ULTIMATE HEALTH PLANS

2023 Benefits Overview

Medicare Advantage Plan Information

This booklet provides an overview of what we cover and what you pay for the below listed plans. It does not list every service covered, limitation, or exclusion. Please refer to your plan's Evidence of Coverage (EOC) for a complete list of services we cover and to verify the benefits listed in this booklet. You can access a copy of the EOC online at www.ChooseUltimate.com or request a hard copy be mailed to you by calling 1-888-657-4170 (TTY 711).

We are available from 8:00 am to 8:00 pm, Monday through Friday. Between October 1 and March 31, we are available Monday through Sunday from 8:00 am to 8:00 pm.

Core Plans

- **Premier by Ultimate (HMO)**
  Plan Numbers: 001, 013-3, 013-4, 028, 031, 045, 046, and 047
- **Premier Plus by Ultimate (HMO)**
  Plan Number: 032

Chronic Special Needs Plans (C-SNP)

- **Advantage Care by Ultimate (HMO C-SNP)**
  Plan Numbers: 019-1, 019-2, 021, 026, 029, 033, 050, 051, and 052
- **Advantage Care CHF by Ultimate (HMO C-SNP)**
  Plan Numbers: 022 and 024
- **Advantage Care COPD by Ultimate (HMO C-SNP)**
  Plan Numbers: 023, 025, and 034

Dual Special Needs Plans (D-SNP)

- **Advantage Plus by Ultimate (Full) (HMO D-SNP)**
  Plan Number: 035
- **Advantage Plus by Ultimate (Partial) (HMO D-SNP)**
  Plan Number: 036

Ultimate Health Plans is an HMO plan 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.

Discrimination is against the law. Ultimate Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. 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 1-888-657-4170 (TTY: 711).

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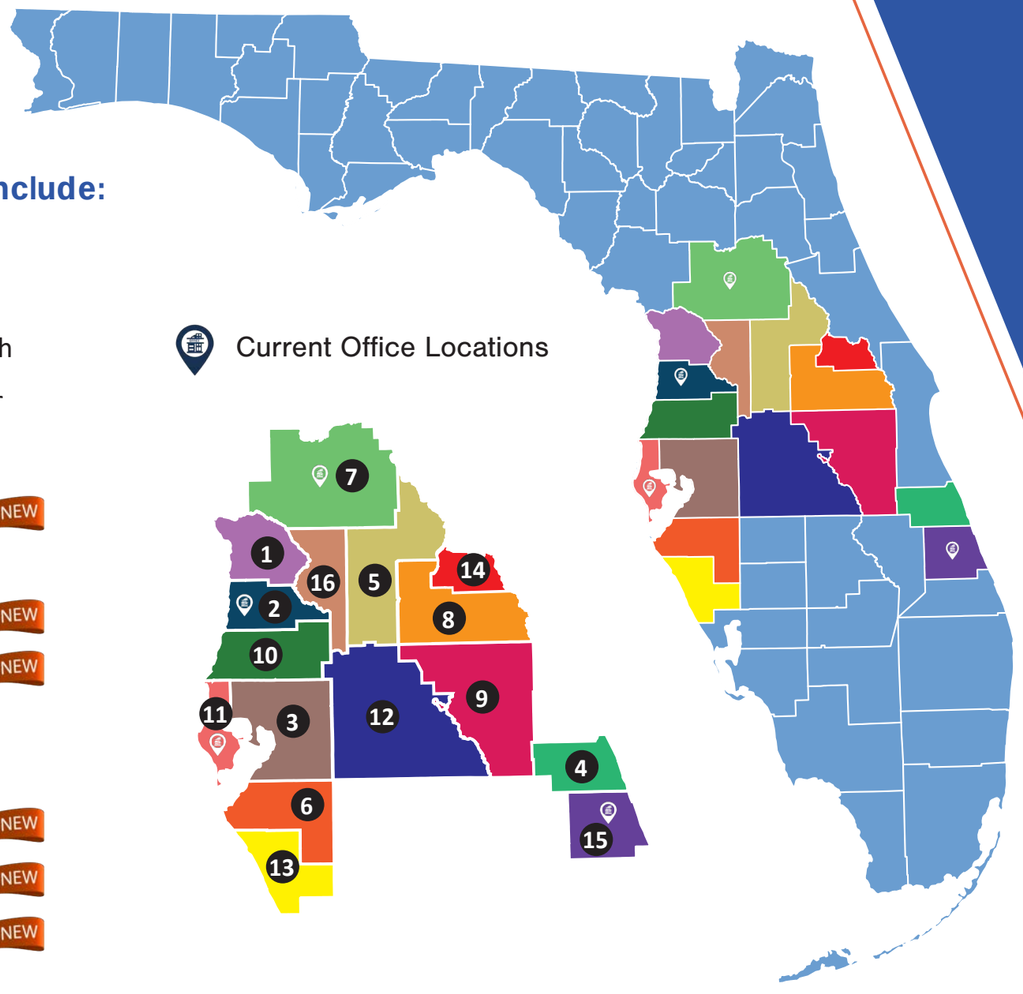
Service Area



Counties Include:

1. Citrus
2. Hernando
3. Hillsborough
4. Indian River
5. Lake
6. Manatee NEW
7. Marion
8. Orange NEW
9. Osceola NEW
10. Pasco
11. Pinellas
12. Polk NEW
13. Sarasota NEW
14. Seminole NEW
15. St. Lucie
16. Sumter

Current Office Locations

GOOD HEALTH IS WHERE YOU LIVE!

Premier & Premier Plus by Ultimate (HMO)

Our **Core Plans** offer prescription drug coverage and many other valuable benefits such as low copays, over-the-counter allowance, vision, dental, and hearing. Members of Premier by Ultimate enjoy a Part B Premium reduction each month.

Advantage Care by Ultimate (HMO C-SNP)

Our **Chronic Special Needs Plans** are specially designed for individuals who have been diagnosed with a chronic or disabling condition. Medicare premiums, copays, co-insurance, and deductibles may vary based on the level of Extra Help received.

Qualifying conditions include:

- **Diabetes**
- **Cardiovascular Diseases:**
  - Cardiac Arrhythmias
  - Coronary Artery Disease
  - Peripheral Vascular Disease
  - Chronic Venous Thromboembolic Disorder
- **Chronic Congestive Heart Failure**
- **Chronic Lung Disorders:**
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Chronic Bronchitis
  - Asthma
  - Pulmonary Fibrosis
  - Pulmonary Emphysema

Advantage Plus by Ultimate (Full and Partial) (HMO D-SNP)

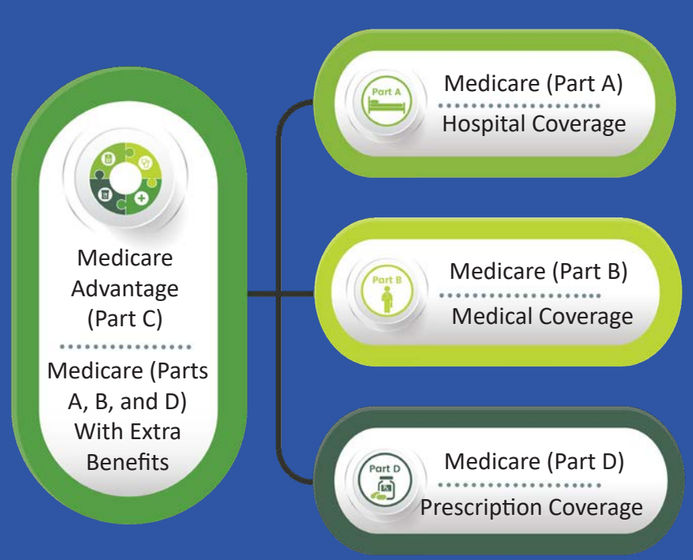
Our **Dual Special Needs Plans** offer drug coverage with no cost-sharing and are available to anyone who has both Medicare and Florida State Medicaid. Premiums, copays, co-insurance, and deductibles may vary based on their level of Medicaid.

Medicare Advantage Basics

What is Medicare?

Medicare is federal health insurance for:

- People who are 65 or older
- Certain younger people with disabilities
- People with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a transplant)



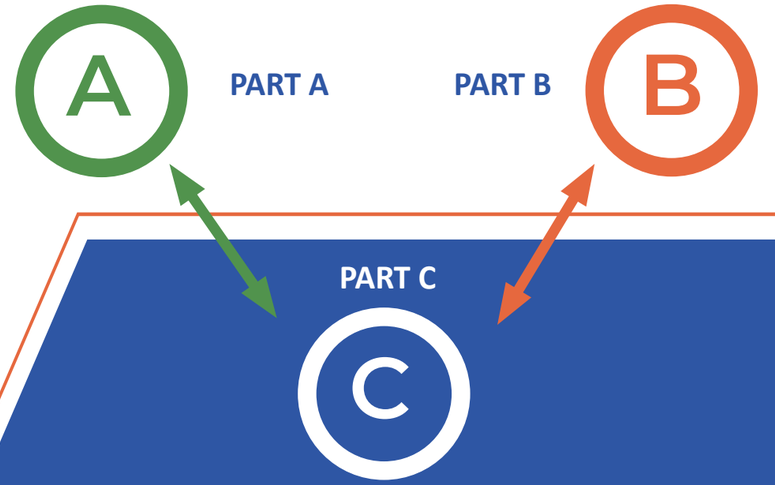
Who is Eligible?

- You must have both Medicare Parts “A” and “B”
- You must be a permanent resident for at least 6 months out of the year in the plan's service area
- You must be actively enrolled in the Florida State Medicaid Program to be eligible for our dual special needs plans
- You must have a qualifying chronic condition to be eligible for our chronic special needs plans

Maximum Out-of-Pocket (MOOP)

MOOP is the most you pay out-of-pocket during the calendar year for covered Part A and Part B services.

