

2023



Summary of Benefits

Citrus | Hernando | Pasco

Citrus

- 021 Advantage Care by Ultimate (HMO C-SNP)
- 022 Advantage Care CHF by Ultimate (HMO C-SNP)
- 023 Advantage Care COPD by Ultimate (HMO C-SNP)

Hernando

- 019-1 Advantage Care by Ultimate (HMO C-SNP)
- 024 Advantage Care CHF by Ultimate (HMO C-SNP)
- 025 Advantage Care COPD by Ultimate (HMO C-SNP)

Pasco

- 019-2 Advantage Care by Ultimate (HMO C-SNP)
- 024 Advantage Care CHF by Ultimate (HMO C-SNP)
- 025 Advantage Care COPD by Ultimate (HMO C-SNP)



ULTIMATE
HEALTH PLANS

Good health is where you live.

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, Manatee, Marion, Orange, Osceola, Pasco, Pinellas, Polk, Sarasota, Seminole, 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 Care by Ultimate (HMO C-SNP), Advantage Care COPD by Ultimate (HMO C-SNP), and Advantage Care CHF by Ultimate (HMO C-SNP) plans. 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 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.

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, be diagnosed with a qualifying chronic condition, and live in the plan's service area.

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.

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.

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Important Message About What You Pay for Insulin - You won't pay more than \$10 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

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.

Plan Name	Advantage Care by Ultimate (HMO C-SNP) 019-1	Advantage Care by Ultimate (HMO C-SNP) 019-2	Advantage Care CHF by Ultimate (HMO C-SNP) 024	Advantage Care COPD by Ultimate (HMO C-SNP) 025
Service Area	Hernando	Pasco	Hernando & Pasco	Hernando & Pasco
Special Needs Plan Eligibility Criteria	Diagnosed with Diabetes and/or Cardiovascular Disorders	Diagnosed with Diabetes and/or Cardiovascular Disorders	Diagnosed with Chronic Heart Failure	Diagnosed with Chronic Lung Disorders

Plan Name	Advantage Care by Ultimate (HMO C-SNP) 021	Advantage Care CHF by Ultimate (HMO C-SNP) 022	Advantage Care COPD by Ultimate (HMO C-SNP) 023
Service Area	Citrus	Citrus	Citrus
Special Needs Plan Eligibility Criteria	Diagnosed with Diabetes and/or Cardiovascular Disorders	Diagnosed with Chronic Heart Failure	Diagnosed with Chronic Lung Disorders

Your Benefits and Cost-Sharing

Premiums and Benefits	Advantage Care by Ultimate (HMO C-SNP) 019-1 & 019-2	Advantage Care CHF by Ultimate (HMO C-SNP) 024	Advantage Care COPD by Ultimate (HMO C-SNP) 025
Monthly Plan Premium	\$0	\$0	\$0
Part B Premium Reduction	\$164.90	\$164.90	\$164.90
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 <i>(does not include prescription drugs)</i>	\$1,750	\$1,750	\$1,750
Inpatient Hospital Coverage	\$50 copay per day for days 1 through 5 \$0 copay per day for days 6 through 90	\$50 copay per day for days 1 through 5 \$0 copay per day for days 6 through 90	\$60 copay per day for days 1 through 5 \$0 copay per day for days 6 through 90
Outpatient Hospital Coverage	\$50 copay	\$50 copay	\$70 copay
Ambulatory Surgery Center (ASC) Services	\$25 copay	\$25 copay	\$25 copay

Your Benefits and Cost-Sharing

Advantage Care by Ultimate (HMO C-SNP) 021	Advantage Care CHF by Ultimate (HMO C-SNP) 022	Advantage Care COPD by Ultimate (HMO C-SNP) 023	What You Need to Know
\$0	\$0	\$0	You must continue to pay your Medicare Part B Premium.
\$164.90	\$164.90	\$164.90	
This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.	
\$1,700	\$1,700	\$2,600	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.
\$70 copay per day for days 1 through 5 \$0 copay per day for days 6 through 90	\$70 copay per day for days 1 through 5 \$0 copay per day for days 6 through 90	\$115 copay per day for days 1 through 5 \$0 copay per day for days 6 through 90	Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. A prior authorization is required for some services.
\$95 copay	\$95 copay	\$150 copay	A prior authorization is required for some services.
\$25 copay	\$25 copay	\$25 copay	A referral and prior authorization may be required for some services.

Your Benefits and Cost-Sharing			
Premiums and Benefits	Advantage Care by Ultimate (HMO C-SNP) 019-1 & 019-2	Advantage Care CHF by Ultimate (HMO C-SNP) 024	Advantage Care COPD by Ultimate (HMO C-SNP) 025
Doctor Visits <i>(Primary Care Providers and Specialists)</i>	Primary Care Providers • \$0 copay Specialists • \$5 copay	Primary Care Providers • \$0 copay Specialists • \$5 copay	Primary Care Providers • \$0 copay Specialists • \$7 copay
Preventive Care	\$0 copay	\$0 copay	\$0 copay
Emergency Care	In the United States • \$60 copay Worldwide • \$100 copay	In the United States • \$60 copay Worldwide • \$100 copay	In the United States • \$75 copay Worldwide • \$100 copay
Urgently Needed Services	\$10 copay	\$10 copay	\$10 copay

