

# 2022 Summary of Benefits



## **Citrus**

035 Advantage Plus by Ultimate (Full) (HMO D-SNP)

036 Advantage Plus by Ultimate (Partial) (HMO D-SNP)

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## **Hernando|Pasco**

037 Advantage Plus by Ultimate (Full) (HMO D-SNP)

038 Advantage Plus by Ultimate (Partial) (HMO D-SNP)

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## **Hillsborough|Pinellas**

039 Advantage Plus by Ultimate (Full) (HMO D-SNP)

040 Advantage Plus by Ultimate (Partial) (HMO D-SNP)

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## **Indian River|St. Lucie**

043 Advantage Plus by Ultimate (Full) (HMO D-SNP)

044 Advantage Plus by Ultimate (Partial) (HMO D-SNP)

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## **Lake|Marion|Sumter**

041 Advantage Plus by Ultimate (Full) (HMO D-SNP)

042 Advantage Plus by Ultimate (Partial) (HMO D-SNP)



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 Advantage Plus by Ultimate (Full) (HMO D-SNP) and Advantage Plus by Ultimate (Partial) (HMO D-SNP). 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](http://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, be enrolled in Medicare Part B, receive assistance from the Florida Medicaid Agency for Health Care Administration (AHCA), and live in the plan’s service area.

Levels of Medicaid

- Full Benefit Dual Eligible (FBDE):** Medicaid helps pay for other cost sharing.
- Qualified Medicare Beneficiary (QMB):** Medicaid helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). These individuals do not receive full Medicaid benefits.
- Qualified Medicare Beneficiary Plus (QMB+):** Medicaid helps pays for Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). These individuals receive full Medicaid benefits.
- Specified Low-Income Medicare Beneficiary (SLMB):** Medicaid helps pay Part B premiums. These individuals do not receive full Medicaid benefits.
- Specified Low-Income Medicare Beneficiary Plus (SLMB+):** Medicaid helps pays Part B premiums. These individuals receive full Medicaid benefits.
- Qualifying Individual (QI):** Medicaid helps pay Part B premiums. These individuals do not receive full Medicaid benefits.
- Qualified Disabled & Working Individuals (QDWI):** Medicaid helps pay Part A premiums. These individuals do not receive full Medicaid benefits.



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](http://www.ChooseUltimate.com), or call us at 1-855-858-7526 (TTY 711) and we will mail you a copy.

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](http://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 and is contracted with the Florida State Medicaid program for Dual Special Needs Plans. Enrollment in Ultimate Health Plans depends on contract renewal.



Your Benefits and Cost Sharing

Plan Name	Advantage Plus by Ultimate (Full) (HMO D-SNP) 035, 037, 039, 041, 043
Service Area	Citrus, Hernando, Hillsborough, Indian River, Lake, Marion, Pasco, Pinellas, St. Lucie, Sumter
Special Needs Plan Eligibility Criteria	FBDE, QMB+, SLMB+ (Levels of Medicaid, refer to page 2)

Premium and Benefits	Advantage Plus by Ultimate (Full) (HMO D-SNP) 035, 037, 039, 041, 043
Monthly Plan Premium	\$0
Deductible	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility <i>(does not include prescription drugs)</i>	\$500
Inpatient Hospital Coverage	\$0 copay per day for days 1-90
Outpatient Hospital Coverage	\$0 copay per day for days 1-90
Ambulatory Surgery Center	\$0 copay
Doctor Visits (Primary Care Providers and Specialists)	\$0 copay
Preventive Care	\$0 copay
Emergency Care	\$0 copay per visit in the United States \$100 copay for Worldwide Emergency Care

Your Benefits and Cost Sharing

Plan Name	Advantage Plus by Ultimate (Partial) (HMO D-SNP) 036, 038, 040, 042, 044
Service Area	Citrus, Hernando, Hillsborough, Indian River, Lake, Marion, Pasco, Pinellas, St. Lucie, Sumter
Special Needs Plan Eligibility Criteria	QMB, SLMB, QI, QDWI (Levels of Medicaid, refer to page 2)

Advantage Plus by Ultimate (Partial) (HMO D-SNP) 036, 038, 040, 042, 044	What You Need To Know
\$0	You must continue to pay your Medicare Part B Premium unless your Part B Premium is paid for you by Florida State Medicaid or another third party.
This plan does not have a deductible.	
\$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.
\$0 copay per day for days 1-90	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.
\$0 copay per day for days 1-90	A prior authorization is required for some services.
\$0 copay	A referral and prior authorization may be required for some services.
\$0 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	Any additional preventive services approved by Medicare during the contract year will be covered. A referral or prior authorization is required for some services.
\$0 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		Advantage Plus by Ultimate (Full) (HMO D-SNP) 035, 037, 039, 041, 043	
Urgently Needed Services		\$0 copay	
Diagnostic Services - Labs/Imaging - Lab services - Outpatient x-rays - Diagnostic tests and procedures - Diagnostic radiological services - Therapeutic radiological services		\$0 copay	
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 <b>\$1,000</b> every year, per hearing aid, per ear.	