Out-of-Pocket Expenses



The following out-of-pocket expenses do not count toward this total:

- Medicare Part A and Part B Premiums
- Part D Prescription Drug Copays
- Supplemental Hearing, Vision, and Dental Services
- Emergency Services Received Outside of the United States and its Territories

Why Choose Ultimate?

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, Manatee, Marion, Orange, Osceola, Pasco, Pinellas, Polk, Sarasota, Seminole, St. Lucie, and Sumter.

Our mission is to provide our members with the best 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 business.

We are also accredited by the National Committee for Quality Assurance (NCQA).

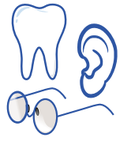
Based on plan selection, you receive a monthly Over-The-Counter (OTC) allowance from **$35 to $125**. That's a savings of **$420 to $1,500 per year**. OTC products can be ordered over the phone or online and shipped to you at no cost. You can also purchase eligible items from participating retailers like your local Walmart with your Ultimate Benefit Card.

Our plans offer fitness benefits through SilverSneakers® at participating locations. Visit SilverSneakers.com or call 1-888-423-4632 (TTY 711) to learn more about this benefit.

Save with a Part B Premium Reduction on select plans. Receive **$150 to $164.90 each month** applied back to your Social Security check. That's a savings of **$1,800 to $1,978.80 per year.**

Our plans include transportation to plan approved locations at no cost. Our Premier and Premier Plus plans receive up to 20 one-way trips. Select Advantage Care and Advantage Plus plans receive unlimited transportation.

Brand-name and Generic prescription drug coverage including Gap coverage is available on all of our plans. Our Dual Special Needs Plans (D-SNP), have no cost-sharing for prescription drugs.



Vision, Hearing, and Dental benefits are offered with all plans. Dental includes both routine and comprehensive coverage. Select plans also include dentures with unlimited extractions, crowns, and root canals.

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 Medicare Advantage (MA) plans as of January 1 and new Medicare beneficiaries who are enrolled in an MA plan during their Initial Coverage Election Period (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 (SEP), 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.

What Happens 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 Member ID Card and Welcome Kit, including important plan documents, soon after you enroll.

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.

Preventive Services at No Cost to You

Preventive Services help you stay a step ahead of your health.

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 2023, either Medicare or our plan will cover those services.

There is no co-insurance, copayment, or deductible for the following preventive services and screenings:

- Annual Wellness and Welcome to Medicare Preventive Visits
- Abdominal Aortic Aneurysm Screening
- Bone Mass Measurement
- Cardiovascular Disease Testing
- Cardiovascular Disease Risk Reduction Visit
- Colorectal Cancer Screening
- Diabetes Screening and Diabetic Self-Management Training

You Pay

$0

- Glaucoma Screening
- Immunization Shots for Flu, Pneumonia, Hepatitis B, and COVID-19 Vaccines
- Screening Mammogram
- Medical Nutrition Therapy
- Pap Smears and Pelvic Exams
- Prostate Cancer Screening (PSA Test)
- Counseling to Stop Smoking and Tobacco Use

This list is not exhaustive. $0 cost-sharing eligibility depends on the network status of the provider rendering services. See our Evidence of Coverage for complete benefit details and restrictions.

Your Primary Care Physician (PCP)

Your PCP meets state and national requirements and is trained to provide you with medical care.

Benefits of having a network PCP:

- Focuses on wellness, prevention, and all of your healthcare essentials
- Ensures quality and safety
- Coordinates care across all specialties and healthcare services such as:

You must use providers in-network with Ultimate Health Plans to receive all services (except for emergency, urgent care, or renal dialysis outside our servicing areas). Neither Medicare nor Ultimate Health Plans are responsible for costs associated with services received from out-of-network providers. Out-of-network providers have no obligation to offer treatment for members of Ultimate Health Plans except during emergencies. Please contact our Member Services at 1-888-657-4170 for more information on using in-network providers.

Your Prescription Drug Benefit Costs

There is no prescription drug cost-sharing for members of our Dual Special Needs Plans. Premier, Premier Plus, Advantage Care, and Advantage Plus members have their medication grouped into one of up to five tiers. The amount you pay for your medication depends on its tier and your coverage stage. Use the plan's drug list (formulary) to determine what tier your medication is on. Our formulary also includes covered drugs, restrictions, and limitations.

Stage 1 is the Yearly Deductible Stage. This payment stage does not apply to you because there is no deductible for the plan.

STAGE 02 Initial Coverage Stage

During this stage, the plan pays its share of the cost of your drugs and you pay your share of the costs. You stay in this stage until your year-to-date "total drug cost" totals $4,660.

STAGE 03 Coverage Gap Stage "Donut Hole"

For generic drugs, you pay a $0 copay for a one-month supply of drugs in Tier 1. You stay in this stage until your year-to-date "out-of-pocket" reaches a total of $7,400.

STAGE 04 Catastrophic Coverage Stage

During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2023).

Coverage Gap

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 $4,660. Not everyone will enter the coverage gap. If you enter the coverage gap, our plans continue to cover drugs in Tier 1 and Tier 5. For drugs in Tier 1 and Tier 5, you pay the copay amounts shown in your Summary of Benefits. 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 reaches $7,400, 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.

How to Find Your Drugs in Our Formulary

Medical Condition

Drugs are categorized based on the condition they treat. For example, drugs used to treat a heart condition are in the "Cardiovascular Agents" category.

Alphabetical Listing

If you are unsure what category to look under, you should look for your drug in the index at the back of the Formulary. This list is in alphabetical order and includes both brand-name and generic drugs. The page number to the right of each of their names provides details about the drug.


ULTIMATE HEALTH PLANS
Good health is where you live.

2023

Prescription Drug Guide
Guía de Medicamentos Recetados

Formulary/Formulario
List of Covered Drugs/Lista de Medicamentos Cubiertos

Premier by Ultimate (HMO)
Premier Plus by Ultimate (HMO)

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN. This formulary was updated on [MM/DD/YYY]. For more recent information or other questions, please contact us at 1-888-657-4170 (TTY users should call 711), Monday through Sunday from 8 am to 8 pm EST (during certain times of the year we may use alternative technologies to answer your call on weekends and Federal holidays), or visit www.ChooseUltimate.com.

LEA: ESTE DOCUMENTO CONTIENE INFORMACIÓN SOBRE LOS MEDICAMENTOS QUE CUBRE ESTE PLAN. Esta lista de medicamentos cubiertos se actualizó el [MM/DD/YYY]. Para obtener información más reciente o si tiene otras preguntas, comuníquese con nosotros llamando al 1-888-657-4170 y para usuarios TTY, 711, de lunes a domingo, de 8:00 a. m. a 8:00 p. m. hora del Este (en ciertos momentos del año podríamos usar tecnologías alternativas para responder sus llamadas los fines de semana y los feriados federales) o visite www.ChooseUltimate.com. H2962_COREFRMLRY_CY23R071122_C

Save With Mail Order

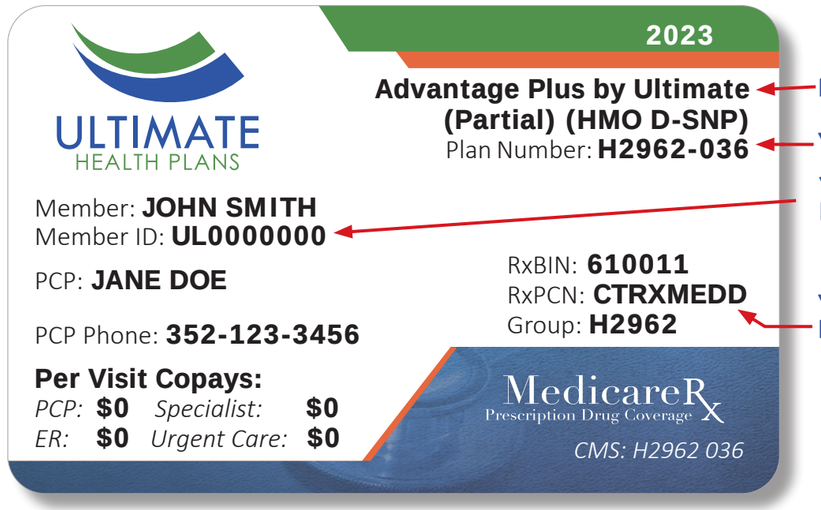
Save time and money by having eligible prescriptions shipped directly to you. You can receive a long-term 3-month ("extended supply") of "maintenance" drugs through our mail-order pharmacy for the cost of a 2-month supply's copayment.

Your Ultimate Health Plans Welcome Kit

You will receive an Ultimate Health Plans Welcome Kit which includes the following materials:

- **Your Welcome Letter**
- **Notification of Availability of Electronic Materials**
  Explains how to view or order the Evidence of Coverage, Drug List (Formulary), and Provider & Pharmacy Directory.
- **Mail Order Pharmacy Form**
- **Advance Directives**
- **Member Rights and Responsibilities**
- **Notice of Privacy Practices**
- **Vaccination Information**
- **Health Assessment Questionnaire**
  Please fill out and return in the postage-paid envelope provided in your Welcome Kit.
- **Care Transition Form**
  If you are currently receiving ongoing medical services that need to continue (such as oxygen) or if you have any scheduled procedures, surgeries, or hospitalizations, please return this form to us in the postage-paid envelope included in your Welcome Kit so that we may ensure a smooth transition of your care.
- **Appointment of Representative (AOR) Form**
  Use this form if you'd like to appoint someone to represent you in formal matters such as Appeals or Grievances. This form does not provide broad legal authority to make another individual's healthcare decisions or allow the release of information unrelated to the formal matters described above.
- **Permission to Share Information (PSI) Form**
  Use this form if you want Ultimate Health Plans to share the information we have about you with a person or organization you designate, such as a family member, friend, or other relative; someone who helps take care of you; or a social worker or healthcare advocacy group.

