapy visits*	**Inpatient hospital stay** • You pay **$170** copay per day for days 1 through 5 • You pay **$0** copay per day for days 6 through 90 **Outpatient group therapy visits** • You pay **$10** copay per session **Outpatient individual therapy visits** • You pay **$20** copay per session
Skilled Nursing Facility	You pay **$0** copay per day for days 1 through 20 You pay **$150** copay per day for days 21 through 40 You pay **$0** copay per day for days 41 through 100

Marion Lake Sumter 016 - Premier Plus by Ultimate	What You Should Know
Inpatient hospital stay • You pay **$0** copay **Outpatient group therapy visits** • You pay **$10** copay per session **Outpatient individual therapy visits** • You pay **$20** copay per session	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. A referral or prior authorization is required for some services. Please contact the plan for more information.
You pay **$0** copay per day for days 1 through 20 You pay **$150** copay per day for days 21 through 44 You pay **$0** copay per day for days 45 through 100	Our plan covers up to 100 days in a SNF. The copays for skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any skilled care in a SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods. A referral or prior authorization is required for some services. Please contact the plan for more information.

Premium and Benefits	Marion Lake Sumter 028 - Premier by Ultimate
Physical Therapy • *Physical therapy visit* • *Speech-language pathology services* • *Occupational therapy visit*	You pay **$20** copay per visit • Physical therapy • Speech-language pathology You pay **$20** copay per visit • Occupational therapy
Ambulance	You pay **$150** copay for Medicare-covered one-way **ground ambulance** benefit You pay **20%** of the cost for Medicare-covered one-way **air ambulance** benefit
Transportation	You pay **$0** copay for up to **20 trips**: • 8 one-way trips (4 round trips) to Primary Care Provider office, eye doctor, specialist or dialysis, AND • 12 one-way trips (6 roundtrips) to physical therapy
Medicare Part B Drugs	You pay **20%** of the cost for • Medicare Part B chemotherapy drugs • Part B medications and contrast agents injected during a service • Other Part B drugs For covered IV Antibiotics, you pay **$0** copay when the service is bundled with Home Health services.

YOUR BENEFITS AND COST SHARING

Marion Lake Sumter 016 - Premier Plus by Ultimate	What You Should Know
You pay **$20** copay per visit • Physical therapy • Speech-language pathology You pay **$20** copay per visit • Occupational therapy	A referral and prior authorization may be required for some services. Please contact the plan for more information. Services performed at an outpatient hospital facility are subject to the outpatient hospital copayment.
You pay **$150** copay for Medicare-covered one-way **ground ambulance** benefit You pay **20%** of the cost for Medicare-covered one-way **air ambulance** benefit	Except in an emergency, this service may require prior authorization. Please contact the plan for more information.
You pay **$0** copay for up to **20 trips**: • 8 one-way trips (4 round trips) to Primary Care Provider office, eye doctor, specialist or dialysis, AND • 12 one-way trips (6 roundtrips) to physical therapy	Trips must be to a plan approved health related location via taxi, rideshare service, bus, van or medical transport (as arranged by plan). A referral or prior authorization is required for some services. Please contact the plan for more information.
You pay **20%** of the cost for • Medicare Part B chemotherapy drugs • Part B medications and contrast agents injected during a service • Other Part B drugs For covered IV Antibiotics, you pay **$0** copay when the service is bundled with Home Health services.	The applicable specialist copay applies when provided during a Physician/Specialist office visit. A referral or prior authorization is required for some services. Please contact the plan for more information.

Premium and Benefits	Marion Lake Sumter 028 - Premier by Ultimate
Foot Care (podiatry services) • *Medicare-covered foot exams and treatment*	You pay **$20** copay per visit
Worldwide Emergency Care	You pay **$75** per visit
Wellness Program • *SilverSneakers® Fitness Program* • *Health Education* • *Additional Smoking and Tobacco Use Cessation*	**You pay nothing**
Chiropractic Care Services	You pay **$20** copay per visit for: • **Medicare-covered** chiropractic services You pay **$20** copay per visit for: • Up to 12 **Routine** chiropractic care visits per year
Acupuncture	You pay **$20** copay per visit for: • Up to 6 **visits** per year
Therapeutic Massage	You pay **$20** copay per visit for: • Up to 4 **visits** per year
Over-the-Counter (OTC)	**You pay nothing for OTC** items, medications and products up to **$45** every month for a total yearly benefit of **$540**

Marion Lake Sumter 016 - Premier Plus by Ultimate	What You Should Know
You pay **$20** copay per visit	A referral is required. Contact the plan for more information.
You pay **$100** per visit	We pay up to $50,000 for covered emergency services received outside the U.S. and its territories. See page 88 for more information.
You pay nothing	See page 87 for a description of the Wellness Programs we offer.
You pay **$0** copay per visit for: • **Medicare-covered** chiropractic services You pay **$20** copay per visit for: • Up to 12 **Routine** chiropractic care visits per year	Medicare-covered Chiropractic Services include manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position).
You pay **$20** copay per visit for: • Up to 6 **visits** per year	A referral is required. Please contact the plan for more information.
You pay **$20** copay per visit for: • Up to 4 **visits** per year	Therapeutic massage sessions must be furnished by a state licensed massage therapist. Massage must be referred by a physician or medical professional as defined by the plan and be health related.
You pay nothing for OTC items, medications and products up to **$45** every month for a total yearly benefit of **$540**	The benefit amount does not accumulate from quarter to quarter. See page 85 for more information.