Your Benefits and Cost-Sharing			
Advantage Care by Ultimate (HMO C-SNP) 021	Advantage Care CHF by Ultimate (HMO C-SNP) 022	Advantage Care COPD by Ultimate (HMO C-SNP) 023	What You Need to Know
Primary Care Providers • \$0 copay Specialists • \$10 copay	Primary Care Providers • \$0 copay Specialists • \$10 copay	Primary Care Providers • \$0 copay Specialists • \$20 copay	A referral or prior authorization is required for some services. A separate copay may apply for each additional service received at an office visit.
\$0 copay	\$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.
In the United States • \$70 copay Worldwide • \$100 copay	In the United States • \$70 copay Worldwide • \$100 copay	In the United States • \$50 copay Worldwide • \$100 copay	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care in the U.S. and its territories. We pay up to \$50,000 for covered emergency services received outside the U.S. and its territories.
\$10 copay	\$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.

Your Benefits and Cost-Sharing			
Premiums and Benefits	Advantage Care by Ultimate (HMO C-SNP) 019-1 & 019-2	Advantage Care CHF by Ultimate (HMO C-SNP) 024	Advantage Care COPD by Ultimate (HMO C-SNP) 025
Diagnostic Services, Labs, and Imaging at a Free-standing Facility or in an Office <ul style="list-style-type: none"> • Lab services • Outpatient x-rays • Diagnostic tests and procedures • Diagnostic radiological services 	Lab Services and X-Rays <ul style="list-style-type: none"> • 20% coinsurance for Genetic Testing • \$0 copay for all other labs and x-rays 	Lab Services and X-Rays <ul style="list-style-type: none"> • 20% coinsurance for Genetic Testing • \$0 copay for all other labs and x-rays 	Lab Services and X-Rays <ul style="list-style-type: none"> • 20% coinsurance for Genetic Testing • \$0 copay for all other labs and x-rays
	Diagnostic Tests and Procedures <ul style="list-style-type: none"> • \$0 copay for Colonoscopy, Endoscopy and other diagnostic, “scopic” procedures, Pulmonary Function Tests, Thyroid Function Tests • \$50 copay for Sleep Studies, Psychological Tests 	Diagnostic Tests and Procedures <ul style="list-style-type: none"> • \$0 copay for Colonoscopy, Endoscopy and other diagnostic, “scopic” procedures, Pulmonary Function Tests, Thyroid Function Tests • \$50 copay for Sleep Studies, Psychological Tests 	Diagnostic Tests and Procedures <ul style="list-style-type: none"> • \$0 copay for Colonoscopy, Endoscopy and other diagnostic, “scopic” procedures, Pulmonary Function Tests, Thyroid Function Tests • \$50 copay for Sleep Studies, Psychological Tests
	Diagnostic Radiological Services <ul style="list-style-type: none"> • \$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 	Diagnostic Radiological Services <ul style="list-style-type: none"> • \$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 	Diagnostic Radiological Services <ul style="list-style-type: none"> • \$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

Your Benefits and Cost-Sharing			
Advantage Care by Ultimate (HMO C-SNP) 021	Advantage Care CHF by Ultimate (HMO C-SNP) 022	Advantage Care COPD by Ultimate (HMO C-SNP) 023	What You Need to Know
Lab Services and X-Rays <ul style="list-style-type: none"> • 20% coinsurance for Genetic Testing • \$0 copay for all other labs and x-rays 	Lab Services and X-Rays <ul style="list-style-type: none"> • 20% coinsurance for Genetic Testing • \$0 copay for all other labs and x-rays 	Lab Services and X-Rays <ul style="list-style-type: none"> • 20% coinsurance for Genetic Testing • \$0 copay for all other labs and x-rays 	A prior authorization is required for some services. All services performed at an outpatient hospital facility are subject to the outpatient hospital copayment.
Diagnostic Tests and Procedures <ul style="list-style-type: none"> • \$0 copay for Colonoscopy, Endoscopy and other diagnostic, “scopic” procedures, Pulmonary Function Tests, Thyroid Function Tests • \$50 copay for Sleep Studies, Psychological Tests 	Diagnostic Tests and Procedures <ul style="list-style-type: none"> • \$0 copay for Colonoscopy, Endoscopy and other diagnostic, “scopic” procedures, Pulmonary Function Tests, Thyroid Function Tests • \$50 copay for Sleep Studies, Psychological Tests 	Diagnostic Tests and Procedures <ul style="list-style-type: none"> • \$0 copay for Colonoscopy, Endoscopy and other diagnostic, “scopic” procedures, Pulmonary Function Tests, Thyroid Function Tests • \$50 copay for Sleep Studies, Psychological Tests 	
Diagnostic Radiological Services <ul style="list-style-type: none"> • \$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 	Diagnostic Radiological Services <ul style="list-style-type: none"> • \$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 	Diagnostic Radiological Services <ul style="list-style-type: none"> • \$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 	

