2022 Summary of Benefits

Citrus|Hernando|Pasco

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)

Pasco

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

ULTIMATE HEALTH PLANS
Good health is where you live.

H2962_SBCORECHP_CY22R082721_C

About Ultimate Health Plans

Ultimate Health Plans is a local Medicare Advantage plan based in Spring Hill, Florida. We proudly service the counties of Citrus, Hernando, Hillsborough, Indian River, Lake, Marion, Pasco, Pinellas, St. Lucie, and Sumter.

Our mission is to provide all members with the highest quality healthcare with access to highly qualified physicians. We hold ourselves accountable for treating our members with dignity and respect, providing world-class customer service, and recognizing our commitment to the community as a local corporation.

About this Booklet

This booklet provides you with a summary of costs and benefits covered by our Premier by Ultimate (HMO) and Premier Plus by Ultimate (HMO). It does not list every service covered by the plan or list every limitation or exclusion. For a complete list of services we cover, please refer to the plan's Evidence of Coverage (EOC) on our website at **www.ChooseUltimate.com**, or call us at 1-855-858-7526 (TTY 711) and we will mail you a copy. We are open Monday through Sunday from 8:00 am - 8:00 pm EST. During certain times of the year we may use alternative technologies to answer your call on weekends and Federal holidays.

Ultimate Plan Types

Medicare Health Maintenance Organization (HMO): A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage. Generally, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Medicare HMO Special Needs Plan (HMO SNP): An HMO Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

Who can join?

To join our plan you must be entitled to Medicare Part A and be enrolled in Medicare Part B.

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 in-network providers and pharmacies. If you use providers that are not in our network, the plan may not pay for these services. You can view our plan's Provider and Pharmacy Directory on our website at **www.ChooseUltimate.com**, or call us at 1-855-858-7526 (TTY 711) and we will mail you a copy.

CORE
Citrus|Hernando|Pasco

Does this plan cover my Prescription Drugs?

To find out what drugs we cover and any restrictions, view our plan's List of Covered Drugs (also called the Formulary) on our website at **www.ChooseUltimate.com**, or call us at 1-855-858-7526 (TTY 711) and we will mail you a copy.

How do I learn more about Original Medicare?

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.

CORE
Hernando|Pasco

Your Benefits and Cost Sharing

Plan Name	Premier by Ultimate (HMO) 001	Premier by Ultimate (HMO) 013-3	Premier Plus by Ultimate (HMO) 014-1
Service Area	Hernando	Pasco	Hernando & Pasco

Premium and Benefits	Premier by Ultimate (HMO) 001	Premier by Ultimate (HMO) 013-3	Premier Plus by Ultimate (HMO) 014-1
Monthly Plan Premium	**$0**	**$0**	**$0**
Part B Reduction	**$144**	**$130**	**$0**
Deductible	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	**$2,800**	**$2,800**	**$1,500**
Inpatient Hospital Coverage	**$115** copay per day for days **1-5** **$0** copay per day for days **6-90**	**$125** copay per day for days **1-5** **$0** copay per day for days **6-90**	**$0** copay per day for days **1-90**
Outpatient Hospital Coverage	**$150** copay	**$150** copay	**$100** copay
Ambulatory Surgery Center	**$25** copay	**$25** copay	**$25** copay
Doctor Visits (Primary Care Providers and Specialists)	**Primary Care Providers** - **$0** copay **Specialist** - **$20** copay	**Primary Care Providers** - **$0** copay **Specialist** - **$20** copay	**Primary Care Providers** - **$0** copay **Specialist** - **$5** copay
Preventive Care	**$0** copay	**$0** copay	**$0** copay
Emergency Care	**$75** copay per visit in the United States **$100** copay for Worldwide Emergency Care	**$75** copay per visit in the United States **$100** copay for Worldwide Emergency Care	**$50** copay per visit in the United States **$100** copay for Worldwide Emergency Care

CORE
Citrus

Your Benefits and Cost Sharing

Plan Name	Premier by Ultimate (HMO) 013-4	Premier Plus by Ultimate (HMO) 014-2
Service Area	Citrus	Citrus