Your Member ID Card



Name of Your Ultimate Plan

Your Plan Benefit Number

Your Ultimate Member Identification Number

Your Plan Prescription Information

Member Services Toll-Free Number

Important Phone Numbers for You

MEMBER SERVICES	**1-888-657-4170** *(TTY 711)*
Behavioral/Mental Health	1-800-627-1259
Dental	1-800-340-8869
Vision	1-800-210-5511
Hearing	1-800-313-2763
Over-the-Counter Benefit	1-855-422-0039
Transportation Assistance	1-855-306-0700
24/7 Pharmacy Help Desk	1-800-311-7517
24/7 Nurse Advice Hotline	1-855-238-4687

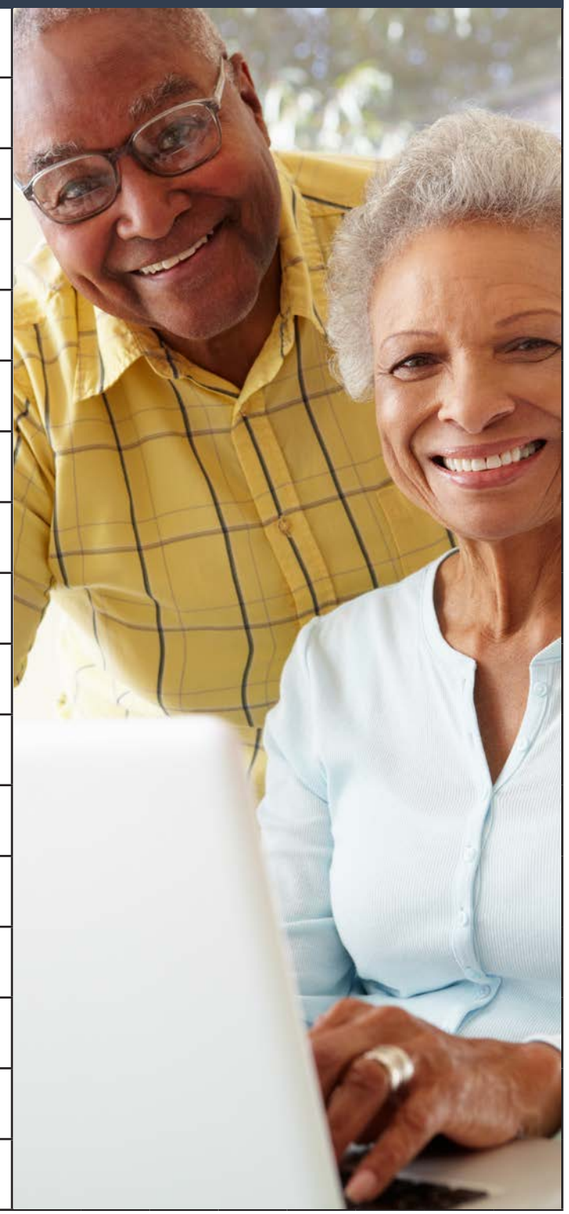
www.ChooseUltimate.com **Portal.MyUltimateHP.com**
This card must be presented when services are requested. It does not certify eligibility for benefits. Misuse of this card to obtain benefits constitutes fraud.

Provider Services: 1-888-657-4171
Claims Address: Ultimate Health Plans, PO Box 3340, Spring Hill, FL 34606
Claims EDI: 77022

Address for Your Provider to Submit Medical Claims

Ultimate Plan Finder

Plan Type	Core Plans (HMO)									Chronic Special Needs Plans (HMO C-SNP)														Dual Eligible Special Needs Plans (D-SNP)	
Plan Name	Premier by Ultimate (HMO) Premier Plus by Ultimate (HMO)									Advantage Care Advantage Care Advantage Care						by Ultimate (HMO C-SNP) CHF by Ultimate (HMO C-SNP) COPD by Ultimate (HMO C-SNP)								Advantage Plus by Ultimate (Full) (HMO D-SNP) Advantage Plus by Ultimate (Partial) (HMO D-SNP)	
Plan ID Number	001	013-3	013-4	028	031	032	045	NEW 046	NEW 047	019-1	019-2	021	022	023	024	025	026	029	033	034	NEW 050	NEW 051	NEW 052	035	036
Citrus			✓			✓						✓	✓	✓										✓	✓
Hernando	✓					✓				✓					✓	✓								✓	✓
Hillsborough							✓									✓	✓							✓	✓
Indian River					✓	✓													✓	✓				✓	✓
Lake				✓										✓				✓						✓	✓
NEW Manatee									✓											✓			✓	✓	✓
Marion				✓										✓				✓						✓	✓
NEW Orange								✓												✓	✓			✓	✓
NEW Osceola								✓												✓	✓			✓	✓
Pasco		✓				✓					✓				✓	✓								✓	✓
Pinellas							✓									✓	✓							✓	✓
NEW Polk							✓													✓		✓		✓	✓
NEW Sarasota									✓											✓			✓	✓	✓
NEW Seminole								✓												✓	✓			✓	✓
St. Lucie					✓	✓													✓	✓				✓	✓
Sumter				✓										✓				✓						✓	✓



Premier by Ultimate (HMO) Plan Number	Hernando 001	Pasco 013-3	Citrus 013-4	Lake/Mar/Sum 028	IndRiv/St.Luc 031	Hills/Pine/Polk 045
Maximum Out-of-Pocket	$1,900	$1,900	$1,800	$2,500	$2,000	$2,800
Premium	$0	$0	$0	$0	$0	$0
Part B Premium Reduction	$164.90	$155.00	$150.00	$150.00	$160.00	$164.90
INPATIENT CARE						
Inpatient Hospital (Acute & Mental)	$60 - $115 (days 1-5) $0 (days 6-90)	$95 (days 1-5) $0 (days 6-90)	$60 (days 1-5) $0 (days 6-90)	$170 (days 1-5) $0 (days 6-90)	$85 (days 1-5) $0 (days 6-90)	$90 (days 1-5) $0 (days 6-90)
Skilled Nursing Facility	$0 (days 1-20) $150 (days 21-40) $0 (days 41-100)	$0 (days 1-20) $150 (days 21-40) $0 (days 41-100)	$0 (days 1-20) $150 (days 21-40) $0 (days 41-100)	$0 (days 1-20) $150 (days 21-40) $0 (days 41-100)	$0 (days 1-20) $150 (days 21-40) $0 (days 41-100)	$0 (days 1-20) $150 (days 21-40) $0 (days 41-100)
OUTPATIENT CARE						
Primary Care Visit	$0	$0	$0	$0	$0	$0
Specialist Visit	$10	$10	$10	$20	$10	$15
Chiropractor Visit/Podiatry Visit	$10 / $10	$10 / $10	$10 / $10	$20 / $20	$10 / $10	$15 / $15
Home Health Services	$0	$0	$0	$0	$0	$0
Physical and Speech Therapy	$20	$20	$10	$20	$15	$15
Occupational Therapy	$20	$20	$10	$20	$15	$15
Outpatient Hospital Visit	$75	$75	$195	$150	$150	$150
Ambulatory Surgery Center Visit	$25	$25	$25	$25	$20	$25
Outpatient Mental Health (Indiv./Group)	$10	$10	$10	$20 / $10	$10	$15 / $10
Outpatient Substance Abuse (Indiv./Group)*	$15	$15	$10	$20	$40	$15
EMERGENCY SERVICES						
Ambulance Ground/Air	$150 / 20%	$150 / 20%	$150 / 20%	$150 / 20%	$150 / 20%	$150 / 20%
Emergency Care	$75	$75	$70	$75	$75	$75
Urgently Needed Care	$10	$10	$10	$10	$10	$10
Worldwide ER Care	$100; $50,000 max	$100; $50,000 max	$100; $50,000 max	$100; $50,000 max	$100; $50,000 max	$100; $50,000 max
OUTPATIENT SERVICES*						
CTA, MRA, PET, SPECT, & Other Nuclear Tests	$100	$100	$100	$150	$100	$100
Diagnostic Stress, Nerve Conduction, CT, MRI	$50	$50	$50	$50	$50	$50
Diagnostic Ultrasound & Echo	$25	$25	$25	$25	$25	$25
Laboratory (in Network)	$0	$0	$0	$0	$0	$0
Therapeutic Radiology	20%	20%	20%	20%	20%	20%
X-rays (in Network)	$0	$0	$0	$0	$0	$0
SUPPLIES						
Diabetic Supplies & Education	$0	$0	$0	$0	$0	$0
Durable Medical Equipment	0% - 20%	20%	20%	20%	20%	20%
Prosthetic Devices	20%	20%	20%	20%	20%	20%

*Outpatient service copays are for services received at a freestanding facility or office.