Premium and Benefits	Marion Lake Sumter 028 - Premier by Ultimate
Telehealth Services	You pay **$0** copay per visit for: • **Primary care** telehealth services, including 24 Hour Nurse Advice Line You pay **$20** copay per visit for: • **Specialist** telehealth services • **Mental health** telehealth services
Meal Benefits	You pay a **$0** copay for **meals** immediately following a hospital stay.
Medical Equipment/Supplies • *Durable Medical Equipment (e.g., wheelchairs, oxygen)* • *Prosthetics (e.g., braces. artificial limbs)* • *Diabetes supplies*	You pay **20%** of the cost for • **Durable Medical Equipment** (DME) • **Prosthetics** You pay **$0** copay for • Diabetes **monitoring supplies** • Diabetes **self-management training** • Diabetic **shoes**

Marion Lake Sumter 016 - Premier Plus by Ultimate	What You Should Know
You pay **$0** copay per visit for: • **Primary care** telehealth services, including 24 Hour Nurse Advice Line You pay **$20** copay per visit for: • **Specialist** telehealth services • **Mental health** telehealth services	A referral is required for specialist telehealth services. Please contact the plan for more information.
You pay a **$0** copay for **meals** immediately following a hospital stay.	Two meals per day are offered for 7 days, provided they are ordered by a physician or case manager.
You pay **20%** of the cost for • **Durable Medical Equipment** (DME) • **Prosthetics** You pay **$0** copay for • Diabetes **monitoring supplies** • Diabetes **self-management training** • Diabetic **shoes**	Authorization is required for some services. Please contact the plan for more information.

How Much Do I Pay in Each Stage?

WHAT YOU SHOULD KNOW

What you pay for a drug depends on which "drug payment stage" you are in when you get the drug. Because these plans do not have a deductible, you begin in the Initial Coverage stage.

During this stage, our plan also covers select insulins. You pay a $25-35 copay for select insulins. To find out which drugs are select insulins, review our plan's drug list (also called the formulary).

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. Not everyone will enter the coverage gap.

If you enter the coverage gap, our plans continue to cover drugs in Tier 1 Preferred Generic. For drugs in Tier 1 you pay the copay amounts shown below or 25% of the plan's cost, whichever is less. Additionally, during the coverage gap stage, your out-of-pocket costs for select insulins will be $25-35.

For covered brand name drugs you pay 25% of the price (plus a portion of the dispensing fee) while in the coverage gap. You stay in the coverage gap stage until your costs total $6,550, which is the end of the coverage gap and the beginning of the catastrophic coverage stage, during which the plan pays most of the cost for your drugs.

Cost-Sharing may change depending on the pharmacy you choose (i.e. network, out of network, mail order, LTC, home infusion, etc.), the days supply (i.e. 30 days or 90 days) and when you enter another stage of the Part D benefit. If you reside in a long-term care facility and use a Long Term Care (LTC) pharmacy, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy. For more information on the additional pharmacy-specific cost-sharing and the stages of the benefit, please call us or access our Evidence of Coverage online.

028 - Premier by Ultimate

		RETAIL PHARMACY	MAIL ORDER PHARMACY
Sumter / Lake	Initial	Your cost for a one-month supply filled at a network retail pharmacy: Tier 1: Generic • You pay: **$0** per prescription Tier 2: Preferred Brand • You pay: **$35** per prescription Tier 3: Non-Preferred Brand • You pay: **$60** per prescription Tier 4: Specialty Tier • You pay: **33%** of the cost	Your cost for a 90-day supply filled at a network mail order pharmacy: Tier 1: Generic • You pay: **$0** per prescription Tier 2: Preferred Brand • You pay: **$70** per prescription Tier 3: Non-Preferred Brand • You pay: **$120** per prescription
Marion	Coverage Gap	Your cost for a one-month supply filled at a network retail pharmacy: Tier 1: Generic • You pay: **$0** per prescription	Your cost for a 90-day supply filled at a network mail order pharmacy: Tier 1: Generic • You pay: **$0** per prescription

OUTPATIENT PRESCRIPTION DRUGS

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		RETAIL PHARMACY	MAIL ORDER PHARMACY
Sumter / Lake	Initial	Your cost for a one-month supply filled at a network retail pharmacy: Tier 1: Generic • You pay: **$0** per prescription Tier 2: Preferred Brand • You pay: **$30** per prescription Tier 3: Non-Preferred Brand • You pay: **$70** per prescription Tier 4: Specialty Tier • You pay: **33%** of the cost	Your cost for a 90-day supply filled at a network mail order pharmacy: Tier 1: Generic • You pay: **$0** per prescription Tier 2: Preferred Brand • You pay: **$60** per prescription Tier 3: Non-Preferred Brand • You pay: **$140** per prescription
Marion	Coverage Gap	Your cost for a one-month supply filled at a network retail pharmacy: Tier 1: Generic • You pay: **$0** per prescription	Your cost for a 90-day supply filled at a network mail order pharmacy: Tier 1: Generic • You pay: **$0** per prescription

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Good health is where you live.