Premier by Ultimate (HMO) 013-4	Premier Plus by Ultimate (HMO) 014-2	What You Need To Know
$0	**$0**	You must continue to pay your Medicare Part B Premium.
$120	**$0**	
This plan does not have a deductible.	This plan does not have a deductible.	
$2,800	**$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 prescription drug costs, health expenses incurred during foreign travel, or supplemental benefit costs.
$125 copay per day for days **1-5** **$0** copay per day for days **6-90**	**$50** copay per day for days **1-5** **$0** copay per day for days **6-90**	Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. A prior authorization is required for some services.
$195 copay	**$150** copay	A prior authorization is required for some services.
$25 copay	**$25** copay	A referral and prior authorization may be required for some services.
Primary Care Providers - **$0** copay **Specialist** - **$20** copay	**Primary Care Providers** - **$0** copay **Specialist** - **$20** copay	A referral or prior authorization is required for some services. A separate copay may apply for each additional service receive at an office visit.
$0 copay	**$0** copay	Any additional preventive services approved by Medicare during the contract year will be covered. A referral or prior authorization is required for some services.
$75 copay per visit in the United States **$100** copay for Worldwide Emergency Care	**$75** copay per visit in the United States **$100** copay for Worldwide Emergency Care	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 pay up to **$50,000** for covered emergency services received outside the U.S. and its territories.

Premium and Benefits	Premier by Ultimate (HMO) 001	Premier by Ultimate (HMO) 013-3	Premier Plus by Ultimate (HMO) 014-1
Urgently Needed Services	**$10** copay	**$10** copay	**$10** copay
Diagnostic Services - Labs/Imaging - Lab services - Outpatient x-rays - Diagnostic tests and procedures - Diagnostic radiological services - Therapeutic radiological services	**Lab Services** - **$0** copay **Outpatient X-Rays** - **$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	**Lab Services** - **$0** copay **Outpatient X-Rays** - **$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	**Lab Services** - **$0** copay **Outpatient X-Rays** - **$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
Hearing Services	**$0** copay for - Routine hearing exam (1 every year) - Hearing aid fitting and evaluation (1 every year) - Hearing aids Our plan pays up to **$1,000** every year, per hearing aid, per ear.	**$0** copay for - Routine hearing exam (1 every year) - Hearing aid fitting and evaluation (1 every year) - Hearing aids Our plan pays up to **$1,000** every year, per hearing aid, per ear.	**$0** copay for - Routine hearing exam (1 every year) - Hearing aid fitting and evaluation (1 every year) - Hearing aids Our plan pays up to **$1,000** every year, per hearing aid, per ear.

Premier by Ultimate (HMO) 013-4	Premier Plus by Ultimate (HMO) 014-2	What You Need To Know
$10 copay	**$10** copay	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.
Lab Services - **$0** copay **Outpatient X-Rays** - **$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 ConductionCT, 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	**Lab Services** - **$0** copay **Outpatient X-Rays** - **$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 prior authorization is required for some services. All services performed at an outpatient hospital facility are subject to the outpatient hospital copayment.
$0 copay for - Routine hearing exam (1 every year) - Hearing aid fitting and evaluation (1 every year) - Hearing aids Our plan pays up to **$1,000** every year, per hearing aid, per ear.	**$0** copay for - Routine hearing exam (1 every year) - Hearing aid fitting and evaluation (1 every year) - Hearing aids Our plan pays up to **$1,000** every year, per hearing aid, per ear.	Services must be rendered by a participating provider in the Plan’s hearing vendor network.