Your Benefits and Cost-Sharing			
Premiums and Benefits	Advantage Care by Ultimate (HMO C-SNP) 019-1 & 019-2	Advantage Care CHF by Ultimate (HMO C-SNP) 024	Advantage Care COPD by Ultimate (HMO C-SNP) 025
Diagnostic Services, Labs, and Imaging at an Outpatient Hospital <ul style="list-style-type: none"> • Lab services • Outpatient x-rays • Diagnostic tests and procedures • Diagnostic radiological services 	Lab Services and X-Rays <ul style="list-style-type: none"> • 20% coinsurance for Genetic Testing • \$50 copay for all other labs and x-rays 	Lab Services and X-Rays <ul style="list-style-type: none"> • 20% coinsurance for Genetic Testing • \$50 copay for all other labs and x-rays 	Lab Services and X-Rays <ul style="list-style-type: none"> • 20% coinsurance for Genetic Testing • \$70 copay for all other labs and x-rays
	Diagnostic Tests and Procedures <ul style="list-style-type: none"> • \$50 copay for Colonoscopy, Endoscopy and other diagnostic, “scopic” procedures, Pulmonary Function Tests, Thyroid Function Tests • \$50 copay for Sleep Studies, Psychological Tests 	Diagnostic Tests and Procedures <ul style="list-style-type: none"> • \$50 copay for Colonoscopy, Endoscopy and other diagnostic, “scopic” procedures, Pulmonary Function Tests, Thyroid Function Tests • \$50 copay for Sleep Studies, Psychological Tests 	Diagnostic Tests and Procedures <ul style="list-style-type: none"> • \$70 copay for Colonoscopy, Endoscopy and other diagnostic, “scopic” procedures, Pulmonary Function Tests, Thyroid Function Tests • \$70 copay for Sleep Studies, Psychological Tests
	Diagnostic Radiological Services <ul style="list-style-type: none"> • \$50 copay for Ultrasounds and Echocardiography • \$50 copay for Stress, Nerve Conduction, CT, MRI • \$75 copay for CTA, MRA, PET, SPECT, other nuclear medicine tests 	Diagnostic Radiological Services <ul style="list-style-type: none"> • \$50 copay for Ultrasounds and Echocardiography • \$50 copay for Stress, Nerve Conduction, CT, MRI • \$75 copay for CTA, MRA, PET, SPECT, other nuclear medicine tests 	Diagnostic Radiological Services <ul style="list-style-type: none"> • \$70 copay for Ultrasounds and Echocardiography • \$70 copay for Stress, Nerve Conduction, CT, MRI • \$75 copay for CTA, MRA, PET, SPECT, other nuclear medicine tests
Hearing Services	\$0 copay for <ul style="list-style-type: none"> • Routine hearing exam (1 every year) • Hearing aid fitting and evaluation (1 every year) • Hearing aids 	\$0 copay for <ul style="list-style-type: none"> • Routine hearing exam (1 every year) • Hearing aid fitting and evaluation (1 every year) • Hearing aids 	\$0 copay for <ul style="list-style-type: none"> • Routine hearing exam (1 every year) • Hearing aid fitting and evaluation (1 every year) • Hearing aids
	Our plan pays up to \$2,000 (\$1,000 per hearing aid, per ear) every year.	Our plan pays up to \$2,000 (\$1,000 per hearing aid, per ear) every year.	Our plan pays up to \$2,000 (\$1,000 per hearing aid, per ear) every year.

Your Benefits and Cost-Sharing			
Advantage Care by Ultimate (HMO C-SNP) 021	Advantage Care CHF by Ultimate (HMO C-SNP) 022	Advantage Care COPD by Ultimate (HMO C-SNP) 023	What You Need to Know
Lab Services and X-Rays <ul style="list-style-type: none"> • 20% coinsurance for Genetic Testing • \$95 copay for all other labs and x-rays 	Lab Services and X-Rays <ul style="list-style-type: none"> • 20% coinsurance for Genetic Testing • \$95 copay for all other labs and x-rays 	Lab Services and X-Rays <ul style="list-style-type: none"> • 20% coinsurance for Genetic Testing • \$150 copay for all other labs and x-rays 	A prior authorization is required for some services. All services performed at an outpatient hospital facility are subject to the outpatient hospital copayment.
Diagnostic Tests and Procedures <ul style="list-style-type: none"> • \$95 copay for Colonoscopy, Endoscopy and other diagnostic, “scopic” procedures, Pulmonary Function Tests, Thyroid Function Tests • \$95 copay for Sleep Studies, Psychological Tests 	Diagnostic Tests and Procedures <ul style="list-style-type: none"> • \$95 copay for Colonoscopy, Endoscopy and other diagnostic, “scopic” procedures, Pulmonary Function Tests, Thyroid Function Tests • \$95 copay for Sleep Studies, Psychological Tests 	Diagnostic Tests and Procedures <ul style="list-style-type: none"> • \$150 copay for Colonoscopy, Endoscopy and other diagnostic, “scopic” procedures, Pulmonary Function Tests, Thyroid Function Tests • \$150 copay for Sleep Studies, Psychological Tests 	
Diagnostic Radiological Services <ul style="list-style-type: none"> • \$95 copay for Ultrasounds and Echocardiography • \$95 copay for Stress, Nerve Conduction, CT, MRI • \$95 copay for CTA, MRA, PET, SPECT, other nuclear medicine tests 	Diagnostic Radiological Services <ul style="list-style-type: none"> • \$95 copay for Ultrasounds and Echocardiography • \$95 copay for Stress, Nerve Conduction, CT, MRI • \$95 copay for CTA, MRA, PET, SPECT, other nuclear medicine tests 	Diagnostic Radiological Services <ul style="list-style-type: none"> • \$150 copay for Ultrasounds and Echocardiography • \$150 copay for Stress, Nerve Conduction, CT, MRI • \$150 copay for CTA, MRA, PET, SPECT, other nuclear medicine tests 	
\$0 copay for <ul style="list-style-type: none"> • Routine hearing exam (1 every year) • Hearing aid fitting and evaluation (1 every year) • Hearing aids 	\$0 copay for <ul style="list-style-type: none"> • Routine hearing exam (1 every year) • Hearing aid fitting and evaluation (1 every year) • Hearing aids 	\$0 copay for <ul style="list-style-type: none"> • Routine hearing exam (1 every year) • Hearing aid fitting and evaluation (1 every year) • Hearing aids 	Services must be rendered by a participating provider in the Plan's hearing vendor network. Members will be provided a selection of manufacturers of hearing aids from which to choose.
Our plan pays up to \$2,000 (\$1,000 per hearing aid, per ear) every year.	Our plan pays up to \$2,000 (\$1,000 per hearing aid, per ear) every year.	Our plan pays up to \$2,000 (\$1,000 per hearing aid, per ear) every year.	