PREVENTIVE SERVICES						
Annual Wellness Visit	$0	$0	$0	$0	$0	$0
Bone Mass Measurement	$0	$0	$0	$0	$0	$0
Colorectal Screening	$0	$0	$0	$0	$0	$0
Flu, Pneu., Hep. B, & COVID-19 Vaccine	$0	$0	$0	$0	$0	$0
Mammograms	$0	$0	$0	$0	$0	$0
Pap Smears/Pelvic Exams	$0	$0	$0	$0	$0	$0
Prostate Cancer Screening	$0	$0	$0	$0	$0	$0
Renal Dialysis	20%	20%	20%	20%	20%	20%
PART B DRUGS						
Part B Drugs	20%	20%	20%	20%	20%	20%
PART D DRUGS						
Gap Coverage	Tier 1: $0	Tier 1: $0	Tier 1: $0	Tier 1: $0	Tier 1: $0	Tier 1: $0
Mail Order (3-month supply)	3 mo. for 2 copays	3 mo. for 2 copays	3 mo. for 2 copays	3 mo. for 2 copays	3 mo. for 2 copays	3 mo. for 2 copays
Insulin Savings Program	Covered	Covered	Covered	Covered	Covered	Covered
Tier 1 Generic	$0	$0	$0	$0	$0	$0
Tier 2 Preferred Brand	$15	$15	$15	$30	$25	$25
Tier 3 Non-Preferred Drug	$60	$60	$60	$60	$65	$60
Tier 4 Specialty	33%	33%	33%	33%	33%	33%
DENTAL (See pages 36-37)						
Fillings	$0; 3 per year	$0; 3 per year	$0; 3 per year	$0; 3 per year	$0; 3 per year	$0; 3 per year
Crown	$0; 1 per year	$0; 1 per year	$0; 1 per year	$0; 1 per year	$0; 1 per year	$0; 1 per year
Simple & Surgical Extractions	$0; 1 of each per year	$0; 1 of each per year	$0; 1 of each per year	$0; 1 of each per year	$0; 1 of each per year	$0; 1 of each per year
Dentures with Unlimited Extractions to Fit	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Root Canal	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Debridement	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
HEARING						
Hearing Aids	$2,000 max ($1,000 per aid)	$2,000 max ($1,000 per aid)	$2,000 max ($1,000 per aid)	$2,000 max ($1,000 per aid)	$2,000 max ($1,000 per aid)	$2,000 max ($1,000 per aid)
Hearing Aid Fitting/Eval & Exam	$0	$0	$0	$0	$0	$0
VISION						
Eyewear Allowance (Glasses/Contacts)	$200	$200	$150	$200	$200	$300
Routine Exam Optometrist/Ophthalmologist	$0	$0	$0	$0	$0	$0
SUPPLEMENTAL BENEFITS						
Fitness Benefit/Nurse Hotline	Covered	Covered	Covered	Covered	Covered	Covered
Meal Benefit	$0 (14 meals)	$0 (14 meals)	$0 (14 meals)	$0 (14 meals)	$0 (14 meals)	$0 (14 meals)
Over-the-Counter (OTC)	$50 per month	$50 per month	$35 per month	$45 per month	$50 per month	$50 per month
Transportation (one-way trips)	$0 (up to 20 trips)	$0 (up to 20 trips)	$0 (up to 20 trips)	$0 (up to 20 trips)	$0 (up to 20 trips)	$0 (up to 20 trips)

Premier by Ultimate (HMO) Plan Number	Orange/Osc/Semi 046	Manatee/Sarasota 047	Premier Plus by Ultimate (HMO) Citrus/Hern/Pasco/IndRiv/St.Lucie 032
Maximum Out-of-Pocket	$3,400	$3,200	$1,200
Premium	$0	$0	$0
Part B Premium Reduction	$160.00	$155.00	$0
INPATIENT CARE			
Inpatient Hospital (Acute & Mental)	$85 (days 1-5) $0 (days 6-90)	$175 (days 1-5) $0 (days 6-90)	$0 (days 1-90)
Skilled Nursing Facility	$0 (days 1-20) $150 (days 21-40) $0 (days 41-100)	$0 (days 1-20) $150 (days 21-40) $0 (days 41-100)	$0 (days 1-20) $150 (days 21-31) $0 (days 32-100)
OUTPATIENT CARE			
Primary Care Visit	$0	$0	$0
Specialist Visit	$10	$25	$0
Chiropractor Visit/Podiatry Visit	$10 / $10	$15 / $25	$0 / $0
Home Health Services	$0	$0	$0
Physical and Speech Therapy	$10	$30	$0
Occupational Therapy	$10	$30	$0
Outpatient Hospital Visit	$95	$150	$100
Ambulatory Surgery Center Visit	$50	$25	$0
Outpatient Mental Health (Indiv./Group)	$10	$25 / $10	$0
Outpatient Substance Abuse (Indiv./Group)*	$10	$30	$5 / $0
EMERGENCY SERVICES			
Ambulance Ground/Air	$175 / 20%	$150 / 20%	$150 / 20%
Emergency Care	$75	$75	$50
Urgently Needed Care	$10	$10	$10
Worldwide ER Care	$100; $50,000 max	$100; $50,000 max	$100; $50,000 max
OUTPATIENT SERVICES*			
CTA, MRA, PET, SPECT, & Other Nuclear Tests	$25	$0	$100
Diagnostic Stress, Nerve Conduction, CT, MRI	$25	$0	$25
Diagnostic Ultrasound & Echo	$25	$0	$0
Laboratory (in Network)	$0	$0	$0
Therapeutic Radiology	20%	20%	20%
X-rays (in Network)	$0	$0	$0
SUPPLIES			
Diabetic Supplies & Education	0% - 20%	0% - 20%	$0
Durable Medical Equipment	20%	20%	20%
Prosthetic Devices	20%	20%	20%

*Outpatient service copays are for services received at a freestanding facility or office.

PREVENTIVE SERVICES			
Annual Wellness Visit	$0	$0	$0
Bone Mass Measurement	$0	$0	$0
Colorectal Screening	$0	$0	$0
Flu, Pneu. & Hep. B Vaccine	$0	$0	$0
Mammograms	$0	$0	$0
Pap Smears/Pelvic Exams	$0	$0	$0
Prostate Cancer Screening	$0	$0	$0
Renal Dialysis	20%	20%	20%
PART B DRUGS			
Part B Drugs	20%	20%	20%
PART D DRUGS			
Gap Coverage	Tier 1: $0	Tier 1: $0	Tier 1: $0
Mail Order (3-month supply)	3 mo. for 2 copays	3 mo. for 2 copays	3 mo. for 2 copays
Insulin Savings Program	Covered	Covered	Covered
Tier 1 Generic	$0	$0	$0
Tier 2 Preferred Brand	$30	$35	$5
Tier 3 Non-Preferred Drug	$60	$85	$45
Tier 4 Specialty	33%	33%	33%
DENTAL (See pages 36-37)			
Fillings	$0; 3 per year	$0; 3 per year	$0; 4 per year
Crown	$0; 1 per year	$0; 1 per year	$0; 1 per year
Simple & Surgical Extractions	$0; 1 of each per year	$0; 1 of each per year	$0; 1 of each per year
Dentures with Unlimited Extractions to Fit	Not Covered	Not Covered	$0; 1 per arch every 5 years
Root Canal	Not Covered	Not Covered	$0; 3 per year
Debridement	Not Covered	Not Covered	$0; 1 every 2 years
HEARING			
Hearing Aids	$2,000 max ($1,000 per aid)	$2,000 max ($1,000 per aid)	$2,000 max ($1,000 per aid)
Hearing Aid Fitting/Eval & Exam	$0	$0	$0
VISION			
Eyewear Allowance (Glasses/Contacts)	$200	$200	$300
Routine Exam Optometrist/Ophthalmologist	$0	$0	$0
SUPPLEMENTAL BENEFITS			
Fitness Benefit/Nurse Hotline	Covered	Covered	Covered
Meal Benefit	$0 (14 meals)	$0 (14 meals)	$0 (14 meals)
Over-the-Counter (OTC)	$50 per month	$50 per month	$50 per month
Transportation (one-way trips)	$0 (up to 12 trips)	$0 (up to 12 trips)	$0 (up to 20 trips)

Advantage Care by Ultimate (HMO C-SNP) Plan Number	Hernando 019-1	Pasco 019-2	Citrus 021	Hills/Pin 026	Lake/Mar/Sum 029	IndRiv/St.Luc 033
Maximum Out-of-Pocket	$1,750	$1,750	$1,700	$1,600	$3,000	$2,800
Premium	$0	$0	$0	$0	$0	$0
Part B Premium Reduction	$164.90	$164.90	$164.90	$164.90	$164.90	$164.90
INPATIENT CARE						
Inpatient Hospital (Acute & Mental)	$50 (days 1-5) $0 (days 6-90)	$50 (days 1-5) $0 (days 6-90)	$70 (days 1-5) $0 (days 6-90)	$60 (days 1-5) $0 (days 6-90)	$120 (days 1-5) $0 (days 6-90)	$175 (days 1-5) $0 (days 6-90)
Skilled Nursing Facility	$0 (days 1-20) $120 (days 21-38) $0 (days 39-100)	$0 (days 1-20) $120 (days 21-38) $0 (days 39-100)	$0 (days 1-20) $150 (days 21-38) $0 (days 39-100)	$0 (days 1-20) $150 (days 21-38) $0 (days 39-100)	$0 (days 1-20) $150 (days 21-38) $0 (days 39-100)	$0 (days 1-20) $150 (days 21-38) $0 (days 39-100)
OUTPATIENT CARE						
Primary Care Visit	$0	$0	$0	$0	$0	$0
Specialist Visit	$5	$5	$10	$10	$20	$20
Chiropractor Visit/Podiatry Visit	$5 / $5	$5 / $5	$10 / $10	$10 / $10	$20 / $20	$20 / $20
Home Health Services	$0	$0	$0	$0	$0	$0
Physical and Speech Therapy	$10	$10	$10	$10	$20	$30
Occupational Therapy	$10	$10	$10	$10	$0	$30
Outpatient Hospital Visit	$50	$50	$95	$150	$150	$150
Ambulatory Surgery Center Visit	$25	$25	$25	$25	$25	$50
Outpatient Mental Health (Indiv./Group)	$5	$5	$10	$10	$20 / $10	$20 / $10
Outpatient Substance Abuse (Indiv./Group)*	$20 / $10	$20 / $10	$20 / $10	$20 / $10	$20 / $0	$30 / $15
EMERGENCY SERVICES						
Ambulance Ground/Air	$150 / 20%	$150 / 20%	$150 / 20%	$150 / 20%	$150 / 20%	$150 / 20%
Emergency Care	$60	$60	$70	$75	$75	$60
Urgently Needed Care	$10	$10	$10	$10	$10	$10
Worldwide ER Care	$100; $50,000 max	$100; $50,000 max	$100; $50,000 max	$100; $50,000 max	$100; $50,000 max	$100; $ 50,000 max
OUTPATIENT SERVICES*						
CTA, MRA, PET, SPECT, & Other Nuclear Tests	$75	$75	$75	$75	$75	$75
Diagnostic Stress, Nerve Conduction, CT, MRI	$25	$25	$25	$25	$25	$25
Diagnostic Ultrasound & Echo	$0	$0	$0	$0	$0	$0
Laboratory (in Network)	$0	$0	$0	$0	$0	$0
Therapeutic Radiology	20%	20%	20%	20%	20%	20%
X-rays (in Network)	$0	$0	$0	$0	$0	$0
SUPPLIES						
Diabetic Supplies/Education	$0	$0	$0	$0	$0	$0
Durable Medical Equipment	20%	20%	20%	20%	10% (STD W/C) / 20%	20%
Prosthetic Devices	20%	20%	20%	20%	20%	20%

*Outpatient service copays are for services received at a freestanding facility or office.