Your Benefits and Cost Sharing

Premium and Benefits	Premier by Ultimate (HMO) 001	Premier by Ultimate (HMO) 013-3	Premier Plus by Ultimate (HMO) 014-1
Dental Services - Preventive dental services - Comprehensive dental services - Medicare-covered non-routine dental services	**$0** copay for: - 1 oral evaluation every 6 months - 4 cleanings every year - 1 fluoride treatment every 6 months - 2 dental x-rays every year - 1 comprehensive oral exam every 3 years - 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). - 1 simple extraction per year - 1 surgical extraction per year - Unlimited simple and surgical necessary extractions to fit dentures - Dentures limited to 1 of the following per arch every 5 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 - Denture reline (One procedure Code per calendar year) - Necessary anesthesia with covered service - Medically necessary non-routine dental services, as covered by Original Medicare	**$0** copay for: - 1 oral evaluation every 6 months - 4 cleanings every year - 1 fluoride treatment every 6 months - 2 dental x-rays every year - 1 comprehensive oral exam every 3 years - 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). - 1 simple extraction per year - 1 surgical extraction per year - Medically necessary non-routine dental services, as covered by Original Medicare	**$0** copay for: - 1 oral evaluation every 6 months - 4 cleanings every year - 1 fluoride treatment every 6 months - 2 dental x-rays every year - 1 comprehensive oral exam every 3 years - 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). - 1 simple extraction per year - 1 surgical extraction per year - Unlimited simple and surgical necessary extractions to fit dentures - Dentures limited to 1 of the following per arch every 5 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 - Denture reline (One procedure Code per calendar year) - Necessary anesthesia with covered service - Medically necessary non-routine dental services, as covered by Original Medicare

Your Benefits and Cost Sharing

Premier by Ultimate (HMO) 013-4	Premier Plus by Ultimate (HMO) 014-2	What You Need To Know
$0 copay for: - 1 oral evaluation every 6 months - 1 cleaning every 6 months - 1 fluoride treatment every 6 months - 1 dental x-ray every year - 1 comprehensive oral exam every 3 years - 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). - 1 simple extraction per year - 1 surgical extraction per year - Medically necessary non-routine dental services, as covered by Original Medicare	**$0** copay for: - 1 oral evaluation every 6 months - 1 cleaning every 6 months - 1 fluoride treatment every 6 months - 1 dental x-ray every year - 1 comprehensive oral exam every 3 years - 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). - 1 simple extraction per year - 1 surgical extraction per year - Unlimited simple and surgical necessary extractions to fit dentures - Dentures limited to 1 of the following per arch every 5 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 - Denture reline (One procedure Code per calendar year) - Necessary anesthesia with covered service - Medically necessary non-routine dental services, as covered by Original Medicare	**X-Rays may include:** - Intraoral, periapical first radiographic image - Intraoral, periapical each additional radiographic image - Bitewing, single radiographic image, or Bitewings, two, three or four radiographic images - Intraoral, complete series of radiographic images; 1 every 3 years - Panoramic radiographic images covered; 1 every 3 years **Fillings 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 **Simple extractions may include:** - Extraction, erupted tooth or exposed root - Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth **Surgical extractions may include:** - Removal of impacted tooth - Removal of residual tooth roots (cutting 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.