Advantage Plus by Ultimate (Partial) (HMO D-SNP) 036, 038, 040, 042, 044		What You Need To Know	
\$0 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.	
\$0 copay  Therapeutic radiological services - <b>0%</b> coinsurance at a Specialist office - <b>20%</b> coinsurance at all other locations		A prior authorization is required for some 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 <b>\$1,000</b> every year, per hearing aid, per ear.		Services must be rendered by a participating provider in the Plan's hearing vendor network.	



Premium and Benefits		Advantage Plus by Ultimate (Full) (HMO D-SNP) 035, 037, 039, 041, 043
Dental Services		
- Preventive dental services		
- Comprehensive dental services		
- Medicare-covered non-routine dental services		
		\$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
		- 1 complete or partial denture (upper and/or lower) per arch every 5 years
		- Denture reline (One procedure Code per calendar year)
		- Necessary anesthesia with covered service
		- Medically necessary non-routine dental services, as covered by Original Medicare

Advantage Plus by Ultimate (Partial) (HMO D-SNP) 036, 038, 040, 042, 044	What You Need To Know
\$0 copay for:	X-Rays may include:
- 1 oral evaluation every 6 months	- Intraoral, periapical first radiographic image
- 1 cleaning every 6 months	- Intraoral, periapical each additional radiographic image
- 1 fluoride treatment every 6 months	- Bitewing, single radiographic image, or Bitewings, two, three or four radiographic images
- 1 dental x-ray every year.	- Intraoral, complete series of radiographic images; 1 every 3 years
- 1 comprehensive oral exam every 3 years	- Panoramic radiographic images covered; 1 every 3 years
- 1 filling per year	Fillings may include:-
- 1 full mouth debridement every 2 years	-Amalgam, one or more surfaces, primary or permanent
- Scaling/root planing limited to 1 procedure per quadrant per year.	- Resin-based composite, one to three surfaces, anterior, four or more surfaces involving incisal angle
Scaling/root planing for 4 total procedures per year (deep cleaning).	- Resin-based composite, one or more surfaces, posterior
- 1 simple extraction per year	Simple extractions may include:
- 1 surgical extraction per year	- Extraction, erupted tooth or exposed root
- Unlimited simple and surgical necessary extractions to fit dentures	- Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth
- 1 complete or partial denture (upper and/or lower) per arch every 5 years	Surgical extractions may include:
- Denture reline (One procedure Code per calendar year)	- Removal of impacted tooth
- Necessary anesthesia with covered service	- Removal of residual tooth roots (cutting procedure)
- Medically necessary non-routine dental services, as covered by Original Medicare	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.

Premium and Benefits	Advantage Plus by Ultimate (Full) (HMO D-SNP) 035, 037, 039, 041, 043
<b>Vision Services</b> <ul style="list-style-type: none"><li>- Eye exams</li><li>- Eyewear and Contact Lenses</li></ul>	<b>\$0</b> copay for: <ul style="list-style-type: none"><li>- One (1) routine eye exam every year</li></ul> <b>Post-cataract surgery benefits which include:</b> <ul style="list-style-type: none"><li>- One (1) frame from special selection AND/OR</li><li>- Standard single vision, bifocal or trifocal eyeglass lenses. No limit on lenses deemed medically necessary by your provider.</li><li>- Instead of glasses, you may select contact lenses up to the benefit limit of <b>\$500</b></li><li>- Eyeglass add-ons</li></ul> In addition, you may select from one of the following benefit options every year:  <b>Option 1:</b> Yearly benefit limit of up to <b>\$500</b> for eyewear towards one (1) pair of: <ul style="list-style-type: none"><li>- Eyeglasses, frames, lenses and fitting OR</li><li>- Contact lenses, conventional or disposable, and contact lens fitting</li></ul> <b>Option 2:</b> <ul style="list-style-type: none"><li>- <b>\$0</b> copay for your choice of 3 standard pairs of select eyeglasses†, frames and lenses</li></ul>
<b>Mental Health Services</b> <ul style="list-style-type: none"><li>- Inpatient hospital stay</li><li>- Outpatient group therapy visits</li><li>- Outpatient individual therapy visits</li></ul>	<b>\$0</b> copay per day for days <b>1-90</b>  <b>\$0</b> copay for group and individual therapy visits
<b>Skilled Nursing Facility (SNF)</b>	<b>\$0</b> copay per admission