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Premium and Benefits	Pinellas Hillsborough 011 - Premier by Ultimate
Monthly Plan Premium	You pay $0
Part B Premium Reduction	Ultimate Health Plans will reduce your Medicare Part B premium by up to **$130.00 per month.**
Deductible	This plan **does not** have a deductible.
Maximum Out-of-Pocket Responsibility	**$2,800**
Inpatient Hospital Coverage	You pay **$120** copay per day for days 1 through 5 You pay **$0** copay per day for days 6 through 90
Outpatient Hospital Coverage	You pay **$25** copay per visit for **Ambulatory Surgical Center** services You pay **$150** copay per visit for **Outpatient Hospital** services
Doctor Visits *(Primary Care Providers and Providers)*	You pay **$0** copay per visit for **Primary Care Provider** You pay **$20** copay per visit for **Specialist**
Preventive Care	**You pay nothing**
Emergency Care	You pay **$75** copay per visit
Urgently Needed Services	You pay **$10** copay per visit

Pinellas Hillsborough 012 - Premier Plus by Ultimate	What You Should Know
You pay $0	
Not applicable for this plan	You must continue to pay your Medicare Part B premium.
This plan **does not** have a deductible.	
$1,500	This amount is the most you'll pay for copays, coinsurance and other costs for in-network medical services for the year. It does not include Part D drugs.
You pay **$0** copay	Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. A referral or prior authorization is required for some services. Please contact the plan for more information.
You pay **$25** copay per visit for **Ambulatory Surgical Center** services You pay **$100** copay per visit for **Outpatient Hospital** services	A referral or prior authorization is required for some services. Please contact the plan for more information.
You pay **$0** copay per visit for **Primary Care Provider** and **Specialist**	A referral or prior authorization is required for some services. Please contact the plan for more information.
You pay nothing	For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. Any additional preventive services approved by Medicare during the contract year will be covered. A referral or prior authorization is required for some services. Please contact the plan for more information. See page 89 for more information about the preventive services we cover.
You pay **$50** copay per visit	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. We also cover supplemental Emergency Care worldwide (See **Worldwide Emergency Care** on page 88.)
You pay **$10** copay per visit	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services.

Premium and Benefits	Pinellas Hillsborough 011 - Premier by Ultimate
Diagnostic Services Labs/Imaging • *Lab services* • *Outpatient X-Rays* • *Diagnostic tests and procedures* • *Diagnostic radiological services* • *Therapeutic radiological services*	**Lab Services** • You pay **$0** copay **Outpatient X-Rays** • You pay **$0** copay **Diagnostic Tests and Procedures** You pay the following: • **$25** copay for Colonoscopy, Endoscopy and other diagnostic "scopic" procedures, Pulmonary Function Tests and Thyroid Function Tests • **$75** copay for Sleep Study and Psychological Tests **Diagnostic Radiological Services** You pay the following in addition to the office visit copay: • **$25** copay for Ultrasounds and Echocardiography • **$50** copay for Stress, Nerve Conduction, CT, MRI • **$100** copay for CTA, MRA, PET, SPECT, other nuclear medicine tests **Therapeutic Radiological Services** (such as radiation treatment for cancer): • **20%** of the cost A referral or prior authorization is required for some services. Please contact the plan for more information. All services performed at an outpatient hospital facility are subject to the outpatient hospital copayment.
Hearing Services • *Exam to diagnose and treat hearing and balance issues* • *Routine hearing exam* • *Hearing aid fitting and evaluation* • *Hearing aids*	You pay **$0** copay for • 1 **routine hearing exam** per year • **Exam to diagnose and treat hearing and balance issues** *Our plan pays up to $2,000 every two years for hearing aids.* You pay **$10** copay for • 1 hearing aid fitting/evaluation per year • Per hearing aid

YOUR BENEFITS AND COST SHARING

Premium and Benefits	Pinellas Hillsborough 012 - Premier Plus by Ultimate
Diagnostic Services Labs/Imaging • *Lab services* • *Outpatient X-Rays* • *Diagnostic tests and procedures* • *Diagnostic radiological services* • *Therapeutic radiological services*	**Lab Services** • You pay **$0** copay **Outpatient X-Rays** • You pay **$0** copay **Diagnostic Tests and Procedures** You pay the following: • **$0** copay for Colonoscopy, Endoscopy and other diagnostic "scopic" procedures, Pulmonary Function Tests and Thyroid Function Tests • **$50** copay for Sleep Study and Psychological Tests **Diagnostic Radiological Services** You pay the following in addition to the office visit copay: • **$0** copay for Ultrasounds and Echocardiography • **$25** copay for Stress, Nerve Conduction, CT, MRI • **$50** copay for CTA, MRA, PET, SPECT, other nuclear medicine tests **Therapeutic Radiological Services** (such as radiation treatment for cancer): • **20%** of the cost A referral or prior authorization is required for some services. Please contact the plan for more information. All services performed at an outpatient hospital facility are subject to the outpatient hospital copayment.
Hearing Services • *Exam to diagnose and treat hearing and balance issues* • *Routine hearing exam* • *Hearing aid fitting and evaluation* • *Hearing aids*	You pay **$0** copay for • 1 **routine hearing exam** per year • **Exam to diagnose and treat hearing and balance issues** *Our plan pays up to $2,000 every two years for hearing aids.* You pay **$5** copay for • 1 hearing aid fitting/evaluation per year • Per hearing aid

Premium and Benefits	Pinellas Hillsborough 011 - Premier by Ultimate
Dental Services • *Preventive dental services* • *Comprehensive dental services* • *Medicare-covered non-routine dental services*	You pay **$0** copay for: • 1 **oral evaluation** every 6 months • 1 **cleaning** every 6 months • 1 **fluoride treatment** every 6 months • 1 **dental X-Ray** per year • 1 **comprehensive oral exam** every 3 years • 1 **simple extraction** per year • 1 **filling** per year • **Scaling/root planing** limited to 1 procedure per quadrant per year. Scaling/root planing for 4 total procedures per year (deep cleaning) • Medicare-covered non-routine dental services