Your Benefits and Cost Sharing

Premium and Benefits	Premier by Ultimate (HMO) 001	Premier by Ultimate (HMO) 013-3	Premier Plus by Ultimate (HMO) 014-1
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 **$0** copay for: - Exam with optometrist **$20** copay for: - Exam with ophthalmologist Our plan pays up to **$200** per year for eyewear. **$0** copay for: - Contact lenses OR - 1 pair of standard CR-39 eyeglass lenses AND/OR - 1 eyeglass frame **$50** copay for: - Upgrade to progressive lenses **$40** copay for: - 1 additional pair of prescription sunglasses per year **$30** copay for photochromic lenses **Post-cataract surgery benefits which include:** - 1 frame from special selection AND/OR - Standard single vision, bifocal or trifocal eyeglass lenses. No limit on lenses deemed medically necessary by your provider. - Instead of glasses, you may select contact lenses up to the benefit limit	Our plan covers - 1 routine eye exam per year - Exam(s) to diagnose and treat diseases and conditions of the eye **$0** copay for: - Exam with optometrist **$20** copay for: - Exam with ophthalmologist Our plan pays up to **$200** per year for eyewear. **$0** copay for: - Contact lenses OR - 1 pair of standard CR-39 eyeglass lenses AND/OR - 1 eyeglass frame **$50** copay for: - Upgrade to progressive lenses **$40** copay for: - 1 additional pair of prescription sunglasses per year **$30** copay for photochromic lenses **Post-cataract surgery benefits which include:** - 1 frame from special selection AND/OR - Standard single vision, bifocal or trifocal eyeglass lenses. No limit on lenses deemed medically necessary by your provider. - Instead of glasses, you may select contact lenses up to the benefit limit	Our plan covers - 1 routine eye exam per year - Exam(s) to diagnose and treat diseases and conditions of the eye **$0** copay for: - Exam with optometrist **$0** copay for: - Exam with ophthalmologist Our plan pays up to **$200** per year for eyewear. **$0** copay for: - Contact lenses OR - 1 pair of standard CR-39 eyeglass lenses AND/OR - 1 eyeglass frame **$50** copay for: - Upgrade to progressive lenses **$40** copay for: - 1 additional pair of prescription sunglasses per year **$30** copay for photochromic lenses **Post-cataract surgery benefits which include:** - 1 frame from special selection AND/OR - Standard single vision, bifocal or trifocal eyeglass lenses. No limit on lenses deemed medically necessary by your provider. - Instead of glasses, you may select contact lenses up to the benefit limit

Your Benefits and Cost Sharing

Premier by Ultimate (HMO) 013-4	Premier Plus by Ultimate (HMO) 014-2	What You Need To Know
Our plan covers - 1 routine eye exam per year - Exam(s) to diagnose and treat diseases and conditions of the eye **$0** copay for: - Exam with optometrist **$20** copay for: - Exam with ophthalmologist Our plan pays up to **$150** per year for eyewear. **$0** copay for: - Contact lenses OR - 1 pair of standard CR-39 eyeglass lenses AND/OR - 1 eyeglass frame **$50** copay for: - Upgrade to progressive lenses **$40** copay for: - 1 additional pair of prescription sunglasses per year **$30** copay for photochromic lenses **Post-cataract surgery benefits which include:** - 1 frame from special selection AND/OR - Standard single vision, bifocal or trifocal eyeglass lenses. No limit on lenses deemed medically necessary by your provider. - Instead of glasses, you may select contact lenses up to the benefit limit	Our plan covers - 1 routine eye exam per year - Exam(s) to diagnose and treat diseases and conditions of the eye **$0** copay for: - Exam with optometrist **$20** copay for: - Exam with ophthalmologist Our plan pays up to **$150** per year for eyewear. **$0** copay for: - Contact lenses OR - 1 pair of standard CR-39 eyeglass lenses AND/OR - 1 eyeglass frame **$50** copay for: - Upgrade to progressive lenses **$40** copay for: - 1 additional pair of prescription sunglasses per year **$30** copay for photochromic lenses **Post-cataract surgery benefits which include:** - 1 frame from special selection AND/OR - Standard single vision, bifocal or trifocal eyeglass lenses. No limit on lenses deemed medically necessary by your provider. - Instead of glasses, you may select contact lenses up to the benefit limit	- 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. - Contact lenses fitting is not covered benefit.