PREVENTIVE SERVICES						
Annual Wellness Visit	$0	$0	$0	$0	$0	$0
Bone Mass Measurement	$0	$0	$0	$0	$0	$0
Colorectal Screening	$0	$0	$0	$0	$0	$0
Flu, Pneu., Hep. B, & COVID-19 Vaccine	$0	$0	$0	$0	$0	$0
Mammograms	$0	$0	$0	$0	$0	$0
Pap Smears/Pelvic Exams	$0	$0	$0	$0	$0	$0
Prostate Cancer Screening	$0	$0	$0	$0	$0	$0
Renal Dialysis	20%	20%	20%	20%	20%	20%
PART B DRUGS						
Part B Drugs	20%	20%	20%	20%	20%	20%
PART D DRUGS						
Gap Coverage	Tier 1 & 5:$0/$10	Tier 1 & 5:$0/$10	Tier 1 & 5:$0/$10	Tier 1 & 5:$0/$10	Tier 1 & 5:$0/$10	Tier 1 & 5:$0/$10
Mail Order (3-month supply)	3 mo. for 2 copays	3 mo. for 2 copays	3 mo. for 2 copays	3 mo. for 2 copays	3 mo. for 2 copays	3 mo. for 2 copays
Insulin Savings Program	Covered	Covered	Covered	Covered	Covered	Covered
Tier 1 Generic	$0	$0	$0	$0	$0	$0
Tier 2 Preferred Brand	$10	$10	$20	$15	$20	$20
Tier 3 Non-Preferred Drug	$50	$50	$60	$55	$60	$70
Tier 4 Specialty	33%	33%	33%	33%	33%	33%
Tier 5 Select Care Drugs	$10	$10	$10	$10	$10	$10
DENTAL (See pages 36-37)						
Fillings	$0; 3 per year	$0; 3 per year	$0; 3 per year	$0; 3 per year	$0; 4 per year	$0; 3 per year
Crown	$0; 1 per year	$0; 1 per year	$0; 1 per year	$0; 1 per year	$0; 1 per year	$0; 1 per year
Simple & Surgical Extractions	$0; 1 of each per year	$0; 1 of each per year	$0; 1 of each per year	$0; 1 of each per year	$0; 1 of each per year	$0; 1 of each per year
Dentures with Unlimited Extractions to Fit	$0; 1 per arch every 5 years	$0; 1 per arch every 5 years	Not Covered	Not Covered	$0; 1 per arch every 5 years	Not Covered
Root Canal	$0; 1 per year	$0; 1 per year	$0; 1 per year	$0; 1 per year	$0; 1 per year	$0; 1 per year
Debridement	$0; 1 every 2 years	$0; 1 every 2 years	Not Covered	Not Covered	Not Covered	Not Covered
HEARING						
Hearing Aids	$2,000 max ($1,000 per aid)	$2,000 max ($1,000 per aid)	$2,000 max ($1,000 per aid)	$2,000 max ($1,000 per aid)	$2,000 max ($1,000 per aid)	$2,000 max ($1,000 per aid)
Hearing Aid Fitting/Eval & Exam	$0	$0	$0	$0	$0	$0
VISION						
Eyewear Allowance (Glasses/Contacts)	$300	$300	$200	$300	$200	$200
Routine Exam Optometrist/Ophthalmologist	$0	$0	$0	$0	$0	$0
SUPPLEMENTAL BENEFITS						
Fitness Benefit/Nurse Hotline	Covered	Covered	Covered	Covered	Covered	Covered
Meal Benefit	$0 (14 meals)	$0 (14 meals)	$0 (14 meals)	$0 (14 meals)	$0 (14 meals)	$0 (14 meals)
Over-the-Counter (OTC)	$75 per month	$75 per month	$75 per month	$75 per month	$75 per month	$75 per month
Transportation (one-way trips)	$0 (unlimited)	$0 (unlimited)	$0 (unlimited)	$0 (unlimited)	$0 (unlimited)	$0 (unlimited)
Healthy Foods Card (non-rolling)	$75 per month	$75 per month	$75 per month	$75 per month	$75 per month	$75 per month

Advantage Care by Ultimate (HMO C-SNP)				Advantage Care CHF by Ultimate (HMO C-SNP)	
Plan Number	**Orange/Osc/Sem 050**	**Polk 051**	**Man/Sar 052**	**Citrus 022**	**Hern/Pasco 024**
Maximum Out-of-Pocket	$3,400	$3,200	$3,400	$1,700	$1,750
Premium	$0	$0	$0	$0	$0
Part B Premium Reduction	$164.90	$164.90	$164.90	$164.90	$164.90
INPATIENT CARE					
Inpatient Hospital (Acute & Mental)	$160 (days 1-7) $0 (days 8-90)	$160 (days 1-5) $0 (days 6-90)	$165 (days 1-5) $0 (days 6-90)	$70(days 1-5) $0 (days 6-90)	$50(days 1-5) $0 (days 6-90)
Skilled Nursing Facility	$0 (days 1-20) $150 (days 21-38) $0 (days 39-100)	$0 (days 1-20) $150 (days 21-38) $0 (days 39-100)	$0 (days 1-20) $150 (days 21-38) $0 (days 39-100)	$0 (days 1-20) $150 (days 21-38) $0 (days 39-100)	$0 (days 1-20) $120 (days 21-38) $0 (days 39-100)
OUTPATIENT CARE					
Primary Care Visit	$0	$0	$0	$0	$0
Specialist Visit	$15	$15	$15	$10	$5
Chiropractor Visit/Podiatry Visit	$15 / $15	$15 / $15	$15 / $15	$10 / $10	$5 / $5
Home Health Services	$0	$0	$0	$0	$0
Physical and Speech Therapy	$20	$20	$20	$10	$10
Occupational Therapy	$20	$20	$20	$10	$10
Outpatient Hospital Visit	$195	$195	$195	$95	$50
Ambulatory Surgery Center Visit	$25	$25	$25	$25	$25
Outpatient Mental Health (Indiv./Group)	$15 / $10	$15 / $10	$15 / $10	$10	$5
Outpatient Substance Abuse (Indiv./Group)*	$20	$20	$20	$20 / $10	$20 / $10
EMERGENCY SERVICES					
Ambulance Ground/Air	$150 / 20%	$150 / 20%	$150 / 20%	$150 / 20%	$150 / 20%
Emergency Care	$75	$75	$75	$70	$60
Urgently Needed Care	$10	$10	$10	$10	$10
Worldwide ER Care	$100; $50,000 max	$100; $50,000 max	$100; $50,000 max	$100; $50,000 max	$100; $50,000 max
OUTPATIENT SERVICES*					
CTA, MRA, PET, SPECT, & Other Nuclear Tests	$25	$25	$0	$75	$75
Diagnostic Stress, Nerve Conduction, CT, MRI	$25	$25	$0	$25	$25
Diagnostic Ultrasound & Echo	$25	$25	$0	$0	$0
Laboratory (in Network)	$0	$0	$0	$0	$0
Therapeutic Radiology	20%	20%	20%	20%	20%
X-rays (in Network)	$0	$0	$0	$0	$0
SUPPLIES					
Diabetic Supplies & Education	$0	$0	$0	$0	$0
Durable Medical Equipment	20%	20%	20%	20%	20%
Prosthetic Devices	20%	20%	20%	20%	20%

*Outpatient service copays are for services received at a freestanding facility or office.

PREVENTIVE SERVICES					
Annual Wellness Visit	$0	$0	$0	$0	$0
Bone Mass Measurement	$0	$0	$0	$0	$0
Colorectal Screening	$0	$0	$0	$0	$0
Flu, Pneu. & Hep. B Vaccine	$0	$0	$0	$0	$0
Mammograms	$0	$0	$0	$0	$0
Pap Smears/Pelvic Exams	$0	$0	$0	$0	$0
Prostate Cancer Screening	$0	$0	$0	$0	$0
Renal Dialysis	20%	20%	20%	20%	20%
PART B DRUGS					
Part B Drugs	20%	20%	20%	20%	20%
PART D DRUGS					
Gap Coverage	Tier 1 & 5:$0/$10	Tier 1 & 5:$0/$10	Tier 1 & 5:$0/$10	Tier 1 & 5:$0/$10	Tier 1 & 5:$0/$10
Mail Order (3-month supply)	3 mo. for 2 copays	3 mo. for 2 copays	3 mo. for 2 copays	3 mo. for 2 copays	3 mo. for 2 copays
Insulin Savings Program	Covered	Covered	Covered	Covered	Covered
Tier 1 Generic	$0	$0	$0	$0	$0
Tier 2 Preferred Brand	$25	$25	$25	$20	$10
Tier 3 Non-Preferred Drug	$60	$65	$70	$60	$50
Tier 4 Specialty	33%	33%	33%	33%	33%
Tier 5 Select Care Drugs	$10	$10	$10	$10	$10
DENTAL (See pages 36-37)					
Fillings	$0; 3 per year	$0; 3 per year	$0; 3 per year	$0; 3 per year	$0; 3 per year
Crown	$0; 1 per year	$0; 1 per year	$0; 1 per year	$0; 1 per year	$0; 1 per year
Simple & Surgical Extractions	$0; 1 of each per year	$0; 1 of each per year	$0; 1 of each per year	$0; 1 of each per year	$0; 1 of each per year
Dentures with Unlimited Extractions to Fit	Not Covered	Not Covered	Not Covered	Not Covered	$0; 1 per arch every 5 years
Root Canal	$0; 1 per year	$0; 1 per year	$0; 1 per year	$0; 1 per year	$0; 1 per year
Debridement	Not Covered	Not Covered	Not Covered	Not Covered	$0; 1 every 2 years
HEARING					
Hearing Aids	$2,000 max ($1,000 per aid)	$2,000 max ($1,000 per aid)	$2,000 max ($1,000 per aid)	$2,000 max ($1,000 per aid)	$2,000 max ($1,000 per aid)
Hearing Aid Fitting/Eval & Exam	$0	$0	$0	$0	$0
VISION					
Eyewear Allowance (Glasses/Contacts)	$300	$300	$300	$200	$300
Routine Exam Optometrist/Ophthalmologist	$0	$0	$0	$0	$0
SUPPLEMENTAL BENEFITS					
Fitness Benefit/Nurse Hotline	Covered	Covered	Covered	Covered	Covered
Meal Benefit	$0 (14 meals)	$0 (14 meals)	$0 (14 meals)	$0 (14 meals)	$0 (14 meals)
Over-the-Counter (OTC)	$100 per month	$75 per month	$75 per month	$75 per month	$75 per month
Transportation (one-way trips)	$0 (up to 12 trips)	$0 (up to 12 trips)	$0 (up to 12 trips)	$0 (unlimited)	$0 (unlimited)
Healthy Foods Card (non-rolling)	$75 per month	$75 per month	$75 per month	$75 per month	$75 per month