Your Benefits and Cost-Sharing			
Premiums and Benefits	Advantage Care by Ultimate (HMO C-SNP) 019-1 & 019-2	Advantage Care CHF by Ultimate (HMO C-SNP) 024	Advantage Care COPD by Ultimate (HMO C-SNP) 025
Dental Services <ul style="list-style-type: none"> Preventive dental services Comprehensive dental services Medicare-covered non-routine dental services 	\$0 copay for <ul style="list-style-type: none"> 1 oral evaluation every 6 months 1 cleaning every 6 months 1 fluoride treatment every 6 months 2 dental x-rays every year 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 Unlimited simple and surgical necessary extractions to fit dentures 1 root canal per year Dentures may include 1 of the following per arch every 5 years: <ul style="list-style-type: none"> 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 Maxillary or mandibular denture relines (1 per year) 	\$0 copay for <ul style="list-style-type: none"> 1 oral evaluation every 6 months 1 cleaning every 6 months 1 fluoride treatment every 6 months 2 dental x-rays every year 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 Unlimited simple and surgical necessary extractions to fit dentures 1 root canal per year Dentures may include 1 of the following per arch every 5 years: <ul style="list-style-type: none"> 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 Maxillary or mandibular denture relines (1 per year) 	\$0 copay for <ul style="list-style-type: none"> 1 oral evaluation every 6 months 1 cleaning every 6 months 1 fluoride treatment every 6 months 2 dental x-rays every year 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 Unlimited simple and surgical necessary extractions to fit dentures 1 root canal per year Dentures may include 1 of the following per arch every 5 years: <ul style="list-style-type: none"> 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 Maxillary or mandibular denture relines (1 per year)

Your Benefits and Cost-Sharing			
Advantage Care by Ultimate (HMO C-SNP) 021	Advantage Care CHF by Ultimate (HMO C-SNP) 022	Advantage Care COPD by Ultimate (HMO C-SNP) 023	What You Need to Know
\$0 copay for <ul style="list-style-type: none"> 1 oral evaluation every 6 months 1 cleaning every 6 months 1 fluoride treatment every 6 months 2 dental x-rays every year 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 	\$0 copay for <ul style="list-style-type: none"> 1 oral evaluation every 6 months 1 cleaning every 6 months 1 fluoride treatment every 6 months 2 dental x-rays every year 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 	\$0 copay for <ul style="list-style-type: none"> 1 oral evaluation every 6 months 1 cleaning every 6 months 1 fluoride treatment every 6 months 2 dental x-rays every year 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 Unlimited simple and surgical necessary extractions to fit dentures 1 root canal per year Dentures may include 1 of the following per arch every 5 years: <ul style="list-style-type: none"> 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 Maxillary or mandibular denture relines (1 per year) 	X-rays may include: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Extraction, erupted tooth, or exposed root Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth Surgical extractions may include: <ul style="list-style-type: none"> Removal of impacted tooth Removal of residual tooth roots (cutting procedure) Additional Coverage: <ul style="list-style-type: none"> Medically necessary nonroutine dental services, as covered by Original Medicare Necessary anesthesia with covered service Some services may require prior authorization.