Premium and Benefits	Premier by Ultimate (HMO) 001	Premier by Ultimate (HMO) 013-3	Premier Plus by Ultimate (HMO) 014-1
Mental Health Services - Inpatient hospital stay - Outpatient group therapy visits - Outpatient individual therapy visits	**$115** copay per day for days **1-5** **$0** copay per day for days **6-90** **$10** copay for group therapy visits **$20** copay for individual therapy visits	**$125** copay per day for days **1-5** **$0** copay per day for days **6-90** **$10** copay for group therapy visits **$20** copay for individual therapy visits	**$0** copay per day for days **1-90** **$0** copay for group therapy visits **$5** copay for individual therapy visits
Skilled Nursing Facility (SNF)	**$0** copay per day for days **1-20** **$150** copay per day for days **21-40** **$0** copay per day for days **41-100**	**$0** copay per day for days **1-20** **$150** copay per day for days **21-40** **$0** copay per day for days **41-100**	**$0** copay per day for days **1-20** **$150** copay per day for days **21-31** **$0** copay per day for days **32-100**
Physical Therapy - Physical therapy visit - Speech-language pathology services - Occupational therapy visit	**$20** copay per visit - Physical therapy - Speech-language pathology **$20** copay per visit - Occupational therapy	**$20** copay per visit - Physical therapy - Speech-language pathology **$20** copay per visit - Occupational therapy	**$5** copay per visit - Physical therapy - Speech-language pathology **$5** copay per visit - Occupational therapy

Premier by Ultimate (HMO) 013-4	Premier Plus by Ultimate (HMO) 014-2	What You Need To Know
$125 copay per day for days **1-5** **$0** copay per day for days **6-90** **$10** copay for group therapy visits **$20** copay for individual therapy visits	**$50** copay per day for days **1-5** **$0** copay per day for days **6-90** **$10** copay for group therapy visits **$20** copay for individual therapy visits	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.
$0 copay per day for days **1-20** **$150** copay per day for days **21-40** **$0** copay per day for days **41-100**	**$0** copay per day for days **1-20** **$150** copay per day for days **21-31** **$0** copay per day for days **32-100**	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.
$20 copay per visit - Physical therapy - Speech-language pathology **$20** copay per visit - Occupational therapy	**$20** copay per visit - Physical therapy - Speech-language pathology **$20** copay per visit - Occupational therapy	Services performed at an outpatient hospital facility are subject to the outpatient hospital copayment. A referral and prior authorization may be required for some services.

Your Benefits and Cost Sharing

Premium and Benefits	Premier by Ultimate (HMO) 001	Premier by Ultimate (HMO) 013-3	Premier Plus by Ultimate (HMO) 014-1
Ambulance	**$150** copay for Medicare-covered one-way **ground ambulance** benefit **20%** of the cost for Medicare-covered one-way **air ambulance** benefit	**$150** copay for Medicare-covered one-way **ground ambulance** benefit **20%** of the cost for Medicare-covered one-way **air ambulance** benefit	**$150** copay for Medicare-covered one-way **ground ambulance** benefit **20%** of the cost for Medicare-covered one-way **air ambulance** benefit
Transportation	**$0** copay for 20 one-way transportation trips	**$0** copay for 20 one-way transportation trips	**$0** copay for 20 one-way transportation trips
Medicare Part B Drugs	**20%** of the cost for - Medicare Part B chemotherapy drugs - Part B medications and contrast agents injected during a service - Other Part B drugs	**20%** of the cost for - Medicare Part B chemotherapy drugs - Part B medications and contrast agents injected during a service - Other Part B drugs	**20%** of the cost for - Medicare Part B chemotherapy drugs - Part B medications and contrast agents injected during a service - Other Part B drugs
Foot Care (podiatry services) Medicare-covered foot exams and treatment	**$20** copay	**$20** copay	**$5** copay

Your Benefits and Cost Sharing

Premier by Ultimate (HMO) 013-4	Premier Plus by Ultimate (HMO) 014-2	What You Need To Know
$150 copay for Medicare-covered one-way **ground ambulance** benefit **20%** of the cost for Medicare-covered one-way **air ambulance** benefit	**$150** copay for Medicare-covered one-way **ground ambulance** benefit **20%** of the cost for Medicare-covered one-way **air ambulance** benefit	Except in an emergency, this service may require prior authorization.
$0 copay for 20 one-way transportation trips	**$0** copay for 20 one-way transportation trips	Our plan covers 20 one-way transportation trips to any plan approved locations per benefit year. Please contact Member Services 72 hours in advance to schedule your trip with the following information readily available if applicable: Appointment or expected arrival date and time, address of destination, destination phone number, and, if visiting a provider, the name of physician or practitioner.
20% of the cost for - Medicare Part B chemotherapy drugs - Part B medications and contrast agents injected during a service - Other Part B drugs	**20%** of the cost for - Medicare Part B chemotherapy drugs - Part B medications and contrast agents injected during a service - Other Part B drugs	The applicable specialist copay applies when provided during a Physician/Specialist office visit. A referral or prior authorization is required for some services.
$20 copay	**$20** copay	A referral is required.