Advantage Care COPD by Ultimate (HMO C-SNP) Plan Number	Cit/Lake/Mar/Sum 023	Hern/Hils/Pasco/Pin 025	IndRiv/Man/Orange/Osc/Polk/ Sar/Sem/St.Luc 034
Maximum Out-of-Pocket	$2,600	$1,750	$3,300
Premium	$0	$0	$0
Part B Premium Reduction	$164.90	$164.90	$155.00
INPATIENT CARE			
Inpatient Hospital (Acute & Mental)	$115 (days 1-5) $0 (days 6-90)	$60 (days 1-5) $0 (days 6-90)	$160 (days 1-5) $0 (days 6-90)
Skilled Nursing Facility	$0 (days 1-20) $150 (days 21-38) $0 (days 39-100)	$0 (days 1-20) $150 (days 21-38) $0 (days 39-100)	$0 (days 1-20) $150 (days 21-38) $0 (days 39-100)
OUTPATIENT CARE			
Primary Care Visit	$0	$0	$0
Specialist Visit	$20	$7	$20
Chiropractor Visit/Podiatry Visit	$20 / $20	$7 / $7	$20 / $20
Home Health Services	$0	$0	$0
Physical and Speech Therapy	$30	$7	$30
Occupational Therapy	$30	$7	$30
Outpatient Hospital Visit	$150	$70	$150
Ambulatory Surgery Center Visit	$25	$25	$50
Outpatient Mental Health (Indiv./Group)	$20 / $10	$7	$20 / $10
Outpatient Substance Abuse (Indiv./Group)	$20 / $10	$20 / $10	$30 / $15
EMERGENCY SERVICES			
Ambulance Ground/Air	$150 / 20%	$150 / 20%	$150 / 20%
Emergency Care	$50	$75	$50
Urgently Needed Care	$10	$10	$10
Worldwide ER Care	$100; $50,000 max	$100; $50,000 max	$100; $50,000 max
OUTPATIENT SERVICES*			
CTA, MRA, PET, SPECT, & Other Nuclear Tests	$75	$75	$75
Diagnostic Stress, Nerve Conduction, CT, MRI	$25	$25	$25
Diagnostic Ultrasound & Echo	$0	$0	$0
Laboratory (in Network)	$0	$0	$0
Therapeutic Radiology	20%	20%	20%
X-rays (in Network)	$0	$0	$0
SUPPLIES			
Diabetic Supplies & Education	$0	$0	$0
Durable Medical Equipment	0% (oxygen) / 20%	0% (oxygen) / 20%	0% (oxygen) / 20%
Prosthetic Devices	20%	20%	20%

*Outpatient service copays are for services received at a freestanding facility or office.

PREVENTIVE SERVICES			
Annual Wellness Visit	$0	$0	$0
Bone Mass Measurement	$0	$0	$0
Colorectal Screening	$0	$0	$0
Flu, Pneu., Hep. B, & COVID-19 Vaccine	$0	$0	$0
Mammograms	$0	$0	$0
Pap Smears/Pelvic Exams	$0	$0	$0
Prostate Cancer Screening	$0	$0	$0
Renal Dialysis	20%	20%	20%
PART B DRUGS			
Part B Drugs	20%	20%	20%
PART D DRUGS			
Gap Coverage	Tier 1 & 5:$0/$10	Tier 1 & 5:$0/$10	Tier 1 & 5:$0/$10
Mail Order (3-month supply)	3 mo. for 2 copays	3 mo. for 2 copays	3 mo. for 2 copays
Insulin Savings Program	Covered	Covered	Covered
Tier 1 Generic	$0	$0	$0
Tier 2 Preferred Brand	$20	$10	$20
Tier 3 Non-Preferred Drug	$60	$50	$60
Tier 4 Specialty	33%	33%	33%
Tier 5 Select Care Drugs	$10	$10	$10
DENTAL (See pages 36-37)			
Fillings	$0; 3 per year	$0; 3 per year	$0; 3 per year
Crown	$0; 1 per year	$0; 1 per year	$0; 1 per year
Simple & Surgical Extractions	$0; 1 of each per year	$0; 1 of each per year	$0; 1 of each per year
Dentures with Unlimited Extractions to Fit	$0; 1 per arch every 5 years	$0; 1 per arch every 5 years	Not Covered
Root Canal	$0; 1 per year	$0; 1 per year	$0; 1 per year
Debridement	$0; 1 every 2 years	$0; 1 every 2 years	Not Covered
HEARING			
Hearing Aids	$2,000 max ($1,000 per aid)	$2,000 max ($1,000 per aid)	$2,000 max ($1,000 per aid)
Hearing Aid Fitting/Eval & Exam	$0	$0	$0
VISION			
Eyewear Allowance (Glasses/Contacts)	$200	$300	$200
Routine Exam Optometrist/Ophthalmologist	$0	$0	$0
SUPPLEMENTAL BENEFITS			
Fitness Benefit/Nurse Hotline	Covered	Covered	Covered
Meal Benefit	$0 (14 meals)	$0 (14 meals)	$0 (14 meals)
Over-the-Counter (OTC)	$75 per month	$75 per month	$75 per month
Transportation (one-way trips)	$0 (unlimited)	$0 (unlimited)	$0 (unlimited)
Healthy Food Card (non-rolling)	$75 per month	$75 per month	$75 per month

Plan Number	Advantage Plus by Ultimate (Full) (D-SNP) 035	Advantage Plus by Ultimate (Partial) (D-SNP) 036
Maximum Out-of-Pocket	$500	$500
Premium	$0	$0
Part B Premium Reduction	$0	$0
INPATIENT CARE		
Inpatient Hospital (Acute & Mental)	$0 (days 1-90)	$0 (days 1-90)
Skilled Nursing Facility	$0 (days 1-100)	$0 (days 1-100)
OUTPATIENT CARE		
Primary Care Visit	$0	$0
Specialist Visit	$0	$0
Chiropractor Visit/Podiatry Visit	$0 / $0	$0 / $0
Home Health Services	$0	$0
Physical and Speech Therapy	$0	$0
Occupational Therapy	$0	$0
Outpatient Hospital Visit	$0	$0
Ambulatory Surgery Center Visit	$0	$0
Outpatient Mental Health	$0	$0
Outpatient Substance Abuse	$0	$0
EMERGENCY SERVICES		
Ambulance Ground/Air	$0	$0
Emergency Care	$0	$0
Urgently Needed Care	$0	$0
Worldwide ER Care	$100; $50,000 max	$100; $50,000 max
OUTPATIENT SERVICES*		
CTA, MRA, PET, SPECT, & Other Nuclear Tests	$0	$0
Diagnostic Stress, Nerve Conduction, CT, MRI	$0	$0
Diagnostic Ultrasound & Echo	$0	$0
Laboratory (in Network)	$0	$0
Therapeutic Radiology	0%	0%
X-rays (in Network)	$0	$0
SUPPLIES		
Diabetic Supplies & Education	$0	$0
Durable Medical Equipment	0%	0%
Prosthetic Devices	$0	$0

*Outpatient service copays are for services received at a freestanding facility or office.

PREVENTIVE SERVICES		
Annual Wellness Visit	$0	$0
Bone Mass Measurement	$0	$0
Colorectal Screening	$0	$0
Flu, Pneu., Hep. B, & COVID-19 Vaccine	$0	$0
Mammograms	$0	$0
Pap Smears/Pelvic Exams	$0	$0
Prostate Cancer Screening	$0	$0
Renal Dialysis	0%	20%
PART B DRUGS		
Part B Drugs	0%	0%
PART D DRUGS		
Gap Coverage	Tier 5: $0	Tier 5: $0
Mail Order (3-month supply)	Tier 1-4: 0%; Tier 5: $0	Tier 1-4: 0%; Tier 5: $0
All Covered Drugs	Tier 1-4: 0%; Tier 5: $0; includes all LIS levels	Tier 1-4: 0%; Tier 5: $0; includes all LIS levels
DENTAL (See pages 36-37)		
Fillings	$0; 3 per year	$0; 3 per year
Crown	$0; 1 per year	$0; 1 per year
Simple & Surgical Extractions	$0; 1 of each per year	$0; 1 of each per year
Dentures with Unlimited Extractions to Fit	$0; 1 per arch every 5 years	$0; 1 per arch every 5 years
Root Canal	$0; 1 per year	$0; 1 per year
Debridement	$0; 1 every 2 years	$0; 1 every 2 years
HEARING		
Hearing Aids	$2,000 max ($1,000 per aid)	$2,000 max ($1,000 per aid)
Hearing Aid Fitting/Eval & Exam	$0	$0
VISION		
Eyewear Allowance (Glasses/Contacts)	$500	$500
Routine Exam Optometrist/Ophthalmologist	$0	$0
SUPPLEMENTAL BENEFITS		
Fitness Benefit/Nurse Hotline	Covered	Covered
Meal Benefit	$0 (14 meals)	$0 (14 meals)
Over-the-Counter (OTC)	$125 per month	$125 per month
Transportation (one-way trips)	$0 (unlimited)	$0 (unlimited)
Healthy Foods Card (non-rolling)	$100 per month	$100 per month
Flex Card (vision, dental, and hearing)	$500 per year	$500 per year

Your Over-the-Counter (OTC) & Healthy Food Benefit

Spend freely and live fully with your **Ultimate Benefit Card!** With our program, you will receive:

- Preloaded funds on your benefit card each month
- Access to hundreds of approved OTC products
- Three convenient ways to shop: in-store, online, or by phone

Participating retailers include:

- CVS (No Target stores)
- Publix
- SE Grocers (Winn-Dixie)
- Walgreens
- Walmart
- And more

What Is Approved?