Your Benefits and Cost-Sharing			
Premiums and Benefits	Advantage Care by Ultimate (HMO C-SNP) 019-1 & 019-2	Advantage Care CHF by Ultimate (HMO C-SNP) 024	Advantage Care COPD by Ultimate (HMO C-SNP) 025
Vision Services <ul style="list-style-type: none"> • Eye exams • Eyewear and Contact Lenses 	Our plan covers <ul style="list-style-type: none"> • 1 routine eye exam per year • Exam(s) to diagnose and treat diseases and conditions of the eye 	Our plan covers <ul style="list-style-type: none"> • 1 routine eye exam per year • Exam(s) to diagnose and treat diseases and conditions of the eye 	Our plan covers <ul style="list-style-type: none"> • 1 routine eye exam per year • Exam(s) to diagnose and treat diseases and conditions of the eye
	\$0 copay for <ul style="list-style-type: none"> • Exam with an Optometrist \$0 copay for <ul style="list-style-type: none"> • Exam with an Ophthalmologist 	\$0 copay for <ul style="list-style-type: none"> • Exam with an Optometrist \$0 copay for <ul style="list-style-type: none"> • Exam with an Ophthalmologist 	\$0 copay for <ul style="list-style-type: none"> • Exam with an Optometrist \$0 copay for <ul style="list-style-type: none"> • Exam with an Ophthalmologist
	Our plan provides a yearly benefit limit of up to a \$300 retail value for eyewear: \$0 copay for <ul style="list-style-type: none"> • Contact lenses OR • 1 pair of standard single vision, bifocal or trifocal eyeglass lenses AND/OR • 1 eyeglass frame 	Our plan provides a yearly benefit limit of up to a \$300 retail value for eyewear: \$0 copay for <ul style="list-style-type: none"> • Contact lenses OR • 1 pair of standard single vision, bifocal or trifocal eyeglass lenses AND/OR • 1 eyeglass frame 	Our plan provides a yearly benefit limit of up to a \$300 retail value for eyewear: \$0 copay for <ul style="list-style-type: none"> • Contact lenses OR • 1 pair of standard single vision, bifocal or trifocal eyeglass lenses AND/OR • 1 eyeglass frame
	Our plan offers the following upgrades per year: \$50 copay for <ul style="list-style-type: none"> • Standard progressive lenses 	Our plan offers the following upgrades per year: \$50 copay for <ul style="list-style-type: none"> • Standard progressive lenses 	Our plan offers the following upgrades per year: \$50 copay for <ul style="list-style-type: none"> • Standard progressive lenses
	\$40 copay for <ul style="list-style-type: none"> • 1 additional pair of prescription sunglasses from a set selection with polarized (grey or brown) lenses OR \$30 copay for <ul style="list-style-type: none"> • Photochromic lenses 	\$40 copay for <ul style="list-style-type: none"> • 1 additional pair of prescription sunglasses from a set selection with polarized (grey or brown) lenses OR \$30 copay for <ul style="list-style-type: none"> • Photochromic lenses 	\$40 copay for <ul style="list-style-type: none"> • 1 additional pair of prescription sunglasses from a set selection with polarized (grey or brown) lenses OR \$30 copay for <ul style="list-style-type: none"> • Photochromic lenses
	Post-cataract surgery benefits include: <ul style="list-style-type: none"> • 1 frame from a set selection of frames AND/OR • Standard single vision, bifocal, or trifocal eyeglass lenses • Instead of eyewear, you may select contact lenses up to the yearly benefit limit 	Post-cataract surgery benefits include: <ul style="list-style-type: none"> • 1 frame from a set selection of frames AND/OR • Standard single vision, bifocal, or trifocal eyeglass lenses • Instead of eyewear, you may select contact lenses up to the yearly benefit limit 	Post-cataract surgery benefits include: <ul style="list-style-type: none"> • 1 frame from a set selection of frames AND/OR • Standard single vision, bifocal, or trifocal eyeglass lenses • Instead of eyewear, you may select contact lenses up to the yearly benefit limit

Your Benefits and Cost-Sharing			
Advantage Care by Ultimate (HMO C-SNP) 021	Advantage Care CHF by Ultimate (HMO C-SNP) 022	Advantage Care COPD by Ultimate (HMO C-SNP) 023	What You Need to Know
Our plan covers <ul style="list-style-type: none"> • 1 routine eye exam per year • Exam(s) to diagnose and treat diseases and conditions of the eye 	Our plan covers <ul style="list-style-type: none"> • 1 routine eye exam per year • Exam(s) to diagnose and treat diseases and conditions of the eye 	Our plan covers <ul style="list-style-type: none"> • 1 routine eye exam per year • Exam(s) to diagnose and treat diseases and conditions of the eye 	<ul style="list-style-type: none"> • The per-year benefit amount may be applied to lenses only, frame only, or to both. • Standard eyeglass lenses include: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Option to select Prescription Sunglasses with Polarized (Grey or Brown) Lenses from a special frame selection OR Photochromic Lenses. • Contact lens fitting is not a covered benefit.
\$0 copay for <ul style="list-style-type: none"> • Exam with an Optometrist \$0 copay for <ul style="list-style-type: none"> • Exam with an Ophthalmologist 	\$0 copay for <ul style="list-style-type: none"> • Exam with an Optometrist \$0 copay for <ul style="list-style-type: none"> • Exam with an Ophthalmologist 	\$0 copay for <ul style="list-style-type: none"> • Exam with an Optometrist \$0 copay for <ul style="list-style-type: none"> • Exam with an Ophthalmologist 	
Our plan provides a yearly benefit limit of up to a \$200 retail value for eyewear: \$0 copay for <ul style="list-style-type: none"> • Contact lenses OR • 1 pair of standard single vision, bifocal or trifocal eyeglass lenses AND/OR • 1 eyeglass frame 	Our plan provides a yearly benefit limit of up to a \$200 retail value for eyewear: \$0 copay for <ul style="list-style-type: none"> • Contact lenses OR • 1 pair of standard single vision, bifocal or trifocal eyeglass lenses AND/OR • 1 eyeglass frame 	Our plan provides a yearly benefit limit of up to a \$200 retail value for eyewear: \$0 copay for <ul style="list-style-type: none"> • Contact lenses OR • 1 pair of standard single vision, bifocal or trifocal eyeglass lenses AND/OR • 1 eyeglass frame 	
Our plan offers the following upgrades per year: \$50 copay for <ul style="list-style-type: none"> • Standard progressive lenses 	Our plan offers the following upgrades per year: \$50 copay for <ul style="list-style-type: none"> • Standard progressive lenses 	Our plan offers the following upgrades per year: \$50 copay for <ul style="list-style-type: none"> • Standard progressive lenses 	
\$40 copay for <ul style="list-style-type: none"> • 1 additional pair of prescription sunglasses from a set selection with polarized (grey or brown) lenses OR \$30 copay for <ul style="list-style-type: none"> • Photochromic lenses 	\$40 copay for <ul style="list-style-type: none"> • 1 additional pair of prescription sunglasses from a set selection with polarized (grey or brown) lenses OR \$30 copay for <ul style="list-style-type: none"> • Photochromic lenses 	\$40 copay for <ul style="list-style-type: none"> • 1 additional pair of prescription sunglasses from a set selection with polarized (grey or brown) lenses OR \$30 copay for <ul style="list-style-type: none"> • Photochromic lenses 	
Post-cataract surgery benefits include: <ul style="list-style-type: none"> • 1 frame from a set selection of frames AND/OR • Standard single vision, bifocal, or trifocal eyeglass lenses • Instead of eyewear, you may select contact lenses up to the yearly benefit limit 	Post-cataract surgery benefits include: <ul style="list-style-type: none"> • 1 frame from a set selection of frames AND/OR • Standard single vision, bifocal, or trifocal eyeglass lenses • Instead of eyewear, you may select contact lenses up to the yearly benefit limit 	Post-cataract surgery benefits include: <ul style="list-style-type: none"> • 1 frame from a set selection of frames AND/OR • Standard single vision, bifocal, or trifocal eyeglass lenses • Instead of eyewear, you may select contact lenses up to the yearly benefit limit 	