Premium and Benefits	Premier by Ultimate (HMO) 001	Premier by Ultimate (HMO) 013-3	Premier Plus by Ultimate (HMO) 014-1
Wellness Program - SilverSneakers® Fitness Program - Health Education - Additional Smoking and Tobacco Use Cessation	**$0** copay	**$0** copay	**$0** copay
Chiropractic Care Services	**$20** copay	**$20** copay	**$5** copay
Over-the-Counter (OTC)	up to **$50** every month	up to **$50** every month	up to **$50** every month
Telehealth Services	**$0** copay per visit for: - Primary care telehealth services, including 24 Hour Nurse Advice Line **$20** copay per visit for: - Specialist telehealth services - Mental health telehealth services	**$0** copay per visit for: - Primary care telehealth services, including 24 Hour Nurse Advice Line **$20** copay per visit for: - Specialist telehealth services - Mental health telehealth services	**$0** copay per visit for: - Primary care telehealth services, including 24 Hour Nurse Advice Line **$5** copay per visit for: - Specialist telehealth services - Mental health telehealth services
Meal Benefits	**$0** copay	**$0** copay	**$0** copay
Medical Equipment/Supplies - Durable Medical Equipment (e.g., wheelchairs, oxygen) - Prosthetics (e.g., braces. artificial limbs) - Diabetic supplies	**20%** of the cost for - Durable Medical Equipment (DME) - Prosthetics **$0** copay for - Diabetes monitoring supplies - Diabetes self-management training - Diabetic shoes	**20%** of the cost for - Durable Medical Equipment (DME) - Prosthetics **$0** copay for - Diabetes monitoring supplies - Diabetes self-management training - Diabetic shoes	**20%** of the cost for - Durable Medical Equipment (DME) - Prosthetics **$0** copay for - Diabetes monitoring supplies - Diabetes self-management training - Diabetic shoes

Premier by Ultimate (HMO) 013-4	Premier Plus by Ultimate (HMO) 014-2	What You Need To Know
$0 copay	**$0** copay	
$20 copay	**$20** copay	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).
up to **$35** every month	up to **$35** every month	The benefit amount does not roll-over from month to month.
$0 copay per visit for: - Primary care telehealth services, including 24 Hour Nurse Advice Line **$20** copay per visit for: - Specialist telehealth services - Mental health telehealth services	**$0** copay per visit for: - Primary care telehealth services, including 24 Hour Nurse Advice Line **$20** copay per visit for: - Specialist telehealth services - Mental health telehealth services	A referral is required for specialist telehealth services.
$0 copay	**$0** copay	After an inpatient discharge to home, receive a maximum of 14 meals for a 1 week period. This benefit does not have a yearly maximum.
20% of the cost for - Durable Medical Equipment (DME) - Prosthetics **$0** copay for - Diabetes monitoring supplies - Diabetes self-management training - Diabetic shoes	**20%** of the cost for - Durable Medical Equipment (DME) - Prosthetics **$0** copay for - Diabetes monitoring supplies - Diabetes self-management training - Diabetic shoes	Authorization is required for some services.

OUTPATIENT PRESCRIPTION DRUGS

How do I determine my Prescription Drug cost?

Our plan groups each medication into one of five "Tiers." You will need to use our plan's 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. To find out what drugs we cover, you can see our complete drug list and any restrictions or limitations on our website at 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.

How much do I know how much I pay in each stage?

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 $4,430. Not everyone will enter the coverage gap. If you enter the coverage gap, our plans continue to cover drugs in Tier 1 Generic. For drugs in Tier 1 you pay the copay amounts shown in the prescription drug chart 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 $7,050, 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 the plan's Evidence of Coverage online at www.ChooseUltimate.com.