Advantage Plus by Ultimate (Partial) (HMO D-SNP) 036, 038, 040, 042, 044	What You Need To Know
<b>\$0</b> copay for: <ul style="list-style-type: none"><li>- One (1) routine eye exam every year</li></ul> <b>Post-cataract surgery benefits which include:</b> <ul style="list-style-type: none"><li>- One (1) frame from special selection AND/ <b>OR</b></li><li>- Standard single vision, bifocal or trifocal eyeglass lenses. No limit on lenses deemed medically necessary by your provider.</li><li>- Instead of glasses, you may select contact lenses up to the benefit limit of <b>\$500</b></li><li>- Eyeglass add-ons</li></ul> In addition, you may select from one of the following benefit options every year:  <b>Option 1:</b> Yearly benefit limit of up to <b>\$500</b> for eyewear towards one (1) pair of: <ul style="list-style-type: none"><li>- Eyeglasses, frames, lenses and fitting OR</li><li>- Contact lenses, conventional or disposable, and contact lens fitting</li></ul> <b>Option 2:</b> <ul style="list-style-type: none"><li>- <b>\$0</b> copay for your choice of 3 standard pairs of select eyeglasses†, frames and lenses</li></ul>	<b>Routine eye exam Includes:</b> <ul style="list-style-type: none"><li>- Vision test/refraction and dilation</li></ul> <b>Eyeglass add-ons include:</b> <ul style="list-style-type: none"><li>- Ultraviolet protection and scratch resistant coating</li><li>- Standard no-line bifocals</li><li>- Transition lenses</li></ul> †See one of our in-network vision providers for more information on your no cost eyeglass options.
<b>\$0</b> copay per day for days <b>1-90</b>  <b>\$0</b> copay for group and 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.
<b>\$0</b> copay per admission	Our plan covers up to 100 days in a SNF. A referral or prior authorization is required for some services.

Premium and Benefits	Advantage Plus by Ultimate (Full) (HMO D-SNP) 035, 037, 039, 041, 043
<b>Physical Therapy</b> - Physical therapy visit - Speech-language pathology services - Occupational therapy visit	<b>\$0 copay</b>
<b>Ambulance</b>	<b>\$0 copay</b>
<b>Transportation</b>	<b>\$0 copay for unlimited trips</b>
<b>Medicare Part B Drugs</b>	<b>\$0 copay</b>
<b>Flex Card</b>	up to <b>\$500</b> every year
<b>Special Supplemental Benefits for the Chronically ill</b> - Healthy Foods Card	up to <b>\$25</b> every month
<b>Foot Care (podiatry services)</b> Medicare-covered foot exams and treatment	<b>\$0 copay</b>

Advantage Plus by Ultimate (Partial) (HMO D-SNP) 036, 038, 040, 042, 044	What You Need To Know
<b>\$0 copay</b>	A referral and prior authorization may be required for some services.
<b>\$0 copay</b>	Except in an emergency, this service may require prior authorization.
<b>\$0 copay for unlimited trips</b>	Our plan covers <b>unlimited</b> transportation 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.
<b>\$0 copay</b>	The applicable specialist copay applies when provided during a Physician/Specialist office visit. A referral or prior authorization is required for some services.
up to <b>\$500</b> every year	The Flex Card benefit is a prepaid Visa card that may be used to cover costs which exceed the plan allowed benefits for hearing, dental and vision services.
up to <b>\$25</b> every month	The Healthy Foods Card is a monthly allowance to spend at participating retailers towards the purchase of healthy foods such as vegetables, fruit, bread, rice, milk, and more. Some restrictions may apply. The benefit amount does not roll-over from month to month.  To be eligible for this benefit, you must be diagnosed with one of the following chronic conditions: Chronic alcohol and other drug dependence, Autoimmune disorders, Cancer, Cardiovascular disorders, Chronic heart failure, Chronic kidney disease (any stage), Dementia, Depression, Diabetes, End-stage liver disease, End-stage renal disease (ESRD), Hypercholesterolemia, Hypertension, Severe hematologic disorders, HIV/AIDS, Chronic lung disorders, Chronic and disabling mental health conditions, Neurologic disorders, Stroke, Tobacco abuse
<b>\$0 copay</b>	A referral is required.

Premium and Benefits	Advantage Plus by Ultimate (Full) (HMO D-SNP) 035, 037, 039, 041, 043
<b>Wellness Program</b> - SilverSneakers® Fitness Program - Health Education - Additional Smoking and Tobacco Use Cessation	\$0 copay
<b>Chiropractic Care Services</b>	\$0 copay
<b>Over-the-Counter (OTC)</b>	up to \$115 every month
<b>Telehealth Services</b>	\$0 copay
<b>Meal Benefits</b>	\$0 copay
<b>Medical Equipment/Supplies</b> - Durable Medical Equipment (e.g., wheelchairs, oxygen) - Prosthetics (e.g., braces, artificial limbs) - Diabetic supplies	\$0 copay

Advantage Plus by Ultimate (Partial) (HMO D-SNP) 036, 038, 040, 042, 044	What You Need To Know
\$0 copay	
\$0 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 \$115 every month	The benefit amount does not roll-over from month to month.
\$0 copay	A referral is required for specialist telehealth services.
\$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.
\$0 copay	Authorization is required for some services.