Your Benefits and Cost-Sharing			
Premiums and Benefits	Advantage Care by Ultimate (HMO C-SNP) 019-1 & 019-2	Advantage Care CHF by Ultimate (HMO C-SNP) 024	Advantage Care COPD by Ultimate (HMO C-SNP) 025
Mental Health Services • Inpatient hospital stay • Outpatient group therapy visits • Outpatient individual therapy visits	\$50 copay per day for days 1 through 5	\$50 copay per day for days 1 through 5	\$60 copay per day for days 1 through 5
	\$0 copay per day for days 6 through 90	\$0 copay per day for days 6 through 90	\$0 copay per day for days 6 through 90
	\$5 copay for group therapy visits \$5 copay for individual therapy visits	\$5 copay for group therapy visits \$5 copay for individual therapy visits	\$7 copay for group therapy visits \$7 copay for individual therapy visits
Skilled Nursing Facility (SNF)	\$0 copay per day for days 1 through 20	\$0 copay per day for days 1 through 20	\$0 copay per day for days 1 through 20
	\$120 copay per day for days 21 through 38	\$120 copay per day for days 21 through 38	\$150 copay per day for days 21 through 38
	\$0 copay per day for days 39 through 100	\$0 copay per day for days 39 through 100	\$0 copay per day for days 39 through 100
Physical Therapy • Physical therapy visit • Speech-language pathology services • Occupational therapy visit	\$10 copay copay per visit • Physical therapy • Speech-language pathology \$10 copay per visit • Occupational therapy	\$10 copay copay per visit • Physical therapy • Speech-language pathology \$10 copay per visit • Occupational therapy	\$7 copay copay per visit • Physical therapy • Speech-language pathology \$7 copay per visit • Occupational therapy
Ambulance	\$150 copay for Medicare-covered one-way ground ambulance benefit	\$150 copay for Medicare-covered one-way ground ambulance benefit	\$150 copay for Medicare-covered one-way ground ambulance benefit
	20% coinsurance for Medicare-covered one-way air ambulance benefit	20% coinsurance for Medicare-covered one-way air ambulance benefit	20% coinsurance for Medicare-covered one-way air ambulance benefit

Your Benefits and Cost-Sharing			
Advantage Care by Ultimate (HMO C-SNP) 021	Advantage Care CHF by Ultimate (HMO C-SNP) 022	Advantage Care COPD by Ultimate (HMO C-SNP) 023	What You Need to Know
\$70 copay per day for days 1 through 5	\$70 copay per day for days 1 through 5	\$115 copay per day for days 1 through 5	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 6 through 90	\$0 copay per day for days 6 through 90	\$0 copay per day for days 6 through 90	
\$10 copay for group therapy visits \$10 copay for individual therapy visits	\$10 copay for group therapy visits \$10 copay for individual therapy visits	\$10 copay for group therapy visits \$20 copay for individual therapy visits	
\$0 copay per day for days 1 through 20	\$0 copay per day for days 1 through 20	\$0 copay per day for days 1 through 20	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.
\$150 copay per day for days 21 through 38	\$150 copay per day for days 21 through 38	\$150 copay per day for days 21 through 38	
\$0 copay per day for days 39 through 100	\$0 copay per day for days 39 through 100	\$0 copay per day for days 39 through 100	
\$10 copay copay per visit • Physical therapy • Speech-language pathology \$10 copay per visit • Occupational therapy	\$10 copay copay per visit • Physical therapy • Speech-language pathology \$10 copay per visit • Occupational therapy	\$30 copay copay per visit • Physical therapy • Speech-language pathology \$30 copay per visit • Occupational therapy	Services performed at an outpatient hospital facility are subject to the outpatient hospital copayment. A referral or prior authorization may be required for some services.
\$150 copay for Medicare-covered one-way ground ambulance benefit	\$150 copay for Medicare-covered one-way ground ambulance benefit	\$150 copay for Medicare-covered one-way ground ambulance benefit	Except in an emergency, this service may require prior authorization.
20% coinsurance for Medicare-covered one-way air ambulance benefit	20% coinsurance for Medicare-covered one-way air ambulance benefit	20% coinsurance for Medicare-covered one-way air ambulance benefit	