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 maintenance 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.

Your Benefits and Cost Sharing

CORE
Citrus|Hernando|Pasco

Hernando, Pasco, & Citrus	Premier by Ultimate (HMO) 001 Premier by Ultimate (HMO) 013-3 Premier by Ultimate (HMO) 013-4				
Stage	**Cost Sharing Tier**	**Copay or coinsurance for a 30-day supply at Retail Pharmacy**	**Copay or coinsurance for a 90-day supply at Retail Pharmacy**	**Copay or coinsurance for a 90-day supply at Mail Order Pharmacy**	**Copay or coinsurance for a 31-day long-term care supply**
Initial	Tier 1	$0	$0	$0	$0
	Tier 2	$35	$105	$70	$35
	Tier 3	$60	$180	$120	$60
	Tier 4	33% coinsurance	Not Covered	Not Covered	33% coinsurance
Coverage Gap	Tier 1	$0	$0	$0	$0

Hernando, Pasco, & Citrus	Premier Plus by Ultimate (HMO) 014-1 Premier Plus by Ultimate (HMO) 014-2				
Stage	**Cost Sharing Tier**	**Copay or coinsurance for a 30-day supply at Retail Pharmacy**	**Copay or coinsurance for a 90-day supply at Retail Pharmacy**	**Copay or coinsurance for a 90-day supply at Mail Order Pharmacy**	**Copay or coinsurance for a 31-day long-term care supply**
Initial	Tier 1	$0	$0	$0	$0
	Tier 2	$25	$75	$50	$25
	Tier 3	$50	$150	$100	$50
	Tier 4	33% coinsurance	Not Covered	Not Covered	33% coinsurance
Coverage Gap	Tier 1	$0	$0	$0	$0

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 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 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 medicine 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, 2023.

☐ 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).

CORE
Citrus|Hernando|Pasco

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements: Discrimination is Against the Law

Ultimate Health Plans complies with applicable Federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender, identity, ancestry, marital status, or religion in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities. Ultimate Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages

If you need these services, contact Ultimate Health Plans Member Services. If you believe that Ultimate Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender, identity, ancestry, marital status, or religion in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities, you can file a grievance with the Ultimate Health Plans Grievance Department. Address: P.O. Box 6560, Spring Hill, FL 34611. Phone: 1-888-657-4170 (TTY users dial 711). Fax: 1-800-313-2798.
Email: GrievanceAndAppeals@ulthp.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, an Ultimate Health Plans Grievance Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-657-4170 (TTY: 711).
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-888-657-4170 (TTY: 711).
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-657-4170 (TTY: 711).
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-657-4170 (TTY: 711).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-657-4170 (TTY: 711）。
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-657-4170 (ATS: 711).
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-657-4170 (TTY: 711).
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-657-4170 (телетайп: 711).
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-657-4170 (رقم هاتف الصم والبكم: 117).
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-657-4170 (TTY: 711).
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-657-4170 (TTY: 711).
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-657-4170 (TTY: 711)번으로 전화해 주십시오.
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-657-4170 (TTY: 711).
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-657-4170 (TTY: 711).
เรียน: ถาคุณพดภาษาไทยคุณสามารถใชบริการชวยเหลือทางภาษาไดฟรี โทร 1-888-657-4170 (TTY: 711)

To learn more, call

1-855-858-7526 (TTY 711)

Monday – Sunday
8 am to 8 pm

Visit our website at **www.ChooseUltimate.com**
or stop into one of our local offices.

Community Outreach Offices

17820 SE 109th Ave., Ste 103
Summerfield, FL 34491

2713 Forest Road
Spring Hill, FL 34606

4058 Tampa Road, Ste 7
Oldsmar, FL 34677

ULTIMATE
HEALTH PLANS
Good health is where you live.

Corporate Office

1244 Mariner Boulevard|Spring Hill, FL 34609