OTC Products

- Allergy and sinus
- Cold and flu
- Dental and oral health
- Diabetic care
- Digestive health
- Eye and ear care
- First aid
- Foot care
- Home health care and daily living
- Incontinence products
- Pain relief
- Skin care
- Sleep aids
- Smoking cessation products
- Supports, braces, and wraps
- And more

Healthy Food*

- Fresh fruit and vegetables
- Canned fruit and vegetables
- Frozen produce and meals
- Fresh salad kits
- Dairy products
- Meat and seafood
- Beans and legumes
- Pantry staples – flour, spices, etc.
- Soups
- Nutritional shakes and bars
- Healthy grains, cereals, pastas, etc.
- Water/vitamin water
- Prepared meals from momsmeals.com/S3
- And more

*To receive the Healthy Foods benefit, you must be a member of our Advantage Plus DSNP plan or Advantage Care CSNP plan and be diagnosed with a qualifying chronic condition. Please refer to your Evidence of Coverage for details.

Flex Benefit

Our Advantage Plus by Ultimate (D-SNP) members enjoy $500 each year on a prepaid Visa card that may be used to cover costs which exceed the plan allowed benefits for hearing, dental, and vision services.

Papa Pals

We all need a pal sometimes. That's why we are partnering with Papa to offer members a hand to help, a shoulder to lean on, and an ear to listen — when, where, and how they need it most.

Pals bring companionship, assistance with light household tasks, transportation, errands, meal prep, pets, technology and more — right to their front door.

TECHNOLOGY
Help with computers, smart phones, and tablets.

HOUSE NEEDS
Light cleaning, meal prep, organizing, or pet help.

TRANSPORTATION
Doctors appointments, errands, grocery and pharmacy shopping.

COMPANIONSHIP
Chat, play board games, watch a movie, take a walk, or exercise.

Your Vision Benefits

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 a **$0** copay.

Our benefit includes:

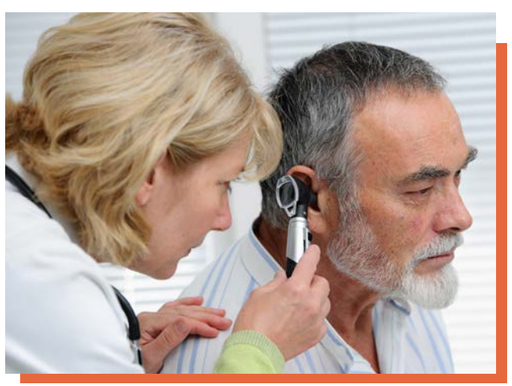
- Contact lenses or
- One pair of standard single-vision, bifocal or trifocal lenses and/or
- One eyeglass frame

You can upgrade your standard lenses to progressive lenses for just a **$50** copay, or get a pair of sunglasses for a **$40** copay, and photochromatic lenses for a **$30** copay.

Members of our Dual Special Needs Plans (D-SNP) also enjoy **$0** copays with the option to select the vision benefit that's right for them.

Your Hearing Benefits

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, hearing aids, and fitting evaluations for a **$0** copay. Our plan pays up to **$2,000** every year ($1,000 limit per hearing aid, per ear).



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.

Your Dental Benefits

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 a **$0** copay.

We cover routine services, such as:

- Cleaning
- Dental x-rays
- Fluoride treatments
- Oral evaluations and exam
- Comprehensive dental benefits, such as fillings and extractions
- Select plans offer full-mouth debridement and dentures

Pages 36-37 show plan-specific coverage.

Your Evidence of Coverage also contains a list of covered services, restrictions, limitations, and costs.

2023 DENTAL PLAN BENEFITS

01 Preventive Dental Benefits

All Plans

- 1 oral evaluation every 6 months
- 1 cleaning every 6 months
- 1 fluoride treatment every 6 months
- 2 dental x-rays every year

02 Comprehensive Dental Benefits

Premier by Ultimate (HMO) — **013 -3 – Pasco**
Premier by Ultimate (HMO) — **013 -4 – Citrus**
Premier by Ultimate (HMO) — **028 – Lake, Marion, & Sumter**
Premier by Ultimate (HMO) — **031 – Indian River & St. Lucie**
Premier by Ultimate (HMO) — **045 – Hillsborough, Polk, & Pinellas**
Premier by Ultimate (HMO) — **046 – Orange, Osceola, & Seminole**
Premier by Ultimate (HMO) — **047 – Manatee & Sarasota**

- 1 comprehensive oral exam every 3 years
- 3 fillings per year
- 1 crown per year
- 4 periodontal scaling and root planing procedures per quadrant per year (deep cleaning)
- 2 periodontal maintenance procedures following active surgery per year
- 1 simple extraction per year
- 1 surgical extraction per year

03 Comprehensive Dental Benefits

Premier Plus by Ultimate (HMO) — **032 - Citrus, Hernando, Pasco, Indian River, & St. Lucie**

- 1 comprehensive oral exam every 3 years
- 4 fillings per year
- 1 crown per year
- 1 full mouth debridement every 2 years
- 4 periodontal scaling and root planing procedures per quadrant per year (deep cleaning)
- 2 periodontal maintenance procedures following active surgery per year
- 1 simple extraction per year
- 1 surgical extraction per year
- 3 root canals per year
- Dentures - 1 per arch every 5 years
- Unlimited simple and surgical necessary extractions to fit dentures

04 Comprehensive Dental Benefits

Advantage Care by Ultimate (HMO C-SNP) — **019-1 – Hernando**
Advantage Care by Ultimate (HMO C-SNP) — **019-2 – Pasco**
Advantage Care CHF by Ultimate (HMO C-SNP) — **024 – Hernando & Pasco**
Advantage Care COPD by Ultimate (HMO C-SNP) — **023 – Citrus, Lake, Marion, & Sumter**
Advantage Care COPD by Ultimate (HMO C-SNP) — **025 – Hernando, Hillsborough, Pasco, & Pinellas**
Advantage Plus by Ultimate (Full) (HMO D-SNP) — **035 – All Counties**
Advantage Plus by Ultimate (Partial) (HMO D-SNP) — **036 – All Counties**

- 1 comprehensive oral exam every 3 years
- 3 fillings per year
- 1 crown per year
- 1 full mouth debridement every 2 years
- 4 periodontal scaling and root planing procedures per quadrant per year (deep cleaning)
- 2 periodontal maintenance procedures following active surgery per year
- 1 simple extraction per year
- 1 surgical extraction per year
- 1 root canal per year
- Dentures - 1 per arch every 5 years
- Unlimited simple and surgical necessary extractions to fit dentures

05 Comprehensive Dental Benefits

Advantage Care by Ultimate (HMO C-SNP) — **021 – Citrus**
Advantage Care by Ultimate (HMO C-SNP) — **026 – Hillsborough & Pinellas**
Advantage Care by Ultimate (HMO C-SNP) — **033 – Indian River & St. Lucie**
Advantage Care by Ultimate (HMO C-SNP) — **050 – Orange, Osceola, & Seminole**
Advantage Care by Ultimate (HMO C-SNP) — **051 – Polk**
Advantage Care by Ultimate (HMO C-SNP) — **052 – Manatee & Sarasota**
Advantage Care CHF by Ultimate (HMO C-SNP) — **022 – Citrus**
Advantage Care COPD by Ultimate (HMO C-SNP) — **034 – Indian River, Manatee, Orange, Osceola, Polk, Sarasota, Seminole, & St. Lucie**

- 1 comprehensive oral exam every 3 years
- 3 fillings per year
- 1 crown per year
- 4 periodontal scaling and root planing procedures per quadrant per year (deep cleaning)
- 2 periodontal maintenance procedures following active surgery per year
- 1 simple extraction per year
- 1 surgical extraction per year
- 1 root canal per year

06 Comprehensive Dental Benefits

Advantage Care by Ultimate (HMO C-SNP) — **029 – Lake, Marion, & Sumter**

- 1 comprehensive oral exam every 3 years
- 4 fillings per year
- 1 crown per year
- 4 periodontal scaling and root planing procedures per quadrant per year (deep cleaning)
- 2 periodontal maintenance procedures following active surgery per year
- 1 simple extraction per year
- 1 surgical extraction per year
- 1 root canal per year
- Dentures - 1 per arch every 5 years
- Unlimited simple and surgical necessary extractions to fit dentures