Your Benefits and Cost-Sharing			
Premiums and Benefits	Advantage Care by Ultimate (HMO C-SNP) 019-1 & 019-2	Advantage Care CHF by Ultimate (HMO C-SNP) 024	Advantage Care COPD by Ultimate (HMO C-SNP) 025
Transportation	\$0 copay for unlimited trips	\$0 copay for unlimited trips	\$0 copay for unlimited trips
Medicare Part B Drugs	20% coinsurance for <ul style="list-style-type: none"> Medicare Part B chemotherapy drugs Part B medications and contrast agents injected during a service Other Part B drugs 	20% coinsurance for <ul style="list-style-type: none"> Medicare Part B chemotherapy drugs Part B medications and contrast agents injected during a service Other Part B drugs 	20% coinsurance for <ul style="list-style-type: none"> Medicare Part B chemotherapy drugs Part B medications and contrast agents injected during a service Other Part B drugs
Foot Care (<i>podiatry services</i>) Medicare-covered foot exams and treatment	\$5 copay	\$5 copay	\$7 copay
Wellness Program <ul style="list-style-type: none"> SilverSneakers® Fitness Program Health Education Additional Smoking and Tobacco Use Cessation 	\$0 copay	\$0 copay	\$0 copay
Over-the-Counter (OTC)	Up to \$75 every month	Up to \$75 every month	Up to \$75 every month

Your Benefits and Cost-Sharing			
Advantage Care by Ultimate (HMO C-SNP) 021	Advantage Care CHF by Ultimate (HMO C-SNP) 022	Advantage Care COPD by Ultimate (HMO C-SNP) 023	What You Need to Know
\$0 copay for unlimited trips	\$0 copay for unlimited trips	\$0 copay for unlimited trips	Our plan covers health-related transports to any plan approved location. Please call 855-306-0700 (TTY 711) 72 hours in advance to schedule your trip. Please have the following information readily available if applicable: <ul style="list-style-type: none"> Appointment or expected arrival date and time Address of destination Destination phone number If visiting a provider, the name of physician or practitioner
20% coinsurance for <ul style="list-style-type: none"> Medicare Part B chemotherapy drugs Part B medications and contrast agents injected during a service Other Part B drugs 	20% coinsurance for <ul style="list-style-type: none"> Medicare Part B chemotherapy drugs Part B medications and contrast agents injected during a service Other Part B drugs 	20% coinsurance for <ul style="list-style-type: none"> 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.
\$10 copay	\$10 copay	\$20 copay	A referral is required.
\$0 copay	\$0 copay	\$0 copay	
Up to \$75 every month	Up to \$75 every month	Up to \$75 every month	The benefit amount does not roll over from month to month.

Your Benefits and Cost-Sharing			
Premiums and Benefits	Advantage Care by Ultimate (HMO C-SNP) 019-1 & 019-2	Advantage Care CHF by Ultimate (HMO C-SNP) 024	Advantage Care COPD by Ultimate (HMO C-SNP) 025
In-Home Support Service • Papa Pals	\$0 copay for companion and caregiver support services	\$0 copay for companion and caregiver support services	\$0 copay for companion and caregiver support services
Special Supplemental Benefits for the Chronically Ill • Ultimate Benefit Card	Up to \$75 every month	Up to \$75 every month	Up to \$75 every month
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% coinsurance for • Durable Medical Equipment (DME) • Prosthetics \$0 copay for • Diabetes monitoring supplies \$0 copay for • Diabetes self-management training \$0 copay for • Diabetic shoes	20% coinsurance for • Durable Medical Equipment (DME) • Prosthetics \$0 copay for • Diabetes monitoring supplies \$0 copay for • Diabetes self-management training \$0 copay for • Diabetic shoes	20% coinsurance for • Durable Medical Equipment (DME) • Prosthetics 0% coinsurance for • Oxygen \$0 copay for • Diabetes monitoring supplies \$0 copay for • Diabetes self-management training \$0 copay for • Diabetic shoes

Your Benefits and Cost-Sharing			
Advantage Care by Ultimate (HMO C-SNP) 021	Advantage Care CHF by Ultimate (HMO C-SNP) 022	Advantage Care COPD by Ultimate (HMO C-SNP) 023	What You Need to Know
\$0 copay for companion and caregiver support services	\$0 copay for companion and caregiver support services	\$0 copay for companion and caregiver support services	Services include but are not limited to companionship, house tasks, transportation, and help with technology. Please call 888-884-3614 (TTY 711) for assistance.
Up to \$75 every month	Up to \$75 every month	Up to \$75 every month	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, you must have a qualifying chronic condition.
\$0 copay	\$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% coinsurance for • Durable Medical Equipment (DME) • Prosthetics \$0 copay for • Diabetes monitoring supplies \$0 copay for • Diabetes self-management training \$0 copay for • Diabetic shoes	20% coinsurance for • Durable Medical Equipment (DME) • Prosthetics \$0 copay for • Diabetes monitoring supplies \$0 copay for • Diabetes self-management training \$0 copay for • Diabetic shoes	20% coinsurance for • Durable Medical Equipment (DME) • Prosthetics 0% coinsurance for • Oxygen \$0 copay for • Diabetes monitoring supplies \$0 copay for • Diabetes self-management training \$0 copay for • 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 5 "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 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 **\$10** copay for a one-month supply of 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 \$4,660. Not everyone will enter the coverage gap. If you enter the coverage gap, our plans continue to cover drugs in **Tier 1 Generic and Tier 5 Select Care Drugs**. For drugs in **Tier 1 and 5** you pay the copay amounts shown in the prescription drug chart. Additionally, during the coverage gap stage, your out-of-pocket costs for a one-month supply of select insulins will be **\$10**.