Pinellas Hillsborough 012 - Premier Plus by Ultimate	What You Should Know
You pay **$0** copay for: • 1 **oral evaluation** every 6 months • 1 **cleaning** every 6 months • 1 **fluoride treatment** every 6 months • 1 **dental X-Ray** per year • 1 **comprehensive oral exam** every 3 years • 1 **simple extraction** per year • 1 **filling** per year • 1 **full-mouth debridement** every 2 years • 1 **Bridge/Denture** per arch every 3 years • **Scaling/root planing** limited to 1 procedure per quadrant per year. Scaling/root planing for 4 total procedures per year (deep cleaning) • Medicare-covered non-routine dental services	**X-Rays may include:** • Intraoral, complete series of radiographic images • Intraoral, periapical radiographic image • Bitewing, single radiographic image, or Bitewings, two, three or four radiographic images • Panoramic radiographic image • Full mouth and panoramic images covered every 3 years. **Simple Extraction may include:** • Extraction, erupted tooth or exposed root • Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth **Filling may include:** • Amalgam, one, or more surfaces, primary or permanent • Resin-based composite, one to three surfaces, anterior, four or more surfaces, involving incisal angle • Resin-based composite, one or more surfaces, posterior Services must be performed by a participating general dentist. Our plan covers non-routine dental services that are medically necessary prior to another Medicare-covered medical procedure. Periodontal maintenance, gingival irrigation, and localized delivery of antimicrobial agents, like Arestin®, are not covered, and the member is responsible for the additional charge, even though scaling/root planing is covered. Some services may require prior authorization. Please contact the plan for more information. *For plan 012 only* **Denture may include 1 of the following per arch per 3 years:** • Complete denture, maxillary or mandibular • Immediate denture, maxillary or mandibular • Maxillary or mandibular partial denture, resin base • Maxillary or mandibular partial denture, cast metal, resin base • Maxillary or mandibular partial denture, flexible base

Premium and Benefits	Pinellas Hillsborough 011 - Premier by Ultimate
Vision Services • *Eye exams* • *Eyewear and Contact Lenses*	**Our plan covers** • 1 **routine eye exam** per year • **Exam(s) to diagnose and treat diseases and conditions of the eye** You pay **$0** copay for: • Exam with optometrist You pay **$20** copay for: • Exam with ophthalmologist Our plan pays up to **$200** per year for eyewear. You pay **$0** copay for: • **Contact lenses** OR • 1 pair of standard CR-39 **eyeglass lenses** AND/OR • 1 **eyeglass frame** You pay **$50** copay for: • Upgrade to **progressive lenses** You pay **$40** copay for: • 1 additional pair of **prescription sunglasses** per year OR • **$30** copay for **photochromic lenses** **Post Cataract Surgery Benefit**: • 1 frame from special selection AND/OR • Standard CR-39 eyeglass lenses as medically necessary, no limit on lenses after cataract surgery • Instead of glasses, may select contact lenses up to the eyewear benefit limit of $200

YOUR BENEFITS AND COST SHARING

Pinellas Hillsborough 012 - Premier Plus by Ultimate	What You Should Know
Our plan covers • 1 **routine eye exam** per year • **Exam(s) to diagnose and treat diseases and conditions of the eye** You pay **$0** copay for: • Exam with optometrist You pay **$0** copay for: • Exam with ophthalmologist Our plan pays up to **$200** per year for eyewear. You pay **$0** copay for: • **Contact lenses** OR • 1 pair of standard CR-39 **eyeglass lenses** AND/OR • 1 **eyeglass frame** You pay **$50** copay for: • Upgrade to **progressive lenses** You pay **$40** copay for: • 1 additional pair of **prescription sunglasses** per year • **$30** copay for **photochromic lenses** **Post Cataract Surgery Benefit**: • 1 frame from special selection AND/OR • Standard CR-39 eyeglass lenses as medically necessary, no limit on lenses after cataract surgery • Instead of glasses, may select contact lenses up to the eyewear benefit limit of $200	• The per-year benefit amount may be applied to lenses only, frame only or to both. • Standard eyeglass lenses include: ▶ Single Vision, ▶ Bifocal (FT 28) or ▶ Trifocal (7X28) lenses • The upgrade to progressive lenses does not impact the per-year limit on eyewear. • The additional prescription sunglasses benefit is in addition to and does not impact the per-year benefit limit on eyewear. This benefit may be utilized once per year. • Additional Prescription Sunglasses OR Photochromic Lenses benefit allows: • Option to select Prescription Sunglasses with Polarized (Grey or Brown) Lenses from a special frame selection OR Photochromic Lenses. • The Prescription Sunglasses with Polarized (Grey or Brown) Lenses is subject to a $40 copay. • The Photochromic Lenses is subject to a $30 copay. • Contact lenses fitting is not covered benefit.

Premium and Benefits	Pinellas Hillsborough 011 - Premier by Ultimate
Mental Health Services • *Inpatient hospital stay* • *Outpatient group therapy visits* • *Outpatient individual therapy visits*	**Inpatient hospital stay** • You pay **$120** copay per day for days 1 through 5 • You pay **$0** copay per day for days 6 through 90 **Outpatient group therapy visits** • You pay **$10** copay per session **Outpatient individual therapy visits** • You pay **$20** copay per session
Skilled Nursing Facility	You pay **$0** copay per day for days 1 through 20 You pay **$150** copay per day for days 21 through 40 You pay **$0** copay per day for days 41 through 100

Pinellas Hillsborough 012 - Premier Plus by Ultimate	What You Should Know
Inpatient hospital stay • You pay **$0** copay **Outpatient group therapy visits** • You pay **$0** copay per session **Outpatient individual therapy visits** • You pay **$0** copay per session	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. A referral or prior authorization is required for some services. Please contact the plan for more information.
You pay **$0** copay per day for days 1 through 20 You pay **$150** copay per day for days 21 through 31 You pay **$0** copay per day for days 32 through 100	Our plan covers up to 100 days in a SNF. The copays for skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any skilled care in a SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods. A referral or prior authorization is required for some services. Please contact the plan for more information.