2023 COVERED DENTAL BENEFIT CODES

ULTIMATE HEALTH PLANS

PREVENTIVE

Code	Procedure Description	Prior Authorization Required	Copay Amount
DIAGNOSTIC (EXAMS AND X-RAYS)			
D0120	Periodic Oral Evaluation	No	$0
D0140	Limited Oral Evaluation	No	$0
D0160	Oral Evaluation, Problem Focused	No	$0
D0170	Re-Evaluation, Limited, Problem Focused	No	$0
D0171	Re-Evaluation, Post Operative Office Visit	No	$0
D1110	Prophylaxis (Cleaning)	No	$0
D1206	Topical Application of Fluoride Varnish	No	$0
D1208	Topical Application of Fluoride – Excluding Varnish	No	$0
D0220	Intraoral, Periapical, First Radiographic Image	No	$0
D0230	Intraoral, Periapical, Each Additional Radiographic Image	No	$0
D0270	Bitewing, Single Radiographic Image	No	$0
D0272	Bitewings, Two Radiographic Images	No	$0
D0273	Bitewings, Three Radiographic Images	No	$0
D0274	Bitewings, Four Radiographic Images	No	$0
D0210	Intraoral, Complete Serieso of Radiographic Images	No	$0
D0330	Panoramic Radiographic Image	No	$0

COMPREHENSIVE

Code	Procedure Description	Prior Authorization Required	Copay Amount
DIAGNOSTIC (EXAMS AND X-RAYS)			
D0150	Comprehensive Oral Evaluation	No	$0
RESTORATIVE			
D2140	Amalgam, One Surface, Primary or Permanent	No	$0
D2150	Amalgam, Two Surfaces, Primary or Permanent	No	$0
D2160	Amalgam, Three Surfaces, Primary or Permanent	No	$0
D2161	Amalgam, Four or More Surfaces, Primary or Permanent	No	$0
D2330	Resin-Based Composite - One Surface, Anterior	No	$0
D2331	Resin-Based Composite - Two Surfaces, Anterior	No	$0
D2332	Resin-Based Composite, Three Surfaces, Anterior	No	$0
D2335	Resin-Based Composite, Four or More Surfaces, Involving Incisal Angle	No	$0
D2391	Resin-Based Composite - One Surface, Posterior	No	$0
D2392	Resin-Based Composite - Two Surfaces, Posterior	No	$0
D2393	Resin-Based Composite - Three Surfaces, Posterior	No	$0
D2394	Resin-Based Composite, Four or More Surfaces, Posterior	No	$0
D2740	Crown	No	$0
D2750	Crown	No	$0
D2751	Crown	No	$0
D2752	Crown	No	$0

COMPREHENSIVE

Code	Procedure Description	Prior Authorization Required	Copay Amount
ENDODONTICS			
D3310	Root Canal	No	$0
D3320	Root Canal	No	$0
D3330	Root Canal	No	$0
PERIODONTICS			
D4355	Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis on a Subsequent Visit	No	$0
D4341	Periodontal Scaling and Root Planing - Per Quadrant (4 or More Teeth)	No	$0
D4342	Periodontal Scaling and Root Planing - Per Quadrant (1 to 3 Teeth)	No	$0
D4910	Periodontal Maintenance Procedures - Following Active Surgery	No	$0
ORAL AND MAXILLOFACIAL SURGERY			
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	No	$0
D7210	Extraction, Erupted Tooth Requiring Removal of Bone and/or Sectioning of Tooth, and Including Elevation of Mucoperiosteal Flap if Indicated	No	$0
D7220	Removal of Impacted Tooth, Soft tissue	No	$0
D7230	Removal of Impacted Tooth, Partially bony	No	$0
D7240	Removal of Impacted Tooth, Completely Bony	No	$0
D7241	Removal of Impacted Tooth, Complication	No	$0
D7250	Removal of Residual Tooth Roots (Cutting Procedure)	No	$0
REMOVABLE PROSTHODONTICS			
D5110	Complete Denture, Maxillary	Yes	$0
D5120	Complete Denture, Mandibular	Yes	$0
D5130	Immediate Denture, Maxillary	Yes	$0
D5140	Immediate Denture, Mandibular	Yes	$0
D5211	Maxillary Partial Denture, Resin Base	Yes	$0
D5212	Mandibular Partial Denture, Resin Base	Yes	$0
D5213	Maxillary Partial Denture, Cast Metal, Resin Base	Yes	$0

COMPREHENSIVE

Code	Procedure Description	Prior Authorization Required	Copay Amount
REMOVABLE PROSTHODONTICS CONT.			
D5214	Mandibular Partial Denture, Cast Metal, Resin Base	Yes	$0
D5225	Maxillary Partial Denture, Flexible Base	Yes	$0
D5226	Mandibular Partial Denture, Flexible Base	Yes	$0
D5730	Reline Complete Maxillary Denture (Chairside)	No	$0
D5731	Reline Complete Mandibular Denture (Chairside)	No	$0
D5740	Reline Maxillary Partial Denture (Chairside)	No	$0
D5741	Reline Mandibular Partial Denture (Chairside)	No	$0
D5750	Reline Complete Maxillary Denture (Laboratory)	No	$0
D5751	Reline Complete Mandibular Denture (Laboratory)	No	$0
D5760	Reline Maxillary Partial Denture (Laboratory)	No	$0
D5761	Reline Mandibular Partial Denture (Laboratory)	No	$0
NON-ROUTINE SERVICES*			
D9215	Local Anesthesia In Conjunction With Operative or Surgical Procedures	No	$0
D9222	Deep Sedation/General Anesthesia, Initial 15 Minutes	No	$0
D9223	Deep Sedation/General Anesthesia – Each Subsequent 15 Minute Increment	No	$0
D9230	Inhalation of Nitrous Oxide/Analgesia, Anxiolysis	No	$0
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia, Initial 15 Minutes	No	$0
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia – Each Subsequent 15 Minute Increment	No	$0

Using Your Benefits and Services

Ultimate Health Plans partners with vendors to provide benefit services, including dental, vision, hearing, fitness, over-the-counter (OTC) supplies, meals, and transportation. When you visit a dental provider, tell them your insurance is Aflac through Ultimate Health Plans. When you visit a vision provider, tell them your insurance is Premier Eye Care through Ultimate Health Plans.

Member Services **1-888-657-4170 (TTY 711)**

October 1 - March 31: Monday - Sunday, 8 am - 8 pm
April 1 - September 30: Monday - Friday, 8 am - 8 pm

American Specialty Health	Acupuncture & Chiropractic	American Specialty Health	888-577-0055
beacon health options	Behavioral Health	Beacon Health Options www.beaconhealthoptions.com/find-a-provider/	800-627-1259
	MDLive – Telemedicine	Beacon Health Options www.mdlive.com	855-849-3650
Aflac Benefits Solutions	Dental	Aflac Benefits Solutions www.aflacbenefitssolutions.com	800-340-8869
SilverSneakers	Gym Benefit	SilverSneakers www.silversneakers.com	888-423-4632
20/20 Hearing Care Network	Hearing	20/20 Hearing www.2020hearingnetwork.com/	800-313-2763
papa	In-Home Support	Papa Pals	800-348-7951
LabCorp Laboratory Corporation of America	Laboratory Provider	LabCorp www.labcorp.com	800-845-6167
MOM'S MEALS	Meal Delivery	Ultimate Member Services	888-657-4170
Carenet Health Engaging. For the better.	Nurse Hotline - 24/7	Carenet Health	855-238-4687
SOLUTRAN	Over-the-Counter (OTC) Healthy Food, & Flex Cards	Solutran www.healthybenefitsplus.com/chooseultimate	855-422-0039
OPTUMRx	Prescription Drug Benefit - 24/7	OptumRx www.optumrx.com/members	800-311-7517
	Prescription Mail Order	OptumRx Pharmacy Refills & Questions	877-889-6358
WTS Wheelchair Transport Service	Transportation	Wheelchair Transport Service	855-306-0700
PREMIER EYE CARE	Vision	Premier Eye Care providerdirectory.premiereyecare.net/	800-210-5511

Personalized Healthcare at Your Fingertips, 24/7, With Our Easy and Convenient Member Portal

How to Enroll

- Have your red, white, and blue Medicare ID Card or proof of eligibility ready.
- If enrolling in one of our Dual Special Needs Plans (D-SNP), you will need your Medicaid ID Card or proof of eligibility.
- Select a Primary Care Physician (PCP).
- You can find in-network PCPs through our Provider & Pharmacy Directory. We will mail you a printed copy. Visit our website at https://chooseultimate.com/Home/FindDoctor to find a digital copy and our online lookup tool.
- Complete our paper enrollment application or visit https://chooseultimate.com/Home/EnrollNow to enroll online.

You can also use our Formulary to look up your prescription drugs. We will mail you a printed copy. Visit https://chooseultimate.com/Home/PrescriptionDrugs to find a digital copy.

Your agent can assist you with these steps and answer any questions you may have. If you would like to find a local agent, please call us at 1-855-858-7526 (TTY 711).

Your Important Information

Agent Name: _____

Agent Telephone Number: _____

Plan Name: _____

Plan Benefit Package (PBP) Number: _____

Enrollment Confirmation Number: _____

Effective Date: _____

Network PCP Name: _____

Network PCP Phone Number: _____

Network PCP Office Address: _____

Have Additional Questions?

- ✓ Check Your Plan's Evidence of Coverage or Summary of Benefits
- ✓ Visit a Community Outreach Office
- ✓ Visit our Website at www.ChooseUltimate.com
- ✓ Call Member Services at **1-888-657-4170 (TTY 711)**

We are open 8:00 am to 8:00 pm, Monday through Friday. Between October 1 and March 31, we are available Monday through Sunday from 8:00 am to 8:00 pm.

NOTES

Community Outreach Offices

4058 Tampa Rd, STE 7
Oldsmar, FL 34677

600 N US Hwy 1, STE A
Fort Pierce, FL 34950

17820 SE 109th Ave, STE 103
Summerfield, FL 34491

2713 Forest Rd
Spring Hill, FL 34606

To learn more, call

1-855-858-7526 (TTY 711)

October 1 - March 31:
Monday - Sunday, 8 am - 8 pm

April 1 - September 30:
Monday - Friday, 8 am - 8 pm

Like us on: facebook

Visit our website at
www.ChooseUltimate.com