OUTPATIENT PRESCRIPTION DRUGS

Advantage Plus by Ultimate Full & Partial

Medicare approved Ultimate Health Plans to provide covered prescription drugs to our members at no cost to you as part of the Value-Based Insurance Design program. This program lets Medicare try new ways to improve Medicare Advantage plans. Refer to our Formulary for a list of covered drugs.

Prescription Drugs	Retail Pharmacy	Mail Order Pharmacy
Annual Prescription Deductible	There is <b>no Deductible</b>	There is <b>no Deductible</b>
30-day or 90-day supply of All Covered Drugs	<b>\$0</b> copay	<b>\$0</b> copay

SUMMARY OF MEDICAID-COVERED BENEFITS

The table below contains a summary of the benefits covered by AHCA (Medicaid) and Advantage Plus by Ultimate Full & Partial. Medicaid is a joint Federal and state government program that helps with medical costs for certain people who have limited incomes and resources. Those that have both Medicaid and Medicare are known as dual eligible. What you pay for covered services may depend on your level of Medicaid eligibility. These benefits may be subject to prior authorization.

Service	Florida State Medicaid	Advantage Plus by Ultimate Full & Partial
Allergy Services	Covered	Covered
Ambulance Transportation	Covered	Covered
Ambulatory Surgical Center Services	Covered	Covered
Anesthesia Services	Covered	Covered
Assistive Care Services	Covered	Covered
Behavioral Health Assessment Services	Covered	Covered
Behavioral Health Community Support Services	Covered	Covered
Behavioral Health Intervention Services	Covered	Covered
Behavioral Health Medication Management	Covered	Covered
Behavioral Health Overlay	Covered	Covered
Cardiovascular Services	Covered	Covered
Child Health Services Targeted Case Management	Covered	Covered
Chiropractic Services	Covered	Covered
County Health Department (CHD) Services	Covered	Covered
Dental Services	Covered	Covered
Dialysis Services	Covered	Covered
Durable Medical Equipment and Medical Supplies	Covered	Covered
Early Intervention Services	Covered	Covered
Emergency Transportation Services	Covered	Covered
Evaluation and Management Services	Covered	Covered
Federally Qualified Health Center Services	Covered	Covered

Service	Florida State Medicaid	Advantage Plus by Ultimate Full & Partial
Gastrointestinal Services	Covered	Covered
Genitourinary Services	Covered	Covered
Hearing Services	Covered	Covered
Home Health Services	Covered	Covered
Inpatient Hospital Services	Covered	Covered
Integumentary Services	Covered	Covered
Laboratory Services	Covered	Covered
Medical Foster Care Services	Covered	Covered
Mental Health Targeted Case Management	Covered	Covered
Neurology Services	Covered	Covered
Non-Emergency Transportation Services	Covered	Covered
Nursing Facility Services	Covered	Covered
Occupational Therapy	Covered	Covered
Oral and Maxillofacial Surgery Services	Covered	Covered
Orthopedic Services	Covered	Covered
Outpatient Hospital Services	Covered	Covered
Pain Management Services	Covered	Covered
Personal Care Services	Covered	Covered
Physical Therapy Services	Covered	Covered
Podiatry Services	Covered	Covered
Prescribed Drug Services	Covered	Covered
Private Duty Nursing	Covered	Covered
Radiology and Nuclear Medicine Services	Covered	Covered
Regional Perinatal Intensive Care Center Services	Covered	Covered
Reproductive Services	Covered	Covered
Respiratory System Services	Covered	Covered
Respiratory Therapy Services	Covered	Covered
Rural Health Clinic Services	Covered	Covered
Specialized Therapeutic Services	Covered	Covered
Speech-Language Pathology	Covered	Covered
Statewide Inpatient Psychiatric Program	Covered	Covered
Transplant Services	Covered	Covered
Visual Aid Services	Covered	Covered
Visual Care Services	Covered	Covered

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



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](mailto: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 لعدة اللغوية تتوانر لك بالمرحان. اتصل برؤم 0714-756-888-1 (رؤم 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: ถาคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-657-4170 (TTY: 711)



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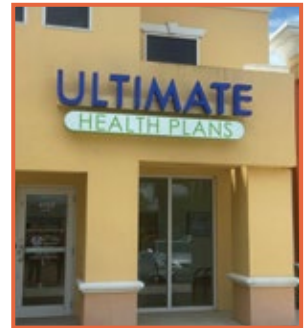
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