Premium and Benefits	Pinellas Hillsborough 011 - Premier by Ultimate
Physical Therapy • *Physical therapy visit* • *Speech-language pathology services* • *Occupational therapy visit*	You pay **$20** copay per visit • Physical therapy • Speech-language pathology You pay **$20** copay per visit • Occupational therapy
Ambulance	You pay **$150** copay for Medicare-covered one-way **ground ambulance** benefit You pay **20%** of the cost for Medicare-covered one-way **air ambulance** benefit
Transportation	You pay **$0** copay for up to **20 trips**: • 8 one-way trips (4 round trips) to Primary Care Provider office, eye doctor, specialist or dialysis, AND • 12 one-way trips (6 roundtrips) to physical therapy
Medicare Part B Drugs	You pay **20%** of the cost for • Medicare Part B chemotherapy drugs • Part B medications and contrast agents injected during a service • Other Part B drugs For covered IV Antibiotics, you pay **$0** copay when the service is bundled with Home Health services.

YOUR BENEFITS AND COST SHARING

Pinellas Hillsborough 012 - Premier Plus by Ultimate	What You Should Know
You pay **$5** copay per visit • Physical therapy • Speech-language pathology You pay **$0** copay per visit • Occupational therapy	A referral and prior authorization may be required for some services. Please contact the plan for more information. Services performed at an outpatient hospital facility are subject to the outpatient hospital copayment.
You pay **$150** copay for Medicare-covered one-way **ground ambulance** benefit You pay **20%** of the cost for Medicare-covered one-way **air ambulance** benefit	Except in an emergency, this service may require prior authorization. Please contact the plan for more information.
You pay **$0** copay for **unlimited** trips to Primary Care Provider office, eye doctor, specialist, dialysis or physical therapy	Trips must be to a plan approved health related location via taxi, rideshare service, bus, van or medical transport (as arranged by plan). A referral or prior authorization is required for some services. Please contact the plan for more information.
You pay **20%** of the cost for • Medicare Part B chemotherapy drugs • Part B medications and contrast agents injected during a service • Other Part B drugs For covered IV Antibiotics, you pay **$0** copay when the service is bundled with Home Health services.	The applicable specialist copay applies when provided during a Physician/Specialist office visit. A referral or prior authorization is required for some services. Please contact the plan for more information.

Premium and Benefits	Pinellas Hillsborough 011 - Premier by Ultimate	Pinellas Hillsborough 012 - Premier Plus by Ultimate	What You Should Know
Foot Care (podiatry services) • *Medicare-covered foot exams and treatment*	You pay **$20** copay per visit	You pay **$0** per visit	A referral is required. Contact the plan for more information.
Worldwide Emergency Care	You pay **$75** per visit	You pay **$100** per visit	We pay up to $50,000 for covered emergency services received outside the U.S. and its territories. See page 88 for more information.
Wellness Program • *SilverSneakers® Fitness Program* • *Health Education* • *Additional Smoking and Tobacco Use Cessation*	**You pay nothing**	**You pay nothing**	See page 87 for a description of the Wellness Programs we offer.
Chiropractic Care Services	You pay **$20** copay per visit for: • **Medicare-covered** chiropractic services You pay **$20** copay per visit for: • Up to 12 **Routine** chiropractic care visits per year	You pay **$0** copay per visit for: • **Medicare-covered** chiropractic services You pay **$10** copay per visit for: • Up to 12 **Routine** chiropractic care visits per year	Medicare-covered Chiropractic Services include manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position).
Acupuncture	You pay **$20** copay per visit for: • Up to 6 **visits** per year	You pay **$10** copay per visit for: • Up to 6 **visits** per year	A referral is required. Please contact the plan for more information.
Therapeutic Massage	You pay **$20** copay per visit for: • Up to 4 **visits** per year	You pay **$10** copay per visit for: • Up to 4 **visits** per year	Therapeutic massage sessions must be furnished by a state licensed massage therapist. Massage must be referred by a physician or medical professional as defined by the plan and be health related.
Over-the-Counter (OTC)	**You pay nothing for OTC** items, medications and products up to **$50** every month for a total yearly benefit of **$600**	**You pay nothing for OTC** items, medications and products up to **$50** every month for a total yearly benefit of **$600**	The benefit amount does not accumulate from month to month. See page 85 for more information.

Premium and Benefits	Pinellas Hillsborough 011 - Premier by Ultimate
Telehealth Services	You pay **$0** copay per visit for: • **Primary care** telehealth services, including 24 Hour Nurse Advice Line You pay **$20** copay per visit for: • **Specialist** telehealth services • **Mental health** telehealth services
Meal Benefits	You pay a **$0** copay for **meals** immediately following a hospital stay.
Medical Equipment/Supplies • *Durable Medical Equipment (e.g., wheelchairs, oxygen)* • *Prosthetics (e.g., braces. artificial limbs)* • *Diabetes supplies*	You pay **20%** of the cost for • **Durable Medical Equipment** (DME) • **Prosthetics** You pay **$0** copay for • Diabetes **monitoring supplies** • Diabetes **self-management training** • Diabetic **shoes**

YOUR BENEFITS AND COST SHARING

Pinellas Hillsborough 012 - Premier Plus by Ultimate	What You Should Know
You pay **$0** copay per visit for: • **Primary care** telehealth services, including 24 Hour Nurse Advice Line • **Specialist** telehealth services • **Mental health** telehealth services	A referral is required for specialist telehealth services. Please contact the plan for more information.
You pay a **$0** copay for **meals** immediately following a hospital stay.	Two meals per day are offered for 7 days, provided they are ordered by a physician or case manager.
You pay **20%** of the cost for • **Durable Medical Equipment** (DME) • **Prosthetics** You pay **$0** copay for • Diabetes **monitoring supplies** • Diabetes **self-management training** • Diabetic **shoes**	Authorization is required for some services. Please contact the plan for more information.