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 \$7,400, 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.

Cost-Sharing may change depending on the pharmacy you choose (i.e., network, out of network, mail order, long-term care, home infusion, etc.), the day's 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 (LTC) facility and use an 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.

Save even more with MAIL ORDER

You can save more by using Ultimate Health Plans' Mail Order Pharmacy Service! You'll receive a three-month supply of medication delivered straight to your door and pay the same copay that you would normally pay for a two-month supply at your local pharmacy.

Outpatient Prescription Drugs

Plans		Advantage Care by Ultimate (HMO C-SNP) 019-1, 019-2		
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 Coverage Stage				
Tier 1	\$0	\$0	\$0	\$0
Tier 2	\$10	\$30	\$20	\$10
Tier 3	\$50	\$150	\$100	\$50
Tier 4	33% coinsurance	Not Covered	Not Covered	33% coinsurance
Tier 5	\$10	\$30	\$20	\$10
Coverage Gap Stage				
Tier 1	\$0	\$0	\$0	\$0
Tier 5	\$10	\$30	\$20	\$10

Plans		Advantage Care by Ultimate (HMO C-SNP) 021 Advantage Care CHF by Ultimate (HMO C-SNP) 022 Advantage Care COPD by Ultimate (HMO C-SNP) 023		
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 Coverage Stage				
Tier 1	\$0	\$0	\$0	\$0
Tier 2	\$20	\$60	\$40	\$20
Tier 3	\$60	\$180	\$120	\$60
Tier 4	33% coinsurance	Not Covered	Not Covered	33% coinsurance
Tier 5	\$10	\$30	\$20	\$10
Coverage Gap Stage				
Tier 1	\$0	\$0	\$0	\$0
Tier 5	\$10	\$30	\$20	\$10

Plans		Advantage Care CHF by Ultimate (HMO C-SNP) 024 Advantage Care COPD by Ultimate (HMO C-SNP) 025		
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 Coverage Stage				
Tier 1	\$0	\$0	\$0	\$0
Tier 2	\$10	\$30	\$20	\$10
Tier 3	\$50	\$150	\$100	\$50
Tier 4	33% coinsurance	Not Covered	Not Covered	33% coinsurance
Tier 5	\$10	\$30	\$20	\$10
Coverage Gap Stage				
Tier 1	\$0	\$0	\$0	\$0
Tier 5	\$10	\$30	\$20	\$10

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

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit www.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.
- ☐ Review the formulary to make sure your drugs are covered.

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/coinsurance 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 chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.
- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

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, 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
 - 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
 - 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, 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: PO 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>.

Ultimate Health Plans' Multi-Language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-657-4170 (TTY: 711). Someone who speaks English or the needed language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-657-4170 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-888-657-4170 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-888-657-4170 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-657-4170 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-657-4170 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-888-657-4170 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelman. Unsere Dolmetscher erreichen Sie unter 1-888-657-4170 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-657-4170 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-657-4170 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-888-657-4170 (برقياً: 117). سيقوم شخص بمساعدتك. هذه خدمة مجانية ما يتحدث العربية

Hindi: हमारे स्वास्थ्य या दवा योजना के बारे में आपके किसी भी प्रश्न का उत्तर देने के लिए हमारे पास मुफ्त दुभाषाया सेवाएं हैं। दुभाषाया प्राप्त करने के लिए, बस हमें 1-888-657-4170 (TTY: 711) पर कॉल करें। कोई हद्दी बोलने वाला आपकी मदद कर सकता है। यह एक नःशुल्क सेवा है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-657-4170 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-657-4170 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-657-4170 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-657-4170 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご利用になるには、1-888-657-4170 (TTY: 711) にお電話ください。日本語を話す人 者が支援いたします。これは無料のサービスです。

Gujarati: અમારા સ્વાસ્થ્ય અથવા દવાના યાજના વાશે તમારા કોઇપણ પ્રશ્નનાના જવાબ આપવા માટે અમારા પાસે મફત દુભાષણ સેવાઓ છે. દુભાષણ મેળવવા માટે, અમને 1-888-657-4170 (TTY: 711) પર કોલ કરો. ગુજરાતી બોલતી વ્યક્તિતમને મદદ કરી શકે છે. આ એક મફત સેવા છે.

Thai: เรามีบริการล่ามฟรีเพื่อตอบคำถามที่คุณอาจมีเกี่ยวกับสุขภาพหรือแผนยาของเรา หากต้องการล่าม เพียงโทรหาเราที่ 1-888-657-4170 (TTY: 711) คนที่พูดภาษาไทยสามารถช่วยคุณได้ นี่เป็นบริการฟรี

To learn more, call
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