How Much Do I Pay in Each Stage?

WHAT YOU SHOULD KNOW

What you pay for a drug depends on which "drug payment stage" you are in when you get the drug. Because these plans do not have a deductible, you begin in the Initial Coverage stage.

During this stage, our plan also covers select insulins. You pay a $25-35 copay for select insulins. To find out which drugs are select insulins, review our plan's drug list (also called the formulary).

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. Not everyone will enter the coverage gap.

If you enter the coverage gap, our plans continue to cover drugs in Tier 1 Preferred Generic. For drugs in Tier 1 you pay the copay amounts shown below or 25% of the plan's cost, whichever is less. Additionally, during the coverage gap stage, your out-of-pocket costs for select insulins will be $25-35.

For covered brand name drugs you pay 25% of the price (plus a portion of the dispensing fee) while in the coverage gap. You stay in the coverage gap stage until your costs total $6,550, which is the end of the coverage gap and the beginning of the catastrophic coverage stage, during which the plan pays most of the cost for your drugs.

Cost-Sharing may change depending on the pharmacy you choose (i.e. network, out of network, mail order, LTC, home infusion, etc.), the days supply (i.e. 30 days or 90 days) and when you enter another stage of the Part D benefit. If you reside in a long-term care facility and use a Long Term Care (LTC) pharmacy, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy. For more information on the additional pharmacy-specific cost-sharing and the stages of the benefit, please call us or access our Evidence of Coverage online.

		011 - Premier by Ultimate	
		RETAIL PHARMACY	***MAIL ORDER PHARMACY***
Hillsborough	Initial	Your cost for a one-month supply filled at a network retail pharmacy: Tier 1: Generic • You pay: **$0** per prescription Tier 2: Preferred Brand • You pay: **$35** per prescription Tier 3: Non-Preferred Brand • You pay: **$60** per prescription Tier 4: Specialty Tier • You pay: **33%** of the cost	Your cost for a 90-day supply filled at a network mail order pharmacy: Tier 1: Generic • You pay: **$0** per prescription Tier 2: Preferred Brand • You pay: **$70** per prescription Tier 3: Non-Preferred Brand • You pay: **$120** per prescription
Pinellas	Coverage Gap	***RETAIL PHARMACY*** Your cost for a one-month supply filled at a network retail pharmacy: Tier 1: Generic • You pay: **$0** per prescription	***MAIL ORDER PHARMACY*** Your cost for a 90-day supply filled at a network mail order pharmacy: Tier 1: Generic • You pay: **$0** per prescription

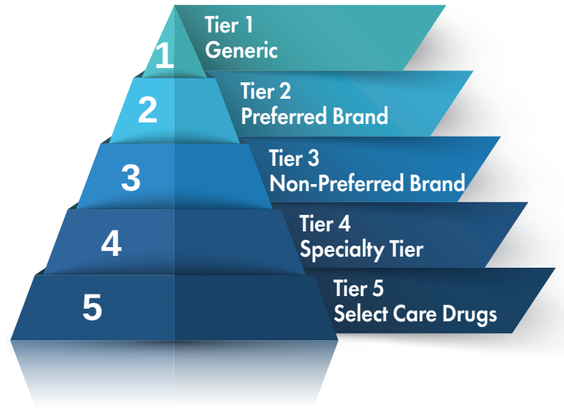
		012 - Premier Plus by Ultimate	
		RETAIL PHARMACY	***MAIL ORDER PHARMACY***
Hillsborough	Initial	Your cost for a one-month supply filled at a network retail pharmacy: Tier 1: Generic • You pay: **$0** per prescription Tier 2: Preferred Brand • You pay: **$25** per prescription Tier 3: Non-Preferred Brand • You pay: **$50** per prescription Tier 4: Specialty Tier • You pay: **33%** of the cost	Your cost for a 90-day supply filled at a network mail order pharmacy: Tier 1: Generic • You pay: **$0** per prescription Tier 2: Preferred Brand • You pay: **$50** per prescription Tier 3: Non-Preferred Brand • You pay: **$100** per prescription
Pinellas	Coverage Gap	***RETAIL PHARMACY*** Your cost for a one-month supply filled at a network retail pharmacy: Tier 1: Generic • You pay: **$0** per prescription	***MAIL ORDER PHARMACY*** Your cost for a 90-day supply filled at a network mail order pharmacy: Tier 1: Generic • You pay: **$0** per prescription

ULTIMATE HEALTH PLANS
Good health is where you live.

Your Prescription Drug Benefit

Determining your drug costs

Our plan groups each medication into one of five “tiers.” You will need to use our plan’s drug list (also called the formulary) to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug’s tier and what stage of the benefit you have reached (see the tables at the end of your county’s listing). To find out what drugs we cover, you can see our complete drug list and any restrictions or limitations on our website, www.chooseultimate.com. Or, call us and we will send you a copy of the drug list. The Formulary may change at any time. You will receive notice when necessary.



Save even more with MAIL ORDER

You can save more by using Ultimate Health Plans’ Mail Order Pharmacy Service!

You’ll receive a **three month** supply of medication delivered straight to your door and pay the same copay that you would normally pay for a **two month** supply at your local pharmacy.

There are two ways to find your drug within the plan’s drug list:

Medical Condition

We group the drugs on our drug list into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Cardiovascular Agents”. If you know what your drug is used for, look for the category name in the drug list. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index included at the back of the drug list. The Index provides an alphabetical list of all the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

Your Over-The-Counter Benefit

We cover Over-the-Counter (OTC) Medications and Supplies

Original Medicare does not cover Over-the-Counter (OTC) medicines. But we do! Our plan covers OTC items, medications and products, including non-prescription drugs and health-related items for our members' personal use. You pay **$0** copay for covered OTC items, medications and products, up to the available benefit limit each month. Our plan even covers the cost of mailing the items to you!

The following categories of items are covered by our OTC benefit:

- ✓ Medicines, ointments and sprays with active medical ingredients that alleviate symptoms, such as antacids, analgesics, anti-bacterial, anti-histamines, anti-inflammatories, antiseptics, decongestants, sleep aids
- ✓ Mouth care, such as toothbrushes, toothpaste, floss, denture adhesives, denture cleaners and gum stimulators
- ✓ First Aid supplies, such as adhesive bandages, gauze and other dressings, antibacterial ointment, peroxide, thermometers, non-sport tapes
- ✓ Minerals and vitamins
- ✓ Fiber supplements, such as pills, powders and non-food liquids that supplement fiber in the diet
- ✓ Hormone replacement, such as phytohormone, natural progesterone or DHEA
- ✓ Weight loss items, such as appetite suppressants and fat absorption inhibitors
- ✓ Topical sunscreen and insect repellent
- ✓ Incontinence supplies, such as diapers and pads
- ✓ In home testing and monitoring, such as equipment to monitor blood pressure, cholesterol, blood sugar, to test for pregnancy, fecal occult blood
- ✓ Bathroom scales may be covered for members with CHF or liver disease to monitor fluid retention

We offer this benefit through a mail order catalog, which contains a list of all plan-covered OTC items and the price of each item. We mail you the catalog, and you may also access it online by visiting www.chooseultimate.com. Simply fill out and mail your order or, to place an order by phone, simply dial 1-855-422-0039 (TTY 711). Our friendly representatives are available to take your order Monday through Friday from 8:00 am to 8:00 pm EST.

Your Vision, Hearing & Dental Benefits

Vision

Original Medicare covers exams to diagnose and treat diseases and conditions of the eye. We cover those eye exams and much more! We also cover a yearly routine eye exam. In addition, we cover eyeglasses or contact lenses for **$0** copay.

Our benefit includes:

- *Contact lenses or*
- *One pair of standard single-vision, bifocal or trifocal lenses and/or*
- *One eyeglass frame*

Our benefit is flexible! You can use the eyewear benefit in whatever way works for you: for lenses only, frame only or for both. You can even upgrade your standard lenses to progressives for just **$50** copay, and you can get a pair of sunglasses for a **$40** copay, photochromatic **$30** copay.

Dental

Generally, Original Medicare doesn't cover preventive dental services, but our plan does. Our plan helps you stay healthy with our preventive dental benefits, all with **$0** copay.

We cover routine services, such as:

- *Cleaning*
- *Dental x-rays*
- *Fluoride treatments*
- *Oral evaluations and exam*
- *Comprehensive dental benefits, like filling and extraction*
- *Some plans offer full-mouth debridement*
- *Some plans offer dentures*

Hearing

Original Medicare covers diagnostic hearing and balance evaluations to determine if you need medical treatment. We cover those evaluations and much more! We also cover an annual routine hearing exam for **$0** copay and hearing aids and fitting evaluations at low, affordable copays (**$5** or **$10** depending on the plan you choose). Our plan pays up to **$2,000** for hearing aids every two years.

You'll find the hearing aid products and services available to our members are top of the line. They even include connectivity to your phone or other smart device as well as applications to help you manage your hearing aid. Scheduling an appointment is easy with our hearing-specialized concierge customer service that guides you through finding a hearing provider.

Staying Active with Your Fitness Benefit

Plan members enjoy the SilverSneakers® Fitness program

SilverSneakers® Fitness is a health and physical activity program designed for Medicare beneficiaries. SilverSneakers® includes a fitness membership with access to locations nationwide (including women-only locations).

Members can use equipment and take group exercise classes. In addition to a basic membership at participating locations, members can participate in low-impact SilverSneakers® classes and have access to a specially trained Senior Advisor.

SilverSneakers® Steps is an alternative for members who can't get to a participating location and is a self-directed physical activity program that allows members to choose one of four available kits to use at home or on the go — general fitness, strength, walking or yoga.

For more information and to find SilverSneakers® participating locations, visit silversneakers.com or call 1-888-423-4632 (TTY: 711), Monday through Friday, 8 am to 8 pm EST.

Additional Benefits You'll Receive

Additional Smoking and Tobacco Use Cessation Attempts

We cover additional smoking and tobacco use cessation attempts (counseling to stop smoking and tobacco use) beyond what is covered under the Preventive Services benefit. Unlimited attempts are covered at no additional cost. Each counseling attempt includes up to four face-to-face visits.

Health Education

The Health Education program is designed to help you develop knowledge and self-care skills and to foster the motivation and confidence necessary to use those skills to improve and maintain your health. Educational services are provided by a certified health educator or other licensed professionals and include information about specific disease processes, treatments and drug therapies, signs and symptoms to watch for, self-care strategies and techniques, dietary restrictions, and nutritional counseling through written materials and one-on-one interactive telephonic coaching sessions. We offer this service to all members who need education about a specific disease or condition.

Our 24/7 Nurse Hotline

Members can call the hotline to talk with a nurse 24 hours a day, 7 days a week to obtain health information, guidance, and support regarding an immediate health concern or questions about a particular medical condition at no additional cost. Members may reach the Nursing Hotline by calling 1-855-238-4687. Calls to this line are free. TTY users should dial 711.

Worldwide Emergency Care Coverage

Attention World Travelers: We Cover Emergency Care World-Wide. Our members get covered emergency medical care and ambulance services whenever they need it, anywhere in the world! We'll pay up to $50,000 for emergency services received outside the U.S. and its territories.

Transportation

Now getting to your appointments is easier than ever. We arrange for and cover your transportation to your medical appointments, such as Primary Care Provider, Specialist, Eye Doctor, Dialysis and Physical Therapy office visits.

Preventive Services

Preventive services help you stay at the top of your game

For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2021, either Medicare or our plan will cover those services.

There is no coinsurance, copayment, or deductible for the following preventive services and screenings.

You pay $0 for

- Abdominal Aortic Aneurysm Screening
- Annual Wellness and Welcome to Medicare Preventive Visits
- Bone Mass Measurement
- Cardiovascular Disease Testing
- Cardiovascular Disease Risk Reduction Visit
- Colorectal Cancer Screening
- Diabetes Screening and Diabetic Self-Management Training
- Glaucoma Screening
- Immunization shots for flu, Pneumonia and Hepatitis B
- Screening Mammograms
- Medical Nutrition Therapy
- Pap Smears and Pelvic Exams
- Prostate Cancer Screening (PSA test)
- Counseling to Stop Smoking and Tobacco Use

We also cover additional screenings not listed here. See our Evidence of Coverage for the complete list of benefit details and restrictions.

Enrolling in an Ultimate Medicare Advantage Plan

When Can You Enroll?

Each fall, from **October 15 until December 7**, Medicare allows you to enroll in or change your Medicare health and drug coverage during the Annual Enrollment Period (AEP). It's important to review your coverage during this time to make sure it will meet your needs for the coming year.

From **January 1 to March 31**, individuals enrolled in MA plans as of January 1 and new Medicare beneficiaries who are enrolled in an MA plan during their ICEP may enroll in another MA plan or disenroll from their MA plan and return to original Medicare.

In certain special situations, enrollment or changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area are allowed to make a change at other times of the year. To find out if you are eligible for a Special Enrollment Period, please contact our plan, call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048), or visit the Medicare website at www.medicare.gov.

Choosing the Right Plan

Use this booklet as your guide to find the information you need:

- ✓ Review our benefits and costs to make sure the plan you're considering is right for you — see pages 5-82
- ✓ Make sure the doctors and other providers you want to use are in our network — see page 2
- ✓ Make sure the drugs you take are on our drug list - see page 84
- ✓ If you have questions or need help, attend one of our free meetings or call us for a convenient no-obligation appointment with one of our licensed benefit consultants

Enrolling in an Ultimate Medicare Advantage Plan

Complete an enrollment form — there are several ways to enroll:

- You can enroll online on the Medicare website by going to the below link, entering your zip code and typing the word Ultimate in the box labeled “Plan Name.” To enroll online, visit: https://www.medicare.gov/find-a-plan/questions/enroll-now.aspx
- Enroll at one of our free meetings
- **For a personalized enrollment experience, call us for a convenient no-obligation appointment with one of our licensed benefit consultants. You may reach us at 1-855-858-7526 (TTY users dial 711), Monday - Sunday 8 am-8pm. During certain times of the year we may use alternative technologies to answer your call on weekends and Federal holidays.**

Here’s what happens next after you enroll:

We’ll send you a letter to verify your enrollment and tell you how to contact us with any questions.

You’ll receive your ID card and welcome kit, including important plan documents, soon after you enroll.

Jan 1

You can start enjoying your benefits on the first day your enrollment becomes effective. AEP enrollments are effective on January 1. Enrollments at other times of the year typically become effective the first day of the following month.

CALL US TODAY

1-855-858-7526
(TTY 711)

Call today to find a **free meeting** near you or to schedule a **no-obligation appointment** with one of our licensed benefit consultants.

For accommodations of persons with special needs at sales meetings call 1-855-858-7526 (TTY users dial 711), Monday-Sunday, 8am-8pm. During certain times of the year we may use alternative technologies to answer your call on weekends and Federal holidays.

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 1-855-858-7526 (TTY users call 711).

Understanding the Benefits

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit www.chooseultimate.com or call 1-855-858-7526 (TTY users call 711) 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.
- 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.

Understanding Important Rules

- You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2022.
- 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).

If you want to know more about the coverage and costs of Original Medicare, look in your current “Medicare & You” handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Ultimate Health Plans is an HMO with a Medicare contract.
Enrollment in Ultimate Health Plans depends on contract renewal.

Notes

Notes

Notes

ULTIMATE
HEALTH PLANS
Good health is where you live.

To learn more, call
1-855-858-7526 (TTY 711)
Monday – Sunday
8 a.m. to 8 p.m.

Visit our website at
www.ChooseUltimate.com
or stop in to one of our local offices.

COMMUNITY OUTREACH OFFICE

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Spring Hill, FL 34606

CORPORATE OFFICE

1244 Mariner Boulevard
Spring Hill, FL 34609

LAKE-SUMTER-MARION OFFICE

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